

**TOWARDS A RELATIONAL UNDERSTANDING OF
EMBODIED THERAPEUTIC RELATIONSHIPS: A
QUALITATIVE STUDY OF BODY-FOCUSED
PRACTITIONERS' EXPERIENCES**

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Abstract

This study aimed to further our understanding of embodied therapeutic relationships within counselling psychology.

Theoretical challenges to the influence of Cartesian dualism on Western medicine and therapeutic practices that led to a largely disembodied view of the mind are reviewed with regard to the embodied nature of subjectivity, and the importance counselling psychologists place on relating to clients within the therapeutic relationship. The need for a reauthorisation of the body as an essential part of the therapeutic relationship is proposed.

A series of four case studies of the lived experience of practitioners of body-focused therapies working in complementary healthcare was conducted, using an interpretive phenomenological analysis (IPA) approach. This aimed to explore potential aspects of embodied relating not widely considered by talking therapists.

Three core areas were identified that constituted the three superordinate themes of: *'Embodied awareness and sense of personhood'*, *'Intersubjectivity and authentic use of self'* and *'Mind-body connection, disconnection and reconnection'*.

These analyses are discussed in relation to relatively recent research findings in neuroscience, developmental psychology and the application of attachment theory and current developments in relational approaches to psychotherapy that champion embodied therapeutic relationships. Implications for counselling psychology training and practice are identified.

Key words: embodied therapeutic relationships, body-focused therapies complementary healthcare, interpretive phenomenological analysis, neuroscience, attachment theory, relational approaches to psychotherapy.

Reflective Premise for researching Embodied Therapeutic Relationships

When I began my studies in Counselling Psychology I was working as a Counsellor in a residential rehabilitation centre for alcohol and drug addiction. Here adult male and female residents received medical detoxification and health monitoring from qualified nursing staff, had daily therapeutic input and gained peer support from their fellow residents. My role involved facilitating individual and group therapy within a therapeutic community (TC) model (Roberts, 1997) that incorporated aspects of the Alcoholics Anonymous 12-step programme (Alcoholics Anonymous, 1955), cognitive therapy (Beck, 1993; Wenzel, Liese, Beck, & Friedman-Wheeler, 2012) psychodynamic (Flores, 1997) existential and interactional psychotherapy (Matano & Yalom, 1991) within its integrative perspective.

In this setting, emphasis was placed on treating the whole person in the initiation of recovery from drug and alcohol (chemical) dependency. Physical symptoms of withdrawal, medical consequences of abuse, personal neglect and anti-social behaviours were addressed in an environment that offered emotional support, care and encouragement. The TC model provided an holistic mode of treatment that could be seen as a mind-body approach in the way that talking therapy was prioritised alongside activities such as walks in the countryside or on the beach, yoga, resident's personal reflective time, regular meal times and shared domestic responsibilities. It was the norm for therapeutic hugs to be exchanged between clients and staff at the end of every therapy session. Just as I became aware of noting the changes in clients' bodies as they became chemical free, I looked for bodily signs of peer empathy and identification when I facilitated group therapy and clients shared their experiences. In my individual sessions I was conscious of how emotions were expressed non-verbally by my clients and felt by me, as illustrated in the following example.

A female client who I had been working with for several weeks disclosed she had used drugs throughout her pregnancy and had pretended she wanted the child to please her boyfriend. She told me that when she went into hospital to give birth she had used drugs as soon as the baby was born as it was quickly taken to the

special care unit for treatment for neonatal withdrawal symptoms. As she began telling me this in my therapy room, she was sat facing me in the chair opposite. She talked slowly but deliberately and as she recounted the painful details tears began to fall down her cheeks; she dropped her gaze and I could no longer see her face as her hair covered up her shame. She couldn't look at me but continued to face herself as she carried on with her story. I couldn't see her face but sensed her tears were still flowing as I noted the tremble in her voice and felt my eyes watering and a pain in my chest. As if it wasn't enough not to face me as she talked she turned her body away from me as well until by the time she stopped speaking she was a contorted figure in the chair facing the wall behind her.

There was a mixture of feelings felt and expressed that followed. For the client she talked of fearing my reaction and I surmised she anticipated being despised, disregarded and admonished. As this didn't happen the contortion in her body released its hold and she was able to look at me again. For me I felt immense sadness and empathy but also a heaviness in my body until there had been sufficient resolution in the client that meant she left the room looking how I felt – still sad but also relieved and lighter.

When I left the addiction centre I went to work as a trainee Forensic Psychologist in the psychology department of a Category B adult male prison. Category B prisons accommodate prisoners for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult (Prisoners' Advice Service, 2014). Consequently, the level of security this implies meant there was a very distinct culture change in my working environment.

At that time therapeutic interventions in prison were predominantly based on the philosophy of manualised cognitive behavioural therapy (CBT) group interventions referred to as 'programmes' that emerged from the 'What Works' agenda (McGuire, 1995). In response to the call to tackle recidivism, these programmes were designed to interrupt and change old patterns of behaviour as a means of curtailing re-offending in relation to acquisitive crime, violent and sexual offences and problematic drug and alcohol use amongst offenders. A didactic teaching approach was stipulated in this setting that focused on specified treatment

objectives and rated outcomes, which involved the group facilitators being video-monitored in each session. This left no scope for flexibility or diversity in the use of CBT or use of aspects of any other therapeutic model, and I found that very different and difficult to adjust to.

However, my previous experience within the addiction centre meant that I was able to provide one-to-one therapy for prisoners presenting with mental health and emotional difficulties. But the constraints of the prison environment meant that my mode of therapy delivery was very different. There were no dedicated therapeutic spaces instead therapy rooms were converted cells on prison accommodation wings or at best medical treatment rooms on the hospital wing. For security reasons doors were never completely shut and I had to ensure that I positioned myself by the alarm button in the room and closer to the exit than the client. This obvious and purposely constructed interpersonal distance was further pronounced by the censured use of touch. There were no therapeutic hugs in this environment. The professional protocol was to shake hands with the prisoner when you first met them and then again after the total number of therapy sessions were complete. Often the duration of the therapy was quite brief i.e. 8-10 sessions but sometimes I worked with clients over a lengthy timeframe for example 12 -18 months. Any embodied sense of the therapeutic relationship in this context was gained from a non-bodily contact perspective.

During my time as a trainee Forensic Psychologist I completed my MSc in Counselling Psychology. I had a longstanding interest in the therapeutic relationship and this was the topic I chose to investigate for the research component of the MSc. My research sample was taken from clients who had been in one-to-one therapy with me in either the addiction centre or the prison. Using a mixed methods approach I administered the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989) to all the participants. Based on Bordin's (1980) pantheoretical, tripartite (bonds, goals, and tasks) conceptualization of the therapeutic alliance, my use of this quantitative measure indicated the 'bond' within the therapeutic relationship was most important for these individuals. I then conducted semi-structured interviews with a small selection of the participants asking them what was personally important or memorable about the relationship

they had formed with me as their therapist. I analysed their responses using the qualitative approach of grounded theory. The results revealed client perceptions of trustworthiness and being non-judgemental as significant factors in the relationship.

One participant, a prisoner I had worked with for nineteen months commented that after feeling judged all his life he hadn't felt judged for anything he had told me, for the offence he had committed (arson and attempted murder) or the way he looked (he had extensive burn scarring on his face and hands incurred during the offence). I remember the initial handshake at the beginning of my therapeutic work with this man being awkward and embarrassing as I hadn't realised his hands were fire scarred. I was shocked by the look and feel of them and then concerned whether this may have caused him pain, whether he saw my shock and how he may have interpreted this.

As he began his therapy, his disfigurement became part of the discourse. Medically, he had a series of hospital appointments regarding treatment plans including plastic surgery. Psychologically, he talked of his ambivalence about going to these appointments. Now clean of alcohol and drugs and further along in the grieving process than when he committed the offence (he was mourning the loss of his relationship with his wife and contact with their two sons), he no longer felt suicidal and vengeful for his wife leaving him. He felt remorseful and self punishing. As the therapy progressed, he did attend the appointments and whilst his medical treatment eased some of the physical pain he experienced, the cosmetic changes were slight and unkindly, derogatory reference to his appearance was often made by others.

By the time my therapy came to an end with this client I was well accustomed, and perhaps conditioned, in terms of the limited bodily contact of initial and end session handshakes. I hadn't given it much thought when I went to see him for the last time. I felt a little sad but very glad that he had done well and pleased that he was moving on with his life as well as his prison sentence (he was moving to a lower category prison). Inevitably, he took this opportunity to thank me for the work I had done with him. Most often with my prison clients this would be a genuine but

brief statement of thanks and appreciation but in this case, perhaps because of the unusually lengthy timeframe, the client spoke of it being important to him not just because it helped him 'sort his head out' but because he had felt accepted and not judged. As he held out his hand to shake mine, I held out mine to reciprocate but then changed my mind (and my body) and gave him a hug instead. It was a split second decision; it felt appropriate as a handshake seemed an inadequate acknowledgement of his expressed emotion, and it was received as it was intended.

Although I remained clear of the authentic demonstration of my embodied response, I later doubted the appropriateness of my use of touch in this instance and in this environment and I talked about it in my next supervision session. I had kept the same supervisor that I had had when I was working in the addiction centre. As he listened to me relay the details of how this happened and the anxiety of my reaction to it, he reminded me of how at ease I was with giving therapeutic hugs in my previous job and invited me to reflect on the difference.

Having since completed my MSc in Counselling Psychology and qualified in Forensic Psychology I now work in private practice and although I combine my counselling and forensic practice I no longer work in any type of institution. But from my experience of doing so, I have great respect for what each of them taught me in relation to how therapy can be delivered and received in demanding residential settings.

In each of the examples of my therapeutic practice I have given here, I cannot say what my clients' impressions were of how their body and mine became a part of the therapeutic relationship. At the time it never occurred to me to ask them, it was just part of the therapeutic process we were in. As I gained more experience as a psychologist and therapist I maintained my interest in the relationship between therapists and their clients. As I began to become increasingly curious of the role the body has to play in the therapeutic relationship, this therefore seemed a natural choice of research topic for this Doctorate study.

One of the settings I work in now is a complementary health care clinic where most of my colleagues practice some form of bodywork. Querying the embodied

nature of the therapeutic relationship led to the more specific question of what can I (and counselling psychologists in general) learn from bodywork practitioners regarding the role of the body in the therapeutic relationship?

Introduction

This thesis qualitatively explores the accounts practitioners of body-focused therapies gave of how they experienced their therapeutic relationships, within the context of complementary health care practice in the South of England.

The lack of consistency on how the body has been viewed in counselling psychology (Wolfe, Dryden & Strawbridge, 2003) has resulted in the embodied nature of the therapeutic relationship being a much under-researched area in this field of therapeutic practice.

Specifying the embodied nature of the therapeutic relationship implies there is an alternative position of a disembodied therapeutic relationship; and in turn therefore, a split between attention placed on what happens between client and therapist in the therapeutic encounter as a meeting of (disembodied) minds (Mollen, 2014), and that of a meeting of bodies. Commenting on this, Shaw (2003) refers to the body as occupying a peculiar space within the therapeutic encounter as if psychotherapists are unsure where to locate it, or even whose body to concentrate on - the client's or the therapist's?

An historical overview of how the body has been represented in psychotherapy highlights the impact mind-body dualism has had on psychotherapeutic culture that has subsequently resulted in difficulties integrating bodily phenomena into psychotherapy practice. Credited to the 17th century French philosopher Rene Descartes, the premise of mind and body as separate entities, which do not co-exist in unity, has perpetuated a long-standing and pervasive convention within the arena of health and wellbeing in Western society (Bayer and Malone, 1998). Certainly the way the development of Western medicine promoted mind-body dualism as an alternative to the previously held Christian orthodox views of human being as spiritual beings combining body and soul as one, greatly thwarted the development of medical science (Metha, 2011). The rise of positivism and the scientific method based on empirical observation and measurement also served to strengthened this position (Hart, 1985).

It follows therefore that as a Western cultural practice, psychotherapy was also been highly influenced by these principles. Indeed, the founders of many models of psychotherapy such as Freud, Jung, Reich and Adler in the psychoanalytical tradition (McLeod, 1997), Wolpe with regard to behaviour therapy and Ellis in terms of cognitive behaviour therapy, (Prochaska & Norcross, 2007) all had medical backgrounds. Paradoxically, it is well known that at the very inception of psychotherapy (psychoanalysis) Freud interacted with his analysands' bodies (Totten, 2002) and it is cogently argued that drive theory is in fact a theory of how bodily impulses are received and transformed through their psychic representations (Totten, 1998, 2014). However, following his theoretical stance of the ego harnessing the impulses of the id like a rider guiding a horse (Freud, 1933) Freud's move towards analysing and interpreting the rational mind, set the scene for a move away from an explicit focus on the body in the development of mainstream psychotherapy practice, that has largely been perpetuated across modalities to date (Sykes Wylie, 2013).

In sum Cartesian dualism laid down the position that a person is viewed as living through two histories of events; that of the physical world comprising of what happens in and to the body and that of the mental world concerning the function of the mind (Ryle, 1949, 2002). The way in which this dictated history in Western society can be seen in how, with the exception of psychiatry, the medical profession seized the body to work on and left the mind to the developing field of psychotherapy. Connelly (2013) commented on the dangers inherent in continuing to adhere to such a dualistic approach: "that fails to take into account the way in which the mind and the psyche are shaped by our embodied corporeal experiences" (Connolly, 2013:636) and that "can cloud our perception, skew our theoretical conceptualizations and even distort our clinical work" (McDougall, 1995:157)

In a challenge to this, Merleau-Ponty's phenomenological enquiry into the nature of perception provides a non-dualistic framework that conceptualises the body as a 'lived body' or intersubjective presence, reuniting mind and body based on his premise that: "it is through my body that I understand other people" (Merleau-Ponty, 1962:186). The implication this has for talking therapy, and counselling

psychology in particular, is that the therapeutic endeavour can be acknowledged as an embodied encounter, requiring authorisation of client and therapist subjectivities and relationships and attention to be paid to the body as well as the mind in pursuit of psychological healing and change.

Until relatively recently only a few studies had gone some way towards theorising and exploring the therapeutic relationship as an embodied relationship (see Boardella, 1997, Kepner, 1993, 2003), offering an alternative conceptualisation of how the therapeutic encounter can be understood and utilised to greater effect within psychotherapy. However, with these primarily focusing on the client's body alone, not that of the psychotherapist or how the two interact (Rumble, 2009; Shaw, 2003), consideration of the embodied therapeutic relationship within psychotherapy has tended to be viewed as an 'optional extra' means of therapists gaining information about their clients' psychological processes (Totten, 2015). As such it has remained relatively marginal to the core themes of talking therapy. Moreover, when the therapist's bodily experiences have been considered, these have generally been explained as the identification of embodied representations of psychodynamic concepts such as countertransference or projective identification (Field, 1989; McDougal, 1993; Ross, 2000; Stone, 2006) and thus located back with the client.

In an attempt to redress this under theorising of the role the body plays in co-constructing experience and shaping our internal worlds within psychotherapeutic practice (Orbach, 2004), there has been a move for the therapist's body to be viewed as a relational subjectivity in its own right, and as an active participant in the therapeutic interaction alongside the client's body (Diamond, 2001; Orbach, 2006; Rumble, 2010; Shaw, 2003). This change of stance has emerged in response to the current advances in research such as those with regard to neuroscience (see Corzolino, 2014; Porges, 2011; Shore, 2012) infant research within developmental psychology (Trevarthen, 2004; Bateman & Fonagy, 2011) and specifically attachment theory (Bowlby, 1969; Harlow, 1958) and its relevance to relational psychotherapy (Beebe et al 2003; Beebe & Lachmann, 2013) that has shown how the mutual influence and regulation between parent and infant is reproduced within the adult therapeutic relationship (White, 2014).

This has had a marked impact on how the body is acknowledged within clinical practice. Such as shaping psychotherapeutic work with trauma (van der Kolk, 1994, 2005, 2015; Rothschild, 2003, 2010) that recognises the client's embodied experience as central to the pursuit of therapeutic awareness. For example, in eye movement desensitisation and reprocessing (EMDR) (Shapiro, 2001) and Sensorimotor psychotherapy (Ogden, 2014; Ogden, Minton, & Pain, 2006) cognitive and dynamic techniques are combined with somatic approaches that incorporate mindfulness awareness of bodily sensations. These therapeutic modalities address the way in which the body has been shown to hold traumatic memories in its physicality as well as in the mind that are viewed as "potentially disrupting and blocking the effective healing of traumatic relational injuries within the therapeutic relationship" (White, 2004: xvii).

Recognition of the centrality of the body in such approaches has steered a sea change towards the acknowledgement of the importance of the body, as well as the mind, in the field of psychotherapy (Carroll, 2003, 2014) that has seen the emergence of greater integration between therapists (White, 2014). This is perhaps most evident between the field of 'mainstream' psychotherapy developed from psychoanalysis (Freud, 1940; 1964) that followed dualistic thinking and the field of body psychotherapy pioneered by Wilhelm Reich (1972) that works against the split between body and mind by addressing the implications and meaning of bodily expressions (Eiden, 1999).

This is illustrated in the description Carroll (2014) gives of how she utilises aspects of both her body psychotherapy training and common approaches to psychotherapy in her adaptation of Stephen Mitchell's (2000) model of four modes of relating in psychotherapy. Carroll redefines these as the four different lenses of: procedural organisation (observable aspects of the client's and therapist's body such as posture, gestures, vocabulary etc.), affect regulation (emotions felt, explored and deconstructed within therapy), self-other configuration (the symbolic aspects of the client-therapist relationship historically understood as transference and countertransference) and intersubjectivity within the therapeutic relationship seen as the way in which "the therapist's body and the client's body act as both resource and container for mutual meeting" (Carroll, 2014:14). Carroll views these

lenses as a multi-dimensional means of attending to the body that is applicable not just to all relational approaches to psychotherapy but to creative human relationships in general.

Similarly, at the heart of embodied relational psychotherapy or ERT (Totten, 2005; Totten & Priestman, 2012) is the premise that two of the key aspects of being human are that we are all 'embodied and relational' beings, and hence the exploration of one within the therapeutic relationship entails the exploration of the other. Therefore, "our theory of the therapeutic relationship needs to be remade from the ground up as a fully embodied account - not just of body psychotherapy but of *all* psychotherapy" (Totten, 2015: xviii). This increased acknowledgement of the body, or more specifically the bodies in the consulting room, together with the now widespread acceptance that the therapeutic relationship in talking therapy both provides a facilitative environment for specific change and is therapeutic in and of itself (Greenberg, 2014; Miller, 2012; Weerassekera, et al, 2001), highlights the scope to deepen our understanding of how embodied therapeutic relationships are experienced within psychotherapy.

From a practitioner perspective, there are an increasing number of psychotherapists and body psychotherapists accounts of embodied relating within their therapeutic practice that consider their bodies alongside the bodies of their clients. For example, in his experiences of working with people with learning and physical disabilities Linington (2014), talks of having a sense of his body and the body of his client being brought into the therapeutic encounter in a more mutually intersubjective way. For example he recalls how he became aware of his own changing thoughts and embodied feelings when a particular client expressed their envy of his able (unlike his own disabled) body. Similarly, in her re-evaluation of the concept of countertransference to include bodily symptoms alongside mental representation Orbach (2006) expressed curiosity as to what therapeutic value her body could offer her clients.

Referencing Bessel van der Kolk's seminal article entitled '*The Body Keeps the Score*' regarding trauma and embodied memory, Erskine (2014: 25) disclosed how his body kept an unconscious 'score' of his childhood trauma that he only became

aware of through his own experience of music therapy. Describing himself not as a body psychotherapist but as “a psychotherapist who focuses on the body and the unconscious stories requiring resolution”, Erskine outlines his use of bodywork alongside talking therapy (such as aspects of Art therapy, movement and dance therapy), which like music therapy work with pre-symbolic and procedural memories.

As an adjunct to these accounts, and since it is the body that has previously been overshadowed or omitted from such considerations, I propose that questioning practitioners who work primarily with the body may add a further perspective to the developing picture of embodied relating within psychotherapy that is currently emerging. It is anticipated therefore, that analysis of how embodied therapeutic relationships are experienced by body-focused practitioners may hold valuable insights for talking therapy and specifically counselling psychology. Given the exploratory and interpretive nature of the study, a purposeful sample of four bodywork practitioners working in complementary healthcare was chosen, within a collective case study design, aimed to increase understanding of the phenomenon (Stake, 2000). As such, conclusions drawn from the research findings have the potential to enhance psychotherapeutic practice to include more embodied ways of working with and relating to clients.

Terminology and Definitions

Body-focused Practitioners

I have used the term body-focused practitioners as an overarching term to differentiate between those practitioners who concentrate on talking therapies and prioritise verbal interactions in their therapeutic practice as opposed to those who concentrate on working therapeutically with the body. Within this study, all of the participants were considered to be body-focused practitioners as they each practiced a form of bodywork. This is based on the definition of bodywork as a central theme in complementary and alternative medicine (CAM) (Sointu 2006) that may involve the practitioner assessing, diagnosing, handling, treating, manipulating and monitoring the bodies of others (Twigg et al, 2011).

To clarify the use of terminology within this thesis, I have used the terms 'body-focused practitioner/therapist', 'bodywork practitioner/therapist', 'body-focused practice/therapy' and 'bodywork' interchangeably.

Talking Therapies

Talking therapy, as opposed to bodywork, is a generic term used to describe a variety of approaches within the field of counselling and psychotherapy where trained practitioners work with people to effect positive change and enhanced well-being (BACP, 2010).

To clarify the use of terminology within this thesis, I have used 'talking therapy', 'psychological therapy', 'psychotherapy' and 'counselling' interchangeably in reference to therapeutic interventions that concentrates on the verbal exchange between the therapist and their clients. The term 'counselling psychology' is used in a more specific way when referring to the researcher's discipline.

Literature Review

Consideration of the expanse of literature relating to the therapeutic relationship in talking therapy has been examined for the purposes of this review. In relation to the current study, the focus has been placed on the importance of the relationship over therapeutic technique and across modalities within talking therapies. This has centred on reviewing how the embodied nature of the therapeutic relationship has been represented in psychotherapy in general and body psychotherapy specifically. The significance of touch was a key aspect of this. In addition the review examined how the therapeutic relationship is viewed within complementary and alternative medicine (CAM) with specific reference to body-focused therapies.

Decades of comparative studies in talking therapies (see Luborsky, Singer & Luborsky, 1975; Luborsky, Crits-Christophe, Alexander, Margolis, and Cohen, 1983; Horvath and Symmonds, 1991; Orlinsky, Grawe, and Parks, 1994; Clarkson, 1996; Teyber, 2000; Lambert and Barley, 2001; Norcross, 2002; Orlinsky, Ronnestad & Willutzki (2004) have indicated little difference in therapeutic effectiveness across models for example: psychodynamic, humanistic, cognitive etc.; even in respect of exploring what works for what conditions (Roth & Fonagy, 2004). In summing up this perennial finding, Haugh and Paul (2008) reiterate Luborsky's original analogy (Luborsky, Singer & Luborsky, 1975) of the Dodo effect (*from Alice in Wonderland*) that: 'All shall be winners and all shall have prizes' (Haugh and Paul, 2008:10). This has increasingly led to the contention that rather than being theory-driven, therapy should be relationship-driven (Yalom, 2003) as regardless of the therapeutic modality: "the work lies in the creative space between, in the relationship" (Clarkson, 2003: xvi) as the relationship is indeed the therapy (Kahn, 2001).

The Therapeutic Relationship within Talking Therapies

The therapeutic relationship has been defined as a both a personal and an impersonal relationship (Strupp and Binder, 1984) that expresses the feelings and attitudes the therapist and client have towards each another (Gelso and Carter,

1985, 1994), in a shared experience of relational reality within the therapeutic encounter (Orlinsky et al., 2004).

The origins of the concept of a therapeutic relationship in psychotherapy can be traced back to the work of Freud (1913/1958) and the development of psychodynamic theory. Freud believed a positive attachment formed between therapist and client as the client associated the 'kindly and accepting' disposition of the therapist with that of loving and supportive authority figures in their past. By projecting positive qualities gleaned from these relationships onto the therapist, in the process known as positive transference, the client endowed the therapist with integrity and authority. This strengthened the client's belief in the therapist's ability to help them and their own ability to face their painful and traumatic experiences within the therapeutic encounter (Horvath, 2000). In addition, issues relating to negative transference (hostile feelings directed towards the therapist by the client) and countertransference (the redirection of a therapist's own feelings towards a client) were seen as giving rise to further analysis and understanding as they emerge within the therapeutic relationship (Howard, 2008).

Later psychoanalytical writers speculated that a real relationship (rather than one built on transference) could emerge from healthy, reality-based interaction between the therapist and the client. For example, Greenson's 'non-neurotic' transference model proposed the client moved back and forth between the unconscious process of positive transference and the conscious process of realistic attachment to the relationship between themselves and the therapist, until neurotic attachment patterns were eventually resolved (Greenson, 1967).

Early forms of behaviour therapy held a different view in terms of both the centrality of the relationship and its development. Stemming from social learning theory and the work of Skinner and Watson (Baum, 2005) emphasis was placed on changing behaviour via the use of techniques rather than the psychoanalytic practice of bringing unconscious material into the client's awareness (Haugh & Paul, 2008). A positive relationship with the behaviour therapist was seen to be as a result of the therapist's effectiveness in bringing about change in the client, rather than the relationship prompting such change. Over time the idea of the

therapeutic relationship gained more prominence within the behavioural therapeutic orientation, as the development of the client's skills and re-structuring of their thoughts, attitudes and behaviour was acknowledged to take place in a dynamic interpersonal context of the therapist-client dyad. Specifically, Horvath (2000) claims most cognitive behaviour therapists now view the relationship as providing a therapeutic milieu of safety and trust that enables the client to learn implement and practice the techniques necessary to promote therapeutic change. For example, a requirement of cognitive therapy for psychosis (CBTp) an adaptation of CBT tailored to the specific needs of people with psychosis, is the fostering of a therapeutic relationship that is genuinely collaborative, empowering, and characterised by explicit warmth, positive regard, and transparency (Johns, Jolley, Keen, & Peters, 2013; Jolley et al., 2015).

A further conceptual shift in the emphasis of the power of the real relationship within the therapeutic endeavour was seen in the work of Carl Rogers (1951, 1957) who proposed the helping relationship in itself holds a strong healing function. This represented a unique and revolutionary position at the time that centred around three main hypotheses: firstly, that the 'core conditions' of empathy, congruence and unconditional positive regard, are both necessary and sufficient for the client to initiate their own healing process; secondly, that the presence of these conditions supports growth and change in all clients irrespective of the theoretical framework adhered to by the therapist; and thirdly, Rogers emphasised it to be the responsibility of the *therapist alone* to provide these necessary conditions for client development (Rogers, 1980). Subsequent theorists in the person-centred field have advocated for these three core conditions to be viewed as a gestalt (Lietaer, 2002; Merry, 2004; Wyatt, 2001) in the same way as hue, brightness and saturation are facets of colour that together culminate in its vividness and impact (Bohart et al, 2002) and constitute what Mearns and Cooper refer to as "the full power of the therapeutic relationship – as manifest at relational depth" (Mearns and Cooper, 2002: 36).

In response to the call for a comprehensive conceptualisation of the relationship across therapeutic orientations, Bordin (1979, 1980) presented a pantheoretical formulation of the therapeutic alliance, consisting of three interactive components

namely the therapeutic bond, tasks and goals. The bond between therapist and client refers to the interpersonal elements of the relationship such as trusting and liking. The goals refer to the consensus between them in terms of what is to be achieved in therapy and the tasks refer to how this should be done (Bordin, 1979). In presenting this Bordin stepped away from the original psychodynamic concept of the working alliance by suggesting that whilst the initial phases of therapy may still be influenced by past relationships and unresolved bonds the alliance was primarily a 'here and now' relationship. Similarly, whilst he agreed with Rogers's concept of the relationship being generic across all helping professions, Bordin saw this as a collaborative venture between therapist and client thus making it a two-way rather than a one-way process.

Clarkson's Five Relationship Modalities

The working alliance is one of the five possible modalities Petruska Clarkson presents in her transtheoretical psychotherapeutic framework conceptualising the client-therapist relationship (Clarkson, 1995, 1996, 2003). Clarkson defines the working alliance as the aspect of the therapeutic encounter that needs to be established in order for the work of therapy to commence. It is described as a powerful joining of forces between the client and therapist that energises and supports the difficult and often painful process of psychotherapy (Bugental, 1987) and is characterised by mutual liking, trust and respect (Brammer and Shostrom, 1968). Psychoanalytic theory conceptualises the working alliance as an implicit or explicit contract between therapist and client (Greenson, 1967). Contracting is also seen across a variety of other approaches stretching from the explicitly rigid parameters of the medical model seen in some cognitive behavioural therapies to the more fluid structure and alternative vocabulary used in the existential perspective, where mutual engagement in the client's existential venture (Merleau-Ponty, 1962) forms the groundwork to make the therapy possible (Clarkson, 2003).

The working alliance is positively correlated with therapeutic change across treatment approaches and irrespective of the clinical issues presented

(Castonguay & Beutler, 2005; Constantino et al., 2002; Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000). It is seen to have a curative quality in its own right as well as being the foundation for specific techniques and is therefore directly and indirectly associated with positive therapy outcome (Horvath, Del Re, Fluckiger & Symonds, 2011).

Clarkson's second modality, *the transference/counter-transferential relationship* is described as "the experience of unconscious wishes and fears transferred onto or into the therapeutic partnership" (Clarkson, 2003:67), and through the replication of past patterns within the therapeutic space, effective resolution is made possible. Despite drawing heavily on psychoanalytic theory, Clarkson views this relationship to be apparent across therapeutic orientations. In her view transference and countertransference phenomena may be invited, resolved, minimised or avoided and pose a threat to the quality of the working alliance that may be disrupted, impaired or destroyed as a result (Clarkson, 2003).

The relevance of the transference/counter-transferential relationship to embodiment and this current study, can be seen in how therapist countertransference can be acted out and noted in the bodily action of the therapist (Plakun, 2007). Examples of such embodied responses to the client are: tiredness, boredom, sadness, sexual arousal, anger and aggression. Familiarity with so called somatic countertransference experiences enables the therapist to extend their range of bodily perceptions, while also increasing their capacity for sensory and emotional containment and for contact with the 'ineffable' experience of the unconscious (Freud, 1915; Bion, 1965/1991; Warnecke, 2009).

The reparative/developmentally needed relationship is concerned with the repair of previously deficient, abusive or over protective parenting experience and the reinstating of healthy developmental processes. Stemming from attachment theory Bowlby (1969/1988) and Bartenieff & Lewis (1980) identify an absence of feeling held in mind (Fonagy, 2000) and a lack of secure infant attachment as having a traumatic impact on mind and body. Whilst the therapist's availability to the client or presence is often considered to be reparative in itself (Clarkson, 2003; Jacobs, 1989), specific examples of this reparative function in psychotherapy are Alice

Miller's advocacy relationship (2005), Winnicott's (1958) holding environment, the reparenting techniques of Schiff et al (1975) and the empathic reflection seen in the person-centred approach (Clarkson, 2003). From an embodiment perspective, it is argued that consistent nurturing behaviour from the primary caregiver mediated through eye contact, rhythm, sound, reciprocity, synchrony and the sensory-motor experience of holding (Meekums, 2002) helps preserve a child's emotional and physical balance. Therefore, this has been seen to support the legitimacy of use of movement and touch within the therapeutic relationship (Manford, 2014).

Clarkson's fourth modality is the *person to person relationship*, otherwise referred to as the I-Thou or I-You relationship (Buber, 1970), the real relationship or the core relationship (Barr, 1987). Clarkson's conceptualisation of the person-to-person relationship is characterised by the therapist's genuine feelings and congruence as opposed to the 'unreal' features of the transference relationship. Hence, rather than the therapeutic relationship being an 'as if' phenomenon that with analysis can facilitate other relationships, it is the therapist's genuine relationship that helps to heal the client (Yalom, 1980). Defined as a dialogic relationship and concerned with authentic humanness shared by client and therapist, the person to person relationship is particularly noted in the humanistic and existential approaches and in ordinary life (Clarkson, 2003).

In addition to theoretical orientation, things that affect the extent to which a person-to-person relationship can develop include the therapist's style, level of maturation and crucially the degree of self awareness (Wade, 1996; Wilber, 2000). In the pursuit of an authentic therapeutic relationship certain writers call for this highly developed level of therapist self awareness and self knowledge to include a focus on issues of embodiment in what they call mind-body unity (Rowan, 2005) or mind/body holism (Vick, 2002) in this way of working.

The *transpersonal relationship* is defined by Petruska Clarkson (2003:20) as:

"The timeless facet of the psychotherapeutic relationship, which is impossible to describe, but refers to the spiritual, mysterious or currently inexplicable dimension of the healing relationship."

Acknowledged in Jungian psychology (Jung, 1940) and within the humanistic/existential approach (Rowan, 1993) this aspect of the therapeutic relationship is theorised as potentially including sacred, religious, spiritual or unconscious connections. Acknowledging these to likely to be quite rare, Clarkson's view is that when they do occur they are transcendent experiences.

Rowan (2005) discusses this in terms of the boundaries between the therapist and client falling away as they occupy the same time and space at what he calls the 'level of the soul' or what Budgell (1995) calls 'linking'. However, Rowan warns that this level of relating to a client requires sophisticated skills such as Wilber refers to as the 'subtle level of psychospiritual development' (Wilber, 2000) or what Mahayana Buddhism calls 'Sambhogakaya' the Buddha body that experiences the fruits of Buddhist practice (Kapleau, 1967). West (2008) contends that spirituality is an inevitable aspect of the therapeutic encounter and whilst it may be in the foreground or in the background 'if it is in the client's life, it will be in the counselling encounter' (West, 2008: 198). The challenge therefore is for the psychotherapist to be aware of this potentiality and to be open to the prospect and prepared to work in this dimension within the parameters of the relationship.

In this transtheoretical framework, each modality is presented as a state rather than a stage in the therapeutic process that may show prominence at different times and overlap within other modalities in each individual client experience. Clarkson suggests each modality is available for constructive use in psychotherapy and needs to be attended to in order for the relationship to provide effective therapist presence and therapeutic process (Clarkson, 2003).

The Role of the Body in the Therapeutic Relationship within Psychotherapy

Existing literature on the focus placed on the body in the therapeutic relationship within psychotherapy was reviewed. This revealed various studies focusing on how the client's body is attended to, particularly in relation to treatment for trauma (Ogden, 2014, Ogden, Minton & Pain, 2006; Van der Kolk, 1994, 2005, 2015) and learning gained from attachment theory (Golding and Hughes, 2012; Rothschild, 2000, 2003, 2010). In contrast, the role of the therapist's body within the

therapeutic relationship has not as yet, been equally explored (Rumble, 2010; Shaw, 2003) with minimal attention paid to what the therapist's body may have to say about how the relationship is experienced. Rather, as a therapeutic resource this embodied response and its interpretation has largely been considered as a lesser adjunct to the therapist's verbal skills and as such the body has been under theorised in terms of the role it plays in constructing experience and shaping our internal worlds (Orbach, 2004).

For example, what has been described as the 'physical embodiment' of receptiveness or conveyance of interest by the therapist (Owen, 2004) only extended to the use of body language and gaze to communicate attention and emotion to the client Cozolino (2004) or non-verbal communication such as the paralinguistic behaviour of head nods or postural structure (Dryden, Horton & Mearns, 1995). Some studies have reported therapists' physical reactions within a therapeutic encounter such as sudden feelings of hunger or tiredness (Field, 1989; Matthew, 1998; McDougal, 1993; Ross, 2000; Samuels, Stone, 2006, Plakun, 2007). These, as Rumble points out have been explained in terms of the psychodynamic concepts such as countertransference or projective identification (Rumble, 2010). The implication therefore, is that after psychotherapeutic interpretation these somatic phenomena experienced in the body of the therapist are relocated to the body of the client. Seeing the limitations of this Shaw (2003) calls for the study of embodiment in the therapist to acknowledge theories about how their body relates to their perceptions of the therapeutic encounter not their clients.

This can be seen to have untold relevance to the study of therapeutic process. For example from a psychodynamic perspective, the lack of inclusion of the therapist's body not only deprives the client of the possibility of understanding and making use of corporeal mirroring but also deprives the therapist of a fundamental therapeutic tool (Connelly, 2013). From a relational perspective, it is acknowledged that within the therapeutic process, clients recreate the same conflicts that brought them to therapy within the therapeutic relationship and, for change to occur they must work through emotionally painful and ingrained relational scenarios with the therapist (Strupp, 1980). When the therapist's

response does not fit the client's old problematic relational schema the opportunity is created for the client to experience the relationship in a different way and for them to develop a new more positive way of relating. Teyber (2000) stresses this to warrant a move away from purely concentrating on the dialogue within psychotherapy:

"In order to work with the process dimension, the therapist must make a perceptual shift away from the overt content of what is discussed and begin to track the relational process of how people are interacting as well."

(Teyber, 2000:15).

The proposition here therefore, is that in order for psychotherapists to effectively help their clients improve their ability to relate to self and others, they must include their own sense of self in this intersubjective process of embodied 'coupling' and sharing of meaning (Diamond, 2001). Rumble (2010) refers to this as the embodied intersubjectivity that forms the background to the dialogue characteristic of the therapeutic encounter, offering the possibility for the therapist to both follow the client's discourse and attend to the significance of their body. What this stresses is the mutual interpersonal nature of body and mind relating, which is encapsulated in Merleau-Ponty's writing:

"As bodies begin to relate, each body's significance takes up residence in that of the other, providing each participant with an inner felt sense of the other's posture (Merleau-Ponty, 1962)"

(Rumble, 2010:132).

Drawing on the ideas of Merleau-Ponty and the phenomenological movement in general, Shaw (2003/ 2004) presents a convincing case for the further inclusion of bodily awareness and consideration within talking therapy. Whilst acknowledging other researchers who have taken forward the idea of therapy as an embodied experience (see Boadella, 1997; Sampson, 1998; Staunton, 2002; Totten, 2003), Shaw presents his own perspective (as a registered osteopath and trained psychotherapist) alongside his research findings. This study involved 90 therapists from the UK and mainland Europe, representing the major schools in

psychotherapy, and found unequivocal support for developing further therapists understanding of bodily sensations and phenomena within the therapeutic encounter.

This can be seen as a reminder perhaps, that *bodies* and not just minds are very present in the therapy room. Ernst and Goodison (1981) hold the view that attending to the body is a crucial part of any therapeutic approach, stating that we *are* our bodies and that as such any changes that occur within our personality are automatically reflected on a physical level as well as an emotional level. However, King (2011) draws attention to the paradox of how little the role of the body has been generally understood in a psychotherapeutic context, yet therapists are:

“Confronted with the body as a metaphor for the whole self; as Freud stated: ‘The ego is first and foremost a bodily ego’ (Freud, 1923:26) so therapy with no body is impossible”.

(King, 2011:156).

This apparent anomaly is maybe best understood by considering how the growth of psychoanalytic theory and practice saw Freud devote himself to developing a conceptual framework of the mind in respect of the body’s drives, which resulted in him becoming increasingly remote from the physical relevance of the body. Exceptions to this can be seen in the interest Melanie Klein paid to the body’s role in forming what she described as ‘categories of experience’ (Klein 1930,1988); in the work of analyst Georg Groddeck who employed the use of deep massage in his practice and spoke of his patients being ‘betrayed’ by their unconscious impulses and involuntary movements: “the patient’s changing expressions reveal hidden secrets of his soul” (Groddeck, 1931/1977:236); and in Sandor Ferenczi’s development of somatic trauma therapy (Totten,1998; Rothschild, 2000).

However, it was William Reich who most notably took forward inclusion of the body in psychotherapy, and who is considered to have founded body psychotherapy as a distinct field of psychotherapy (Totten, 2014). Having been greatly influenced by his association with Sigmund Freud, Reich broke with the psychoanalytic tradition deploring its taboo on the use of touch, its disregard of

body language and the slowness of therapeutic change. Reich introduced both touch and bodywork into the therapeutic process linking this to dynamic principles, believing our childhood experiences to develop within the structure of our bodies. For example the child who was not allowed to cry would learn to tighten their lip muscles and tense their back resulting in this tension becoming a permanent part of their muscle structure so that they develop lines around the mouth and backache later in life. Likewise, the child forced to carry too much responsibility or exposed to an environment in which they were often fearful, would develop rounded shoulders (Ogden, 2014). Ernst and Goodison (1981) comment on how such connections between physical tensions and emotional expression have manifested in our everyday language, for example in phrases such as 'he's got a stiff upper lip' or 'she's got the world on her shoulders'.

Reich argued that the body displayed evidence of a person's history and experience of childhood trauma that built up into a protective 'character armour' (Reich, 1972). He believed the natural energy that normally flowed through the body could become blocked at various points where the body had set up defences to some forbidden impulse or painful trauma. These physical or somatic blocks had a restricting effect on a person's cognitive, emotional and relational functioning (Young, 2007) and so by working on these blocks and releasing the energy, the person might be made more healthy and happy.

Other prominent figures in the field of psychotherapy such as Fritz Perls, Carl Jung and Arnold Mindell also maintained a focus on embodiment within their therapeutic orientation. That is to say, Perls, as the founder of Gestalt therapy emphasised the 'here and now' context of bodywork and the process aspect of the body later developed into Body Process therapy by Kepner (1993). Jung introduced the concept of 'somatic unconscious' to describe the pains, discomforts, tensions, energy constriction, arousal and other embodied feelings experienced by the client (Schwartz-Salant, 1986). And in his development of Process Oriented Psychology, Mindell viewed the client's process as manifesting within and switching between a collection of channels (i.e. thought, vision, hearing, relationship and world/synchronous events) that included awareness of movement and bodily state

via the kinaesthetic and proprioceptive channels (Chodorow, 1991; McNeely, 1987; Totten, 2003).

Whilst body psychotherapy is seen to have a basis of psychoanalytical concepts and techniques, it is most commonly understood to be a form of humanistic psychotherapy. Now referred to as post-Reichian therapies (West, 1994), body therapy includes: Lowen's Bioenergetics therapy (1977), Boadella's ideas of biosynthesis (Boadella, 1988, 1997) and Totten's embodied relational therapy (Totten, 2003, 2005, 2014). The way in which body psychotherapists perceive the relationship between the body and the mind is fundamental to their work, having evolved to a position whereby it integrates a focus on the transference and countertransference positions of the psychodynamic tradition; an emphasis on phenomenology and the here and now immediacy of the gestalt approach and the critical importance of the core conditions of the person-centred and humanistic traditions (Soth, 1999).

Notably, body psychotherapy has in the past been taken less seriously than other forms of psychological therapy being aligned to so called alternative therapies such as primal therapy, re-birthing or shiatsu and seen therefore as a 'fringe' therapy (Staunton, 2002). Body psychotherapy has been accused of trying to reverse the cultural dominance of mind over body by taking a polarised position in the field, seeing the mind as the problem and the body as the solution (Soth, 2005) and as a result has been neither acknowledged nor valued as a legitimate approach to healing alongside the prominence of talking therapies.

However, in an attempt to redress this, the integral-relational approach to body psychotherapy (that combines psychodynamic and humanistic principles) provides a valuable alternative to what has been viewed as an over-reliance on insight, language, reflection and mental understanding within the field of psychotherapy in general (Soth, 2005). Indeed, body psychotherapy has been defined as a therapy for the whole person that might be more accurately defined as 'bodymind psychotherapy' or 'holistic psychotherapy'. Consequently mainstream psychotherapy would effectively be demoted to a status of 'verbal therapy (only)' (Totten, 2003:25). This view fits with a common observation over recent years that

within mainstream psychotherapy an emphasis has been placed on mentally and verbally orientated approaches such as cognitive therapy, problem-orientated brief therapies and systems therapy (Kepner, 1993).

One explanation for this can be found in the way that the body is directly brought into the therapeutic encounter by touch. In talking therapy, this has largely been seen as problematic, contentious or simply taboo due to the fear induced by the question of appropriateness of touching the body within the therapeutic encounter. However, the timely findings from research in neuroscience (Carroll, 2005, 2006, 2009; Corzolino, 2014; Ogden, Minton, & Pain, 2006; Porges, 2011; Shore, 2012) and the pertinence of attachment theory and infant research (Bateman & Fonagy, 2011, Bowlby, 1952, 1957; Harlow, 1958; Trevarthen, 2004) have afforded body psychotherapy renewed support and respect, confirming what body psychotherapists “*have already discovered through direct, often literally hands-on, experience.*” (Totten, 2014:41).

Touch in the Therapeutic Relationship

It is not possible to talk about how the body may be more visibly acknowledged in the therapeutic relationship without mentioning touch. Whilst acknowledging that touch can be experienced as re-traumatising and a violation on the body, it can also be experienced as a genuine display of person-to-person relating, a demonstration of support and compassion or a process of emotional elucidation (Smith, 1998). In what can be viewed as the first established method of treating the body in a psychotherapeutic framework, Reichian therapy advocated the use of touch on the client's body to encourage awareness of how the ‘character defences’ (manifesting in the bodily posture and ‘muscular armouring’ developed in childhood to protect the child from painful emotions) could be released (Leijssen, 2006). Support for this view can be seen in the current advances in the fields of neuroscience (Seigel, 2007; Shore, 2014) and biochemistry (Pert, Dreher & Ruff, 1998) that have found that the brain maintains plasticity throughout the lifespan, which allows the modification of neural connections in response to new experience including the sensorimotor information obtained from touch.

This has implications for the therapeutic relationship per-se and for specific psychotherapeutic endeavours such as in attachment therapy (Hughes, 2007, 2011) where the considered use of touch (Smith, 1998; Hunter & Struve, 1998) within the therapeutic relationship is viewed as an important feature of attunement and reparation of an experience of the less than satisfactory primary attachment relationship (Uphoff, 2008). Sunderland, (2007) argues that children who grow up with little or no experience of communication via touch acquire 'troubled bodies' viewing themselves as untouchable and unlovable. As psychotherapists therefore, withholding touch from such clients may be viewed as a failure to provide unconditional positive regard (Rogers, 1957) and the chance of therapeutic personality change that is the very basis of the therapeutic endeavour.

In contrast, within complementary therapy it is taken for granted that touch has a healing function by those practitioners who come into contact with clients' bodies and for whom it is an integral part of their work (Fox, 2008). This is understood as the use of skilful bodily contact that is a means of helping the client in some way i.e. to energise them, align vertebrae, soothe pain, aid joint mobility or shift stagnant energy. Equally it is assumed that clients' who seek such bodywork are aware that their body will be touched in the process and in a way that is acceptable and beneficial to them.

Body-focused therapy within Complementary Healthcare

Bodywork or body-focused therapy can broadly be described as an array of different healing practices that work on or through the body (see Heckler, 1984; Grossinger, 1995, 1998). Common practices within our current Western culture include physiotherapy, osteopathy, massage therapy, Reiki and Shiatsu. Craniosacral therapy, Bowen therapy, Trager and Colonic Hydrotherapy are also included in this category of complementary healthcare practices. Distinctions between different types of bodywork are as varied as the techniques themselves but most would argue that they are based upon a mind-body unity, which at its most elementary contends that changes in the body affect thoughts, feelings and attitudes and vice-versa. Whilst this is a belief shared with body psychotherapists,

bodywork practitioners are differentiated from practitioners of body psychotherapy in that they are neither trained in or profess to carry out psychotherapy alongside their concentration on the body.

The distinction between bodywork practices and body psychotherapy is clearly made by the European Association of Body Psychotherapy which states that whilst bodywork always involves the use of touch, movement and breathing, body psychotherapy may also involve these but goes beyond this as body therapists work on a person as the embodiment of mental, emotional, social and spiritual life. Conversely, some bodywork practitioners contend that in concentrating on their bodywork techniques they achieve a higher level of skill in bodywork interventions than body psychotherapists (Grossinger, 1995).

The Therapeutic Relationship in Body-focused therapy

Research studies in the UK, USA and other Western nations show that complementary and alternative medicine (CAM) use is steadily increasing and that currently almost half of the population seek some form of complementary and alternative therapies to treat problems of health and wellbeing (Barcan, 2011). Stone & Katz (2005) suggest people who seek CAM over traditional medicine, do so in the belief they will be treated as individuals rather than a set of symptoms and that the context of their illness such as recent life events and social circumstances, will also be taken into account (Fox, 2008). This is seen as one of the key features of the therapeutic relationship for CAM practitioners where symptoms are understood as pertaining to the whole body and the interconnectivity of mind, body and spirit is assumed insofar as healing on one of these levels will have beneficial effects on the others (Mitchell & Cormack, 1998).

Whilst the language of 'healing' is distinctive to CAM practitioners, the notion of relating to clients as an important element of the therapeutic encounter has obvious parallels with talking therapies where therapist qualities of warmth, empathy and respect are acknowledged as essential to the process of change and positive therapeutic outcome. However, with reference to a more detailed examination of counsellors' and psychotherapists' training in with regard to the

professional therapeutic relationship, Fox (2008) calls for complementary therapists to seize aspects of learning from talking therapists to promote a better understanding of the impact the therapeutic relationship has on their clients and themselves. This indicates a level of recognition within complementary therapy that practitioners who are not formally trained in talking therapy have the capacity to increase their learning from talking therapists with regard to developing more positive therapeutic relationships.

The wide variety of body-focused therapies that are practiced within complementary healthcare, whilst differing from what are considered more conventional approaches to health and wellbeing, share the common goal of promoting positive change within the person. This has been described in terms of how they all propose to evoke the self-healing capacities of the body by placing an emphasis on a holistic approach to the person; acknowledging the interaction of a person's spirit, mind & body within a physical, social and cultural context. As a result, the need for treatment to be a synergy of cathartic elements, transcending the mind-body split implicit in reductionist scientific medicine, is suggested (Fulder, 1996). It follows therefore, that this philosophy of all things being interconnected is intrinsically bound in a therapeutic relationship between the client and practitioner (Wright & Sayre-Adams, 2001).

Building on this premise, it is the consideration of how the therapeutic relationship can be understood from the perspective of a selection of body-focused practitioners within complementary healthcare that provides the focus for this study.

Research Rationale & Aims

As this literature review has shown there is an extensive body of research that supports the salience of the therapeutic relationship in counselling, psychotherapy and counselling psychology and urges practitioners to reflect on how best to use themselves within this relationship to promote positive change in the health and wellbeing of their clients. See for example Rogers (1951, 1981), Horvath & Symonds (1991), Clarkson (1996, 2003), Teyber (2000) and Kahn (2001). In his book 'Between Therapist and Client' Michael Kahn (2001) argues that by enhancing their awareness of the subtleties and changes in the relationship, therapists increase the level of safety within it and provide themselves with the most powerful tool for the development of the therapy "because the relationship *is* the therapy" (Kahn, 2001:1)

Lambert and Barley (2001) conducted a review of over one hundred studies concerning the therapeutic relationship and psychotherapy outcome. Focusing on four areas that influenced client outcome, these were: extra therapeutic factors, expectancy effects, specific therapy techniques, and therapeutic relationship factors. In concluding relationship factors to have most impact on therapeutic outcome, they invited therapists to consider their position within their dyad as:

"Improvement in psychotherapy may best be accomplished by learning to improve one's ability to relate to clients and tailoring that relationship to individual clients."

(Lambert and Barley, 2001:77).

Within this literature review a strong argument has been identified for the therapeutic relationship to be more overtly recognised as an embodied relationship within talking therapy (see Shaw, 2003, 2004; Rumble, 2010; Totten, 2014, 2015). Whilst it is acknowledged that within certain realms of psychotherapy such as in gestalt therapy and body psychotherapy, this emphasis is well established, it is only relatively recently that embodiment has been more thoroughly validated within

mainstream psychotherapy. This is seen in recent approaches such as Sensorimotor psychotherapy (Ogden & Minton, 2000; Ogden, Minton & Pain, 2006; Lamgmuir, Kirsh & Classen, 2012) and embodied-relational therapy, or ERT (Totten, 2005; Totten & Priestman, 2012) where the inclusion of a focus on the body within the therapeutic relationship alongside the mind is no longer marginalised.

However, in the wake of pertinent discoveries in neuroscience and the subsequent rapid developments in the application of attachment theory to clinical practice (Rothschild, 2010; Golding & Hughes, 2012) greater integration between psychotherapists and body psychotherapist has been noted within the relational approach to therapeutic work (Carroll, 2014; White, 2014). Evidence of this can be seen in the various idiographic accounts of psychotherapists discussing their experiences of embodied therapeutic relationships as important advances in their practice (see for example Linington, 2014; Mollen, 2014; Orbach, 2010). This has been matched with what can be described as a renewed vigour of body psychotherapists to redefine their position of always having viewed the therapeutic relationship as an embodied relationship (Carroll, 2014; Totten, 2015).

Whilst further research within this seemingly converging field of psychotherapy/body psychotherapy could well strengthen this position, it is a position that combines some degree of bodywork or body acknowledgement with verbal therapeutic interventions. However given that it is the body that has been largely absent from research into the therapeutic relationship, I propose that the accounts of therapists who work primarily with the body will add an additional perspective as an adjunct to what psychotherapists and/ body psychotherapists are clearly now offering.

Theoretically, this builds on the premise that bodily knowledge precedes cognitive knowledge and arises from action in the world (Merleau-Ponty, 1962) and the assertion that bodywork is a means of accessing this bodily knowledge (Barcan, 2013). Furthermore, on a practical level, practitioners of body-focused therapies can be seen to possess a high degree of bodily awareness and expertise due to the very nature of their work (Fox, 2008; Grossinger, 1995).

Therefore, this study was designed to explore how the concept of embodied therapeutic relationships may contribute to furthering our understanding of the therapeutic relationship in counselling psychology by eliciting the views and experiences of four body-focused practitioners working in complementary healthcare.

Methodology

Rationale for use of Qualitative Methodology

My decision to use a qualitative rather than a quantitative research methodology in this study was influenced by current debate within the field of counselling psychology (see for example O'Neill, 2002; Ponterotto, 2005; Smith, 2011). That is to say that whilst the scientist-practitioner model provides evidence-based practice and quantifiable data, and thus presents a clear conceptual framework within which research and practice can develop (Woolfe, Dryden and Strawbridge, 2003), greater flexibility is called for in the way that psychotherapy practice is researched and represented (Blair, 2010; Corrie & Callahan, 2000; Finlay, 2011). Specifically, use of qualitative methodology to analyse intersubjective accounts of phenomena may be a more applicable approach to many issues in the study of counselling psychology (Strawbridge and Woolfe, 2003). As clarification of phenomena from a 'lived through' perspective not only yields useful knowledge but is also as legitimate a form of science as any other (Giorgi & Giorgi, 2008).

It is an exploration of the lived through experience of four bodywork practitioners and the specific questioning of their intersubjective therapeutic relationships with their clients that forms the basis of this study. Smith et al (2009) describe the phenomenological concept of intersubjectivity as our shared and relational engagement in the world and our ability to communicate with, and make sense of, each other within it. Todres, (2011) calls for the use of intersubjectivity to be the focus of research activity as a way of furthering our existing understanding:

“The phenomenologically orientated researcher engages with accounts of experiences in a way that can articulate important understandings from these experiences and that may be relevant to others and take intersubjective understanding further.”

(Todres, 2011:27)

In line with the embodied focus of this study, Finlay (2011) specifies how phenomenological researchers seek to gain insight into our embodied being in the

world 'by focusing explicitly on the kinaesthetic, sensory, visceral and 'felt sense' dimensions of bodily lived experience' whilst also acknowledging bodies form part of 'our emotional-cognitive, relational and social worlds' (Finlay, 2011:30). More poignantly, she draws the comparison between phenomenological researchers and therapists, listing their shared activities to include critical and reflexive intuitive interpretation, inferential thinking and bodily awareness. It is argued therefore, that therapists are well placed to be the 'true torch bearers' of research in that they naturally and intrinsically engage in the process of investigative enquiry within the nature of their therapeutic process (Howard, 1986). Moreover, specific qualities of self-awareness (Creswell, 1998), subjectivity (LeCompte & Preissle, 2003) and reflexivity (Morrow, 2005) have been discussed in the exploration of how the use of self can shape, create and construct evidence, interpretation, analysis and theory in qualitative analysis.

Research Design

Interpretative Phenomenological Analysis (IPA) (Smith, 2008) of the participant interviews was chosen as the qualitative research method in this study due to the emphasis it places on investigating 'what happens when the everyday flow of lived experience takes on a particular significance for people' (Smith, Flowers & Larkin, and 2009:1). This matches my interest in seeking to understand and conceptualise how body-focused therapists experience the therapeutic relationship in their particular bodywork practice. A semi-structured interview was used as a means of evoking comprehensive accounts of their experiences rather than the participants' being prompted or guided by me as the researcher. The anticipated outcome was one of gaining understanding rather than explanation, focusing on exploring experiences 'flexibly and in detail' (Smith and Osborn, 2003), and specifically embodied understanding, which unlike cognitive understanding includes embodied, aesthetic experience and application (Todres, 2011:3). In addition, a reflective journal was used to capture my reflections as the researcher on the research process.

The Epistemology of IPA

IPA is a relatively recently developed approach to qualitative research enquiry that has quickly become one of the best known and commonly used methodologies within psychology (Smith, 2011). Initially IPA was most extensively used by health psychologists, particularly in the United Kingdom, in studies focusing on existential and illness experience (Finlay, 2011). However, its relevance to research into additional aspects of the lived experience of health and well being has meant that it has gained in popularity not just in the field of health psychology but also with counselling psychologists, occupational therapists and physiotherapists (Smith, 2010; Clarke, 2009).

From a theoretical perspective, IPA draws from the philosophical thought of phenomenology, specifically hermeneutic phenomenology, in its endeavour to examine and interpret subjective experience cleanly, purely as it is experienced in its own terms. Emphasis is placed on describing the conscious central meaning or essence of the phenomena under study and the meaning or reality of the phenomena is conceptualised within the consciousness of each individual participant. As an example of experiential rather than a discursive qualitative method (Reicher, 2000) 'IPA believes in a chain of connection between embodied experience, talk about that experience and a participants making sense of, and emotional reaction to, that experience' (Smith, 2011:10).

In aiming to produce knowledge relating to what and how participants think about and experience the phenomena under investigation, IPA acknowledges the influence the researcher's own thoughts and assumptions will have on this. Consequently, the task this demands of the IPA researcher is to 'set aside' or 'bracket off' what they already know (Husserl, 1982; Smith et al, 2009). This allows exploration of the participant's subjective perception of significant life events or experiential states, as an appreciation of their personal truth and avoids fitting their experience into pre-existing categorisations or modes of thought. This requires the IPA researcher to conduct a detailed examination of participants lived experience, the meaning of that experience and the 'meaning making' process participants engage in as they reflect on, and attempt to make sense of their experience (Smith, Flowers & Larkin, 2009; Smith, 2011).

In attempting to capture the actual essence of experience (Husserl, 1982) IPA recognises that the researcher's understanding and interpretation of participants' accounts of their lived experience will be influenced by her own thoughts, beliefs and assumptions and as such the conceptualisation of participants experience requires interpretation on the part of the researcher (Willig, 2001). As the researcher, this requires an acceptance on my part that my frame of reference in relation to my analysis of the participant accounts cannot be totally excluded by the bracketing off process. This will therefore, have a bearing on the interpretation of the meaning for myself as well as for my participants. In this respect Jonathan Smith describes IPA as '*a double hermeneutic*, whereby the researcher is trying to make sense of the participant making sense of what is happening to them' (Smith, 2011:10).

IPA is idiographic in terms of the commitment to detail it makes in analysing participant's lived experience. 'It wants to know in detail what the experience for *this* person is like, what sense *this* particular person is making of what is happening to them' (Smith, 2009:3). This calls for in-depth analysis of a small number of participants or indeed single case studies (Smith, Flowers & Larkin, 2009). When using multiple cases, patterns of convergence and divergence are searched for leading to the formation of both shared themes amongst participants and recognition of their idiosyncratic representations.

IPA is therefore consistent with counselling psychology philosophy and practice as it has its origins in phenomenological, existential and humanistic thinking and in the emphasis it places on the therapeutic process and phenomenological understanding rather than diagnostic criteria (Fairfax, 2008). It argues for the need to consider human beings in a holistic manner, prioritising a search for meaning and understanding (Strawbridge and Woolfe, 2003).

Use of Self in the Research Process

Use of IPA involved me as the researcher engaging in an interpretative relationship with the transcripts in order to understand the content and complexity of meanings conveyed by the participants. In aiming to understand the world of the

participant IPA holds that this understanding can only be achieved through the researcher's engagement with and interpretation of the participant's account. Thus the analysis is both phenomenological, representing the participant's view of the world, and interpretative, dependent on the researcher's own views and standpoint (Willig, 2001). Making the point more strongly, Heidegger (1962) states that any interpretation made will be generated from their own 'fore-conception' That is to say the prior experiences, assumptions and preconceptions the researcher, and indeed the reader, bring to the encounter that leads them to look at any new stimulus in the light of their own prior experience.

Therefore, the researcher's self identity, intentions and self-constructions lend themselves to important choices in how the data is created and represented. Moch & Gates (2000) suggest various ways of recording and reflecting on the research experience from keeping journals charting the researcher's thoughts and feelings about the research to processing the experience with a counsellor or spiritual healer or capturing the essence in poetry. They purport any one of these activities to enable the researcher to engage with the reality of how they may be affected by the research experience. In consideration of this I chose to use a reflective journal throughout the process of data collection, transcription and analysis to reflect upon the implications of my personal and epistemological assumptions that shaped the research process. In addition, my own personal experience of receiving the four different types of body-focused therapy from each of the participants was included within this.

Interview Schedule

In order to understand how practitioners made sense of their experiences, a semi-structured interview schedule was used. This enabled me as the researcher to enter into a dialogue with each participant where questions could be modified in light of responses and areas of interest that arose could be probed in more detail than more structured methods may allow (Smith, 1995). The interview schedule contained a minimal selection of broad open-ended questions supplemented with prompts, which were used to elicit narratives regarding:

- Participants' knowledge and understanding of the therapeutic relationship.
- Examples of therapeutic relationships they had experienced with their clients.
- The embodied nature of these therapeutic relationships.
- The amount and nature of verbal communication used in their bodywork practice.
- What talking therapists might learn from bodywork practitioners.

The interview schedule guide questions can be viewed in Appendix III

The interview schedule was piloted with an individual who was not part of the final research study. The pilot interview was conducted as a means of reviewing and developing the interview and analysis process and the participant was chosen due to their experience of being both a bodywork practitioner and a counsellor.

Participants & Sampling

A purposive sample of body focused practitioners was sought for this study. Purposeful sampling is a technique widely used in qualitative research for the identification and selection of information-rich cases (Patton 2002) that are especially knowledgeable about or experienced with a phenomenon of interest (Cresswell & Plano Clark, 2011).

Following the guidelines for IPA research, four participants were recruited with the aim of obtaining detailed accounts of individual experience, yielding a rich corpus of data to allow exploration of similarities and differences between participants without being overwhelmed by the amount of data generated (Smith, Flowers & Larkin, 2009).

The four participants were treated as a series of individual case studies. It was believed that analysis of each of their particular accounts would help to develop ways of looking at this relatively new area of study (Smith, Flowers & Osborn, 1997) leading to a better understanding or theorising of embodied therapeutic relationships within counselling psychology. As collective case studies typically necessitate researchers choosing their cases (Stake, 2006), being able to

investigate thoroughly and understand the phenomenon of interest depends heavily on appropriate selection of each case (Patton, 1990; Stake, 2006; Vaughan, 1992; Yin, 2003). Whilst it is noted that IPA usually calls for a fairly homogenous research sample, it is important to highlight that this is not a concern of phenomenological research when analysed as a case series. In this instance it is recognised that 'the exploration of one phenomenon from multiple perspectives can help the IPA analyst to develop a more detailed and multi-faceted account of the phenomenon' (Smiths, Flowers & Larkin, 2009:52).

The four participants *Hannah, Archie, Jilly & Rhian* were all white British, aged between 30 and 60 and were qualified and experienced bodywork practitioners working in complementary healthcare in the South of England.

Hannah was a Craniosacral therapy practitioner. Within her practitioner information leaflet Craniosacral therapy is described as a system of manipulation of the body by light touch for the purpose of facilitating the body's self-healing capacity by finding and correcting cerebrospinal fluid blockages and imbalances within the Craniosacral system (the dura mater of the central nervous system and the cerebrospinal fluid within it) that are thought to cause sensory, motor, or intellectual dysfunction.

Archie was a Trager practitioner. Within his practitioner information leaflet Trager is described as a bodywork technique that aims to develop an individual's awareness of body movement patterns that relieve pain and promote relaxation. It consists of two components: tablework, in which the practitioner, in a meditative state, uses touch and gentle pressure on the client's body and Mentastics, a set of self-guided mental and physical exercises that the practitioner teaches the patient, which are designed to relieve tension and allow the body to move more freely.

Jilly was a Colonic Hydrotherapy practitioner. Within her practitioner information leaflet Colonic Hydrotherapy is described as a cleansing and detoxification procedure, in which the entire colon is irrigated by means of water that may contain enzymes or herbs, introduced through the rectum and circulated through the colon. The maintenance of colon health via Colonic hydrotherapy is thought to be linked to general health and well-being.

Rhian was a Bowen therapy practitioner. Within her practitioner information leaflet Bowen therapy is described as a bodywork technique in which soft tissue stimulation is performed by gentle pressure from the thumb and fingers; it is used primarily for musculoskeletal conditions and stress-related disorders and for symptomatic relief in chronic conditions.

Participant Recruitment

Information regarding the nature of the proposed study was advertised on flyers distributed within complementary healthcare settings in the South of England. A copy of the Research Project Outline Information Sheet for Participants (see Appendix I), was given to those practitioners who expressed an interest in taking part in the study. This contained a brief overview of the study and information regarding the research aims, what was required of participants and contact details for me, as the researcher, and members of my supervisory team. A tear-off reply slip was incorporated into the form to be completed by those practitioners who wished to participate in the study and return envelopes were provided. On receiving these reply slips I met with each practitioner to discuss the nature of the research task in more detail. The inclusion criteria for the study were that participants were qualified and experienced body-focused practitioners who worked in private practice in the field of complementary healthcare and were all over the age of eighteen.

Ethical Considerations

Ethical approval to proceed with the study was granted by the University Faculty Ethics Committee. Ethical procedural guidelines were followed in relation to participant confidentiality, informed consent and other issues such as their right to withdraw from the research at any time; any potential risks identified and risk management strategies. These were included in the Participants Information Sheet and Consent Form (see Appendices I & II).

Interview Process

Each participant was interviewed for approximately one hour either in a consulting room at the clinic where they practiced or in a private room at an alternative venue of their choice. A semi-structured interview schedule was used as a guide for each interview, which allowed scope for alternative questions to be posed in any or each interview in an attempt to elicit key themes emergent in the participants' narratives. The interview schedule was not necessarily followed in its entirety or to the same extent for each participant in recognition of them as experiential experts on the topic (Smith, Flowers & Larkin, and 2009:64). All interviews were audio-recorded. Following each interview I arranged a date to meet with the participant for the purpose of receiving a session of their particular form of body-focused therapy. This experience then informed my analysis of the research interview along with the consideration of the reflections I made in my reflective diary.

Transcription and Data Protection

Each interview was transcribed verbatim. Participants' names and any other identifiable data were changed to protect their privacy and issues of confidentiality. The audio-recordings and anonymised written transcripts were stored in line with University policy and procedure and kept securely in accordance with guidance from the Data Protection Act (1998). Only I accessed the audio recordings and I then shared the anonymised transcripts with my research supervisors. Extracts from the transcripts have been included in this text. In the convention employed a series of dots.....was used to signify pauses made by participants, omitted parts of the continuous discourse were acknowledged by the following symbols [] and any emphasis of speech such as stressed words was represented by italics.

Data Analysis

In accordance with the IPA methodology suggested by Smith & Osborn (2008) the data was analysed as follows:

- (i) My analysis of the data began by looking in detail at the transcript of one of the four participant interviews.
- (ii) I read this transcript numerous times to ensure I became as familiar as possible with the text. I then made comments in the right-hand margin regarding what was considered interesting or significant. This included paraphrasing of what was said, apparent associations, similarities, differences or contradictions, use of language, preliminary interpretations and the sense I gained of the participant's personhood.
- (iii) Using these initial notes I then documented emerging theme titles in the left-hand margin to express the essential quality of what I found in the text.
- (iv) I then compiled the emergent themes in a list and looked for connections between them.
- (v) A final list of themes was then produced that I felt captured most strongly the participant's views.
- (vi) I repeated this process for each of the three remaining transcripts. Each account was treated on its own merits as an individual case study and therefore ideas from prior analyses were 'bracketed' off in order to be consistent with IPA's idiographic commitment. A list of master themes for each participant was then produced (see Table 1).
- (vii) I then compiled a list of superordinate themes that ran across all four transcripts (see Table 2).
- (viii) Further consultation with my research supervisors was sought at this stage in order to critically examine themes and check on levels of agreement.
- (ix) The themes were then translated into a narrative account for each participant that constituted the final write-up of the four case studies. The themes in each account were explained and illustrated using verbatim extracts from of the original transcripts. Care was taken to distinguish between what the participant actually said and the researcher's interpretation of it and links were made to the existing literature.

- (x) The themes were drawn together and similarities and differences across the four accounts were highlighted in the concluding part of the final write-up.
- (xi) A reflective journal was used throughout the process of data collection, transcription and analysis to reflect upon the implications of personal and epistemological assumptions that shaped the research.

Reflexivity

In aiming to understand the world of the participant IPA holds that this understanding can only be achieved through the researcher's engagement with and interpretation of the participant's account. Thus the analysis is both phenomenological, representing the participant's view of the world, and interpretative, dependent on the researcher's own views and standpoint (Willig, 2001). There is recognition therefore of how my self-identity, self-constructions and personal perspectives add to important choices in my analysis and representation of the data. I kept a journal throughout the process of data collection, transcription and analysis. As suggested by Moch & Gates (2000) I used this to reflect upon the implications of personal and epistemological assumptions that shaped the research process. Included in this were my reflections on experiencing each of the different types of body-focused therapy from each of the four participants after I had interviewed them for this study.

In the next four chapters my analysis of each of the participant accounts is presented in the form of individual case studies followed by the followed by an exploration of the master themes and superordinate themes derived from these transcripts. In the final two chapters the results are discussed, conclusions drawn and clinical implications are suggested.

Analysis & Results

Master Themes & Superordinate Themes

A list of Master themes and Superordinate themes derived from my analysis of the reported experiences of *Hannah*, *Archie*, *Jilly* and *Rhian* are presented in Table 1 and Table 2 below.

Table 1: List of Master Themes

Participant Pseudonym	Master Themes
Hannah	<u>Noticing routes to Rapport Building</u> <u>Mind, Body and Yes we do all have a Soul</u> <u>Knowing</u> <u>'Into their Body' & Out of their Mind</u>
Archie	<u>It's a little bit like you put the music on and we've both had a dance together</u> <u>It's not therapy but without this rapport you're just working on their body.</u> <u>Tuning in to the Body, Mind and Chi</u> <u>Honouring being with the client: 'it's a sharing of oneness of the opportunity that we exist in life'</u> <u>Touch and the relationship: 'you're aware of all of these levels but you don't knit them together'</u>

Jilly	<p><u>Honour & Trust: ‘it really is quite an Honour to have people trust me’</u></p> <p><u>Knowing: ‘it’s intuitive, you know, it’s something that I do’</u></p> <p><u>Energy: ‘it’s just an energy thing that goes on’</u></p> <p><u>Embodied Language: ‘the body doesn’t lie, the body will speak the deepest truth’</u></p>
Rhian	<p><u>‘Having that Connection: and really meeting them before you treat them.. is really important to me’</u></p> <p><u>Not keeping Boundaries: ‘makes the room quite messy’</u></p> <p><u>Embodied Knowing: ‘people hold their stories at different levels’</u></p> <p><u>I do a treatment ...leave the room ‘and let the body respond and see what’s most important’</u></p>

Table 2: List of Superordinate Themes

Superordinate Themes	Sub Themes
Embodied Awareness and Sense of Personhood	<p><u>Personal identity:</u> The back story – what brought them to practice as a body therapist = <i>acknowledgement of mind-body-soul unity (H), beauty in the bodily form (A), spiritual crisis (J) illness in her own body (R)</i></p> <p><u>Personal identity:</u> Sense of self = <i>self as embodied soul (H), way of being: yoga, meditation (A), found spiritual self (J) personal growth and (Buddhist)</i></p>

	<p><i>compassion (R)</i></p> <p><u>Ways of Knowing:</u> Professional competency (H, R) + reliance on 'letting go' (A, J,)</p> <p>Use of touch on the body (H, A, J, R)</p> <p>Intuitive sense – felt sense/body empathy (H, A, J, R)</p>
<p><u>Mind-body Connection, Disconnection and Reconnection</u></p>	<p><u>Holistic Worldview:</u> Self and other as combined mind, body, (emotions, spirit) and soul (H, A, J, R)</p> <p><u>Mind-body imbalance:</u> Prioritisation of the mind = no sense of soul (embodiment) (H) The head (mind) gets in the way (A, J, R)</p> <p><u>Healing as unity:</u> Reprioritising the body by listening to and unblocking the life force (H), Tuning into the body and facilitating the Chi (A), Recognising the energy moving (J) Giving the Body space to re-wind and remedy (R)</p>

Case Studies

The Master themes derived from my analysis of the transcripts were translated into a narrative account for each participant. These are presented below in the form of four individual case studies.

Case Study 1:

Embodied Therapeutic Relationships in Craniosacral Therapy

Hannah was a mother and grandmother, who worked part-time as a Craniosacral therapist practicing this form of bodywork from a purpose built therapy room at her home. Working mainly with adults her practitioner information leaflet listed conditions she could help people with as: asthma, back pain, headaches, post-dental trauma and menstrual pain. When I interviewed her she was six months into a three year course studying specialist baby Craniosacral therapy and had begun to work with infants to help them with their birth trauma. For Hannah, her experience of being a Craniosacral therapist was dominated by how the training had not only led to her obtaining her professional status but had also strongly impacted on her personhood. She spoke of it transforming her into a different person, one who came to view herself and others as a combined mind, body and spirit with a sense of her soul.

Alongside her Craniosacral practice, Hannah was an established Co-counsellor. The Co-counselling International website (<http://www.co-counselling.org.uk/>) describes co-counselling as a self-help system of personal growth. It is a reciprocal form of peer counselling in which there are no experts; the client is in charge, working on their own deep process by primarily 'discharging and re-evaluating' their personal distress. The counsellor's role is to give the client their full and supportive attention by means of verbal and non-verbal behaviour aimed at facilitating the client's process. Hannah valued the level of skill and personal development Co-counselling had afforded her, and saw how it had informed her Craniosacral practice, particularly with regard to the importance she placed on being attentive and present for her clients.

According to information provided by the Craniosacral therapy association website (<http://craniosacral.co.uk/>) any physical injuries or emotional stresses that impact on the body's tissues cause it to contract and if prolonged this may result in physical problems (e.g. back pain, migraine, tension) or emotional disorders (i.e. anxiety or depression) that restrict the body's functioning. During a Craniosacral therapy session the client lies on a treatment table whilst the therapist uses their

hands to listen to what is going on in the physiology of the client's body and then supports the body's innate ability to balance, restore and heal itself. Developments in osteopathy indicated all cells in the human body express a rhythmic movement fundamental to life which is termed the 'craniosacral or cerebral motion'. Restrictions in the body's functioning are detected by Craniosacral therapists in the way this motion is expressed and by using touch to amplify the pattern the body is holding, the therapist gives an opportunity to release the constriction and restore optimal functioning. This reduces stress and increases energy levels, which may result in clients becoming aware of physical sensations such as heat, tingling or pulsations or experiencing clarity of mind and a feeling of general well-being as:

“Through the simplicity of gentle listening touch, Craniosacral Therapy offers a distinctive stillness that allows your mind and body to rest deeply and begin to restore a natural balance. Craniosacral Therapy recognizes and assists the connections between body, mind and emotions. In the peaceful space created during a session these strands can become more fully integrated.”

Craniosacral Therapy Association information leaflet.

Craniosacral therapy is described as client-led and whilst the above quotation depicts the mind, body and emotions as inter-related, it is the body rather than the mind that sets the pace and priority of the therapy. Craniosacral therapy claims it may benefit people with almost any condition and because it is gentle and non-invasive is suitable for people of all ages. It is considered extremely beneficial for babies and young children who have experienced birth trauma as they respond particularly well to the non-verbal language used to communicate and work with them therapeutically.

Within the interview Hannah discussed her experience of working as a Craniosacral therapist with adults and with babies. The importance of the soul to her in how she experienced her therapeutic relationships and her sense of personhood was the central theme that emerged from the interview. Other prominent themes alongside this were: embodiment, knowing, being a combined

mind, body and spirit and the importance she placed on therapeutic presence and rapport building.

Noticing routes to Rapport Building

The most important thing about establishing the therapeutic relationship for Hannah was developing rapport with each client, and in the case of babies, also with the parents who brought them for treatment. For her, rapport was about making a connection with them and enabling them to feel safe with her. Hannah told me that she did this by spending quite a lot of time talking before she embarked on the bodywork. With the adults she made them feel comfortable and relaxed by letting them know she had noticed them, asking them questions such as 'where did that skirt come from? (L13) how was your journey and 'what car do you drive?' (L19). She also used her knowledge of body language to help her understand and respond to their presentation in the room. For example:-

A limp person is generally someone who's not particularly present either in their body or in their mind; or a stiff one, they're probably really nervous and [] I put them at rest (L 78-81).

Hannah specifically relied on interpreting such body language displays when she worked with babies, where there was an obvious absence of any verbal exchange between them. The following quotations highlight how the route to her rapport building with babies required her to notice and respond to what she described as them 'giving her permission' to work with them:

With the baby therapy it's, it's about establishing a rapport and then being available for that baby to make contact with you and we're trained to notice when that baby's given you permission and I think there's a degree of that with whoever I might have as my client. A degree of, I don't quite know how to put it into words but a holding perhaps, and you've, I've established my safety and ability to listen to them, and babies will often do it by showing you something about their/your trauma, or they will make physical contact with you (L18-24).

A baby is really ready to work; a baby's really keen to get rid of their traumas they've come with because they're so recent they haven't got the great build up in, like us, in how to squash it down. [] I have treated a little one, and I did get his permission to work with him, in a physical way. He came and sat almost leaning against my legs and I thought "ahh I think that's...acceptance!" and eventually I said would it be alright if I put my hands onto his head, and he and his mum they agreed to say yes. But I think in retrospect I could have stopped there and asked mum how she felt about it because I, in retrospect, I think I rushed it a bit even though I'd spent about ¾ of an hour establishing the safety [] Because I think he said no to begin with and his mum said "You know what we talked about this didn't we" and that's what it would be like [] (*and then*) his system did go to work immediately and showed me quite a lot (L 92-105).

This physical permission giving as Hannah described it, resembles the contracting process in counselling psychology and other talking therapies, that forms part of Clarkson's Working Alliance modality of the therapeutic relationship (Clarkson, 2003), whereby a mutual verbal agreement is sought between the therapist and the client to enter into the therapeutic relationship. In contracting, clear parameters are set in order to reduce the likelihood of miscommunication and misunderstandings. Hannah alluded to comparable priorities being necessary in her therapeutic work with babies and reflected on how she may not have been accurately attuned to the baby's bodily indications of permission giving in this particular therapeutic encounter.

Hannah's need to establish safety and an ability to listen as part of her rapport building in her Craniosacral therapy are accepted requirements for the development of a therapeutic relationship in all talking therapies, (see Sills, 2011, Hamilton & Dinat, 2007, Clarkson, 2003). Her use of the term 'holding' as a description of how she conceptualised the process that facilitates this, is drawn from Winnicott (1965) following his research into the parent-child relationship. Namely that the nurturing and caring behaviour a mother engages in with her child, which results in a sense of trust and safety, is achieved through physical bodily holding to help the child feel safe and secure, psychological holding to keep tension and frustration from becoming too great and overwhelming for them and in

the creation of a 'holding space' within which they feel protected and able to be themselves.

Acknowledgement of the importance of Winnicott's writings in the theoretical underpinning of the Craniosacral perspective is made by Franklyn Sills (2011) where the concept of holding and the holding environment are attributed to psychoanalytic and psychodynamic psychotherapy. In linking this to the therapeutic relationship, Winnicott (1965) believed the 'holding environment' was crucial to the therapeutic relationship and could be created through the therapist's direct engagement with a client much in the way that Hannah talked of establishing rapport with her clients.

Just as she repeatedly spoke of 'noticing' how the adults presented themselves in terms of their verbal and non-verbal engagement with her, Hannah talked of noticing what type of cries babies made, how they positioned their bodies and how and when they gave or held back their permission for her to start the Craniosacral therapy with them. She suggested it was they, rather than the adults, who were most receptive to the holding environment she created as the following extracts illustrate:

Babies also have a wonderful way of noticing, they have much higher, erm, availability in their antennae for knowing what the atmosphere is in the room, and the better I get hopefully I will seem like someone who understands baby language and will be there for them - once I've got the parents to a right spot (L82-86).

What I have already learned is how important it is to first of all 'hold the relational field' it's called, which is to understand what field the baby has come with, who its parents are, which parent, which person in the room has the lowest tolerance factor, [] the person who is least able to hear and listen and be in the present [] and it will be a question of noticing "oh the dad doesn't seem to be doing much" or "the dad just seems to be staring at the floor" that I call a low tolerance factor [] the baby on the whole will be the person with the best tolerance and can't wait to get going with their...erm, story but they will be holding back waiting until there is enough tolerance in the room (L30- 47).

The way Hannah talked of needing to be aware of how the inter-dependent maternal-paternal-child field of interaction played out in her therapy room, implied that before she could start the bodywork with the client baby she had to develop her rapport building with the parents. She called this getting them to 'the right spot'. Here the therapeutic relationship effectively extended to include her relationship with each parent alongside her therapeutic relationship with their child. What Hannah termed the baby's relational field, can again be linked to the work of Winnicott (see Winnicott, 1960; Ogden, 2001, 2004) who defined this as the nature and quality of the maternal-paternal relationships in the early childhood holding environment that are pivotal to the child's developing sense of selfhood and being in the world.

Hannah's explanation of holding the baby's relational field as her need to understand the 'field' the baby comes with, has parallels to various psychotherapeutic approaches. In Gestalt therapy for example, people are viewed to always be part of what is termed an organism-environment field which forms and maintains their identity and sense of self. Gestalt therapists adopt a holistic approach to therapy and incorporate work with the body, knowledge of the client's current relationships/systems and residue of childhood systems to bring the relational 'field forces' into awareness and effect therapeutic change (Yontef, 2002). Likewise, Family Systems therapy views the individual not as an autonomous figure but as part of a wider process of interaction between themselves and their family members. It is the pattern of interpersonal dynamics between family members or those in the wider system that are felt to reveal important insights into the individual (Dallos & Draper, 2010).

So what is apparent here is that in making those initial familial relationships Hannah needed to have a high level of awareness of what was greeting her in the therapy room; the verbal and non-verbal messages she had to interpret and act upon to build the rapport she was aiming for. Additional elements to this, as indicated in the quote below, appear to have been the consideration she gave to how she presented in the room and the concentration she placed on the therapeutic space she created:

I suppose what is specific to me rather than to my therapy, is that I put people at ease by I think being quite relaxed myself and feeling at ease, and in my environment being as I want it [] I put effort into how my building looks [] I do try to come early to the session to get myself into the right frame of mind, and I think that frame of mind is really relevant [] to the sort of bodywork I do [] sometimes I'm a bit disembodied and I need to be embodied for the work (L121-144).

The importance Hannah placed on being relaxed and at ease with her clients' suggests she believed there was a potential reciprocal nature to the sense of wellbeing she demonstrated. In essence she modelled how she would like them to be and creating the right conditions to promote feelings of relaxation and ease included having her therapy building as she wanted it. Research studies into the impact of the physical environment of the counselling setting: what kind of building it is, where it is, how it is decorated etc., have found that attention to such details can have a marked affect on clients' perceptions of counsellor competence, friendliness, and quality of care (Nasar & Devlin, 2011; Pressly & Heesacker, 2001) and plays an important part in establishing the therapeutic alliance (Bedi, 2006).

Going to her therapy room early so that she had time to prepare for a Craniosacral session involved Hannah getting herself into 'the right frame of mind' and an 'embodied' state of being. Although she stated this preparation routine was part of her rather than her therapy, it appears to set the basis for therapeutic presence, which in Biodynamic Craniosacral therapy is necessary for the practitioner to demonstrate in order for them to become orientated to the client's inherent capacity to heal (Sills, 2011). Therapist presence in talking therapies is defined as the way in which a therapist attends to the client by being fully in the moment with and for them (Hycner, 1993; Hycner and Jacobs, 1995) on a multitude of levels, physically, emotionally, cognitively, spiritually and relationally (Geller & Greenberg, 2002, 2012) and is the foundation for deep relational contact (Geller, 2013). It is referred to as an aspect of Buber's I-thou relationship. According to Buber (1958) healing emerges from the meeting that occurs between two people as they become fully present with each other and in

observing that, space is created for the spiritual dimension to emerge (Hycner, 1993).

The nature and relevance of Hannah's presence to how she formed her therapeutic relationships became more evident as she went on to talk of how her training to become a Craniosacral therapist had transformed her. She spoke of how this had increased her self-awareness, not only in terms of giving credence to her embodied existence but also in terms of her sense of spiritual identity.

Mind, Body and Yes we do all have a Soul

In the following quotation Hannah explained how through her previous learning, she had become very knowledgeable about the human body as an entity or object, but had no awareness of inhabiting her body or being alive in an embodied sense. She attributed this to her lack of awareness of her soul and her realisation that she had been living purely in her head:

I came to this work with no feeling of soul, no feeling of being in my body, I was just a mind and I had already learnt quite a few of the strange terminologies like the various holes in the [] bones where nerves come through, where important, erm, arteries and veins and things come through, [] and so people thought "oh she's clever, she's got the answers", well, yes in my mind I can remember and do that sort of thing but anything from there below (*indicating underneath her head*) I was pretty dead actually (L180-185).

Hannah seems to be describing a disembodied experience of herself prior to her training in Craniosacral therapy. This fits with the commonly known Cartesian adage of '*I think therefore I am*' that led to the perceived duality of mind and body, which has since been so influential in how Western medicine approached the study and treatment of illness (Damaiso, 2006). The writings of Merleau-Ponty on this topic can be seen to support this challenge as he claimed the mind cannot be understood as an entity in isolation but rather can only be understood in terms of the body and how it is present in the world and is aware of it:

“For us the body is much more than an instrument or a means: it is our expression in the world, the visible form of our intentions”

(Merleau-Ponty, 1962:5)

Merleau-Ponty’s conceptualisation of embodiment argues that human bodies are both ‘immanent’ – the corporeal flesh and bone through which we experience sensation and are physically present in the world and ‘transcendent’ – our intellectual, imaginative and cognitive processes of consciousness and without the immanent body, our transcendent body would not exist (Ladkin, 2012). In addition, like Hannah, Merleau-Ponty also believed the soul has an important part to play in our perception of our bodily existence as the following quote highlights:

“The union of the soul and the body is not an amalgamation between two mutually external terms, subject and object, brought about by arbitrary decree. It is enacted at every instant in the movement of existence”

(Merleau-Ponty, 1962:102)

In the extract below the way in which Hannah talked of *knowing* she was ‘body, mind and spirit’, combining her mind as she thought about it and her body as she practiced bringing her soul into her body, demonstrates Merleau-Ponty’s position:

To me embodied means [] that I’m aware of my soul, and I’m aware of it being in my body and [] the more I think about it, the more I practice and the more I develop the more I *know* that I’m body, mind and spirit and I have to be all three and all three have to be in this chair at the same time. And it stems from,erm, you know the soul (L140-143).

Hannah’s experience of embodiment centered on her appreciation of her soul and what that meant to her. How she described this indicates she put mental and physical effort into maintaining her embodied self and sense of embodiment both as part of her way of being, and crucially with regard to being a Craniosacral

therapist. She needed to be a combined mind, body and spirit with a sense of her own soul when she sat in her therapist's chair. Knowing this is, she said gained through practicing it, it's not something that she knew implicitly; she had to learn it. The extract below shows her depth of emotion attached to this revelation as she talked of *loving* the thought of being a soul; a thought that she implied had not been prompted or indulged in her childhood that had encouraged the prioritisation of her mind over her body:

I really *love* it, I *love* the thought of being a soul and I was never talked to about having a soul as a child [] having a mind, absolutely, the most important thing was to have a mind, it's very much a class background thing that, to have a mind you can rise above you can, you know, you can forget everything else, "body, no, don't bother about your body, hurt your finger? Ahh, doesn't matter, and soul, I don't think so, we don't have souls", oh yes we do! [] Craniosacral therapy believes that, I think it definitely believes we came from a divine source, and that it's manifested in what is the main medium of my work which is the cerebrospinal fluid [] this cerebrospinal fluid, carries what they call the breath of life which I think is the soul and they can, I can, feel where that has been interrupted (L146-174).

Having been encouraged to develop only her mind, her body and her soul had been left out of the picture with any suggestion of their importance denied. In contrast to how she had been influenced by her upbringing, Hannah explained that it was the acknowledgement of the very existence of the soul in the theoretical underpinning of Craniosacral therapy that had had such a profound effect on her and had changed her as a person. Her description of this evoked the sense that she had gone through a process of reclaiming her body alongside her mind and together with her spirit; these were now co-creators of her personhood.

Knowing

However, in suggesting this there was a tentative nature to the way that Hannah spoke about it. On several occasions she stopped the conversation, hesitating whether to carry on talking about the soul. The sense this gave was that Hannah

was checking out my reaction to what she was saying as if to gain an understanding of how acceptable what she knew for herself about the soul was to a psychologist/researcher:

I think a soul really knows how it would like it to be and well, soul is very crucial to my work to Craniosacral work and I don't know whether I'd tell you anymore about that at this stage or a bit later on (L113-115).

I don't know if I'm talking terminology that you don't like or that you think "Oh God!" (L143-144).

I might stop from time to time because I'm finding it quite excitingly scary and I know it's not normally the terminology that we all use in the world. I think we could do with using it a bit more because it's beautiful (L159-161).

Hannah's caution here could be linked to critiques in counselling and psychotherapy of the secularisation of our culture and avoidance of spiritual and religious matters in favour of scientific principles of the medical model of illness and treatment (See McCabe, 2008, & Suzuki, 1997). In particular Corey,(2005) identified that over the last thirty years there has been a tendency in psychology and medicine to rely on the principles of cognitive psychology rather than other insight-based methods, culminating in, for example, the introduction of the NHS Improving Access to Psychological Therapies (IAPT) initiative that prioritizes CBT (Stratton, 2009; Rizq, 2012). Conversely, it appears that Hannah gained access to her spirituality by virtue of the insight into embodiment she'd received from the position held in Craniosacral therapy that 'the breath of life' or cerebrospinal fluid is our source of divinity which for her is the soul. She knew this to be true in her experience of herself and she experienced her clients as embodied souls that she had therapeutic access to by her:

Incredibly light, and sensitive and aware touch, because I need to feel through my hands what's going on in your system (L190-191).

Partly what I'm looking for with my hands-on is to feel a complete flow of the tides and to be able, and I can, I can feel the flow of the tide coming up into the

head [] in my awareness I think and I think this just happens being an instrument (L 238-242).

Hannah's description of her hands becoming a receiver of information from the client on the table as an instrument that enabled her to detect disruptions and blockages in the flow of 'the breath of life' can be seen as a mechanical analogy. Ironically this could appear to draw on the Cartesian 'body as machine metaphor' where the body is viewed as picking up information in a manner much like a barometer or radar (Shaw, 2003). However, the same analogy is used in talking therapies to refer to a much more relational understanding of interpersonal interaction (Clarkson, 2003).

As Hannah talked more about how she felt through her hands it was as if this felt sensation confirmed what she *knew* in her mind but then she needed to take her mind or her brain as she put it, away from what was happening, split-off and detached. The suggestion being she needed not to rely on the sense of knowing she had in her mind as this could be too attached to herself as an expert on her clients, but rather she saw her function as a mirror required to facilitate the client's process of self healing:

I know what it's doing [] and *know* "okay it seems to be stuck in the thorax, whereabouts in the thorax?" [] And because my brain is staying a distance away I'm not getting too involved, I'm not getting too sucked into my ego of saying "oh I can sort this, I know how to do this", none of that's necessary because actually it's the client who knows how to sort it, I act like a sort of a mirror and because I know there is something stuck in their thorax, I might then go to the thorax actually and have my hands under where I feel the blockage, and there's something intuitive about the client [] which is longing and waiting for that to be spotted (L249- 263).

This extracts suggests the client's body and Hannah's body are in some sort of dialogue of embodied *knowing* and what Hannah does in her therapist role is detect, highlight and reflect back what she finds is the concern or blockage the client has. The way she described this was reminiscent of person-centred therapy which has as one of its major principles the belief that it is the client who knows

best what their problems are and the direction to take to effect change (Rogers, 1957). As in the person-centred approach, Hannah talked of reflecting back with her hands the area in the client's body where she felt the difficulty was, and with her voice as she continued to talk to them during the treatment reporting back to them what she was feeling with her hands and on occasions what she wasn't feeling anymore as she described in the following extract:

I think the message goes out of my mind, I think it's trust and I think, oh I don't seem to be getting this feeling anymore, erm, so I might check with them [] so I might say, "oh I don't seem to be getting the feeling anymore what's happened?" And they might say "Oh, you've touched a very sore spot and it's pretty emotional for me" so I feel they've shut down; or I can feel that they're really busy in their head, they're in a mindful space and I don't want them in a mindful space, I want them to forget their mind and let their body do the speaking, and then let their soul do the speaking (L284 -309).

This suggests that Hannah's relationship with her clients is a sort of process of her knowing what it is that she has been trained to feel in her hands, checking out that this is an accurate reflection of what her client is presenting with by detaching her mind from this process and relying more on the bodily and verbal exchange between her and her client. Her aim was to work with the embodied client, the person whose soul was in their body and who was not living in their mind. It is as if Hannah's therapeutic relationships became about soul relating; she needed to be aware of hers and she needed her clients' to be in touch with theirs.

'Into their Body' & Out of their Mind

How Hannah brought her clients back in touch with their soul was by talking to them and inviting them to think of a place or a situation that was special to them, somewhere where they felt good about themselves which to Hannah indicated their soul was present:

People nearly always say walking on the moors, or walking by the sea, or interacting with people, basically your soul just has to be present, [] if I feel

they are very much in their head I might ask them to go to that place in their mind where they feel happy, or I might ask them to go to a place in their body [] so I might say “What feels comfortable in your body?” They might say their feet so I might say “Well tell me how your feet feel” so that takes them out of their head and luckily right down to the other end of them, and another bit I do too, which I didn’t mention is I spend a long time getting them comfortable on the table and talking them in to being relaxed and in touch with their body. I ask them to notice whether their shoulders seem to be on, at the same pressure on the table, whether their pelvis seems to be level or does one leg feel heavier than the other, so I’m sort of talking them into their body (L322-332).

Making sure her clients were embodied in this way, that they could tell her how their feet felt, were aware of how evenly they were lying on the therapy table or could imagine themselves in their special place enabled Hannah to relate to them as their soul. In terms of the therapeutic relationship this indicated that the relating was ‘soul to soul’ as there was an interesting parallel here between how she needed her clients to be and how she needed to be herself when she was delivering her Craniosacral therapy. In preparation for her therapy sessions, Hannah described how she had been taught to be to be aware of her body, to take the time to be attentive to how she was feeling physically and as the following quotation illustrates, this sounds very similar to the way she talked her clients into their bodies:

They taught me by, erm, quite a quite a lot of meditation at the beginning of each course, and meditation which started always with, by feeling yourself sitting in the chair actually really just notice what part of you is sitting on the chair, where does it touch the chair, how does it touch the chair, and imagining roots going down from you into the ground and your connection to the earth [] and learning to trust myself, learning to trust, that’s the other thing they did was feel how you are in the chair, feel grounded, allow yourself to come up, they didn’t say this but I think ultimately to feel energy coming down into your head. I hate using words like energy [] but there is such a thing as divine energy, from the sun and the moon, just the beauty and the air, anyway, so to

feel that and then to trust what you feel and that's a really big bit I think, of trusting yourself, and then when it comes to working with people, trust what you feel but to ask yourself 'is it me that I'm getting this sensation or is it in my client?' And you do get answers to these questions (L191-207).

The importance for Hannah of being aware of her body and somewhat detaching from her mind was that this allowed her to be grounded. Grounding is a familiar technique used in talking therapies, particularly mindfulness based approaches (Hick & Bein, 2008) that seek to focus the client on the present rather than the past and offers a direct, intuitive way of knowing experience (Crane, 2009). This links to how Hannah talked of feeling embodied and grounded: a 'connection to the earth' and 'divine energy' that enabling her to trust the feelings she was getting – for herself and for her clients. Her task in her Craniosacral work was to be sure that what she was feeling about the client was actually about them and not her. In the following extracts Hannah used the phrases 'in a good place' and 'good in my body' which appear synonymous with her clients 'special place' as she talked of thinking of herself as a piece of the ground or the earth as she put it. Being grounded becomes a process whereby she is aware of her sense of divinity in her acknowledgement that she is a combination of trust, intuition and limited ego, which allows her to be a good therapist:

If I'm in a good place and by a good place I mean that I have spent time sitting in the chair and thinking I'm absolutely just a piece of clod of earth really, but I also come from a divine source, as all clods of earth do, so I actually have a full spectrum in me of intuition and trust and as little ego as possible (L228-131).

The really crucial bit is for me to be good in my body. I can only be a good therapist if I'm..., my work is directly linked to how good I'm feeling about myself, the better I'm feeling about myself the better the sessions I give, the more progress people make, erm, and that's to do with you know, trusting myself again, having [] a sense of my divinity (L337-341).

There is a parallel here with processes in various if not all approaches to counselling and psychotherapy in that the most important thing about being a therapist is the person and their ability to model aliveness and realness within the therapeutic relationship (Clarkson, 2003, Corey, 1997). This sense of realness can be seen in Hannah's need to have as little ego as possible as mentioned in the writings of Carl Jung who believed that individuals must sacrifice their ego or the false sense of who they are, if they are to realise a new level of consciousness, that of their true self (Crowley, 1998).

From this interview with Hannah it was clear that her training in Craniosacral therapy had impacted greatly on her sense of self as a person and as a Craniosacral therapist. Themes of: relating by rapport building, embodiment as accessing the soul, trusting what she knew and not letting the mind overshadow the body or spirit emerged from the interview. There was an overarching spiritual dimension to her work and how she experienced her therapeutic relationships. Whilst this may not ordinarily appear to be echoed in the realm of contemporary talking therapies, there is evidence to support a much more explicit use of a spiritual dimension of soul and divinity rooted in a holistic view of a changed balance of mind, body and soul. Corey (1996) talks of the growing trend to integrate spiritual concerns alongside cultural factors in the assessment and treatment in psychotherapy. But whilst an ever increasing level of diversity in our client population is recognized, spirituality and religion are not given the same level of emphasis, particularly in therapist training courses as such issues as gender, sexuality and ethnicity (West, 2008). Therefore, closer consideration may be called for with regard to how therapists' spiritual and religious values and those of their clients, are influencing the therapeutic process (see Clarkson, 1996, 2003; Johnson, 2013; Rowan, 2012; Todres, 2011).

Case Study 2:

Embodied Therapeutic Relationships in Trager

Archie was a husband and father who worked in private practice as a Trager bodywork therapist at several complementary healthcare clinics in the South West of England and was a member of the Complementary Therapists Association. His background in painting, illustration, graphic design and photography had led him into an initial career in the film industry spanning twenty five years. During this time his increased fascination with the human form in movement, dance and stillness, prompted him to train and qualify in Swedish massage. Having then experimented in developing his own form of bodywork, he discovered Trager and realised he had found what he described as 'a perfect vehicle for his way of being'. Archie believed his longstanding daily practice of yoga and meditation influenced the value he placed on mental and physical wellbeing, and that his lifelong love of animals had nurtured the caring aspect of his personality and his tactile, sensitive approach to bodywork.

According to the UK Trager website (<http://www.trager.co.uk/>) the Trager approach to bodywork, developed by Dr Milton Trager in the mid 1900's, has two major components: the hands-on table work performed by the practitioner on the client's body and floor exercises called Mentastics that are demonstrated and taught to the client by the Trager practitioner. The table work is described as a process of psychophysical integration that involves the practitioner's application of soft therapeutic touch in rhythmic moves on the client's body tissues in what are called Reflex Response techniques. These are used to reawaken movement by stimulating specific muscles and the nervous system. This is said to impart new easy and comfortable feelings to the client by accessing their unconscious mind, where they can then override and replace blocked posture and movement patterns that have accumulated as a result of injuries or experiences of mental or physical stress. Mentastics are described as gentle and mindful body movements such as stretching, swinging and rocking, which educate the nervous system to what it feels like to be free of restriction and chronic pain. All of the movements practiced

in Trager are designed to make the client more aware of body and mind sensations (Liskin, 1996).

Archie's practitioner information leaflet claims Trager can offer increased understanding of yourself and your body, a way of moving that is freer, softer, lighter and without effort and of that gives relief from such complaints as back pain, sciatica, aches and stiffness and symptoms of stress such as muscular tension, constipation, eczema, anxiety and migraines. Archie described Trager as a mind-body approach to positive health facilitated by deep relaxation, increased physical mobility and mental clarity; by actively involving the client in awakening the connection between their mind and body the mind can 'let go' so that stressful mental and physical patterns release their hold on a person. Examples he gave of how such patterns are felt in the body were stiffness, pain and restricted mobility. Having practiced Trager over many years Archie had experienced this form of bodywork to evoke beneficial responses to the variety of physical ailments and imbalances his clients came to him with.

Within the interview Archie discussed his lived experience of his therapeutic relationships and how these were underpinned by his personal and professional views on embodiment. Themes identified were his need to establish rapport to reconnect mind and body, the meditative approach he had as a practitioner that enabled him to relate and work with his clients, his belief in the Chi energy, honouring his clients, levels of touch and meeting within the therapeutic relationship and how Archie conceptualised the relationship he had with his clients as 'dancing together'.

It's a little bit like you put the music on and we've both had a dance together

Archie's background in the performing arts was evident in the way he described his therapeutic relationships with his Trager clients. For him working with the body was underpinned by his appreciation of the beauty he found in the bodily form of both humans and animals, as indicated in this comment:

When a cat moves or a horse moves it's poetry in motion; when a dancer, a ballet dancer or baroque dancer moves it's fantastic! I just get chilled out watching beauty (L451-452).

Archie's use of analogies of bodies in motion, and specifically dance provided a visual picture of his therapeutic relationships as embodied encounters that were fluid and kinaesthetic. The following quotations illustrate how he experienced bodies as both aesthetically expressive, and as a source of relaxation or 'chill out' in terms of how working on the body had an effect on him as well as his clients:

If somebody is, let's say a lady has a very delicate body; it's a joy to work on because you are working with something that is very refined and delicate, and so you acquire that delicateness because you have to be part of it, you can't be separate (L246-248).

It's a good chill out for myself you know. Say if a client found, on a rating of 1-10 of how it was for them, [] so if they get 7 or 8 out of a session I might get 5 out of it because it's freed me up you know, I feel like I've been part of the flow. It's a little bit like you put the music on and we've both had a dance together you know, I haven't put the music on and watched you dance we've both been doing it (L254-270).

Archie's use of phrases such as being 'part of the flow' and 'dancing together' indicates he connected with his clients in a bodily sense, suggesting he experienced a kind of body empathy (Bateson, 2009; Cooper, 2001; Gallagher, 2005; Mearns & Cooper, 2005; Strukus, 2011) with them. Body empathy or kinesthetic empathy as it is also known is: "the feeling of sharing another person's movement or vicariously experiencing another person's movement simply by watching" (Strukus, 2011:89). In addition, these extracts suggest Archie became part of a reciprocal process of interaction within his therapeutic relationships as he spoke of experiencing the transfer of the client's qualities of 'refinement' and 'delicacy' as an inevitability of him making that connection with them. This can be viewed as similar to dialogic or intersubjective approaches in talking therapies.

When I asked what the most important thing was for him about the relationships he built up with his clients, Archie said it was recognizing they enjoyed what they were receiving and found it helpful to them. He explained how: 'that in itself is just a thank you, it's the thank you; I enjoy being part of that process' (L339-340). The following quotation highlights this and indicates he viewed helping people as a facet of humankind that underpinned why he was in a helping profession:

Well yeah I mean it's one of the wonderful things of human beings, if someone has come to you for help you give what you feel is good and you feel good about helping, that's the plus that's why we do it (L263-265).

Within his 'dancing together' analogy there appears to be three key elements of Archie's personhood that were pivotal to his Trager practice. Namely: his appreciation of the beauty of bodies, his enjoyment in helping people and how he also benefited from being part of the bodywork process. There is a resonance here with the Relational approach to psychotherapy that acknowledges the relational quality of meeting requires attunement, empathy and mutuality (Buber, 1958, Mearns & Cooper, 2005) and places the therapist into the therapeutic relationship as a co-creator of the relationship (Pelham, 2008). Specifically:

"The challenge is to meet the client as a fellow human being....and offer a relationship that recognises and honours the other person"

(Pelham, 2008:106-107)

Within the interview Archie described the relationships he formed with his clients in a manner that indicated both of these qualities Pelham identifies. The theme of honouring is discussed later; this next section concentrates on Archie's use of self as a 'fellow human being' in his therapeutic relationships.

It's not therapy *but* without this rapport you're just working on their body.

Archie told me that the most important thing for him about having a therapeutic relationship with his clients was to ensure they felt comfortable with him as a practitioner before he commenced the Trager bodywork. This involved him making

eye contact with them, having an open posture and crucially for him inviting conversation, because he said: 'without this dialogue piece, without this rapport coming to you about their anxieties or stresses or strains you're just working on their body' (L339-440). Archie's aversion to this reinforces his definition of his practice of Trager as a mind-body approach to bodywork and supports, as Mitchell and Cormack (1998) identify, how complementary and alternative medicine (CAM) practitioners work in a holistic way, ascribing to the belief of an interconnection between mind body and spirit. Indeed according to Archie's practitioner information leaflet, it is only when the relationship between body-mind and spirit is connected in Trager that healing and rejuvenation can take place.

Writing on the need for therapists to attend to the wellbeing of the client in complementary therapy as an holistic therapeutic practice, Sharma (1994) states:

"The comfort and sustaining of a patient and the cultivation of optimistic fortitude is an important aspect of compassionate therapeutics, disposing the physical 'part' of the (whole) person to mend".

(Sharma, 1994:97)

Archie indicated he used a combination of verbal and non-verbal strategies to encourage his clients to feel comfortable with him. However, as the following extract illustrates, he didn't view his use of dialogue in this rapport building as an attempt to counsel his clients, but indicated it was more of a social conversation that required him to relate and respond to them in naturalistic manner:

What the client offers up to you is of their own evocativeness. They've offered that up to you because it's just come out they haven't actually been asked a question, I'm not asking questions I'm not a therapist you know, I'm not counselling them but if they offer up something to me, I would just listen [] I might say something but that's just a conversation it's not therapy it's just me relating to them as if we would as if we were in the pub or a restaurant (L441-446).

Here Archie made a clear distinction between the manner and intention of his verbal interaction with his clients and that of his view of talking therapy. On

discussing this further, he explained that in his view people who were attracted to seek bodywork as a way of answering their problems, were either attuned to bodywork, accepting that touch could be helpful for them, or aware they had anxiety problems that were manifesting physically. Whereas he saw people who were attracted to talking therapy as seeking an 'academic analysis' or form of support to help them with their difficulties. For him, talking in his Trager sessions was not a therapeutic practice in itself but was a means by which he established and maintained a relationship with his clients that provided a context for him to work on the body. It can be argued that the manner in which he did this indicated an authentic use of self, which is in accordance with Petruska Clarkson's 'person-to-person' relationship modality, which she defines as:

"The dialogic relationship or core relationship. It concerns the authentic humanness shared by client and therapist. It has also been referred to as the 'real' dimension of the therapeutic relationship."

(Clarkson, 2003:15)

Archie gave the impression that he was being both authentic and spontaneous in his verbal communication, in much the same way as was seen in Hannah's account in the previous chapter where she sought to establish safety and an ability to listen as part of her rapport building in her Craniosacral therapy. In stressing he was not seeking to use verbal communication to do anything other than establish rapport with his clients, the impression this gave was that whilst connecting with the client Archie remained focused on their needs and the reason they have come to him, which was to receive the Trager therapy. As Fox (2008) remarks:

"A little ordinary chat at the beginning of a session oils the wheels, of course, and helps put people at ease but too much detracts from the real reason you're both there."

(Fox, 2008:99)

This is reinforced by the next extract that illustrates how Archie's relating and use of active listening to what his clients had to say, not only helped him establish rapport but also enabled him to effect a mind-body focus to his work:

When you are just relating to their issues and [] in that listening you move them into the first sequence of the treatment which is often for them to stand just to feel themselves, just to stand and to just to tune into [] “How do you feel? Anything in your body that’s actually talking to you, that’s giving you some instance of attention?” (L60-63).

Archie told me he often needing to remind his clients that they have a body that can give them valuable feedback about their wellbeing and therefore, as the above extract indicates he needed to prompt them to become aware of their embodied feelings, as if directing the body to be more prominent within the therapeutic encounter. The way in which Archie did this, by getting his clients to ‘tune into’ their body to evoke their body consciousness and become aware of any physical sensations they were experiencing, forms part of the theme of tuning into the body and mind discussed in the next section.

Overall the sense I got from Archie regarding how he experienced establishing rapport with his clients was that he saw it as essential to make sure his clients felt comfortable with him so that the relationship between them could produce the mind-body emphasis he needed to be able to deliver the Trager therapy effectively.

Tuning in to the Body, Mind and Chi

The concept of ‘tuning into’ the body and mind within his therapeutic relationships was a recurrent theme that ran through Archie’s account. For example, he explained the purpose of drawing his clients’ attention to their bodies as they stood in stillness, and then via the guided Mentastics (the free movement floor exercises), was to initiate a process whereby they received embodied feedback in relation to how they were at that initial stage of the Trager treatment. Archie referred to this as a ‘state’ his clients became aware of (or tuned-into) and as the following extract indicates he drew their attention back to this state when he repeated the Mentastics sequence after he had finished the hands on Trager treatment to endorse the client’s embodied feeling of what they had just received on the table:

To go back into that state, to stand and say how do they feel and ‘what’s your body telling you?’ And they might say “ah yes, my neck feels just great” or whatever it is’ [] be in their body again so that they can then move around and then do some activity so that it not only um, not only gives them a feeling of fluidity and openness but it underlines that that is possible (L67-74).

These last two extracts seem to indicate the verbal dialogue within the therapeutic relationship for Archie was replaced by an embodied dialogue that had a different set of meanings and implications for him. No longer purely communicating authentic interest for rapport building, Archie was requesting embodied feedback to promote and reflect on any bodily changes his clients experienced as a result of the hands on Trager treatment. Getting his clients to tune into their body, and reacquaint themselves with embodied feelings (such as less restricted and more fluid movement), suggests the client then had a more integrated sense of self as mind and body; the result of this was that Archie had a more integrated ‘mind and body’ client to work with and relate to.

Archie explained how in his practice as a Trager therapist he tuned into his clients in this ‘mind-body’ way particularly concentrating on parts of the body that were very tight and unable to move. In the following extract he gave an example of how he would do this if a client came to him with a frozen shoulder:

Some people can be very open; some people are just terribly tightened up you know, so tight. So for instance [] (*pats the chair arm cushion*) if this was someone’s shoulder and there’s just no movement in it at all, it’s just locked off...whereas another person’s shoulder, (*touches a loose cushion*) this is lying and it’s open and you can just work through it. With this one here, (*chair arm cushion*) you just have to tune into that shoulder, just think softness and lightness and just very gently coerce it, just very, very gently coerce it to give confidence feedback to the brain of the client to recognise that everything is okay. They don’t have to worry, about anything, it’s all okay (L101-104).

The way that Archie described this suggests the aim of tuning into areas of the client’s body with restricted movement was to facilitate, or in Archie’s words ‘gently coerce’ the body to increase its level of mobility. It also demonstrates how this is

dependent on a mind body connection in what Liskin (1996) describes as a process of state dependent learning (Moulin, 2006) where associations are developed between positive feeling states and improved bodily functioning:

“By returning later to the positive feeling state, the body then automatically returns to its improved functioning. This new learning counteracts body learning received under more stressful conditions which may have become associated with bodily tension, holding, guarding, or weakness and paralysis.”

(Liskin, 1996:129)

Archie's use of terminology here is paralleled in the field of psychotherapy, where openness is discussed in terms of the client's ability to share their thoughts and feelings with the therapist so that together they can work through the problems the client presents with. The reassurance Archie offered within this process also echoes how a talking therapist's skills may be shown by their ability to give the client the confidence to feel it will be safe for them to be open with their therapist. The initial stages of psychotherapy, and more specifically the setting up of the therapeutic frame, signify how the structure of the psychotherapeutic relationship and the client and therapist's perceptions of each other are set. According to Sedgwick (2006) this is how:

“The basic conditions for psychotherapy become established, such that the process can take over, or is entrusted to take over. Psychotherapy involves a setting up and then a letting go”.

(Sedgwick, 2001:120)

Archie described the practice of Trager as being reliant on clients 'letting go' of the hold their mind had over their body to enable them to absorb more of the bodywork process, resulting in them experiencing freer physical movement and enjoyment. He explained that unlike other forms of bodywork such as Swedish massage where:

You the practitioner *is* doing the work [] manipulating and moving joints and tissue around. With Trager you don't do that, you allow the limbs to do the work [] with the co-operation of the client who has let go (L880-93).

Writing on this differentiation, Liskin (1996) points out that Trager is functional rather than structural and seeks to free the form of the body rather than re-align or reposition it. As Archie had stated the co-operation of his clients was essential to this process, I asked him how they got to that 'let go' stage in the therapeutic relationship. He told me this depended on the 'borders that they've got up in their psyche' (L96), suggesting, as the following quotation highlights, his clients needed to surrender the measure of mental control they had over their body:

There's that kind of subtle play that's at a very deep level that's happening and [] it's either going to happen or it's not, it depends purely on the moment the client can let go, can just say "yes" (L127-129).

This implies that Archie was almost powerless to help the client to experience positive change until or unless the client could let go. His reference to what this entails being 'at a very deep level' suggests this was a multifarious process and in order to instill this he told me he used his imagination to tune into the body to get to the mind of the client in an attempt to break down the barriers of the psyche. As the following extract shows Archie did this 'in faith' that this process would happen and with an acknowledgement from him that he was drawing on his belief in Chi or the 'energy of the universe' to assist him:

The imagination of the practitioner is tuning into the joints say for instance and just almost like working at a cellular level just in faith really. Because really what you do you don't do it. The thing that moves everything is the Chi; it's the energy in the universe, the energy that's transformed into action through the mind. [] So it is that sort of openness that you're aspiring to or recognising that that shoulder is not locked it is potentially resting in its frozen state but it will open up, it will because that's its nature (L106-114).

This gives the impression that for Archie his therapeutic relationships became about him relating to his clients not just as their physical body connected to their

mind but also included their energy body, or what body psychotherapists refer to as their subtle body (Cameron, 2002; Woolger, 2002). For him the energy was the Chi, which is a concept taken from the Eastern philosophy of Taoism and in Chinese medicine is referred to as life force energy. Chi is believed to flow up the back and down the front of the body and should circulate throughout the body without disruption and in a smooth, powerful fashion if pain-free, optimal health is to be maintained (Woolger, 2002:206). This suggests therefore, that Archie used tuning into the Chi as a means of connecting with his clients in an embodied sense and at a deeper level of relating both physically at the body's cellular level and energetically at a spiritual level.

Archie's daily practice of yoga and meditation that are an integral part of his personhood can be seen to fit with this aspect of Trager therapy and how this influences his experience of his therapeutic relationships. Another example of how he tuned into the energy of his clients was seen in the way he talked of perceiving different energy levels when he met his clients and how this influenced how he was with them: 'like you meet someone for the first time, there's something that comes off them and you know what you can say and what you can't say, or whatever' (L162-164). He also spoke of noticing changes in clients' energy levels after a Trager session that he attributed to them having 'fed their bodies with more Chi' (L227).

However, perhaps the most poignant reference to this he made was when he described how tuning in to his clients and creating this embodied connection with them required him to achieve a specific mental state referred to in Trager as 'Hook-up':

"A state of expanded mental, physical and spiritual awareness. One becomes aware of a connection between inner and outer experiences, between one person and another and a gnosis or inner knowing connection to universal being. Some would call it a state of communion".

(Blackburn, 2004:115)

Archie likened his experience of hook-up to that of open-eyed meditation, explaining how he entered a quieter mental state that allowed him to tune into the client at a deeper level of relational resonance. He talked of hook-up as a natural state that he believed could be achieved by therapists other than those working in Trager if they were really in tune with the client's wellbeing and the 'universality of the energy'. Commenting on the potential universality of hook-up Blackburn (2004) cites Juhan as asserting hook-up to be *"like the measles...you catch it from someone who has got it"* (Juhan, 1993) and claims the experience of hook-up results in the client feeling gently held, and respected in a state of peacefulness, trust and non-pressured 'letting go'. In the following extracts Archie talked of how his client's experienced this:

That is the benefit that allows them to then get into.., and the ability to surrender to themselves to their own body that it will flow and move in a more sublime and easier way, it's purely because their mind has let go and [] the body is very relaxed and open. And in that process of the client receiving that Trager [] if they've had a frozen shoulder or pain in their buttock or thigh or whatever the pleasant experience that they are receiving overshadows kind of reprogrammes that cellular memory [] and so that allows the physicality of the client to become rejuvenated with pleasurable new experiences (L522-533).

They go into their sub-conscious state which is ideal because then the mind's not in the way so even if they are asleep they're not consciously aware what's happening but their cellular memory is receiving everything (L211-213).

The impression this gives is that in achieving hook-up Archie's therapeutic relationships involved him relating to his clients in a manner that made it possible for him to work with them to achieve positive effect with the Trager therapy. In addition there is an acknowledgement that this is a two-way process that the client has to trust in him as a practitioner to allow this to happen. During the interview Archie conveyed an appreciation of how his clients contributed and committed to this, which is captured in the next section in which he talked of honouring his clients.

Honouring being with the client: 'it's a sharing of oneness of the opportunity that we exist in life'

Honouring is a familiar concept within talking therapy. For example, it is one of the the four principles of Existential psychotherapy (Lantz, 2004; Cooper, 2015). Solution-focused therapy talks of honouring the client's preference for change (Lewis & Osborn, 2004) and in Person-Centered counselling, the most fundamental value is honouring the client as the authority on his or her own life (Bozarth, 1998) or as Rogers phrased it 'prizing' the client (Rogers, 1957/1992). But perhaps the most salient interpretation that fits with Archie's representation of honouring is found in experiential therapy, where it is discussed in relation to honoring the client's readiness and willingness to put themselves in the hands of a therapist (Mahrer, 1996). For Archie honoring appears to be linked to his appreciation of the privileged position he considered himself to be in as a Trager therapist. He talked of feeling fortunate that he had experienced a sense of compatibility with his clients and indicated an acknowledgment of the vulnerability of the client positioned: 'because they've offered themselves so you have to give them respect for that and to honour that, and treat them with care and thoughtfulness' (L294-296).

During the interview Archie gave two distinct examples of how he experienced honouring his clients. The first is in relation to the physicality of his clients bodies. Just as he talked earlier of appreciating beauty in the physical form, in the following extract Archie spoke of honoring the overweight bodily form of some of his clients:

If the client is like 15 stone or something, you know big, and usually the 15 stone weight it usually comes with the large stomach, which becomes like another organ, you know it's like another arm or shoulder, it's just massive. So you're working with that as well, which is quite fun actually! And it's great for ladies 'cause you're honoring their overweightness, you're giving them feedback that this is definitely their body it's not something they need to hide (L232-236).

Here honouring the client's body for Archie seems to be about not judging them on their physical appearance but being accepting of it, particularly in relation to his female clients. Integrating body fat as a legitimate part of their physical form to be touched and worked with can be seen to challenge the social construction of how body fat is often viewed as something that shouldn't be there and is disavowed. Tischner & Malson (2008) emphasize how this is particularly the case for women as slenderness is such a major aspect of our culturally constructed beauty ideal for women (Bordo, 1993; Chernin, 1983; Malson, 1998). Wolf (1991), specifies that standards of Western beauty dictate that women are largely valued by their attractiveness, therefore women's worth is primarily measured by how well they fit into the standards of beauty created in Western society (Carneiro, Zeytinglu & Hort, 2013). In specifying honouring female as opposed to male overweightness, Archie appears to acknowledge this gender differentiation, seeking to address it by talking about working with women's overweight bodies in a positive light and seeing it as his role or perhaps as a fortuitous side effect to give body confidence to the client.

In the next extract Archie's honouring of his clients goes beyond his aesthetic perceptions of the appearance of their physical form, to a more philosophical representation of their personhood, in what he referred to as the 'essence of themselves':

Whether the client is actually a beautiful person or grossly unattractive that's the other nice thing that therapists, body therapists have to work through or be with, is that you are not just working with their physicality you are working with the essence of themselves (L453-455).

The inference here is that Archie experienced 'being with' his clients on both a physical and an esoteric level, as a prerequisite of his role as a body therapist that required him to acknowledge and overcome any personal views he had on physical attractiveness. There is a link here with talking therapy, where the concept of 'being-with' the client is particularly associated with Existential psychotherapy, where priority is placed on non-evaluative monitoring of the therapist's attitude and behaviour (Spinelli, 2008). Archie's use of the phrase

'working through' alongside 'being with' could be seen to infer that his acceptance of his clients as they present to him is process that he needed to commit and attend to. Mearns and Cooper (2005) talk about this in terms of psychotherapist's connecting with their clients at a level of 'relational depth' that is more than not judging a person or accepting them how they are but is "a positive affirmation of the client down to the very essence of their being, a confirmation of their uniqueness, individuality and humanity" (Mearns and Cooper, 2005: 43).

In the following quotation Archie gave a more detailed account of how he experienced relating to his clients in this way. Here, he described it as a privilege to 'be with' a client both on a physical level by holding their head and on a meta-physical level by what he experienced as connecting with their soul. His specific reference to how this related to Craniosacral therapy is a reminder to how in the preceding chapter Hannah also talked of experiencing a depth of therapeutic relationships that involved her connection with the client's soul:

If I am holding someone's head like the people do with Craniosacral, that's part of Trager you just be with their head that to me is a great privilege. You are [] holding the head of a person that is a soul, that has been through many, many thousand lives just like all of us, [] in that holding of that head you have a privilege to just, to be with that for that three or four minutes, their eyes are closed so they are in trust so that this is a privilege to receive even though you're doing nothing just honouring the fact that we're together.And yet when you get off the table we're not together in the same way. Because we were in that moment of transcendence, in a moment of uniqueness, which is not personal it's nothing to do with their personality, it's nothing to do with my personality, it's a sharing of oneness of the opportunity that we exist in life (L457 – 466).

Archie depicted connecting with the soul of a person as a brief and transient encounter that he honoured for what he considered to be his privilege to be part of. His use of the word transcendence implies that at this point his therapeutic relationship was above and apart from the physical relating of bodies or the mental relating of minds and was the ultimate 'being with' experience for him. His use of

the terms 'togetherness' and 'oneness' suggest he experienced complete unity with his clients that required them to trust in him, and him to be fully present within the encounter. Therapeutic presence in the form of a therapist's availability at a certain time and place is felt to be reparative in itself to most clients in psychotherapy (Baldwin, 2000; Clarkson, 2003) "involves bringing the fullness of oneself to the interaction" (Jacobs, 1989:41) and requires therapists to be fully in the moment on a multitude of levels, physically, emotionally, cognitively, spiritually and relationally (Geller & Greenberg, 2002, 2012).

The suggestion of there being different levels within Archie's therapeutic relationships has been commented on so far in terms of how he related to his clients holistically, as mind body and spirit, reference to the cellular level of body memory and the subtle body in his belief in the energy of Chi. In the next section this theme is discussed in relation to Archie's use of touch and details a specific therapeutic relationship Archie described within the interview to illustrate this.

Touch and the relationship: 'you're aware of all of these levels but you don't knit them together'

The final theme identified focuses on how Archie spoke of there being different levels of the therapeutic relationship within his Trager practice that corresponded with his therapeutic use of touch on the body. For example, his initial meeting and rapport building with his clients involved no physical touch; introducing the Mentastics brought movement into the session but he didn't touch his clients until they were on the treatment table and he commenced the hands on Trager work. Archie acknowledged how this transition could be potentially unnerving for the client as they anticipated what was going to happen next. His response to this is outlined in the following quotation:

So you then go through a series of gentle touches to allow them to feel confident and nurtured and cared for. When that feeling is there, embodied in them, you then proceed with the work, although it's obviously sensitive too ..it's not like invasive or sexually explicit at all, even though for some people

who have not been used to touch it can be quite overpowering if they've not been touched, so you do it especially with care (L401-405).

This demonstrates Archie's awareness of the need to gauge the level, amount and timing of touch in his bodywork practice and implies that his clients' feelings of confidence and of being nurtured and cared for, were important aspects of his therapeutic relationships for him that could be evoked by his gentle touch on the body. Archie was also acknowledging of the need to continue to use touch with sensitivity because of what he indicated was the vulnerability of a client when lying on the treatment table. Specifically, his comments about his use of touch being neither 'invasive nor sexually explicit' suggests he had a professional practice boundary that he kept within that protected his therapeutic relationships from being experienced as inappropriate, unpleasant or abusive by his clients.

Writing on this concern in relation to the use of touch in therapeutic practice Kepner (1993) states the most obvious and fundamental boundary a therapist must maintain is that under no circumstance should they engage in any form of sexual relationship with a client. He argues that body-orientated work that uses touch as an intervention tool, places the client and therapist in an unusually close and intimate position. On a physical level this involves a closeness of proximity much more than in a social situation, and places the therapist in a greater position of power and influence over the client who is potentially more vulnerable than in other forms of psychotherapy encounter. In the following extract Archie made reference to these issues and made a very clear distinction between the relationship he had with his clients with and without touch:

There's all these degrees of peoples sensitivity, their vulnerability and what you're.., what they are exposing themselves to so that when they are off the couch there is this definite difference between your relationship with them when they are on the couch. It's like a lateral and vertical, it creates in the mind a whole new set of relationships. Only if for instance, some people are very expressive they want to give you a good hug afterwards, which is quite often the case, then you accept that at that level and it's just a hug [] it's not like you're my girlfriend you're my wife or whatever and you're protecting them

and putting your arm around them to take them downstairs, it finishes. That doesn't get into it. You can't do it otherwise you're into a whole problem of ethics, which you don't want to go into at all. (407-416)

Here Archie indicated he was very conscious of the difference in his practitioner-client relationship as soon as he had stopped touching the client's body. He implied that the lateral relationship (when they are on the couch) and the vertical relationship (when they are off the couch) were not only practically different in terms of positioning and proximity, but that he held them in mind differently. This has echoes of various psychotherapy approaches and particularly the use of the couch in psychoanalysis.

There is also a sense that Archie was vigilant in monitoring and maintaining this boundary, seeing it as needing to be guarded and sustained. There is a suggestion that in accepting a hug initiated by the client in the vertical (no touch) position Archie viewed this as permissible as an expression of 'thank-you' or confirmation of the ending of a session. Or perhaps this was an indication of a reapportioning of the power differential as generally in any dyad it is the person perceived to be more powerful who initiates contact (Fox, 2003).

Whatever the meaning from the client's perspective, Archie made it very clear that for him it represented touch at a 'level' that was of that moment and belonged to the professional relationship he had with them as a practitioner but was not part of an additional social or potentially intimate relationship. His view of the inappropriateness of his use of touch that could be interpreted as anything other than professional is reinforced by Archie's reference to such behaviour having unwanted consequences in terms of what would then be his unethical practice. In the following extract, Archie adds what appears to be a more personal conceptualisation of how he viewed this horizontal (touch) and vertical (no touch) relationship distinction:

If someone's on the couch, you've spent an hour touching and jiggling and moving their limbs and this and that and the other, then they get off the couch and it's as if you've not ever touched them [] it's a totally other world (L290-394).

The way in which Archie described his use of touch as an acknowledgement of prolonged movement and contact with the body and then immediately afterwards almost denied it and distanced himself from it by assigning it to 'another world' again indicates a very distinct demarcation in his relationship with his clients. This reinforces his 'it finishes' comment in the previous extract and suggests that however close and intimate his use of touch on the body was experienced by either him or his clients, the vertical relationship ends as the horizontal relationship re-commences.

In one respect, this may be viewed as a harsh switch from the personal to the impersonal that questions the depth of feeling Archie had towards his clients. However, in the following extract, he gave an example of a therapeutic relationship he had with a female client that did convey a sense of very deep emotional relating. Archie explained he had been treating this client regularly over a period of several years and that both she and her husband had been diagnosed with cancer and she was using Trager "as a way to upgrade their immune system to empower their energy field to go through the struggles of potential cancer for themselves and their husband" (L369-371). The extract refers to an occasion when Archie was treating her in the hospice where her husband was receiving medical care:

She'd just finished her Trager and we sat then on the end of the couch [] and I just put my hand up on the base of her spine [] and she suddenly said she felt this great sweep across her back and I said "that was your husband just saying goodbye to you" and she realised that because he had just died. [] So that's a level where you do get intimate on an emotional level with the client because that's so much a part of why they are coming to you. [] I already had a rapport and she's of the character that she'd tell you her whole personal life anyway whether you wanted to hear it or not you got it but it's always interesting because oddly enough we had very similar backgrounds with all sorts of layers [] in that circumstance it gives a session another horizon because there's layers of it. There's the straight forward treatment, then supporting that there's the relationship, which can be at a professional level and then there's another level that comes in, where you're sharing in emotions [] you're aware of all of these

levels but you don't knit them together into being "you've become my friend for life" (L360-382).

Here Archie indicated there were several levels of connection he might have within a therapeutic relationship: a shared rapport, a social identification and a level of emotional intimacy. In this particular example this level of emotional intimacy was reached at the moment his client's husband died. The way in which Archie described how this was known to them by the experience of his therapeutic touch, can be understood in terms of what Gendlin (1997) referred to as a 'felt sense'. This phenomenon refers to a way of knowing that is responsive to bodily evocative dimensions alongside logic and language (Todres, 2011); a way of embodied understanding. This suggests it was experienced as a moment of relating that fell in to Clarkson's (2003) transpersonal modality: "the spiritual, mysterious, or currently inexplicable dimension of the healing relationship" (Clarkson, 2003:20).

Alongside his identification of what were for him very distinct layers to the therapeutic relationship he had experienced generally, and specifically with regard to this client, Archie was equally unequivocal in terms of how separate they remained, or as he put it 'didn't knit together to make a lifelong friendship'. Thus reinforcing that therapeutic relationships for Archie were ultimately professional relationships regardless of the nature and extent of the physical and/or emotional connection they entailed.

Within this interview with Archie, a central underpinning of the way he experienced his therapeutic relationships was concerned with his way of being and the sense of personhood that influenced his approach to bodywork. Themes of: dancing together with his clients in an appreciation of beauty and mutual benefit, mind-body relating by rapport building and tuning in, the role of the Chi and honouring the physical body and the subtle body and the person as a soul were identified. This culminated in a clear depiction of a variety of levels on which Archie related to his clients that gave both emphasis and boundary to the salience of touch within the therapeutic relationship.

Case Study 3:

Embodied Therapeutic Relationships in Colonic Hydrotherapy

Jilly was a part-time Colonic Hydrotherapist who worked in private practice at a complementary health care clinic in the South West of England. Her practitioner information leaflet claimed colon health has a direct relationship to general health and whilst the colon, like all other organs in the body should be self cleansing, factors such as poor diet and stress inhibit the body's ability to do this. Jilly stated that anyone with a history of consuming a 'Western' diet of predominantly refined or processed foods and is exposed to high levels of stress, could benefit from colon cleansing via Colonic Hydrotherapy. Specific conditions she claimed this form of bodywork could help included: abdominal pain and bloating, fluid retention, liver and kidney conditions, back pain, Candida, ME, asthma, poor concentration, insomnia and psychological problems.

Jilly was also a qualified nurse with thirty years experience working in the National Health Service that had culminated with her being a theatre sister in gastro-intestinal surgery. She recalled how at the start of her nursing career, nurses had a lot of influence over how patients were treated on the hospital wards and used a lot of naturopathic methods in their care practices. However, she felt that increased use of technology and reliance on pharmacy within the NHS had resulted in a move away from this holistic approach. Naturopathic practice is based on a belief in the body's ability to heal itself through a vital energy guiding bodily processes internally and prioritizes natural treatments such as homeopathy, stress reduction and changes in diet and lifestyle over the use of surgery and reliance on drug treatment (Attwood, 2003).

Jilly's decision to leave the nursing profession came after she experienced a 'Kundalini Rise' which she explained as a spiritual awakening that put her on a different path, looking again at more natural ways of doing things and recognising the spiritual element of phenomena. During what she described as a process of self discovery, Jilly began to study natural methods of healing and cleansing the body in order to restore balance and optimal health. Ultimately she discovered

Colonic Hydrotherapy, which she found to be personally profoundly beneficial and this prompted her to train in this form of bodywork.

According to the Association of Registered Colon Hydrotherapists the treatment involves warm filtered water being piped into the colon through a small tube called a speculum that is gently inserted about an inch and a half into the rectum. As the colon fills and empties repeatedly, the therapist massages the abdomen and carefully controls the water pressure and temperature. This promotes the elimination of waste matter and toxic substances and helps restore the natural function of the colon. Additional benefits are said to be observed throughout the body such as fewer headaches, reduced allergic reactions, clearer skin and increased energy and mental clarity (<http://www.colonic-association.org>).

Jilly described her experience of practicing Colonic Hydrotherapy as more than performing a physical bodily procedure. The relationships she had with her clients were important to her, not least because she recognised how invasive, potentially fear inducing and embarrassing the treatment was for them. The way she discussed this led to the initial theme of 'honour & trust'. The other main themes identified within Jilly's account were: ways of 'knowing', the interpretation of her work in terms of 'energy' and her use of an 'embodied language'.

Honour & Trust: 'it really is quite an Honour to have people trust me'

In her account of how she experienced being a Colonic Hydrotherapist, Jilly talked of needing to have a relationship with her clients in order to work with them otherwise 'you're kind of performing a routine on a body but not connecting with a person' (L531). She described how she sought to develop this starting from the initial telephone conversation she had with them when they made the appointment to see her from which she gleaned a lot about the attitude her clients held towards themselves along with the reasons they gave for wanting the treatment. Jilly said she then combined this with the verbal information and non-verbal cues she received from them when she met them. In this initial session, as the following extracts illustrate Jilly saw trust as vital to developing a therapeutic relationship with her clients:

When you meet someone for the first time, from a therapeutic point of view, you have to be able to establish your trustworthiness from the very first second, the very first eye contact (L103-105).

The therapy is actually secondary to the relationship you have with the practitioner, that's the most important thing because it establishes trust and then you can move forward. You can't move it anywhere until you have that (L241-244).

Here Jilly talked of trust as the key to both establishing the relationship and enabling the therapeutic process to follow. In particular, it was her clients' ability to trust her as the practitioner, that she considered so crucial and required her to be aware of how she presented to them from the moment she met them. For example, she talked of it being important that she wasn't 'tetchy' and didn't let her own concerns detract her focus away from the client and the Colonic Hydrotherapy process, or that she forgot how fearful or embarrassed her clients were likely to be and appeared 'scary' to them. To put them at ease, Jilly told me she always talked to her clients before they got onto the couch, and prepared them for the bodywork by telling them when and where she was going to touch them and always explaining what was happening to them. Jilly's conceptualisation of how trust features in her therapeutic relationships is further illustrated in the following extract where she acknowledged the vulnerable and trusting position her clients placed themselves in when they came to her for a Colonic Hydrotherapy treatment:

Because of the nature of what I do [] it really is quite an honour to have people trust me enough not just to perform the act of doing a colonic but to be able to be completely accepting of everything and anything that happens to them in their complete vulnerability (L133-135).

Jilly's use of the term honouring here, as a response to the recognition of the level of trust she experienced her clients demonstrated in her, infers she saw her therapeutic role as a privileged position, because she had been entrusted with her clients 'complete vulnerability'. On a physical level, this involved her seeing and attaching a tube to an intimate part of their body and performing a procedure that rendered them subject to a loss of control over their bodily functions. Fox (2008)

comments that whilst all complementary therapies that involve the practitioner touching the body invoke a level of intimacy within the therapeutic relationship, this is most pronounced in those that necessitate the client's nakedness where the potential for activation of unconscious process is more likely.

Jilly spoke of how this experience was different for each individual and across genders 'men are very much more uptight than women are' (L493), but said that if her clients were able to trust her enough to 'let go' in the treatment then it could be very rewarding for them both physically and mentally. There is a similarity here with how Archie also spoke of his clients needing to 'let go' in his Trager therapy for this to maximise the treatment's effectiveness. What became clear from Jilly's account was that for her Colonic Hydrotherapy was more than just the physical, functional colon cleansing routine; it was a combined mind and body, holistic process. As the following extracts indicate, Jilly didn't see it as her role to direct the Colonic Hydrotherapy procedure, but to guide and honour her clients in this process:

It's not my place to send them out with a scrubbed clean colon at all costs. []
That's not *honouring* the process that the client has to go through, this process that their body wants to go through (L300-304).

I see my job as leading someone to fix themselves, if they need fixing. So really what I do is holding space for them, giving them prompts to be able to come forth with whatever they want to express, and I'm definitely not judging it just allowing things to be exactly as they are. They will go through their own process. I am a sort of facilitator but I don't have any role in telling them what to do or in even..., I mean I guide the process [] and I keep it safe, but I never force the body to yield unless it's ready (L4-11).

This suggests that honouring within her therapeutic relationships involved Jilly monitoring and responding to her clients bodies in a manner that gave them control within the therapeutic encounter. Similarities can be drawn here between the way she described herself as being non-directive and facilitating the client's embodied process, and the theoretical underpinning of Humanistic therapy, particularly Rogers's notion of the client knowing best:

“It is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried”

(Rogers, 1961:11-12)

The difference here is that rather than the client talking about what is to be addressed in therapy, Jilly specified the body as knowing and expressing this under her guidance and facilitation. Her use of the terms ‘holding space’, ‘not judging’, and ‘keeping it safe’ along with trust, are all synonymous with psychotherapeutic definitions of key elements of a therapeutic relationship (see Rogers, 1951, 1959, 1961).

Equally, honouring the trust a client places in a therapist is one of the ethical principles for practice outlined by the British Association for Counselling and Psychotherapy (BACP, 2013). Jilly indicated she acted in accordance with this principle and also applied it to herself and her practice ‘if you’re doing this and you’re committed to it then you honour yourself and you honour the other person, you honour exactly what you are doing’ (L627-629). She told me that this was how she ensured she was able to do her very best for her clients, and that it was what was most important to her in her therapeutic practice, along with ‘knowing what you are doing’ (L661). The concept of knowing, and its relevance to how Jilly experienced her therapeutic relationships was the next major theme identified.

Knowing: ‘It’s intuitive, you know, it’s something that I do’

Throughout the interview, Jilly discussed the concept of knowing in several different ways. In terms of her professional competence she said she relied more on what she knew from her intuition than she did from her professional training in both Colonic Hydrotherapy and nursing, as illustrated in the following extracts:

It’s intuitive; you know, it’s something that I do. It’s this business of um, the learning process where you become aware when you know nothing and you don’t know that you know nothing and then you move onto knowing what you don’t know, and then you move onto being consciously competent until you

move into being unconsciously competent and that's the stage that I'm at, at the moment. And it comes through nursing as well of course (L13-18).

I trained so long ago that we were still half witch I think (*laughs*) [] doing lots of naturopathic practices to manage crises and things on the ward. Nurses seemed to have very much more say over what happened with caring for people, like the surgeons and the physicians were almost invited guests, visitors so we did a lot of naturopathic things which started going out of the window in the 1970's when things became very much more technological and lots more pharmacy and lots more kind of masculine control on things (L90-96).

Jilly's comments here suggest she measured her therapeutic skills in terms of the assimilation of her intuition into her professional practice over time, which she applied to both Colonic Hydrotherapy practice and nursing. Referring to herself as 'half witch' suggests this way of being for her had an esoteric or even magical quality. Historically, witches were seen as women with unexplained powers; often feared and categorized as mentally ill (Szasz, 1972). In an attempt to legitimize the potential healing capacity of woman and offer an explanation as to why this has previously been viewed as secondary to the medical skills of men, Ehrenreich & English (2010) contend that the suppression of witches in medieval Europe was a significant contributor to the rise of a male orientated medical model of healthcare. Jilly's observation of how she felt the National Health Service had changed reinforces this view and infers that her practice as a nurse also changed as a result of this. Specifically in terms of the reduced amount of power and influence she had on the way she behaved towards patients and in terms of the forms of care nurses could provide.

In the following two extracts Jilly gave an indication that this way of intuitive knowing formed a significant aspect of her personhood, as she reflected on how she had experienced this in both her early nursing career and in her childhood:

I used to be able to put myself into the patient if you like [] and I could feel how a paralysed patient wanted to lie, so I was able to position them really comfortably (L327-330).

Looking back now I realise this was present right from being very small. This knowing when things are wrong and knowing when people were actually completely mistaken and hadn't got it right, that it was something in me that knew (L208-211).

The sense this gives is that this knowing for Jilly was both intrinsic and embodied (something in her) and that she could draw on this in relation to her Colonic Hydrotherapy clients, which she attributed to the therapeutic relationships she had with them or as she phrased it 'the whole connection thing' (L79). For example, she said she knew very quickly how 'giving or defended' a client was from such things as watching their body language, listening to the quality and tone of their voice, what they said and noticing whether they listened to her or interrupted her.

Jilly also explained how she knew what physical sensations her clients were experiencing, particularly as the treatment unlocked emotions that had been stored in the body's memory. She commented that despite her belief that it was impossible to separate the body, mind and emotions, her clients were often cut off from feeling things in their body and were therefore unaware that the physical ailments that brought them to her had an emotional origin. The following extract illustrates how Jilly viewed the body as more powerful than the mind, and therefore how alert she felt she needed to be to the body's physical and emotional expression during the Colonic Hydrotherapy:

The colon starts to release and they can feel quite a lot of sadness or anger or fear. I have to be aware of that, and hold the space for them, and reassure them [] if they bottle it verbally, the body will overwhelm them [] I see that happening by the pressure building in them, the tension is building up there's eye movements, there's the colour of skin, there's the way the heat moves there's tension in the way the colon is responding because I can feel the movements. My hands are on the tubes and they're like an extension of them (L271-280).

Here the relationship Jilly had with her clients seems to be concerned with her monitoring their physical and emotional release and providing a reassuring presence both emotionally and physically. This is seen in the way she again talked

of 'holding the space' for her clients, inferring she provided them with a supportive environment akin to Winnicott's holding environment (Winnicott, 1965) and in how she described her hands on the water tubes as a physical extension of the client themselves, and therefore she was both emotionally and physically connecting with them.

With regard to what can be interpreted as her experiencing an embodied connection with her clients, Jilly also spoke of often experiencing physical sensations in her own body: 'I can feel pain and I can feel other things in my body when I'm working with someone and even when I'm sitting with them' (L305-307). With experience she said she was able to recognise that these were not her real feelings and would therefore reassign them to her clients where she knew they belonged. This suggests a high degree of inter-subjectivity between Jilly and her clients and there are obvious parallels here with the Psychodynamic psychotherapy concept of countertransference where feelings and experiences are triggered in the therapist by their identification with the client's experiences, feelings and situation. As cited by Eagle (2000) initially termed 'an obstacle to analysis' by Freud (1910) countertransference has since been considered 'an indispensable instrument' (Gill, 1994) and a 'crucial source of information about the patient' (Gabbard, 1995). The following quotation shows how Jilly checked out her knowing that her embodied feelings related to the client, in order to help them deepen their self awareness:

If I feel something in my body and the client's not [] aware of what really is going on with them, I will say something or lead them to see if, .. no lead them is the wrong word, I'll offer them an opportunity to express something about themselves, which will confirm what I'm feeling (L312-315).

Looking for confirmation of her feelings in this way can be interpreted as Jilly seeking to maintain the inter-relationship between her own mind and body, and the mind and body of her clients whilst still being aware of their separateness. What she knew to be her's and what she knew to be her client's. This 'embodied knowing', how Jilly interpreted her clients' bodies and her own body, links to the writings of Merleau-Ponty on reversibility as discussed by Muller & Tillman (2007):

“Merleau-Ponty argues that my body and yours are not the private mutually exclusive, solipsistic domains of Cartesian philosophy. Rather there is a relation of reversibility between the perceiver and the perceived, between the body as sensing and the body as sensed, between my body and yours.”

(Muller & Tillman, 2007:61)

The way that Jilly experienced receiving information about her clients' bodies through her own body, can also be seen in terms of Gendlin's 'felt sense' a preverbal sense of something that is experienced in the body (Gendlin, 1981) or Cooper's definition of embodied empathy as a full-bodied resonance with the client's being (Cooper, 2013). One particular way in which Jilly conveyed experiencing this phenomenon was in terms of energy. This is discussed in the next section as energy was another theme that was identified within Jilly's account of her experience of practicing as a Colonic Hydrotherapist.

Energy: 'it's just an energy thing that goes on'

Jilly made reference to energy as an aspect of her therapeutic relationships in several ways within the interview. For example, she spoke of her clients' decision to book an appointment with her as an indication that 'the energy within them was moving' (L62) in preparation for the Colonic Hydrotherapy; when she then met them, the first touch she had with a client was 'putting my hand over the solar plexus, so feeling the energy field' (L491). In the following extracts, Jilly described how she experienced feeling energy both within her client's body and in her own body when she was working with her clients:

I can feel the energy and I can feel it moving you know, I can feel it go hot and cold and all sorts of things and tingling and so on (L340-341).

I often feel it in a sort of energetic way, in the chakras. I can feel tightness here in my chest (*demonstrates*) I can feel butterflies in my stomach maybe or my knees will ache or something like that. It's different, different each time (L319-321).

The way Jilly described her body as a receiver of energy, like some sort of barometer or radar picking up information from her clients, is similar to the accounts psychotherapists gave in a study conducted by Shaw (2003) who reported their bodies becoming attuned to the client within the therapeutic encounter “as if they can pick up ‘client material’” (Shaw, 2003:97). Jilly’s account of this phenomenon indicates an holistic conceptualization of mind and body as she interpreted such intersubjectivity within her therapeutic relationships in a physical sensorial way, such as feeling a change in body temperature or an ache, that for her was part of an energetic process as the following extract also illustrates:

When they come in something happens as they move into my space, my energy field and the closest I have ever come to describing it is *Alchemy*, an alchemical process (L35-37).

Jilly’s reference to chakras, energy fields and alchemy give an indication of how she may have conceptualized her therapeutic relationships in terms of energy. Within Complementary and Alternative therapy (CAM) an energy field (also commonly called the aura) is understood as a unique set of atoms and vibrations that surround a person, receiving energy from the universe that sustains the body, mind and emotions. The body’s chakras (translated from Sanskrit to mean ‘spinning wheels of light’) are described as the body’s seven energy centres through which energy flows and nourishes the body with life force energy. These are referred to by different names such as chi, ki, prana, and mana (<http://www.naturaltherpypages.co.uk>).

When I asked Jilly to talk some more about how she viewed energy to be part of her therapeutic relationships, she made reference to the work of Rudolph Hauschka a pioneer of natural medicines and skincare products and author of several books including in 1966 ‘The Nature of Substance, Spirit and Matter’. Jilly explained she shared Hauschka’s view of energy as part of a universal ‘energetic exchange which goes on amongst all substances in the universe’ (L41-42). The way she talked about this as an inevitable and instantaneous reaction between her and her clients is similar to how Carl Jung discussed the potentiality of the

therapeutic relationship in terms of an alchemical process in his book 'Modern Man in search of a Soul':

"The meeting of two personalities is like the contact of two chemical substances: if there is any reaction, both are transformed."

(Jung, 1933:49)

Jung goes on to state that whilst it would be expected for the doctor (therapist) to have an influence over the patient (client) this can only occur if the therapist is also affected by the client. It is possible that such an affect was what Jilly experienced when she talked of there being a 'mutual exchange' (L151) in the positive therapeutic relationships she had experienced. For her, as discussed earlier, she felt honoured the client had trusted her enough to facilitate their process, which as the following extract illustrates, she described as rewarding due to the potential positive outcomes they could experience:

People can have, if they can let go into it, it is very rewarding for them because there is immense clarity and calm afterwards to the point of elation sometimes and I've had a couple of people who've actually had a Kundalini Rise afterwards (L161-163).

Jilly defined Kundalini Rise as an Eastern expression that refers to 'the serpentine energy that's supposed to lie coiled at the base of the spine and it can rise [] clear through the chakras and raise your consciousness' (L168-170). Having experienced this process herself she was able to identify with the positive experience some of her clients had had as a result of her Colonic Hydrotherapy treatment. Whilst she indicated this to have shaped her sense of personhood and spiritual identity, Jilly also spoke of this being a tumultuous time for her and her reflections on this are captured in the following extract:

I saw a whole differentjust completely different world, completely different world because my psychic facility switched on and my healing ability came through. It was pretty turbulent and I was very lucky to escape the psychiatrists (L190-193).

Jilly's comment regarding feeling lucky she wasn't diagnosed with a mental illness suggests the way she presented as a result of experiencing the 'Kundalini Rise' was not treated as a spiritual awakening within Western medicine. She explained how despite not really understanding what was happening to her at the time, she knew it was something very special spiritually, and told me she felt fortunate she had 'been guided to people with whom I can work, the energy's compatible and I've trusted them' (L232-233). This shows Jilly's awareness of her own vulnerability at that time and emphasises the value she placed on having 'compatible energy' as well as trust in her helping relationships and gives an insight into the qualities she valued in her therapeutic relationships.

In contrast Jilly acknowledged having had one or two difficult therapeutic relationships during the time she had been a Colonic Hydrotherapy practitioner. As illustrated in the following extract, she attributed these to her and her client having clashing energies:

There have been a couple of occasions where there's been a real jangle between the two energies [] something moves in the other person so much that they can react with irritation or anger or sudden sadness [] They don't behave in a bad way or anything like that, it's just an energy thing that goes on (L112-118).

Jilly gave a specific example of an occasion when with hindsight she realized she had ignored or overridden signs that the relationship with this female client was difficult. A few days after she had treated the woman she received a letter from her complaining about the treatment. In the following passages Jilly described her reflexive understanding of what had happened:

I do reflective practice of course I do, and these incidents, this is the only one, big one that's happened there's been a couple, always give me cause to reflect on my practice to see what I can do better and see what happened within me to contribute to this. [] I must have been distracted or something not fully present during the time that she arrived or the time that I was treating her and there could be all sorts of reasons for that but I have to take responsibility (L134-140).

What this appears to illustrate is how Jilly prioritised self reflection as a necessary part of her therapeutic role. Reflective practice is as an accepted and essential feature of practice in psychotherapy and counselling and counselling psychology which is used to help therapists fulfil the compulsory requirement for a reflective practice element in their training and continuous personal development as well as this forming part of the supervisory relationship. As cited by Stedmon & Dallos (2009) it has also sustained increased interest across other professions including nursing (Taylor, 2006) general health practitioners (Kember, 2001) Social work (Gould & Taylor, 1996; Fook, 1999) and Medicine (Greenhalgh & Hurwitz, 1998). Whilst historically ensconced in thought processes alone, a more contemporary view of the reflexive process across disciplines looks to the inclusion of sensory imagery, emotions and stored actions as valid forms of reflective activity alongside cognition, memories and language (Stedmon & Dallos, 2009:1).

Jilly said she routinely used reflexive practice to identify and take responsibility for things she hadn't done well (such as not being fully present with the client), that may have contributed to difficult therapeutic relationships. As the following extract highlights she also examined the part she felt the client had to play in this particular encounter:

It will probably bring this lady face to face with herself at some point because that was what it was all about. And all her rage came up and she just vomited onto the paper that night. And I warn people that this might happen "so please don't blame the practitioner" but I didn't with that one so, ...and she wasn't ready to own her stuff anyway. She'd started on a therapeutic path herself, studying some energy work and when you start that of course your own processes start kicking in like mad. You have to look at yourself all the time otherwise you're no help to anyone (L452-459).

This suggests Jilly was identifying with this client's developmental process, drawing parallels with her own spiritual path of learning and self awareness. It also shows how she differentiated between what she considered to be her responsibility in terms of how the client felt about the Colonic Hydrotherapy treatment, and what she felt the client needed to see and accept as theirs.

Reference to the client's rage highlights how Jilly viewed emotion as intrinsic to the embodied nature of her work. Her use of an embodied form of language to describe this is also an example of the final major theme identified.

Embodied Language: 'the body doesn't lie, the body will speak the deepest truth'

Jilly was clear within her account that in addition to Colonic Hydrotherapy being an obviously physical, bodily process, the relationships she had with her clients were embodied relationships because, in her view 'you can't divorce the body from the mind and emotions, it's all part of one process' (L298-299). How she conveyed this interconnectedness was with the use of what I have termed an embodied language. For example, the way she described her client's rage coming up and being vomited onto the paper evokes a vivid image that suggests a process of spontaneous embodied emotional release. This description of how Jilly experienced the client's reflection on their experience of receiving a Colonic Hydrotherapy treatment, echoes the way she described the treatment process itself in that ultimately 'the colon will overwhelm the body' (L273). The Association of Registered Colon Hydrotherapists also details the construction of embodiment in this way and as the following quotation indicates, highlights how this is reflected in language:

"There is a strong link between the gut and the mind, which is seen in our everyday language in phrases such as 'butterflies in the stomach' or 'stomach in knots', which reflect the way our state of mind can adversely affect our normal digestion."

(<http://www.colonic-association.org>).

Jilly used such embodied phraseology particularly when describing the bodily process of the treatment. The following extract illustrates the way she discussed how as well as physical causes digestive problems can also be the result of stress and emotional issues:

The colon [] it's right under the solar plexus, and every shock and insult that ever come their way is lodged in it because the first thing we do if we have an experience like that is tighten and that locks the memory into the tissue (L254-258).

The notion of the body's tissues having a memory that locks in emotional experience is explained as a mind-body process or more accurately, a brain body process involving intercommunication between the autonomic, sensory and somatic systems (Rothschild, 2002). It is particularly linked to research into trauma and the experiences of children who are not cognitively able to remember the details of their early abusive experience:

“Sensory memory is central to understanding how the memory of traumatic events is laid down – how, as Bessel van Kolk (1994) would put it, ‘The Body Keeps the Score’.”

(Rothschild, 2000:44)

Things being out of consciousness, or rather out of the predominant Western tradition of thinking as the primary focus of memory processing, is also suggested in the phrase Jilly used: ‘once we get into the process then all sorts of other things come out of the depths’ (L28-29). Here Jilly was explaining how her clients generally came to her wanting to feel better on a physical level and were unaware that being uncomfortable in the lower part of their body had ‘ramifications’ for the rest of the body, their emotional wellbeing and ‘the whole of their life’. The language she used here provided a very literal analogy of the deep cleansing function of Colonic Hydrotherapy as well as suggesting an expression of verbal disclosure.

In the next extract, Jilly used similar metaphorical language to explain how being receptive to her clients required more than the physicality of her gaze:

It's not just eye contact, you have to have your heart open too and be completely receptive which sometimes means a bit of a smack in the stomach energetically (L107-109).

Reference to needing to have her 'heart open' and potentially receiving 'a smack in the stomach' creates a graphic and impactful visual image of this embodied process for Jilly. In Eastern thought and practices such as yoga and mindfulness meditation, having an open heart is stressed as an ideal way of being that benefits the self and others. In the chakra system the heart chakra is concerned with love, kindness and affection; when it is open, you are compassionate and friendly and you work at harmonious relationships (Berkers, 2014). Given that Jilly had previously made reference to the chakra system and had been unequivocal in stating that having a therapeutic relationship with her clients was important to her, it can be inferred that she worked at having harmonious therapeutic relationships. However, an inherent danger attached to this is suggested by Jilly's warning of the potential negative consequences of feeling as if she had been 'smacked in the stomach'. This implied she might expect to experience shock, violence and pain within the encounter, as which is amplified in this next extract:

Occasionally, just occasionally someone is so defended and deep in their own mire [] that something moves in the other person so much that they can react with irritation or anger or sudden sadness [] then I'm on hyper alert and I'll have to be sort of more careful tread more carefully (L111-119).

Again the language Jilly used is both literal and metaphorical. It conveys a need for her to be vigilant within her therapeutic encounters and aware of a range of emotional reactions the client could experience in response to the treatment that might affect the therapeutic relationship. Her belief in the honesty of such embodied reactions is captured in the following quotation:

The body doesn't lie; the body will speak the deepest truth (L413).

Jilly explained this to mean that in her experience her clients were often unable to speak their truth because their consciousness was such that they were completely cut off from the reality of who they were and often unable to feel things in their body. She suggested this may be an unconscious process or even a conscious or semi-conscious attempt to protect themselves in the face of the confusion she believed people experienced because 'its jolly hard work to get in touch with what's really going on' (L426). This suggests Jilly viewed the body as a sort of

truth teller to be trusted more than what someone was able to say about what they were experiencing. There is an implied identification with her own experience of getting in touch with what was really going on for her and an inference therefore, that allowing the body to be heard within her therapeutic relationships was an important part of her role as a Colonic Hydrotherapist.

From this interview with Jilly it was apparent that her own experience of a spiritual awakening had not only steered her towards practicing as a Colonic Hydrotherapist but also underpinned her sense of personhood. This was reflected in the identified themes of: the importance for her of honouring and trust in her therapeutic relationships, her certainty in knowing through intuition, physical connection and how she interpreted energy to be part of her work and how her use of language reinforced the embodied nature of this. Alongside these there was a poignant recurrent differentiation Jilly made between Western methods of medical treatment and alternative methods of healthcare originating in Eastern philosophy and naturalistic practices.

Case Study 4:

Embodied Therapeutic Relationships in Bowen Therapy

Rhian was a full-time Bowen therapist who practised in two locations in different areas of the UK. In the South West of England her Bowen therapy practice was in a well established Complementary Healthcare clinic, which offered a range of holistic therapies alongside talking therapies. In the North East of England, she practiced within the newly established integrative health centre she had played an important part in setting up that advocated a holistic approach to healing and combined traditional medicine and complementary therapies. Within both practices Rhian worked with people of all ages. According to her practitioner information leaflet common presentations people came to her with were: back and neck pain, sciatica, sports injuries, repetitive strain injury (RSI), and frozen shoulder; in addition she stated that Bowen therapy, also referred to as the 'Bowen Fascial Release Technique' could help people with such conditions as acute and chronic fatigue, digestive problems, respiratory difficulties and infant colic.

Rhian described herself as 'so plugged into the world of Bowen' (L474 - 475). As well as practicing Bowen therapy she worked alongside other Bowen therapists and she was also a tutor with the European College of Bowen Studies teaching the Bowen technique to individuals and healthcare professionals throughout the UK. Rhian continued to study anatomy and the effects of Bowen therapy on the human form and, to support her work with children, she was completing a Certificate in Emotional Literacy for Children with the Institute for Arts in Therapy and Education (IATE).

Rhian told me she trained in Bowen therapy after she discovered for herself how effective it was in resolving physical conditions she had suffered with that had previously been diagnosed as chronic and other treatment approaches had been unable alleviate. Being resigned to the notion that she would have to live with a certain amount of pain and restricted movement, Rhian found her Bowen treatments transformational; intrigued by this she decided to find out more about how this bodywork technique worked.

According to her website, when the body is compromised by physical injury, poor posture, emotional holding or constant stress, symptoms often follow such as: aches and pains, stiffness, headaches, asthma, irritable bowel syndrome and whiplash amongst others. Bowen therapy claims to support and help restore the body's structural and integral functioning. It is described as a gentle hands-on method of bodywork whereby mild non-invasive movements are made across specific areas of muscles, ligaments, tendons and other connective tissue. This triggers the receptors that are involved with the tension of muscles that hold the body in correct alignment. Rhian told me that on most occasions she could get someone out of pain and discomfort within three treatments and then she focused on improving their general wellbeing 'more of a maintenance type work rather than first aid' (L41).

Alongside Rhian's Bowen therapy activities, her spiritual practice of Buddhism was an important and integral part of her life that was central to her sense of personhood. She explained that studying the philosophy of Nichiren Buddhism (a Japanese Buddhist movement in the Mahayana Buddhist tradition) and chanting to raise her life state (a daily morning and evening practice known as 'gongyo' that consists of chanting 'Nam-myoho-renge-kyo' and reciting parts of the Lotus Sutra one of the sacred scriptures of Buddhism) was a fundamental aspect of her life rather than just something in her life. She described this as "my life blood" (L694) and explained how living by these principles had given her "big awakenings" that had influenced all aspects of her life.

Within the interview, the influence of her sense of identity underpinned by her spiritual practice was seen in the way Rhian discussed the therapeutic relationships she had with her clients. Specific themes identified from this were: the importance she placed on having a connection with the person before she started working on their body, her need to maintain personal and professional boundaries within her therapeutic relationships, embodied knowing, and how she experienced the maintenance of connection within her therapeutic relationships in the face of blatant disconnection potentials such as her clients altered states of consciousness and her leaving the room.

‘Having that Connection: ..and really meeting them before you treat them.. is really important to me’

Rhian told me that due to the problem-fixing nature of Bowen therapy, the initial focus being to get the client out of pain, talking with her clients was an important aspect of her therapeutic role. Particularly in the first session when she needed to get a lot of information from them about the difficulties they were experiencing in their body. She stressed that ‘nobody walks through the door and jumps on the table’ (L93) and explained how this verbal information provided her with a baseline assessment that she then used as a comparison to how her clients were each subsequent time she saw them. Whilst it initially seemed as if Rhian was simply describing a fairly standard procedural note-taking exercise, the following extracts indicate that for her this initial conversation she had with her clients was much more of a meaningful process:

When someone walks into the room [] I have to try and find a common ground to meet them, and then when I’ve met them we can get on with the treatment (L420-422).

Because I don’t want to just work on a body and send them out of the room again, I think that’s it really, having that connection with somebody and really meeting them before you treat them [] is really important to me (L254-256).

What this suggests is that Rhian sought to be in a relationship with her clients from the first point of contact she had with them. Seeking to find some ‘common ground’ to ‘meet’ them suggests she was looking for some sort of mutual understanding or purpose in that initial interaction. Specifically, much like for Jilly and for Archie, this served to ensure she wasn’t just working on their body.

Rhian reiterated how important it was for her to ‘have a connection’ and ‘not just work on a body’ later in the interview when she talked about an anatomy course she had attended some months earlier. This had involved her dissecting human cadavers over a five day period and was followed by a one-day conference that I also attended, at which this experiential way of looking at the anatomy of the body was presented and discussed.⁽¹⁾

Rhian used the phrases 'it was an amazing experience' (L547) and 'completely life changing' (L545) to describe how impactful this training course had been for her. She referred to it as a 'respectful' and 'ritualistic process' where the bodies weren't just reduced to the flesh or 'meat' to be worked on, instead she described being asked to choose the bodies she wanted to work with commenting how 'you had to resonate with one in order to work with them' (L556). This implied she had a relational connection with the body of the person in much the same way as she had stated she needed to have a connection with her Bowen therapy clients, except rather than the connection being with the lived body as a fully functioning being in the world, here it was with the body that had lived but was no longer alive.

Citing examples of phenomenological accounts of professionals who work with dead bodies, such as nurses or undertakers, Twigg et al (2011) suggest that although the body is dead, the social person is experienced as still present in the corpse. As Rhian recalled how this experience had unfolded for her, she also appeared to have related to these dead bodies as if they still had a social identity and talked about the connection she had with them in a very similar way as she talked about the connections she had with her clients.

Rhian told me she purposely aimed to get a connection with every client she worked with, even if she was just working with them temporarily for example as a locum when her colleagues were on leave or unwell. She explained how this was an aspect of her practice that was personal to her and that setting aside this time to talk within her sessions, and form a therapeutic relationship with her clients wasn't a standard or required part of Bowen therapy practice. Therefore, it wasn't something that she or other Bowen therapists got a lot of professional guidance on. She summed this up by saying: 'there are rules of bodywork and then how you engage with a person is up to you at the end of the day' (L248-249).

In the following extract Rhian gave an example of how she had made a connection with a six year old girl who had cerebral palsy in what she felt was a spontaneous and unique way:

Like with Kesi who I was working with yesterday [] she hates people touching her and the last physio she worked with it took six months before she'd let her

touch her, so I had no expectations at all to work with Kesi for a good few weeks. And so the first session she came into I just got on the floor and I started playing with her with Lego. Now there's nothing in my Bowen training that says I need to get on the floor and play with Lego but it just makes sense [] that's more of a personal thing, so I got on the floor and I treated her the first time I met her and it's just carried on from there (L399-410).

This description of a first therapeutic meeting indicates Rhian was both flexible in her practice and responsive to how Kesi presented in the session, in order to form a relationship with her that would allow the bodywork to happen. Her decision to engage with Kesi on the floor - where children play, and with 'Lego' - a children's toy, appears to suggest she was intuitively relating to Kesi's world. A child's world where play as a child's natural medium of self-expression is a more accessible means of relating than speech (Axline, 1969) and successfully establishing a relationship between them in this way facilitated the therapeutic touch to follow. Whilst much has been written on whether or not to use touch in psychotherapy (see Hunter & Struve, 1998, Rothschild, 2002; Totton, 2003; Young, 2005, 2007, 2010) as a hands-on body therapy, touch was an inevitable part of Rhian's therapeutic role as a Bowen practitioner. Whilst this indicates she was sensitive in her timing of her use of touch with Kesi, it also seems to have relied on the relationship she was able to establish between them that prompted Kesi to permit her to touch her in that initial session.

Rhian described how her relationship with Kesi continued to require flexibility in her approach because sometimes Kesi would be reluctant to receive the bodywork. This is illustrated in the next extract where Rhian told me about the session she had had with Kesi the day before:

What's very around for me today is treating Kesi yesterday because she came in and she really didn't want to have any work done [] there was one bit of eye contact and then she said "I'm not talking to you" and she wasn't talking to me yesterday at all! [] I find it harder with kids because I can't have that sit down conversation. But I worked two areas of her body in a way I've never worked before and she burst into tears. It was like so quick it was like a matter of 30

seconds and she stood up and gave me this biggest hug! So from not talking to me at all I had touched her on a level that I never had done before and [] she just jumped up and clung onto me [] literally clinging onto me and didn't let go until I said "look you have to go now". And that was really amazingand so I guess that relationship is very important to me. With each person but ..it's particularly I think ...with children it's magnified more than adults and there's less layers of conditioning and stuff in their minds they're just, they're there and they're more responsive (L659-679).

This extract suggests that Rhian's relationship with Kesi was both tentative and deeply emotional for her. Rhian's acknowledgement that she couldn't rely on language as a means of maintaining the relationship as she did with other clients, suggests she had to focus on her use of touch as a means of both delivering the Bowen treatment and continuing and potentially deepening, the connection she had established with Kesi. Touch as a therapeutic technique and touch as an expression of the therapeutic relationship, are two of the five forms of touch in psychotherapy that have been identified by Smith (1998). The hug initiated by Kesi may be viewed as a reciprocal acknowledgement of the significance of the therapeutic relationship to her in the way that Aquino & Lee (2000) cite it as not uncommon for children in therapy to impulsively give an embrace that, if accepted by the therapist can increase the child's sense of self worth.

The way in which Rhian depicted this suggested it resulted in a great moment of intersubjectivity, what Jonathan Smith and colleagues (2009) describe as a shared and relational engagement in the world. As Rhian relayed this story she became tearful and it was apparent this had been a profound experience for her that had stayed at the forefront of her mind. I asked her how she had felt about it at the time and this was her response:

I think I probably did cry but when she left it was like "get rid of that" because I've got someone else coming in two seconds ..but...just very pleased, just my expectation was so low to get such a big response was just very rewarding. Most of the work that I do I could do without being paid for. You don't get one of those but when it does happen it's really nice (L645-686).

Rhian's reaction suggests that despite having low expectations of what she might have been able to achieve in treating Kesi on that day or over the length of time she saw her, it was her perseverance in continuing to connect and work with her that had resulted in what was for her a very rewarding 'big response'. However, there is also an incongruence in her eagerness to "get rid of that" and not dwell on the emotional impact this experience had on her, which occurred in a manner that Sunderland (2007) might refer to as an example of how:

"Children are great teachers of high-intensity relational learning, if we are open to learning"

(Sunderland, 2007:194)

Notwithstanding this, Rhian's readiness to very quickly to 'get rid' of that emotion in her need to compose herself for her next client suggests that even in such emotionally moving moments in her therapeutic encounters she was able to curtail her feelings in order to prioritize her professionalism. Within the interview Rhian talked of not liking to disclose how she was feeling or give clients too much information about herself. Her preference to maintain an impersonal distance within her therapeutic relationships and maintain her professional boundaries, is the next theme identified.

Not keeping Boundaries: 'makes the room quite messy'

Rhian told me that she had gained her knowledge and understanding about the therapeutic relationship from friends who were psychotherapists, from her own experience of what she referred to as 'head talking therapy', and from having made 'mistakes'. When I asked her what she meant by mistakes she began to talk about therapeutic boundaries. She explained that in her experience Bowen therapists were only taught about boundaries in terms of being registered with data protection, keeping client information secure, or learning how to work with the body to ensure they didn't use touch inappropriately. In the following extracts, Rhian described how maintaining boundaries for her was also about making sure she didn't share too much personal information with her clients:

I'm much better if they know nothing about me and I am well, happy and fine all the time. As soon as I cross the boundary and maybe say that I'm busy or I'm stressed or I have something or they have any other knowledge about me outside of 'Rhian the Bowen person in the South West' then it makes the room quite messy (L 21 -24).

I like for them not to know anything, because as soon as someone engages with me in my life if I'm not feeling great it's very hard to say I am feeling great and I don't want to say that I'm not feeling great whilst I'm there to give a professional service (L312-314).

The inference here is that for Rhian making 'mistakes' and 'the room getting messy' were indications that she had disclosed more about herself as a person than she had intended. This had led to her experiencing a dilemma of how to balance being genuine 'not feeling great' and 'giving a professional service'. In the field of psychotherapy such unplanned revealing of personal information by therapists to their clients has been referred to as accidental self-disclosure (Knox, Hess, Peterson & Hill, 1997; Stricker & Fisher, 1990; Zur, 2007); one of five types of self-disclosure: deliberate, unavoidable, inappropriate, client-initiated and accidental, that can lead to the blurring of the boundary between the professional therapeutic relationship and the personal friendship relationship (Zur, 2007, 2011).

Although she had never intended to blur this friendship – professionalism boundary with any of her clients, Rhian acknowledged there had been times when she had found this difficult to maintain particularly, as the following extract illustrates, when she had seen a client regularly over a long period of time:

For a couple of clients I have long term relationships with, it seems odd for them to walk into the room and say "hi" when you know absolutely about everything about them, kind of how they feel mentally or they do physically, what stresses them, what makes them feel happy, for them to go "hi how are you?" doesn't feel right to me (L307-311).

Rhian's comments here suggest that in these circumstances, a level of reciprocity within the therapeutic relationship would have felt more appropriate to her, as

recognition of the level of familiarity she had with these clients that would more usually be associated with friendships and the potential of sharing a level of emotional intimacy. In psychotherapy this is discussed in terms of Clarkson's person-to-person relationship, which recognizes "the real person of the psychotherapist can never be totally excluded from an interactional matrix of therapy" (Clarkson, 2003:17). However, despite the discomfort Rhian indicated she experienced with regard to this, she told me that she always liked to present as 'just a blank canvas for whoever is walking in' (L58). She described how she objectified the relationship between her and her clients by focusing on topics of conversation that were already known to her clients, such as her dog or her teaching commitments, because these were things that 'we can have a conversation about that's not personally reflecting on me but it's something other than just the two of us in the room' (L332-333). This gives the sense that in directing the discourse between herself and her clients towards these less personal /unavoidable aspects of self-disclosure (Farber, 2006; Zur, 2006) Rhian was able to be authentic and keep a professional distance within her therapeutic relationships.

Rhian's adherence to maintaining a professional boundary within her Bowen therapy practice was also seen in the way she spoke of times when she had not given a client a Bowen therapy treatment despite this being what they had come to see her for. Instead she had just listened to them talk, because on those occasions her therapeutic space had become:

A place where people can come and that's just as valuable as doing anything else and I say "you know 'I'm not a head person?'" but if you have that relationship and you've been working with someone for months then sometimes that happens (L67-70).

The following extract relates to one such client:

Someone I had been working on for a long time, her relationship had broken down and she'd started having an affair with somebody I think and she just didn't have any other place that she could think of where she could come in and go "this is what's happened". So I said "I'm not taking any money for this

just it's fine whatever" and she said "well okay take it as a donation or give it away whatever" and left the money on the table and said "I'll see you next week and I need a treatment anyway" (L 73-79).

This example indicates Rhian was attuned to or mindful of the immediate needs of her client, (to talk) and her response, (to listen) showed compassion and sensitivity in an authentic use of self. In discussing mindful compassion and how this can be demonstrated within Mahayana Buddhist practice, therapeutic encounters and interpersonal interactions Gilbert & Choden (2013) state "there is insight based on observation which leads to wise discernment of what to do" (Gilbert & Choden, 2013:119). Such responsiveness is what Stiles et al., (1998) argue is the inherent human quality that is displayed by psychotherapists and contributes to successful therapy outcome (Stiles, 2009; Stiles & Shapiro, 1994).

The transparency of Rhian's statement that she was not a talking therapist and her insistence that she didn't want to be paid for not doing a Bowen therapy treatment, suggests professional integrity on Rhian's part and a desire to maintain both interpersonal and ethical boundaries within this relationship in the face of her altered role within it. The clients reaction – to pay anyway and confirm her next appointment for Bowen therapy, suggests Rhian's presence as a 'listener' to her client's emotional unease, whilst being a different therapeutic activity didn't alter the professional boundaries of the therapeutic encounter.

There are similarities here with the psychotherapeutic concept of the therapeutic frame or "structure" originated in the Psychoanalytic tradition and widely adopted by other schools of therapy as a means of preserving the distinction between therapeutic and other encounters (Cherry & Gold, 1989). For example, from an intersubjective relational approach Bass (2007) views the frame as a set structure that offers safety and security to the clients but as part of the therapeutic process itself reflects conscious and unconscious aspects of both the therapist and the client, rendering it open to revision and alteration to suit the needs of the therapeutic dyad (Ganzer, 2014).

Whilst this example conveys a very caring attitude towards her client, Rhian told me that sharing her personal feelings towards her clients, whether positive or

negative, was not something that she did within her therapeutic relationships. This was illustrated in the account she gave of two clients who she had found it difficult to be around because of how she felt when she saw them: “as soon as they’re in the reception area I start feeling clammy and cold and just, I’d rather not be in the building” (L265-266). This sounded like a very extreme physical and emotional reaction that might result in a practitioner limiting the contact they had with a client by perhaps referring them to an alternative therapist, or as in Psychodynamic psychotherapy identifying it as an important opportunity for countertransference disclosure (Kuhn, 1997). However, Rhian did neither. She explained that she had continued to work with both of these clients and had made a great effort not to make them aware of the adverse feelings she was experiencing towards them. Instead she focused on treating them as ‘human beings’ and, as the following extract illustrates, she questioned what it was about herself that might explain what she was experiencing:

Over the last couple of years I’ve really worked on myself a lot whilst working alongside them. [] I’m really interested in personal growth and there’s nothing better than human to human contact for personal growth. So that’s I guess, that’s an unspoken level of my work that feeds me as a person. It’s that continually building relationships and doing it better each day and each hour that’s how I approach my work I guess (L280-286).

What this seems to indicate is that Rhian was able to keep the focus in her therapeutic encounters with these clients focused on their needs, by setting aside her feelings. As if her ‘here and now’ focus was solely on treating her clients and being professional and her reflective focus was on developing herself personally; stressing her commitment to personal growth, emphasising how relational this was for her and describing it as a vital sustenance of her personhood that implicitly also influences her work.

The intentional and active desire of a person to grow in areas that are salient for them has been termed personal growth initiative (PGI) and comprises of both cognitive and behavioral aspects associated with intentional development (Robitscheck 1998; Robitscheck et al 2012). PGI has been recognized as an

important antecedent of optimal functioning including emotional, social, and psychological well-being and there is evidence that it may positively influence aspects of the therapeutic process (Klockner & Hicks, 2008; Robitschek & Herschberger, 2005). This can be seen to support Rhian's statement about the significance personal growth had for her in terms of developing her relationships. In the next section this is illustrated further in the examples Rhian gave of *knowing* aspects about herself, and of her clients and people in general by relating to them on an embodied level and using what she had learnt from her personal development and training activities to inform this process.

Embodied Knowing: 'people hold their stories at different levels'

One aspect of the theme of embodied knowing is concerned with the way in which Rhian described how she read, interpreted and acted in response to what her clients' bodies were showing her by her use of touch. She told me that at the beginning of each session she spent at least five minutes touching the client's body to see how receptive they were on the day and what had changed since the last time she had seen them. Rhian explained that she would know the changes that had occurred in the client's body from feeling the body tissues and as the following extract indicates, she believed this to be an accurate reflection of what was going on with them:

At the end of the day it doesn't matter if I talk to them or not because I'll *know* as soon as I start working how they are (L102-103).

The inference here is that Rhian trusted the sensory information she received from the body to a greater extent than any changes the client might report, such as less pain or freer joint movement. In the same way she discussed how she could know what was going on for a person without touching them but just by observing their body as indicated in the following quotation:

I saw someone for the first time yesterday who's a performer and [] I've seen him on stage for a number of years and he has a posture where he's very stooped, his head sits forward and his shoulders are very rounded and that's

why his shoulder hurts. [] So, that's going to tell me more than him sitting up straight in the chair saying "oh I have this problem on my right shoulder". I'll tell you more about how someone.. what the pain is the person is holding seeing them in reception when they don't know that I'm looking at them, than when they walk into the room and sit up straight in the chair and say "this is my pain"(L437-447).

This suggests that even without touching the body Rhian felt she had a truer picture of the body's pain than the client was able to convey. It implies she was able to read and interpret her clients' bodies and that she regarded this embodied knowledge as a form of implicit honesty within the therapeutic relationship that enabled her to use her skill as a Bowen therapy practitioner to the best effect. The strength of her sense of knowing in respect of what the body told her is seen in the following extracts where Rhian described having a "jarring" relationship (L206) with a client who denied experiencing any changes over the weeks she had been treating her:

I really find her very, very challenging, because she'll come in and say "nothing's changed for three weeks, nothing's changed" [] I can't work with "nothing's changed" because I need to see, I need her to see that she is changing (L192-196).

Even though she has said nothing's changed it's just the same in these few weeks, I knew when I put my hands on her, her tissue was softer, it was more pliable, there was more communication going from my fingers to her [] even though she still had the pain in her neck she had less headaches, she was sleeping through the night, she wasn't using her inhalers but the pain in her neck was still there so "nothing's changed!" (L210-216).

A paradoxical point that arises here is that whilst Rhian said she knew what the bodily changes were she also referred to 'needing' her client to share her belief in this knowledge. This appears to contradict her previous statement that it didn't matter whether her clients talked to her or not. But in signifying that for her the physical healing was a dual process in terms of the therapist–client relationship, this supports the view she expressed earlier that having a connection with her

clients and not just working on their bodies, was an integral part of her Bowen therapy practice.

When I asked Rhian why she thought this client was unable to recognise she was experiencing changes, her view was that this was due to her lifestyle of working long hours, having difficulty relaxing and living in her “stress response” (L221). Rhian explained that this meant it was difficult for her to get the client to the parasympathetic response state, a natural healing state where blood pressure, breathing rate, and other vital processes normalize, and regenerate (Rossi, 1986) which was where she needed her clients to be in order for the Bowen therapy to have maximum impact. As a result Rhian said she had suggested that the client didn’t continue with her but the client had dismissed this suggestion and was adamant she wanted more treatments. Rhian interpreted this as an indication that ‘even if it’s not a tangible thought, the feeling is that something is changing, I imagine’ (L224-225).

What is also implied here is that Rhian’s desire for her client to be aware and acknowledging of the changes in her she knew were happening, she was looking for her client to be experiencing a relationship between her mind and body. There is a potential similarity here with the role of the Existential therapist to facilitate the client’s own encounter with themselves and therefore work alongside them to help them elucidate and elaborate on their own perspective (Mulhauser, 2014). However, as Mulhauser points out, this approach to talking therapy is viewed as best suited to those who are at the point of seeking to examine and increase their self awareness, which is not where Rhian considered this client to be.

Rhian told me there were also times when she had made a conscious decision not to work with someone who had come to her for Bowen therapy because ‘there are people that I don’t feel are switched on enough in their own bodies to engage in the process of repair at that time’ (L79-80). She gave a specific example of a potential client who had symptoms of blurred vision, poor balance, was using two walking sticks and his body seemed to her to be ‘wasting away’. Rhian told me that within ten minutes she could see his body was being affected in this way by the dentistry work he was having and remarked:

I could support that but he was going to go back and carry on with the work and he wasn't drinking water he wasn't taking exercise he wasn't looking at anything so I was leaving myself and him open to changes that weren't going to be fully supported through. So, in that instance I talked to him for an hour and said, you know it's not quite appropriate in this instance at this time; I'll treat you another time (L82-91).

In this example it appears that Rhian combining her embodied knowledge with the verbal information the client gave her and concluded that this would not be a positive or productive therapeutic encounter. It also further indicates how boundaried she was in her interactions with clients or potential clients, by making decisions about her therapeutic practice that were adhering to what she felt was right or wrong for her to work with, a kind of knowing of self.

These examples of Rhian's experiences of knowing have been shown to rely upon her use of touch and the inferences she made in relation to the physical form of the body informed by her knowledge gained from her study of anatomy. In the following extract, Rhian talked about knowing more about her clients as a result of the experiential learning she had gained from 'the hands on human anatomy course' she had attended just prior to me interviewing her, which had involved her dissecting dead bodies:

Something that really came home to me [] when I was working [] on the different layers of tissue within the body is that people hold their stories at different levels of those layers (L527-528).

This depiction of the dead bodies as story tellers of the person's lived experience evokes the sense that rather than being reduced to their constituent non-living body parts by the process of dissection, Rhian experienced the dead body as revealing an insightful revelation about the person, that is to say more than what she could touch or see in her lived experience with her clients. Specifically, she described feeling an emotional connection with the cadavers and experiencing a deep resonance at a specific point in the dissection process. As the following extract illustrates, this was when she reached the 'superficial fascia' level of the

body, which is the term used to define the thin layer of loose fatty connective tissue underlying the skin that binds it to the parts beneath:

My biggest personal response came at the superficial fascia level [] I was completely spun out I was having out of body experiences and re-living through past stuff of my own and it's really the layer that I live with. I mean if you look at me as a person I have lots of superficial fascia [] and the night of the day that we were working on the superficial fascia my body started going through symptoms of past experiences and I was waking up in pain and all sorts of things, it was the most amazing experience (L545-575).

Here Rhian indicated she identified with the bodies she was working on in terms of her bodily form, defining her lived experience of self in terms of how she presented physically. The way she described her resonance with these dead bodies was as if it had revealed to her precisely where in her body she held her emotional life story and that her body's memory of aspects of her life history had been activated in the way she related to these dead bodies. This suggests that the process of separating and distinguishing between the layers of the body had helped Rhian conceptualise how she and people in general 'hold their stories at different levels' of the body.

The way in which she conveyed her reaction to this as 'the most amazing experience' suggests this was something profound for her. Schmid (2002) describes such experiences within the therapeutic relationship as the therapist being in touch with something both unexpected and enigmatic that can lead to them experiencing a sense of:

"Awe and wonder at these moments of relational depth that, struck by the sheer novelty and beauty of the world that is disclosed to them".

(Mearns & Cooper, 2005:41)

Writing on relational depth in counselling and psychotherapy Cooper (2001) refers to whole bodied empathy as embodied empathy, which he describes as the therapists attunement to a complex, gestalt-like mosaic of a client's embodied being (Mearns & Cooper, 2005). These descriptions appear to apply to Rhian's

experience here, with the obvious distinction between a resonance to dead and living bodies. That aside, the embodied memories Rhian experienced appear to have been associated with past painful experiences, such as those reported by psychotherapy clients who have experienced past trauma. Psychotherapeutic approaches that work with trauma such as Compassion Focused therapy (Lee, 2012) and Trauma therapy (Rothschild, 2000) recognize that bodily sensations associated with traumatic experiences can be remembered in the body. Therefore, the therapist's ability to pay attention to the body can be very informative to the therapeutic relationship as Rothschild argues:

“With some trauma clients, the trauma is reenacted in the transference-sometimes as psychological symptoms (i.e. mistrust), sometimes as somatic symptoms”.

(Rothschild, 2000:82)

Rhian told me that how people hold emotions in their body, and the connection between our physical selves and our emotional selves was a particular area of interest for her. The certainty she expressed in knowing how this was exhibited by her clients within her Bowen therapy practice appears to be a culmination of her ongoing personal development and training activities that appear here to have had a very notable impact on her. In the next section Rhian discussed this further in terms of how she prepared her clients for such a reaction and how she approached working with them. This led to the identification of the final theme of connection and disconnection within the therapeutic relationship.

I do a treatment ...leave the room 'and let the body respond and see what's most important'

Rhian told me that explaining emotional holding in the body to her clients was part of her Bowen therapy practice as she said she needed to prepare them that they might experience an emotional or mental reaction if she released their body from the physical pattern it was holding. She explained this more fully in the following extract:

If you're working with someone who has had a road traffic accident you may find that if you work with them enough, so their brain gets back in touch with the parts of the body it hasn't been in touch with and on line with as much as it should have been, then the body starts recycling back through the range of motion it went through during the car accident [] where it went left right back and then forward and that's been held like that and then all of the mental and emotional bits that get [] stuck in that physical holding (L158 -172).

Whilst she stressed that a person's physical self was very much connected to their emotional self, Rhian went on to explain that in terms of working with them physically she wanted to get their autonomic nervous system (the part of the body's nervous system that regulates key involuntary functions such as heart beat, breathing and digestion) to go into parasympathetic response a therapeutically induced healing (alpha) state that normalises and regenerates these vital process (Rossi, 1986). The following quotation is Rhian's description of this:

so switched off like near sleep if possible and sort of cutting their head out of the way just dealing with how their body responds to touch and where any trauma or stuckness might be in the tissue (L350-354).

The inference here is that in order for her to effect positive change in her clients' physicality Rhian needed to disconnect their physical and emotional aspects of self, so that she could work with the body in isolation and without the head (mind) interfering with this process. She told me that this was why she, like all Bowen practitioners, would leave and re-enter the therapy room several times during a treatment session leaving the client alone and giving the body time and space to process the therapeutic touch it had just received. She illustrates this in the following extract:

So when you put your hands on somebody and do a little bit of work but then allow them the time to process the work during the session you can come back into the room and see that physically there's been a change or they'll feedback to you verbally and say "do you know when you were out of the room this happened?" or " I felt a surge of energy" or "this limb got hotter" or "I got the shivers" or something like that"(L172-177).

Whilst this indicates positive responses in the body were felt by Rhian and acknowledged by her clients when she re-entered the room, to a talking therapist such as myself this practice of not staying in the room with the client throughout the session seems at odds with any sense of being able to maintain a therapeutic relationship. However, it is possible that this is not too dissimilar to a giving a client time to process what is happening in silence within a session of psychotherapy. For example, in relational mindfulness Front (2008) argues that silence plays a pivotal role in the therapeutic relationship as it provides an 'open space' that can facilitate mindful listening and resonant communication and in Jungian analysis the analyst's silence has been viewed as the facilitating the client to find their voice (Schnetzler, 2006) and Bravesmith (2012) argues that:

"Deeply unconscious processes occur in the solitude and it cannot be otherwise, since they have to have already reached a state of symbolization before they can be communicated explicitly."

(Bravesmith, 2012:29)

Indeed Rowan(2005) explicitly refers to leaving the room as another version of the use of silence within the therapeutic encounter that can be a very powerful mode of communication that leaves the client guessing what the therapist might think about the issue and having to "work it out for themselves" (Rowan, 2005:31). This then lends itself to being a potential explanation for how Rhian experienced the disconnection of her conscious relationship with her clients as not jeopardising their therapeutic relationships. This is perhaps particularly so as quite often Rhian would treat two people simultaneously:

I prefer going from one room to another [] than one room to a quiet room where I don't have somebody because you kind of go into the zone where you go "I'm walking into this room afresh what's changed from the last time I was in here?" and then treating accordingly; and then you leave that behind energetically and kind of clear space, walk into the other room and go "okay how has this body changed since the last time I went in?"(L360-369).

Effectively this meant Rhian was moving in and out of two therapeutic relationships at the same time, both of which had breaks in her attention and presence in the room. Such a notion is quite alien to the world of psychotherapy where psychological and physical presence is prioritised (Knox et al, 2013). But the way Rhian talked about this gave a sense that in disconnecting mind and body she was able to focus on the body and switch between bodies whilst sharpening her connection to them. There is also an interesting parallel here with the way that Rhian divided her working week between her practice in the South West of England and her practice in the North East of England focusing on one and then the other but maintaining a connection with and presence in both.

Distinguishing it from other types of hands-on bodywork Rhian referred to Bowen therapy as 'more of a dialogue rather than a monologue' (L135). She explained how for example, chiropractors or osteopaths put people back into skeletal alignment and massage therapists see where a person's muscles are tight and then massage them until they feel the right texture. In her view these types of bodywork act *on* the body by telling it what to do whereas with Bowen therapy the relationship is responsive with the body telling her what to do. She explained this in more detail in the following extract:

The thing with Bowen as a form of bodywork is that as the practitioner I don't decide what gets addressed in the treatment. I do a treatment and let the body respond and see what's most important. The most important thing to that person could be that they sleep better that week, so they have more hours switched off and the body has that many more hours to repair. So they can come back a week later going "the pain is still the same, my back still hurts as it did, but you know I've slept well, I've woken up feeling okay for the last week and I've had more energy in the mornings to get on with the rest of the day" And that's great if somebody comes back to me after one treatment and says that fantastic! I don't need them to be able to touch the floor or whatever I just need their body to start talking to itself again (L633-643).

This suggests that going in and out of the therapy room may be similar to turn-taking in verbal dialogue where information is presented, processed and reacted

to. Rhian depicts her relationship with the client's body as one that facilitates a restoral of the body's ability to communicate with itself again, increasing their embodied awareness just as talking therapists might seek to facilitate consciousness raising in their client. The inference is that the body knows what it needs to do to heal itself but just needs help to facilitate this draws a parallel to the Humanistic approach to psychotherapy:

"As no one else can know how we perceive, we are the best experts on ourselves."

(Rogers, 1959)

Rogers described the therapist's role as freeing the client from the rigidity of their self perception by removing obstacles that were preventing their normal growth and development so that they could become independent and self-directed. Therefore, going out of the room can be seen as a way of Rhian maintaining the therapeutic relationship whilst shifting the focus to a more embodied status. To return to the analogy of the representation of silence within the psychotherapeutic encounter Lehman (2014) cites Yousef (2010) as highlighting how silence in psychotherapy can reflect a paradoxical intimacy in the way it can be viewed as a measure of both proximity and distance.

From this interview with Rhian it was clear that she valued the concept of therapeutic relationships and in response to this she purposefully took time and effort to establish and maintain mind-body connections with her clients. Whilst her personal reflections on how she related to her clients veered into aspects of her personhood and spiritual identity, particularly the emphasis she placed on personal growth, keeping professional boundaries was found to be central to her professional practice. Aspects of embodied knowing were identified as significant indications of how Rhian related to her clients and these relationships were seen to be maintained despite the irony of the physical disconnection Bowen therapy utilizes as part of its healing process.

(1). Gil Hedley A rare insight into the Fascial Planes of the Human Body 3rd September 2008 – Bradfield College, nr. Reading, Berkshire.

Discussion

This study provided a perspective on the lived experience of embodied therapeutic relationships from the accounts of four body-focused practitioners working in the field of complementary healthcare. My analysis of their reported experiences suggests there were three core areas identified that constituted the three superordinate themes of: *'Embodied awareness and sense of personhood'*, *'Intersubjectivity and authentic use of self'* and *'Mind-body connection, disconnection and reconnection'*. In the discussion to follow these themes are examined in turn. Areas of commonality are then considered in the context of Clarkson's transtheoretical framework for the therapeutic relationship. Finally, a critical appraisal is given with regard to how counselling psychologists can incorporate aspects of learning from these the research findings into the core elements and values of their clinical practice.

Embodied awareness and sense of personhood

The theme *'Embodied awareness and sense of personhood'* is concerned with what I have termed the 'back story' each of the participants brought to their bodywork practice. Namely, the aspects of self and ways of being that constituted their personal identity, and their 'ways of knowing' about their clients and themselves that were extensively embodied.

For Hannah this was her belief in the unification of mind, body, spirit and a sense of soul in a person she defined as embodiment, which was confirmed in her craniosacral training: 'I came to this work with no feeling of soul, no feeling of being in my body, I was just a mind' (Hannah L180). For Archie it was the beauty he found in observing and working with the body in his previous career in the arts and his appreciation of the human and animal form: 'when a cat moves or a horse moves it's poetry in motion; when a dancer, a ballet dancer or baroque dancer moves it's fantastic! I just get chilled out watching beauty (Archie L451-452). For Jilly it was the spiritual crisis she had undergone that had resulted in her experiencing a 'kundalini rise' and set her on a different path in her life: 'back then

I was a complete control freak, completely edgy and really the lid blew off in the end, up came the kundalini and I saw a whole different, just completely different world' (Jilly L188-190). And for Rhian it was the transformation from illness she had experienced as a result of being treated with Bowen therapy and the significance she placed on the Buddhist principles she led her life by: 'studying the philosophy of Nichiren Buddhism and chanting to raise my life state has been my life blood' (Rhian L693-694).

Indications of how these experiences had shaped the participants personal identities were seen in the sense of personhood each of them conveyed in their respective research interviews. For example, Hannah's sense of self as an embodied soul was reinforced by her craniosacral therapy practice providing an opportunity for her to relate as her embodied self to the embodied self of her clients. Jilly's spiritual journey that had culminated in her experiencing what she described as a much more aware and fulfilling lifestyle, underpinned her practice as a colonic hydrotherapist. Archie's comment that his longstanding daily practice of yoga and meditation seemed to click into place when he discovered Trager, resulted in him describing it as his perfect vehicle for his way of being. And Rhian's description of herself as being so plugged into the world of Bowen appeared to be augmented by the spiritual path of Buddhism she followed that was particularly seen in her attendance to personal growth and compassion in her life and work.

This sense of personhood was compounded in the various 'ways of knowing' that was a common theme that ran across all four transcripts. On a practical level each participant talked about this in terms of their professional competence, that is to say what they knew about the process involved in their particular form of bodywork informed by their respective training and experience. As all of these: Craniosacral therapy, Trager, Colonic hydrotherapy and Bowen therapy, involved the use of touch on the body, this formed a strong component of the ways of knowing described. The participants all talked about what they could physically feel in their clients' bodies such as: changes in tissue softness, heat and cold, areas of tension and emotional holding. They each indicated they experienced this embodied communication to be more accurate than what their clients could tell them: 'at the end of the day it doesn't matter if I talk to them or not because I'll *know* as soon as

I start working how they are' (Rhian L102-103), 'The body doesn't lie, the body will speak the deepest truth' (Jilly L413).

Knowing when, where and how to touch, was a particularly consideration, so preparing the body to be touched, despite therapeutic touch being an inevitable part of the bodywork, was mentioned by each participant. For example, Archie commented: 'for some people who have not been used to touch it can be quite overpowering if they've not been touched, so you do it especially with care' (Archie L403-405).

In addition, what each of them sensed in their clients' bodies: 'this knowing when things are wrong and knowing when people were actually completely mistaken and hadn't got it right, that it was something in me that knew (Jilly L209-211), and in their own bodies: 'to me embodied means [] that I'm aware of my soul, and I'm aware of it being in my body and [] the more I think about it, the more I practice and the more I develop the more I know that I'm body, mind and spirit (Hannah L140-142) indicated an intuitive sense of self that they used in their bodywork practice. This embodied awareness and use of self constituted a significant aspect of the research findings.

Intersubjectivity and authentic use of self

The theme '*Intersubjectivity and authentic use of self*' is concerned with how the participants actively engaged in forming therapeutic relationships with their clients and the degree to which this was linked to what I have called their authentic use of self in their bodywork. Authenticity as defined in the psychotherapy literature (Rowan, 2005) is achieved through the development of therapists self knowledge and self awareness that facilitates genuine contact with their clients.

A strong element of this theme was the way in which the participants sought to form a therapeutic relationship with their clients prior to commencing the bodywork. This involved them making some sort of connection with them by establishing trust and building rapport. There was an acknowledgement of an initial reliance on verbal communication to establish these working relationships.

This was seen in what Hannah called: 'making it safe' (Hannah L8) which she did by noticing things about her clients she could comment on that initiated the conversation. For example, to put them at ease she commented on the clothes they were wearing or asked how their journey had been and she affirmed the parenting skills of the parents of her infant clients to make them feel good about themselves. Jilly spoke of being attentive to building up the relationship even from the first telephone contact she had with her clients. She was particularly acknowledging of how fearful they were likely to be prior to the colonic hydrotherapy and was conscious therefore, not to enhance this by appearing scary to them when she met them: 'when you meet someone for the first time, from a therapeutic point of view, you have to be able to establish your trustworthiness from the very first second, the very first eye contact' (Jilly L103-105).

An interesting variation was noted in Archie and Rhian's accounts. Whilst they also spoke of how important it was for them to always form a therapeutic relationship with their clients, they were both notably boundaried in this activity. Archie stressed his verbal interaction with his Trager clients was not an attempt at talking therapy: 'I might say something but that's just a conversation it's not therapy, it's just me relating to them as if we would as if we were in the pub or a restaurant' (Archie L444-446). And Rhian emphasised she was happiest if she could limit the amount of self-disclosure in these interactions to a fairly minimal extent: as soon as I cross the boundary and [] they have any other knowledge about me outside of 'Rhian the Bowen person [] then it makes the room quite messy' (Rhian L 21-24).

Use of the body in establishing the therapeutic relationship was seen in how all the participants observed their clients bodies. Particularly in the 'permission giving' means of establishing an agreed basis for working on the body demonstrated in Hannah and Rhian's work with children. Hannah gave an example of a baby moving their body towards her in what she experienced as a sign of acceptance: 'I did get his permission to work with him, in a physical way, he came and sat almost leaning against my legs, I thought "ahh I think that's...acceptance!"' (Hannah L95-96). Rhian's decision to play with Kesi on the floor when she first met her: 'I just got on the floor and I started playing with her with Lego. Now there's nothing in my

Bowen training that says I need to get on the floor and play with Lego but it just makes sense to me' (Rhian L405-407) resulted in her establishing a relationship with Kesi that enabled her to treat her much sooner than she had anticipated.

The authentic nature of the participants' relationship building, which I have interpreted as them experiencing genuine contact with their clients, was seen in the way they related aspects of themselves to the examples they gave of people they had treated. I refer to this as 'soul to soul' relating for Hannah, which for her was making sure that she was embodied and so were her clients: 'I spend a long time getting them comfortable on the table and talking them in to being relaxed and in touch with their body' (Hannah L130-132). For Archie this was captured in his analogy of 'dancing together': 'I feel like I've been part of the flow. It's a little bit like you put the music on and we've both had a dance together you know, I haven't put the music on and watched you dance we've both been doing it' (Archie L268-270). For Jilly there was a sense that having experienced her own spiritual awakening she held that potential for her clients through her colonic hydrotherapy practice: 'if they can let go into it, it is very rewarding for them because there is immense clarity and calm afterwards, to the point of elation sometimes and I've had a couple of people who've actually had a kundalini rise' (Jilly L161-163). For Rhian I got the sense that it was her use of compassion and acceptance of all opportunities for personal growth (even if this meant her enduring difficult client relationships) that indicated she was being true to her authentic self in her professional practice: 'I'm really interested in personal growth and there's nothing better than human to human contact for personal growth. So that's I guess, that's an unspoken level of my work that feeds me as a person' (L282-284).

Mind-body connection, disconnection and reconnection

The theme '*Mind-body connection, disconnection and reconnection*' is concerned with what I have called the 'worldview' of the participants that emphasised mind-body unity in their personal philosophies and in their holistic bodywork practices, which provided the opportunity for the body to be re-prioritised over the mind.

Within this theme all four participants demonstrated an holistic worldview in this sense, describing the way in which they saw themselves and others as a combined mind and body. Jilly and Rhian stressed how for them this included the emotional self: ‘you can’t divorce the body from the mind and emotions it’s all part of one process’ (Jilly L298-299) that could not be separated from the physical self: ‘all of the mental and emotional bits that get [] stuck in that physical holding’ (Rhian L171 -172). For Archie and specifically Hannah, access to the soul formed part of this mind-body unity: ‘we don’t have souls”, oh yes we do! [] Craniosacral therapy believes that!’ (Hannah L146-147), ‘If I am holding someone’s head like the people do with Craniosacral, that’s part of Trager you just be with their head that to me is a great privilege. You are [] holding the head of a person that is a soul’ (Archie L457-459).

All four participants made reference to imbalances between the mind and body. For example, Hannah described the impact of experiencing her mind being prioritised over her body that rendered her with no sense of soul. In finding her own embodied self, it was this sense of soul that she sought to facilitate in working with her clients and to do this she wanted them to: ‘forget their mind and let their body do the speaking, and then let their soul do the speaking’ (Hannah L309). Archie talked of needing the mind to release its hold over the body so that his clients could ‘let go’: ‘they go into their sub-conscious state, which is ideal because then the mind’s not in the way’ (Archie L211-212). Jilly also talked of the varying degrees to which her clients could mentally let go into the bodily process; of how cut off they could be from what was going on in their body and of how ‘if they bottle it verbally, the body will overwhelm them’ (Jilly L274). Rhian talked of wanting the body to take priority over the mind as: ‘cutting their head out of the way and just dealing with how their body responds to touch’ (Rhian L353).

The reconnection of the mind and body is the final aspect of this theme. How this was demonstrated by the participants in this study is what I have termed ‘healing as unity’. This describes how their respective experiences of working with the body were both an embodied and a healing activity. For example Hannah can be seen to reprioritise the body by listening to and unblocking the life force in her craniosacral practice: ‘the main medium of my work which is the cerebrospinal

fluid [] carries what they call the breath of life, which I think is the soul and they can, I can, feel where that has been interrupted' (Hannah L172-174). Archie tuned into the body and facilitated the life energy (Chi) to free the bodily movement in his Trager practice: 'the thing that moves everything is the Chi; it's the energy in the universe, the energy that's transformed into action through the mind' (Archie L108-109). Jilly recognised and responded to the energy moving in the body at different stages of the colonic hydrotherapy treatment and talked of: 'honouring the client, the other person in their own process whatever that may be, whether that is wanting to fix something or wanting to let go' (Jilly L22-24) and Rhian explained why as a Bowen therapist, she left the room whilst treating her clients to give their body time and space to rewind and remedy itself: 'so their brain gets back in touch with the parts of the body it hasn't been in touch with and on line with as much as it should have been' (Rhian L161-162). And Archie described holding the head of a client as symbolic of connecting to their soul as 'a sharing of oneness of the opportunity that we exist in life' (Archie L466).

These research findings will now be discussed in relation to the aims of the study. That is to say in taking the view that the therapeutic relationship in psychotherapy "is the therapy" (Kahn, 2001:1) and therefore improvement in how we relate to clients is recognised as a priority for talking therapists (Lambert & Barley, 2001) that warrants a more universal recognition of the therapeutic relationship as an embodied relationship (Shaw, 2003, 2004; Rumble, 2010; Todres, 2011) with specific reference to the body of the client and the therapist within this.

Area of Commonality & Clarkson's Five Relationship Modalities

One way of understanding the significance of these findings in relation to the research aims is to view them in the context of Clarkson's transtheoretical framework for the therapeutic relationship. To reiterate Clarkson (2003) presents five modalities within this framework as individual states rather than stages in the therapeutic process; each of them may show prominence at different times and overlap with others to varying degrees within each therapeutic encounter.

There are a number of features of the theme '*Intersubjectivity and authentic use of self*' that can be linked to aspects of Clarkson's working alliance modality with its emphasis on their being a powerful joining of forces between the client and therapist that energises and supports the agreed goals of psychotherapy (Bugental, 1987), by engaging in the therapeutic tasks within a context of an affective bond (Bordin, 1980: Constantino et al, 2002). For example, Hannah, Archie, Jilly and Rhian all sought to establish a working relationship at the very first opportunity. In reviewing the amount of evidence that supports a positive correlation between the working alliance and therapeutic change (see Castonguay & Beutler, 2005), the alliance was found to be particularly predictive of positive outcome when measured early in treatment; thus indicating a need for therapists to better understand how to establish the alliance as soon as therapy begins (Castonguay, Constantino, & Holforth, 2006).

In seeking to do this, all four participants could be viewed as setting up the therapeutic frame (Gray, 2014) and particularly with the boundary setting aspect of this as demonstrated by Archie and Rhian. For example, they each indicated they followed what may be viewed as fairly standard contracting arrangements within most forms of therapy such as: length of duration of the session, cost, venue, outline of the treatment procedure etc. There was an additional element of embodied relating within this that was particularly focused on by Hannah and Rhian and their respective work with children. In existential terms such relating without words could be seen as an example of what Merleau-Ponty referred to as a mutual engagement in the client's existential project (Merleau-Ponty, 1962) that makes the therapy possible in a similar way to using a verbal vocabulary as the body has been viewed as capable of implying "*what we want to say*, which can be typical or something very new. It can surprise us. *Our bodies imply the next words and actions to carry our situations forward*" (Gendlin, 1997:28).

In addition, the '*ways of knowing*' feature of the '*Embodied awareness and sense of personhood*' theme includes the participants' reference to how they interpret embodied information for themselves and for their clients. I specifically found the use of their therapeutic touch to be a significant aspect of this because the consideration given to the amount, timing, quantity, quality and interpretation of

touch, indicated it was a relational act, as well as a technical procedure, within the participants' therapeutic encounters. To take this one step further, the intuitive sense the participants had of their bodies as well as their clients' bodies, and the relationship between them clearly links to Clarkson's 'transference/counter-transferential relationship' modality

Specifically, all of the participants talked of *knowing* what was happening in terms of an embodied 'felt sense' (Gendlin, 1997) or body empathy (Cooper, 2001) and somatic countertransference experiences (Orbach & Carroll, 2006). As if their awareness of their own bodily sensations, images, impulses, and feelings offered them a link to the client's healing process and the intersubjective field (Rumble, 2010). For example, in her work with babies Hannah talked of this as awareness of their and their parents' relational field and of using language just to confirm what she sensed in her clients' bodies. Jilly also reported doing this and of having physical feelings in her own body that with experience, she knew belonged to the client she was treating at the time: 'I may feel a sharp pain somewhere but it's a reflection of what's going on there (*in the client's body*) [] I can feel butterflies in my stomach, maybe my knees will ache or something like that, it's different, different each time' (Jilly L317-320). Archie's talk of taking on the physical qualities of his clients, such as delicacy, inferred he experienced a kind of embodied symbiosis in his relationships. And Rhian gave a very vivid description of how she was affected by the cadavers she dissected, and in an example of negative countertransference (Jakubowski, 2012) she described her bodily reactions to two clients she found it difficult to treat: 'as soon as they're in the reception area I start feeling clammy and cold' (Rhian L267).

Clarkson defines the 'reparative/developmentally needed relationship' to be concerned with the repair of previous deficient, abusive or over protective parenting experience and the reinstating of healthy developmental processes. Stemming from attachment theory Bowlby (1969/1988) and Bartenieff & Lewis (1980) identify an absence of feeling held in mind (Fonagy, 2000, Bateman & Fonagy, 2011) and a lack of secure attachment as having a traumatic impact on mind and body. Whilst the therapist's availability to the client is often considered to be reparative in itself, this presence also forms a foundation for the effective use of

specific therapeutic techniques, thus making it indirectly and directly related to positive outcome in therapy (Greenberg, 2014). A specific example of the reparative/developmentally needed function in psychotherapy is Winnicott's (1958) holding environment. Hannah's use of the terminology of holding as an aspect of her therapeutic relationships, can be seen to be a clear example of this. Likewise, this is also seen in Jilly's account of her therapeutic relationships as she spoke of 'holding' the space for her clients when she was treating them.

Clarkson, (2003) cites the empathic reflection seen in the Person-centred approach as another example of how the reparative/developmentally needed function of the relationship is demonstrated. Whilst I consider all four participants to have reflected upon their use of empathy in the accounts they gave in the research interviews, Rhian particularly showed this in the example she gave of when she decided not to treat but to listen to her client. On this particular occasion she felt that this was what she needed the most and therefore her therapeutic space was: 'just a place where people can come and talk and that's just as valuable as doing anything else and I say "you know 'I'm not a head person?" but if you have that relationship and you've been working with someone for months then sometimes that happens' (Rhian L69-72). A more explicitly embodied intersubjective example of this can be seen in the way Archie described how he taught his clients to listen to their bodies by asking them to 'tune into' how they were feeling: "'How do you feel? Is there anything in your body that's actually talking to you that's giving you some instance of attention?'" (ArchieL63-64). This supports the argument for the use of movement and touch within the therapeutic relationship (Manford, 2014) based on the theoretical underpinning that rhythm, sound, reciprocity, synchrony and the sensory-motor experience of holding are elements of the consistent nurturing behaviour from the caregiver helps preserve a child's emotional and physical balance (Meekums, 2002).

In addition to their empathic responding, these analyses illustrated the participants emphasised other qualities of the therapeutic relationship such as: trust, safety, being non-judgemental and honouring in the intersubjectivity between themselves and their clients. These correspond with the Person-centred approach core conditions of congruence, positive regard and empathy said to be sufficient and

necessary for therapeutic personality change (Rogers, 1957), and as an authentic use of self that is associated with Clarkson's 'person-to-person' relationship modality.

For example, Archie demonstrated this in the emphasis he placed on relating to his clients as he might naturally if he was in a social situation. However, all the participants demonstrated this in a deeper sense as they described 'being with' their clients on multiple levels of what is referred to as therapist presence (Geller & Greenberg, 2012). Hannah talked about this in terms of needing to prepare for her sessions by getting to the therapy space early, sitting in the chair getting a sense of being grounded and in focusing on feeling embodied in preparation to meet her client. Jilly described a similar concentration on preparing for each session and Rhian talked about it in terms of the on-going focus she placed on personal growth, one of the ways the person-to-person relationship is viewed to develop (Wade, 1996; Wilber, 2000).

Something that is also relevant here is the view that the pursuit of this authentic therapeutic relationship calls for a highly developed level of therapist self awareness and self knowledge that includes a focus on issues of embodiment in what is referred to as mind-body unity (Rowan, 2005) or mind/body holism (Vick, 2002). This reflects the theme of '*mind-body connection, disconnection and re-connection*' that identified this type of relating for all four participants that can be seen to link to the 'transpersonal relationship' modality.

Described as the least known or understood of Clarkson's five relationship modalities (Rowan, 2005; Whitehouse, 2006) the transpersonal relationship is concerned with what Clarkson (2003:20) defines as the "spiritual, mysterious or currently inexplicable dimension of the healing relationship" that can include sacred, religious, spiritual or unconscious connections that occur as transcendent experiences. Wilber (2000) refers to this as the 'subtle level of psycho spiritual development' and Samuels (1985:21) concludes that "the psychology of the soul turns out to be about people in relationship".

My analysis illustrates this aspect of the relationship to be central for all four participants and to include an embodied sense of soul and spirituality. For

example Archie talked about this in relation to holding his clients' head: 'in that moment of transcendence, in a moment of uniqueness, which is not personal, it's nothing to do with their personality, it's nothing to do with my personality; it's a sharing of oneness of the opportunity that we exist in life' (Archie L457 – 466). It is also seen in how Rhian experienced her relationship with her young client Kesi: 'she just jumped up and clung onto me and it was just such a shock from going from lying there going "oh I can't wait for this to be over" to literally clinging onto me and didn't let go until I said "look you have to go now" and that was really amazing [] you don't get one of those every day' (Rhian L674-688). Hannah described this in relation to needing to feel good in her body because for her being embodied was being in contact with her soul: 'my work is directly linked to how good I'm feeling about myself, the better I'm feeling about myself the better the sessions I give, the more progress people make, erm, and that's to do with you know, trusting myself again, having [] a sense of my divinity (Hannah L337-341). And Jilly referred to this transpersonal quality of the therapeutic relationship in terms of alchemy: 'something happens as they move into my space my energy field and the closest I have ever come to describing it is *Alchemy*, an alchemical process' (Jilly L36-37).

In summary, from these research findings aspects of embodied relating, as construed from the accounts of the body focused practitioners, who took part in this study, can be placed within Clarkson's transtheoretical framework for the therapeutic relationship. In acknowledging fifty years of research that has concluded that it is the bond between the client and the therapist that matters most in successful psychotherapy (Miller, 2012), this supports the argument that counselling psychologists may best achieve this by facilitating an encounter with their client at relational depth (Mearns & Cooper, 2005; Knox, Murphy, Wiggins, & Cooper, 2013). It is argued that such relating involves the therapist's 'whole-bodied empathy' (embodied empathy) or embodied attunement as they resonate with the client's embodied being as a gestalt of their thoughts, feelings and bodily sensations (Cooper, 2001). This can be seen to redress the previously downplayed role of body processes in the therapeutic relationship (Kepner 1993, 1997; Carroll, 2014) and question the largely taboo subject of religion and

spirituality within psychotherapy (Ersahin, 2013; Cooper & McLeod, 2007; Cooper, 2015) that had prompted interest in the integration of Eastern and Western models in therapeutic practice (Welwood 2002; Wilber 2000).

Conclusion & Critical Appraisal

I would argue that these research findings support the need for a more widespread conceptualisation of the therapeutic relationship as an embodied relationship, and hence promote treatment approaches to psychological distress that recognise the mind and the body within the therapeutic endeavour. It is possible that the effective integration of somatic and psychic forms of psychotherapy may be the realisation of what Freud (1940/1964:182) referred to at the inception of psychotherapy as the of yet “undreamed of possibilities of therapy”.

Whilst all four participants recognised mind-body unity as underpinning their practice, what was evident in their respective accounts was the extent to which their absolute belief in their own particular form of bodywork conveyed an idealisation of bodywork in general. A possible explanation for this is that they were all practicing within complementary healthcare settings in the private sector. As such they were working in environments that embraced holistic, naturopathic and alternative methods of health care, rather than those associated with the medical model of treatment practiced within the National Health Service. This was referred to by Jilly who attributed her decision to leave her job as a senior nurse in the NHS to the difficulty she had in adhering to an increasingly medicalised way of treating people. Similarly, Rhian spoke of her own experience of Bowen therapy successfully alleviating her pain where her NHS treatment had failed. Furthermore, it would seem likely that this revered view of what bodywork can offer individuals was reinforced by the respective client base of each of the participants who chose and paid for their treatment.

What this highlights is that the bodywork practitioners in this study shared a view of embodiment as central to their therapeutic practice and their sense of personhood. They worked with the body and they believed in bodywork as a, or

perhaps *the* route to healing and health. From an embodiment perspective, this can be seen to support the current trend in psychotherapy research that marks “a progression beyond the dualistic idea of body and mind towards the idea of embodiment as a process within a relational context” (Carroll, 2014:12). Therefore, acknowledging the importance of a non-dualistic approach to relational psychotherapy calls for an increased emphasis to be placed on enhancing embodied awareness as an integral part of the talking therapy.

However, whilst all the participants also shared the view of body and mind being connected, they varied in the extent to which they saw the mind as fundamental to their therapeutic process. The impression was one of needing to engage the mind through their verbal interaction with their clients, in order to enhance bodily awareness to a level that facilitated their bodywork practice as opposed to this being part of their therapy. For example, Archie made a point of saying that his discussions with his clients were conversations and not therapy, and Rhian made a clear distinction between what she did and ‘head therapy’. In one sense it could be viewed that this position is reversed for psychotherapists as they draw on the body’s contribution to the therapeutic process as a means of informing and assisting talking therapy. However, whilst all the bodywork practitioners in this study valued their therapeutic relationships, for them the bodywork *is* the therapy. Whereas for psychotherapists the suggestion is that the body is recognised alongside the mind in the therapeutic venture or more specifically the therapeutic relationship, which reinforces the premise that the relationship *is* the therapy (Khan, 2001).

Linked to this, my study revealed that an understanding of the therapeutic relationship as discussed and referred to by these participants, was not a focus of their professional training. This finding supports that of a small study carried out by Fox (2008), who reported a variety of indications to suggest complementary therapists did not receive the same level of training with regard to the importance of the therapeutic relationship as psychotherapists. As a response to this Fox advocates more comprehensive training for all CAM practitioners - a proposal that Rhian said that she would welcome. However, I suggest that moreover scope for a

two-way learning potential is indicated, whereby valuable information about the body known to bodywork practitioners could be passed on to psychotherapists.

Whilst I suggest that the analysis of these accounts points to several interesting ways in which this data may be useful to Counselling Psychologists to reflect on in relation to their practice, I am not advocating for the wholesale adoption of these world views on bodywork practice. Rather I suggest that these findings are viewed as a potentially important adjunct to the ongoing development of Counselling Psychology that prioritises the therapist and client relationship within the context of the rigorous training, supervision and professional development requirements of conscientious and ethical practice.

In conclusion, I would suggest this study has shown that the lived experiences of Hannah, Archie, Jilly and Rhian highlight how the therapeutic relationship is indeed an embodied relationship. Moreover I would suggest that this has provided a platform for a more comprehensive consideration of how the therapist's and the client's bodies contribute to this phenomenon that may be particularly relevant to Counselling Psychologists.

Clinical Implications

There are several implications of my study for the field of Counselling Psychology. From a theoretical perspective, the endorsement it gives to establishing embodied therapeutic relationships supports the challenges brought against dualistic thinking with regard to notions of personhood and intersubjectivity. My thesis illustrates how the selected bodywork practitioners experience embodied relationships with their clients, and how the therapeutic process has embodied aspects and symbolic meaning contained within it. Specifically, the memory meaning or procedural organisation (Fogel, 2009) in the bodies of the therapist and client can be understood as contained or constructed in their bodies and then shifting through the bodywork treatment in a process of corporal attendance and awareness raising. In addition the therapeutic relationship, which is embodied and meaningful, supports the premise of embodiment and meaning as intertwined.

Counselling Psychology and other talking therapies, have focused primarily on meaning constructed through discourse and not embodiment, with this separation of one and not both being based largely on dualism. In contrast, this research emphasises the possibility and importance of attending to embodiment as it is intertwined with meaning within the context of the therapeutic relationship, thus supporting new ways of conceptualising the role of the talking therapist in the therapeutic endeavour. In short, the therapeutic relationship can be seen to be formed of both the embodied therapist and the embodied client.

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possible therefore that this may prompt Counselling Psychologists to review the way in which they construe themselves within their therapeutic relationships, which as a consequence may lead to a variation or extension of their professional practice.

This can be seen as particularly pertinent at this current time as this research adds to the rapidly evolving contributions from neuroscience (Cozolino, 2004; Shore, 2003, 2014), attachment theory (see Shemmings, 2011) and developmental psychology (Trevvarthen, 2004) that have seen the introduction of more widespread somatic approaches within psychotherapy. Predominantly, these have been in response to findings that client trauma is often rooted in their pre-verbal experiencing of the world that hinges on their somatic memory (Siegel, 2007).

For example, Blum (2015) proposes ‘embodied mirroring’ (a relational body-to-body technique promoting movement in psychotherapy), to be particularly useful with “preverbally or chronically traumatised or attachment disordered individuals who often present with limited adaptive resources, lack words to describe their experience and are affectively shut down or disconnected” (Blum, 2015: 2). This is explained as the therapist intentionally ‘trying on’ the client’s experience by mirroring how they hold and move their body, fostering “the emergence of embodied countertransference through body-based empathic reflections and psychophysical empathy (Federici-Nebbiosi & Nebbiosi, 2012; Krantz, 2012).

Likewise, in Sensorimotor psychotherapy (Ogden 2014; Ogden & Minton, 2000), the therapist uses the therapeutic relationship to regulate the client’s affective and sensorimotor states and teaches the client to self-regulate by integrating mindfulness practices with what transpires in their moment-to-moment interaction within the therapeutic hour (Ogden & Fisher, 2015).

It is my suggestion that this research indicates potential scope for Counselling Psychologists to increase their awareness of such approaches and give consideration to integrating somatic techniques into their way of working with clients. In turn, this gives rise to my own need for consideration of how I might develop my Counselling Psychology practice. This has particular relevance with

regard to the forensic psychological counselling that I am involved in with children (and families) who have experienced poor early attachments and exhibit indications of trauma in conjunction with an evolving forensic history. For example, research into mindfulness-based parenting interventions indicates that parents experience less reactivity, aggression and more satisfying interactions with their children (Bihari & Mullan, 2014). Equally, successful treatment of forensic clients has identified a collaborative working alliance improves empathy and the capacity to identify with others and has a positive effect on emotional regulation and impulse control thus reducing the intensity of the need to engage in criminal behaviour (Benveniste, 2012).

I acknowledge therefore, that changes in my or any other Counselling Psychologist's practice may be guided by such examples of existing research findings. Moreover, it is notable that this influence is already beginning to change the way in which Counselling Psychologists integrate bodily awareness with the aspects of therapeutic relationship that they already demonstrate in their verbal skills. A specific implication of this is the question of whether the use of touch warrants more prominent consideration with regard to how an embodied therapeutic relationship is formed and maintained within psychotherapy.

This may represent an ethical as well as a practical dilemma for some Counselling Psychologists as the use of touch within talking therapies has always been a contentious issue that has understandably been treated with caution. Well trained therapists are taught to be sensitive to the potential misinterpretation of their use of touch with a client alongside the potential benefits this may hold. Badouk Epstein, (2014:13) describes touch as "the most powerful form of communication throughout the course of one's life, holding immense potential for use as well as misuse, for healing as well as for harm". What may be intended to convey comfort or support may be experienced as abusive and re-traumatising dependent on the client's history, but that absence of touch may be a painful re-experiencing of parental coldness, neglect or fear of physical contact (Clarkson, 2003; Miller, 2012; Rothschild, 2002).

This resonates with me personally with regard to my reflective premise for carrying out this study. Within this I talked of experiencing some dilemma regarding the acceptability of my use of touch in the two very different residential settings where I worked when I commenced my Counselling Psychology training. In the therapeutic community for chemical dependence, the frequent use of affirmative and reassuring touch was an accepted part of the therapeutic focus. Whilst in the category B adult male prison any form of touch, other than a cursory handshake at the beginning and end of a course of therapy, was discouraged.

More recently, I was reminded of this dilemma in relation to a child I had been working with for several months who had originally come to therapy very fearful and dysregulated and it had taken some time for them to trust in the therapeutic relationship with me. Eventually good progress was made in all areas except in relation to them admitting the extent of their forensic history. This had presented an impasse in the therapeutic process that had potential negative consequences for this child's future. However, in one particular session the child came in and sat down and as we looked at each other I noticed their leg was shaking quite unusually and vigorously. As this continued and increased I suddenly touched the child's knee and instantly their leg stopped shaking. As I rapidly assessed my action in response to my thoughts of potential re-traumatisation versus reassurance, the child's body became still and they seemed to calm and centre. Later in that session they admitted the behaviours they were very ashamed of and had previously been unable to accept and discuss, and I concluded that my use of touch at that moment for that particular client had been the right thing to do.

From a professional development perspective, I now feel in a far more informed position in the light of this current research, to judge how my use of touch as part of my embodied relating as a Counselling Psychologist is likely to impact on my client and our therapeutic relationship. In a wider sense, I suggest that this has implications for Counselling Psychologists in general. This research supports recent evidence from neuroscience that indicates touch acts positively on the body by lowering blood pressure, reducing depression and anxiety and stimulating the body's hormones (Bergman, 2005; Perry & Szlavitz, 2010), and Stern's (1990: 99) argument that "the ultimate magic of attachment is touch. And this magic enters

through the skin". This confirms the significant evidence presented decades ago in relation to early attachment in children (Bowlby, 1973; Winnicott, 1960) and infant monkeys (Harlow, 1958) that found that lack of touch resulted in the failure to thrive.

It is possible therefore, that appropriate use of touch as an aspect of embodied relating, may warrant inclusion in continued professional development (CPD) activities for Counselling Psychologists. Indeed this follows the suggestion made by Archie in his participant interview that the use of timely and meaningful touch is something talking therapists could learn from body-focused practitioners: 'in the event of your client breaking down and let's say having a real cry and really feeling bad, you as an individual have the opportunity to reach over and just give them a little pat, just to make a bond, just to say that I'm a human being you're a human being [] if you say I know and feel and understand how you feel, that little touch underlines fully your words. So your words and your meaning or your heart felt meaning, comes in doors, imbedded in a physical way' (Archie L430-437).

Badouk Epstein (2014) would support this idea as illustrated in her identification of the four different types of touch she uses as an adjunct to talking therapy. These are: *consolidation touch* in response to a client's experience of grief or deep emotion, *grounding touch* to encourage the client's awareness of the physical body, *indirect touch* such as covering a client with a blanket and *reassuring touch* such as a hug or a handshake at the end of a session. The decision when to use any of these she attributes to 'body attunement', which she defines as the therapist's ability to trust the countertransference to know the right touch to use, in the right place and at the right time. Notwithstanding this, Badouk Epstein stresses that in order to ensure that ethical practice and crucially the client's safety is maintained, regular supervision is essential when considering engaging with the client in this way.

A further implication therefore, is that Counselling Psychologists may seek to include routine consideration of their use of touch with clients within the discourse of their supervision. For example, this could be discussed within the framework of Clarkson's transtheoretical model of the therapeutic relationship, particularly I

would suggest, with regard to the 'reparative/ developmentally needed' relationship. What's more, this research has implications for how Counselling Psychologists may wish to reconfigure their supervision arrangements in order to focus on embodied relating as central to their therapeutic endeavour. This is in accordance with the Division of Counselling Psychology guidelines for supervision (2005:4) that defines supervision as "a process of ongoing, collaborative, experiential and transformational learning using theoretical understanding and evidence from research and practice that is reflected upon and applied to practice".

In addition, this research also highlights the potential for bodywork practitioners to undertake more robust and regular supervision activities. Only Hannah reported she received regular professional supervision with a fellow bodywork practitioner/ trained supervisor. Rhian said she had in the past been a member of a supervision group for a period of time that was facilitated by a qualified therapist/ supervisor. However, as this was largely attended by talking therapists she had not found it wholly applicable to her work as a body-focused practitioner. Archie, Jilly and Rhian all indicated they could access peer supervision when they felt they needed it, but this was not a regular arrangement for any of them.

However, it is recognised that within the field of complementary and alternative medicine, professional supervision is not generally a requirement of professional registration as it is in Counselling Psychology and other talking therapies. Fox (2008) argues this may contribute to why supervision is often a much underrated and therefore underused resource by complementary therapists. As such there is likely to be a lack of awareness amongst body focused practitioners of the benefits good supervision provides. Such as emotional support to sustain optimal functioning and guard against 'burn out', practical support in respect of the additional educational component it offers and the professional and personal development opportunities it holds as an essential component of safe and competent practice (Stone, 2002).

Nevertheless, this research suggests that the traditional talking therapy mode of supervision delivery may need to be broadened for both bodywork practitioners

and talking therapists, if it is to adequately support embodied relating across professions. For example mindfulness-based supervision (MBS) is presented as a framework for the supervision of mindfulness-based teachers that involves the supervisor enabling the supervisee to discover and connect to their intrinsic ways of knowing (Evans et al., 2014). As well as utilising mindfulness techniques this approach draws on accessing the felt sense in the body (Gendlin, 1997, 2004) and aims to reawaken a creative space and reconnect with the practitioners innate qualities that are often already there but have been missed (Ryan, 2008). Todres (2011) discusses Gendlin's view of 'sense-making' as a process that rather than relying on cognition alone involves the participation of the 'lived body':

“Such lived body participation is always ‘more than words can say’, and the experience of ‘sense making’ involves an engagement with a kind of language that is bodily and sensorily involved. Such a process is not arbitrary but involves what Gendlin calls a ‘felt sense’”.

(Gendlin, 1997)

Furthermore, Todres (2011) presents a model of training students in embodied understanding for the practice of adult psychotherapy that utilises felt- sensing. Finlay (2011) and Kryka, (2011) also argue for a way of accessing bodily knowing that can be successfully used in phenomenological research and therapeutic practice and training. This research supports such models of training to be implemented within Counselling Psychology. Specifically, the strong similarities that have been drawn between Gendlin's approach and that of Trager bodywork practice, with the emphasis in both on the felt experiences of the client and the therapist (Blackburn, 2003), suggests there may be further training and continued professional development (CPD) opportunities to be explored for Counselling Psychologists that involve the sharing of knowledge and experience held by bodywork practitioners.

There is an implication therefore, that Counselling Psychology may be well served to include these developments in an embodied way of relating in therapy and research in future training initiatives within the discipline. The research also suggests an acknowledgement of spirituality may warrant some consideration. As

such, this study can be seen to support Rowan's (2005) model of training based on his view of psychotherapy as comprising of three ways of doing therapy namely: the instrumental way, the authentic way and the transpersonal way. Moreover, this model corresponds with Clarkson's (2003) transtheoretical model of the therapeutic relationship as discussed previously.

The instrumental way refers to psychotherapeutic treatment approaches that focus on producing change within the client by the application of techniques with measurable outcomes such as Rational Emotive Behaviour therapy, Neurolinguistic programming, Cognitive Behavioural therapy and some forms of Psychodynamic therapy. Rowan argues that all forms of therapy resort to this level of working at times, which he likens to the working alliance, the first of Clarkson's (2003) five relationship modalities. In this way of doing therapy, Rowan considers the scope of therapeutic impact to be limited and therefore best suited to short term highly focused interventions.

Rowan's second way of doing therapy is the authentic way. Favoured by the Humanistic and Relational schools, Rowan equates this to Clarkson's (2003) 'person-to person' relationship modality as it involves the therapist's use of self rather than their reliance purely on techniques. It demands a high level of self knowledge and self awareness and places importance on mind-body unity. Finally in the transpersonal way of doing therapy, as in the final relationship modality discussed by Clarkson (2003) there is recognition that "the boundaries between therapist and client may fall away. Both may occupy the level of the soul". (Rowan, 2005:5).

The body-focused therapists in this study all indicated that they worked in each of these three ways, to a certain degree, within their respective practices. I would argue therefore, that this research supports Rowan's recommendation that training in counselling and psychotherapy should recognise all these three ways of doing therapy as this will lead to 'a truly inclusive therapy' to meet the demands of the future.

Strengths and limitations of the study

Assessing qualitative research for quality requires evaluation criteria distinct from those employed by quantitative researchers, criteria that match the goals and values of a qualitative researcher (Yardley, 2000, 2008; Finlay, 2011). Finlay and Evans (2009) present a framework for such evaluation, consisting of what they call 'the 4 R's of Rigour, Relevance, Resonance and Reflexivity (Finlay, 2006, 2011; Finlay & Evans, 2009). Each of these will be discussed in turn and related to this current research study.

Rigour asks whether the research has been competently managed in terms of its coherency, plausibility and justification of interpretation and validity of argument. I would argue that this study was systematically conducted and that each step has been coherently described within this thesis. Attention was paid to detail in the procedure, clarification of the steps in the process and use of supervision and peer appraisal to check my analysis and interpretation of the data.

Relevance asks if the research is applicable to the area of study, if it adds to existing knowledge, enriches our understanding of the human condition or enhances therapeutic practice. I would argue that this research is relevant to Counselling Psychology as the therapeutic relationship is such an intrinsic aspect of the discipline. By widening the appreciation of an embodied sense of this relationship not previously prioritised within the majority of talking therapies, this research adds to knowledge in Counselling Psychology regarding the possibility of incorporating embodied lived experience into research and therapeutic practice; thereby enriching our understanding of the therapeutic process and offering talking therapists a way of improving their practice.

Resonance is concerned with emotional, artistic and spiritual dimensions that readers of the research find that it has reached. The researcher's ability to move away from the interview schedule as the interviews progressed demonstrates how the development of rapport and trust (Smith, Flowers & Larkin, 2009) and responsiveness to the participants' individual stories led to them each giving in-depth accounts. The data produced was rich in terms of how it depicted relationships that had meaning for the participants both professionally and

personally. It was surprising to me as the researcher in how emotionally moving these accounts became as the participants revealed connections between their therapeutic relationships, their choice of therapeutic practice and their own sense of personhood. Formative experiences, creative expression, lifestyle crises and issues of spirituality were all disclosed.

Finally, Reflexivity is concerned with the researchers own level of self-awareness and openness within the research process. I would argue that this was demonstrated in this study by my use of a reflective journal throughout the research process and the regular discussions I had with my supervisors and peers. In particular, receiving each of the body-focused therapies enhanced this by making my reflections experiential as the context shifted from my research domain and I entered into the participant's practitioner space as their client. In all of these experiences I was conscious that it was a slightly false situation. I was not just a receiver of the bodywork but was assessing as well as experiencing the process, comparing it to how each of them had talked about it in their research interview. Much as I tried to 'felt sense' it (Gendlin, 1997) I have to say this got in the way a bit. That was my first piece of learning – I wasn't just being and I imagine I kept my mental hold over my body much more than any of them would have preferred. The following extracts are taken from my reflective journal:

Hannah The preparation was so obvious, there was a calm serenity about the therapeutic space, and I felt anticipated and held as soon as I arrived there. I happily breathed it all in. The Craniosacral therapy was gentle and non-invasive. I imagined the cerebral fluid flowing around inside my body and closed my eyes and enjoyed departures into silence that I hoped were accessing my soul.

Archie When I started the mentastics I felt slightly self conscious and then a feeling of confidence took over and I felt somewhat energised. On the treatment table I felt my body move in accordance with Archie's vibrancy and gentle yet purposeful touch of the Trager. I was much freer doing the final mentastics - not quite dancing but almost!

Jilly Fear, apprehension intrigue, embarrassment...and then cared for and known. Strangely enjoyable in a 'you know it's good for you' kind of a way! Hot and cold as the Colonic Hydrotherapy process got properly underway and just as I was about to say "I've had enough now" Jilly said "I think you've had enough now"! Known indeed. Afterwards I felt lighter, clearer and totally energised – unexpectedly good!

Rhian I really did have only two or three Bowen moves done on my body and then Rhian went out of the room. I wasn't sure what to do or think except probably thought I shouldn't do either. So I relaxed a bit more and found it quite nice to be on my own just lying there but I still had a bit of apprehension about when the door would open. My body seemed to like it though, not forced to do anything.

I held these reflections in mind as I analysed each of the transcripts in turn and then in relation to each other. I felt it deepened the research process for me as it gave me a personal perspective that was an embodied perspective that resonated with me and balanced my thinking. It was a challenge at times to be carrying out a study that focused on the body and not veer towards a largely mentalisation process of research activity. However, counselling psychologists in training must develop "the ability to evaluate critically the primary philosophical paradigms that inform psychological theory with particular regard to their relevance to and impact upon, the understanding of the subjectivity and intersubjectivity of experience throughout human development" (Counselling Psychology candidate handbook, 2014:14) and I believe I have demonstrate this in the completion of this research process.

However, this is notwithstanding the inherent limitations within this study as would be expected with a project of this sort. For example this research sample was not diverse. All participants (one man and three women) were middle class, white and British, and only one of them was of mixed heritage. Therefore, there was no scope to identify what if any areas of difference this obscured. For example, given that some research has suggested ethnic minority clients are more likely to

terminate psychotherapy early when treated by Causcasian therapists (Reis & Brown, 1999) the importance of identifying such things as culture-specific markers for alliance ruptures (Constantino & Wilson, 2007; Crits-Christoph et al., 2011), lends itself to further future investigation.

Another limitation is the fact that due to the small number of participants that took part in this study, it is not possible to make generalisations with regard to the lived experience of other body-focused practitioners working in complementary healthcare settings with regard to how they conceptualise their therapeutic relationships. However, what this study revealed with regard to the importance all four participants placed on establishing a therapeutic relationship with their clients - such that they related to the whole person and 'not just their body', may add to new areas of research that value using alternative and complementary therapies alongside psychotherapeutic interventions. For example, as is being seen in the treatment of eating disorders, addictions and substance use disorders (Madden, Fogarty, & Smith, 2014). Similarly, acupuncture has shown promise as an effective adjunctive therapy in improving co-morbidities such as depression and anxiety levels in the treatment of anorexia nervosa. In response to this, practice guidelines have been produced for acupuncture therapists, to run alongside those that already exist for practitioners of allopathic medicine (Wilson & Shafran, 2005). Notably, these guidelines focus primarily on ensuring a good therapeutic relationship is established and maintained by acupuncturists working in this treatment milieu (Fogarty & Ramjan, 2015).

Completion of this study has indicated areas of convergence between body-focused therapy and Counselling Psychology with regard to how the therapeutic relationship is demonstrated that holds great potential for more integrated therapeutic practices. Areas for learning have been indicated in both directions. For body-focused therapy this is in relation to the potential for increased awareness training with regard to the centrality of the therapeutic relationship in talking therapy and consideration of more robust supervision arrangements to support body-focused practitioners in what was found to be their intricate holistic practice. For Counselling Psychology, this is in relation to expanding the current knowledge and skill base and of our therapeutic practice, supervision, research

and training activities to include a greater awareness of embodied processes alongside emotions, thoughts and behaviours, “in an attempt to deal with the whole person that is so characteristic of therapy today” (Rowan, 2012:25).

References

- Albery, N. (1983) *How to save the body*. London: Revelation Press
- Alcoholics Anonymous (1955) *Alcoholics Anonymous: the story of how many thousands of men and women have recovered from alcoholism*. New York: AA World Services
- Alexandris, A. & Vaslamatzis, G. (1993) *Countertransference: Theory, technique Teaching*. London: Karnac Books
- Aron, L. (1991) The Patient's Experience of the Analyst's Subjectivity *Psychoanalytic Dialogues*. 1, pp. 29–51.
- Aquino A. T & Lee, S. S. (2000) The Use of Nonerotic Touch with Children. *Journal of Psychotherapy in Independent Practice*. 1(3), pp.17-30
- Ashworth, P. D. (1997) The variety of qualitative research. Part one: introduction to the problem, *Nurse Education Today*. 17, pp.215-8
- Atwood, K. C. (2003) Naturopathy: A critical appraisal. *Medscape General Medicine* 5 (4), pp. 39.
- Axline, V.M., (1969) *Play Therapy*. New York: Ballantine Books
- BACP (2010) *What is Counselling and Psychotherapy?* Lutterworth, Leicestershire: British Association for Counselling and Psychotherapy
- BACP (2013) *Ethical Framework for Good Practice in Counselling and Psychotherapy*. Lutterworth, Leicestershire: British Association for Counselling and Psychotherapy
- Badouk Epstein, O. (2014) Touching Trauma: working relationally and safely with the unboundaried body. In Kate White (Ed) *Talking Bodies: How Do We Integrate Working with the Body in Psychotherapy from an Attachment and Relational Perspective?* London: Karnac (pp. 109-124).
- Baldwin, M. (2000). Interview with Carl Rogers on the use of the self in therapy. In

- M. Baldwin (Ed.) *The Use of Self in Therapy*, 2nd edn. New York: Haworth Press, pp. 29–38.
- Barcan, R. (2011) *Complementary and Alternative Medicines: Bodies, Therapies and Senses*. London: Berg
- Barr, J. (1987) Therapeutic Relationship model *Transactional Analysis Journal* 17(4), pp. 141
- Barker, C., Pistrang, N. & Elliot, R. (1994) *Research Methods in Clinical and Counselling Psychology*. London: Wiley
- Bartenieff, I. & Lewis, D. (1980) *Body Movement; Coping with the Environment*. New York: Gordon and Breach
- Bass, A. (2007). When the frame doesn't fit the picture. *Psychoanalytic Dialogues*. 17, pp.1–27.
- Bateman AW, & Fonagy P (2011) Antisocial personality disorder. In *Handbook of Mentalizing in Mental Health Practice*. (eds AW Bateman & Fonagy P) pp 289-308. American Psychiatric Publishing.
- Baum, W., M. (2005) *Understanding Behaviourism: behaviour, culture and evolution* Oxford: Blackwell
- Baum, R. (2013) Transgenerational trauma and repetition in the body: The groove of the wound. *Body, Movement and Dance in Psychotherapy*, 8(1), 34-42
- Bayer, B. & Malone, K. (1998). Feminism, psychology and matters of the body In H. Stam (Ed) *The Body and Psychology* London: Sage
- Beck, A., Wright, F.D., Newman, C. F. & Liese, B. S. (1993) *Cognitive Therapy of Substance Abuse*. London: Guildford Press
- Bedi, R. (2006). Concept mapping the client's perspective on counselling alliance formation. *Journal of Counselling Psychology*. 53, pp.26-35.
- Beebe, B., Rustin, J., Sorter, D., & Knoblauch, S., (2003). Symposium on intersubjectivity in infant research and its implications for adult treatment. III. An

expanded view of forms of intersubjectivity in infancy and its application to psychoanalysis. *Psychoanalytic Dialogues*, 13 (6), 805-841.

Beebe, B., & Lachmann, F. (2013). *The origins of attachment: Infant research and adult treatment*. New York: Routledge

Benveniste, D. (2012) Relational Quandaries in the Treatment of Forensic clients *Clinical Social Work Journal* 40, pp. 326-336

Bergman, N. (2005) More than a cuddle: skin-to-skin contact is key. *Practical Midwife*, 8(9) pp44. PubMed PMID: 16262101.

Berkers, E. (2014) Introduction to the Chakras Available from: <http://www.eclecticenergies.com/chakras/introduction.php> [Accessed 21 January 2015]

Bihari, J & Mullan, E. (2014) Relating Mindfully: A Qualitative Exploration of Changes in Relationships through Mindfulness-Based Cognitive Therapy. *Mindfulness* 5, pp. 46-59

Bion, W., R. (1965/1991) *Transformations*. London: Karnac

Blackburn, J. (2004) Trager-2: hooking up: the power of presence in bodywork. *Journal of Bodywork and Movement Therapies*. 8, pp.114-121

Blair, L. (2010). A critical review of the scientist-practitioner model for counselling psychology. *Counselling Psychology Review*, 25(4), pp. 19-30.

Blum, M. (2015) Embodied Mirroring: A Relational, Body-to-Body Technique Promoting Movement in Therapy *Journal of Psychotherapy Integration*. Advance online publication. <http://dx.doi.org/10.1037/a0038880>

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

Boadella, D (1988) 'Biosynthesis' in J Rowan & W Dryden (eds) *Innovative Therapy in Britain* Milton Keynes: Open University Press.

Boadella, D. (1990) Somatic Psychotherapy: its roots and traditions *Energy and Character* 21 (2), pp.

Boadella, D. (1997) Awakening sensibility, recovering motility. Psycho-physical synthesis at the foundations of body-psychotherapy: the 100-year legacy of Pierre Janet (1859-1947) *International Journal of Psychotherapy*, 2 (1), pp.45-56.

Bohart, A., C., Elliott, R., Greenberg, L., S. & Watson, J., C. (2002) Empathy In J. Norcross (ed) *Psychotherapy Relationships that Work : therapist contributions and responsiveness to patients* Oxford: Oxford University press (pp. 89-108).

Bordin, E.S. (1979) The Generalizability of the Psychoanalytic Concept of the Working Alliance. *Psychotherapy: Theory, Research & Therapy*. 16, pp.252-260.

Bordin, E.S. (1980) Of human bonds that bind or free. Presidential Address to Tenth Annual Convention of society for Research on Psychotherapy, Pacific Grove, California.

Bordo, S. (1993) *Unbearable Weight Feminism, Western Culture, and the Body*. Berkeley, CA: University of California Press.

Bowlby, J. (1969). Attachment and loss, Vol. I: Attachment. New York: Basic Books

Bowlby, J. (1973). Attachment and loss, Vol. 2: Separation. New York: Basic Books.

Bowlby, J. (1980). Attachment and loss, Vol. 3: Loss, sadness and depression. New York: Basic Books.

Bowlby, J. (1988). A secure base: Parent-child attachment and healthy human development. New York: Basic Books.

Bozarth, J. (1998) *Person-Centred Therapy: A Revolutionary Paradigm*. Ross-on-Wye: PCCS Books. London: Sage.

Brammer, L., M. & Shostrom, E., L. (1968). *Therapeutic psychology: fundamentals of actualization counselling and psychotherapy* Englewood Cliffs, NJ: Prentice Hall.

Bragan, K. (1996) *Self and Spirit in the Therapeutic Relationship*. London: Routledge

Bravesmith, A. (2012) Silence lends Integrity to Speech: transcending the opposite of speech and silence in the analytic dialogue *British Journal of Psychotherapy* 28 (2), pp.21-34

Bridges, N. A. (2001) Therapist's self-disclosure: Expanding the comfort zone. *Psychotherapy*. 38, pp.21–30.

British Psychological Society (2005) *Division of Counselling Psychology Guidelines for Supervision* Leicester: British Psychological Society

British Psychological Society (2014) *Qualification in Counselling Psychology Candidate Handbook* Leicester: British Psychological Society

Buber, M. (1958/1970). *I and Thou*. 2nd ed. New York: Charles Scribner.

Budd, S. & Sharma, U. (Eds) (1994) *The Healing Bond: the patient-practitioner relationship and therapeutic responsibility* London: Routledge

Bugental, J., F., T. (1987) *The Art of the Psychotherapist* New York: Norton

Burns, M. L. (2003). Interviewing: Embodied communications. *Feminism & Psychology*. 13(2), pp.229-236.

Burns, M. L. (2006). Bodies that speak: Examining the dialogues on research interactions. *Qualitative Research in Psychology*. 3, pp.3-18.

Cant, S. and Sharma, U. (1999) *A New Medical Pluralism? Alternative Medicine, Doctors and Patients and the State*. London: UCL Press.

Carroll, R. (2014) Four relational modes of attending to the body in Psychotherapy. In Kate White (Ed) *How Do We Integrate Working with the Body in Psychotherapy from an Attachment and Relational Perspective?* London: Karnac (pp. 11-40).

Carneiro, R., Zeytinoglu, S., Hort, F. & Wilkins, E. (2013) Culture, Beauty and Therapeutic Alliance *Journal of Feminist Family Therapy*. 25, pp.80–92

Cameron, R. (2002) Subtle bodywork. In *Body Psychotherapy*. T. Staunton (Ed) London: Routledge pp.148-171

Castonguay, L.G., & Beutler, L. E. (Eds) (2005). *Principles of therapeutic change that work*. New York: Oxford University Press.

Castonguay, L.G., Constantino, M.J., & Holforth (2006) The Working Alliance: where are we and where should we go? *Psychotherapy, Theory, Research, Practice, Training* 43(3), pp. 371-279

Chan, C. H. Y., Chan, C. L. W. & Chan, T. H. Y. (2013). Exploring the clinical efficacy of the Integrative Body-mind-spirit (I-BMS) Healing Model. Abstract presented at the 59th Annual Program Meeting, Council on Social work Education, October 31 – November 3, 2013, Dallas, TX.

Chernin, K. (1983) *Womansize: Tyranny of Slenderness*. London: The Women's Press.

Cherry, E.F. & Gold, S.N. (1989) The Therapeutic Frame Revisited: a contemporary perspective. *Psychotherapy*. 26 (2), pp.162-8

Chodorow, J. (1991) *Dance therapy and depth psychology: the moving imagination* NY: Routledge

Clarke, C. (2009) An Introduction to Interpretative Phenomenological Analysis: A Useful Approach for Occupational Therapy Research *The British Journal of Occupational Therapy* 72(1), pp.37-39.

Clarkson, P. (1995) The Therapeutic relationship in Psychoanalysis, Counselling Psychology and Psychotherapy. London: Whurr.

Clarkson, P, (1996) Researching the 'therapeutic relationship' in psychoanalysis, counselling psychology and psychotherapy – a qualitative inquiry. *Counselling Psychology Quarterly*. 9 (2), pp.143-162.

Clarkson, P (2003) *The Therapeutic Relationship*. 2nd ed. London: Whurr

Connolly, A. (2013) Out of the body: embodiment and its vicissitudes. *Journal of Analytical Psychology* 58, pp.636-656

Constantino, M.J., Castonguay, L.G. & Shutt, A.J. (2002) The Working Alliance: A flagship for the “scientist-practitioner” model in psychotherapy. In: G.S. Tryon (ed) *Counseling based on process research: Applying what we know*. Boston: Allyn & Bacon; 2002. pp. 81–131.

Constantino, M.J. & Wilson, K.R. (2007) Negotiating difference and the therapeutic alliance In J.C. Muran (Ed) *Dialogues of Difference: Studies in diversity in the Therapeutic Relationship* Washington, DC: American Psychological Association (pp. 251-254).

Cooper, M. (2001) Embodied Empathy, in S. Haugh & T. Merry (eds), *Empathy*. Ross-on-Wye: PCCS Books.

Cooper, M. (2013). The intrinsic foundations of extrinsic motivations and goals: Towards a unified humanistic theory of wellbeing. *Journal of Humanistic Psychology*, 53(2), pp.153-171.

Cooper, M. & McLeod, J. (2007) *A pluralistic framework for counselling and psychotherapy: Implications for research*. Counselling and Psychotherapy Research, 7 (3). pp. 135-143.

Cooper, M (2015) *Existential psychotherapy and counselling: Contributions to a pluralistic practice*. London: Sage

Corey, G. (1996) *Theory and Practice of Counselling and Psychotherapy* 5th ed. USA: Brooks/Cole

Corey, G. (2005) *Theory and Practice of Counselling and Psychotherapy* 7th ed. USA: Brooks/Cole

Corrie, S. & Callahan, M. (2000). A review of the scientist-practitioner model: Reflections on its potential contribution to counselling psychology within the context of current healthcare trends. *British Journal of Medical Psychology* 73, pp.413-427

Couch, A.S (1999). Therapeutic functions of the real relationship in psychoanalysis. *Psychoanalytic Study of the Child*. 54, pp.130-168.

Connelly, A. (2013) Out of the Body: embodiment and its vicissitudes *Journal of Analytical Psychology* 58, pp. 636-656

Coward, R. (1989) *The Whole Truth: the Myth of Alternative Medicine*, London: Faber.

Cozolino, L. (2004). *The Making of a Therapist: a practical guide for the inner journey*. New York: Norton

Cozolino, L. (2014). *The Neuroscience of Psychotherapy : Healing the Social Brain*. New York: Norton

Crane, R. (2009) *Mindfulness-Based Cognitive Therapy*. London: Routledge

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). Thousand Oaks, CA: Sage.

Crits-Christoph P, Gibbons MB, Hamilton J, Ring-Kurtz S, Gallop R. (2011) The dependability of alliance assessments: The alliance-outcome correlation is larger than you might think. *Journal of Consulting and Clinical Psychology*. 79(3), pp.267–278.

Crossley, N. (1998) R D Laing and the British anti-psychiatry movement: a socio-historical analysis. *Social Science and Medicine* 47,(7) pp 877-98.

Crowley, V. (1998) *Jungian Spirituality: the only introduction you'll ever need*. London: Thorsons.

Dalai Lama. (1995). *The power of compassion*. Delhi, India: HarperCollins.

Dallos, R. & Draper, R. (2010). *An introduction to family therapy Systemic theory and practice*. Buckingham · Philadelphia: Open University Press

Damasio, A. (2000) *The Feeling of What Happens: body, emotion and the making of consciousness*. London: Vintage

Damasio, A. (2006) *Descartes Error*. London: Vintage

DeYoung, P (2003) *Relational Psychotherapy: a primer*. New York: Bruner-Routledge

- Denzin, N. & Lincoln, Y.S. (Eds.) (1994). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage.
- Diamond, N. (2001) *Towards an interpersonal understanding of bodily experience. Psychodynamic Counselling* 7, pp. 41-62
- Dillon, M.C. (1997). *Merleau-Ponty's Ontology*. 2nd ed Evanston: Northwestern University Press.
- Dryden, W., Horton, I. & Mearns, D. (1995). *Issues in Professional Counsellor Training*. London: Cassel
- Eagle, M. N. (2000) A Critical Evaluation of Current Conceptions of Transference and Counter-transference. *Psychoanalytic Psychology* 17 (1), pp. 24-37
- Eiden, B. (1999) The History of Body Psychotherapy: An overview. *Counseling News—The Voice of Counselling Training* 12, pp15–21.
- Ehrenreich, B. & English, D. (2010) *Witches, Midwives and Nurses: a history of women healers*. New York: The Feminist Press
- Ernst, S. and Goodison, L. (1981) *In Our Own Hands: a book of self-help therapy*. London: The Women's Press Ltd
- Ersahin, Z. (2013) The Elephant in the Room: Implications of the on-going conflict between religion and science, and what pluralism offers working with the (in)visible. *Counselling Psychology Review* 28(2), pp.39-52.
- Erskine, R. G. (2014) Nonverbal stories: The body in psychotherapy. *International Journal of Integrative Psychotherapy*, 5 pp. 21–33.
- Evans, A., Crane, R., Cooper, L., Mardula, J., Wilks, J., Surawy, C., Kenny, M & Kuyken, W. (2014) A Framework for Supervision for Mindfulness-Based Teachers: a Space for Embodied Mutual Inquiry *Mindfulness* 5 (1).
- Farber, B. (2006) *Self-disclosure in psychotherapy*. New York: Guildford Press
- Fairfax, H. (2008). "CBT or not CBT" is that really the question? Re-considering

the evidence base – the contribution of process research. *Counselling Psychology Review*, 23 (4), pp.27-37.

Federici-Nebbiosi, S., & Nebbiosi, G. (2012). The experience of another body on our body in psychoanalysis: Commentary on a paper by Jon Sletvold. *Psychoanalytic Dialogues*, 22, 430–436

Field, N. (1989). Listening with the body: An exploration in the countertransference. *British Journal of Psychotherapy*, 5(4), 512–522.

Finlay, L. (2006). The body's disclosure in phenomenological research. *Qualitative Research in Psychology*. 3 (1), pp.19-30

Finlay, L. (2011). *Phenomenology for Therapists: researching the lived world*. Chichester: Wiley Blackwell

Finlay, L. & Evans, K. (2009) *Relational-centred research for psychotherapists: Exploring meanings and experience*. Chichester: Wiley-Blackwell.

Flores, P.J. (1997) *Group Psychotherapy with Addicted Populations: an integration of twelve-step and psychodynamic theory*. 2nd ed. New York: The Haworth Press

Fogarty, S. & Ramjan, L. M. (2015) Practice guidelines for acupuncturists using acupuncture as an adjunctive treatment for anorexia nervosa. *Complementary therapies in medicine* 23 (1), pp14-22

Fogel, A. (2009) *Body Sense: The Science and Practice of Embodied Self Awareness* New York: Norton

Fonagy, P. (2000) Attachment and Borderline Personality Disorder *Journal of American Psychoanalysis Association* 48(4), pp. 1129-1146

Fook, J. (1999) *Transforming Social Work Practice: Postmodern Critical Perspectives* Hove, UK: Psychology Press

Fox, S. (2008) *Relating to Clients: the therapeutic relationship for complementary therapists*. London: Jessica Kingsley

Freud, S. (1910) The future prospects of psychoanalytic therapy. In N. J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud (Vol. 11, pp.141-151)*. London: Hogarth.

Freud, S (1913/1958). On the beginning of treatment: Further recommendations on the technique of psychoanalysis. In J. Strachey (Ed. and Trans.), *Standard edition of the complete psychological works of Sigmund Freud (Vol. 12, pp122-144)*. London: Hogarth Press

Freud, S. (1915) Observations on Transference-Love (Further Recommendations in the Technique of Psychoanalysis III) SE 12: 157-171

Freud, S (1933) *New Introductory Lectures on Psychoanalysis*. New York: Norton

Freud, S (1940/1964). An outline of psychoanalysis. In J. Strachey (Ed. and Trans.), *Standard edition of the complete psychological works of Sigmund Freud (Vol. 23, pp139-207)*. London: Hogarth Press

Fukuyama, M.A., Siahpoush, F. & Servig, T. D. (2005). Religious and spirituality in a cultural context. In C. S. Cashwell & J. S. Young (Eds.), *Integrating spirituality and religion into counseling* (pp. 123-142). Alexandria, VA: American Counseling Association.

Fulder, S. (1996) *The Handbook of Complementary Medicine*. Oxford: Oxford University Press

Gabbard, G. O. (1995) Countertransference: The emerging common ground. *International Journal of Psychoanalysis*. 75, pp.475-575

Ganzer, C. (2013) Variations from the Therapeutic Frame Paula Shatsky: Losing Ann: Countertransference Aspects of Altering the Frame with a Long-Term Patient Facing Atypical Dementia 58 *Clinical Social Work Journal* 41 (1), pp57–61

Geib, P. (1982) The Experience of Nonerotic Contact in Traditional Psychotherapy: A critical investigation of the taboo against touch. *Dissertation Abstracts International*, 43, 113A

Geib, P. (1998) The Experience of Nonerotic Physical Contact in Traditional Psychotherapy: In E.W. L. Smith, P. R. Clance & S. Imes (Eds.) *Touch in Psychotherapy: theory, research and practice*. New York: Guildford press

Gelsco, C. J. & Hayes, J. A. (1998) *The Psychotherapy Relationship: Theory, research and practice*. Canada: Wiley

Geller, J. D. (2003). Self-disclosure in psychoanalytic-existential therapy. *Journal of Clinical Psychology*. 59(5), pp. 541-554.

Geller, S. M. (2013). Therapeutic Presence: An Essential Way of Being. In Cooper, M., Schmid, P. F., O'Hara, M., & Bohart, A. C. (Eds.). *The Handbook of Person-Centred Psychotherapy and Counselling* (2nd ed.), pp. 209-222. Basingstoke: Palgrave.

Geller, S. M. & Greenberg, L. S. (2002). Therapeutic presence: Therapists' experience of presence in the psychotherapeutic encounter. *Person-Centered & Experiential Psychotherapies*. 1, pp.71-86.

Geller, S. M., & Greenberg, L. S. (2012). *Therapeutic Presence: A Mindful Approach to Effective Therapy*. Washington, DC: APA Publications.

Gendlin, E.T. (1981/2003) *Focusing*. London: Rider

Gendlin, E.T (1996) *Focusing Orientated Psychotherapy*. New York: Guildford press

Gendlin, E.T (1997) *Experiencing and the Creation of Meaning*. Evanston IL: Northwestern University Press

Gendlin, E.T (2004) An introduction to thinking on the edge. *The Folio* 19 (1), pp.1-8

Gilbert, P. (2002). Body shame: A biopsychosocial conceptualization and overview with treatment implications. In P. Gilbert & J. Miles (Eds.), *Body Shame: Conceptualization, research and treatment* (pp.3-54).Hove, UK: Brunner-Routledge.

Gilbert, P. (2009). *The compassionate mind*. London: Constable & Robinson.

- Gilbert, P (2010) Introduction to Compassion Focused Therapy in Cognitive Behaviour Therapy. *International Journal of Cognitive Therapy*, 3(2), pp.97–112
- Gilbert, P (2014) The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology* 53, pp.6–41
- Gilbert, P. & Leahy, R. L. (2007). The therapeutic relationship in the cognitive behavioural psychotherapies. Hove, UK: Brunner-Routledge.
- Gilbert, P & Choden (2013) *Mindful Compassion: using the power of mindfulness and compassion to transform our lives*. London: Robinson
- Gill, M. M. (1994). *Psychoanalysis in transition: A personal view*. Hillsdale, NJ: Analytic Press.
- Gimlin, D. (2007) What is Bodywork? A Review of the Literature, *Sociology Compass* 1(1), pp.353-370.
- Giorgi, A. (1989) The Status of Qualitative Research from a phenomenological Perspective. Paper presented at the Eighth Annual Human Science Research Conference. Aarhus, Denmark.
- Giorgi, A. & Giorgi, B. (2008) Phenomenology In J. A. Smith (ed) *Qualitative Psychology: A practical guide to methods* (2nd Ed) London: Sage
- Glaser, B.G., & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.
- Goddeck, G. (1931/1977) *The Meaning of Illness: Selected Psychoanalytic Writings*, NY: International Universities Press
- Golding, K. S. & Hughes, D. A. (2012) *Creating Loving Attachments: Parenting with PACE to Nurture Confidence and Security in the Troubled Child* London: Jessica Kingsley
- Golding, K. S. & Hughes, D. A. (2014) Creating Loving Attachments: Parenting with PACE to Nurture Confidence and Security in the Troubled Child *Emotional and Behavioural Difficulties* 19 (2), pp. 239-240 Bk Review (Amanda Barrie).

Gould, N & Taylor, I (eds) (1996) *Reflective Learning in Social Work* Aldershot: Arena

Gray, A. (2014) *An Introduction to the Therapeutic Frame*. London: Routledge

Greenberg, L.S. (2014) The Therapeutic relationship in Emotion-focused Therapy. *Psychotherapy* 51 (3), pp.350-357

Greenberg, L.S. & Pinsof, W. (Eds.) (1986) *The Psychotherapeutic Process: A Research Handbook*. New York: Guildford.

Greenhalgh, T. & Hurwitz, B (eds) (1998) *Narrative Based Medicine: Dialogues and Discourse in Medical Practice* London: BMJ Books

Greenson, R.R. (1967) *The technique and practice of psychoanalysis (Vol. 1)*. New York: International Universities Press.

Grossinger, R. (1995) *Planet Medicine*, 2 vols. Berkeley: North Atlantic Books.

Grossinger, R. (1998) Why somatic therapies deserve as much attention as psychoanalysis. In D.H. Johnson and I.J. Grand (eds) *The Body in Psychotherapy: Inquiries in Somatic Psychology*. Berkeley, CA: North Atlantic Books

Hamilton, R & Dinat, N. (2007) *Juta's Counselling Handbook for Healthcare Professionals*. SA: Juta Legal and Academic Publishers

Hart, N. (1985) *The Sociology of Health and Medicine*. Lancashire: Causeway Press

Harrison, C., Jones, R & Huws, J (2012) "We're people who don't touch": Exploring clinical psychologists' perspectives on their use of touch in therapy. *Counselling Psychology Quarterly*. 25(3), pp.277-287

Harlow, H. (1958) The Nature of Love. *American Psychologist* 13, pp.673-685

Haugh, S. & Paul, S. (eds) (2008) *The therapeutic Relationship: perspectives and themes* Ross-on Wye: PCCS Books

Heckler, R.S. (1984) *The Anatomy of Change: East/West Approaches to Body/Mind Therapy*. Boston: Shambala

Hefferon, K., & Gil-Rodriguez, E. (2011). Reflecting on the rise in popularity of interpretive phenomenological analysis. *The Psychologist*, 24 (10), 756-759.

Hegel, G. W. F. (1971) *Philosophy of Mind*. Oxford: Clarendon Press

Heidegger, M. (1927/1962) *Being and Time* (Trans. J. Macquarrie and E. Robinson). Oxford: Blackwell

Heuer, G. (2005) 'In my flesh I shall see god': Jungian body psychotherapy. In Totton, N. (2005) *New Dimension in Body Psychotherapy*. Maidenhead: Open University Press. pp. 102-114.

Hick, S. F. & Bein, T (eds) (2008) *Mindfulness and the Therapeutic Relationship*. New York: Guildford Press

Hollway, W. & Jefferson, T. (2000) *Doing Qualitative research differently: free association, narrative and the interview method*. London: Sage

Horton, J. (1998) Further research on the patient's experience of touch in therapy. Chapter in Smith, E. (ed.) (1998) *Touch in Psychotherapy: Theory, research and practice*. New York: Guildford Press, pp. 127-144.

Howard, G.S. (1986). The Scientist-practitioner in Counselling Psychology: towards a deeper integration of theory, research and practice. *The Counselling Psychologist* 14, pp61-105

Howard, P. (2008) Psychoanalytic Psychotherapy In S. Haugh, & S. Paul, (Eds) *The Therapeutic Relationship: perspectives and themes*, (pp.23-35) Ross-on-Wye: PCCS Books

Horvath, A., O. (2000) The Therapeutic Relationship: From Transference to Alliance Adam. O. Horvath (2), *Journal of Clinical Psychology, Special Issue: Millenium Issue: The Therapeutic Alliance* 56(2), pp. 163-173

Horvath, A. O. (2005) The therapeutic relationship: Research and theory. *Psychotherapy Research*. 15 (1-2), pp. 3-7

Horvath, A.O. & Greenberg, L.S. (1989) Development and validation of the working alliance Inventory. *Journal of Counselling Psychology*. 2, pp.223-233.

Horvath, A.O. & Symonds, D.B. (1991) Relation between Working Alliance and Outcome in Psychotherapy: A Meta-Analysis. *Journal of Counselling Psychology* 38, (2) pp.139-149

Horvath, A.O. & Greenberg, L.S. (1994). *The working Alliance: Theory research and practice*. New York: Wiley.

Horvarth, A. & Bedi, P. (2002) The Alliance In J. Norcross (Ed) *Psychotherapy Relationships That Work: Therapist Contributions and Responsiveness to Patients* (pp. 37-70). New York: Oxford University Press.

Horvarth, A., O., Del Re, A., Fluckiger C. & Symonds, B., D. (2011). Alliance in Individual Psychotherapy. *Psychoterapy* 48(1), pp. 9-16

Howard, P. (2008) Psychoanalytic Psychotherapy In S. Haugh, & S. Paul, (Eds) *The Therapeutic Relationship: perspectives and themes*, (pp.23-35) Ross-on-Wye: PCCS Books

Howe, D. (1993). *On being a client*. London: Sage

Hughes, D. A. (2007) *Attachment-Focused Family Therapy* NY: Norton

Hughes, D. A. (2011) *Attachment-Focused Family Therapy Workbook* NY: Norton

Hunter, M. & Sturve, J. (1998) *The ethical use of touch in psychotherapy*. London: Sage.

Husserl, E. (1982) *Cartesian Meditations. An Introduction to Phenomenology*. Translated by Dorion Cairns. Seventh impression. The Hague/Boston/London: Martinus Nijhoff Publishers,

Hycner, R. (1993). *Between Person and Person: Toward a dialogical psychotherapy*. New York: Gestalt Journal Press.

Hycner, R. and Jacobs, L. (1995). *The Healing Relationship in Gestalt Therapy: A dialogical self psychology approach*. New York: Gestalt Journal Press.

Jacobs, L. (1989) Dialogue in Gestalt Theory and Therapy. *The Gestalt Journal*. 12(1), pp.25-67

Jakubowski, J. A. (2012). *Implicit communication: The body's role in clinical work with trauma survivors*. Unpublished master's thesis, Smith College School for Social Work, Northampton, MA, USA.

Johns, N., Jolley, L.C. Keen, S. & Peters, E. (2013) CBT for people with psychosis In N. Grey & A. Whittingham (Eds)*How to become a more effective CBT therapist Developing meta-competence in clinical practice* Chichester: Wiley-Blackwell

Johnson, R. (2013) *Spirituality in Counseling and Psychotherapy: An Integrative Approach That Empowers Clients*. New Jersey: Wiley

Jolley S., Garety P., Peters E., Fornells-Ambrojo M., Onwumere J., Harris V., et al., (2015). Opportunities and challenges in Improving Access to Psychological Therapies for people with Severe Mental Illness (IAPT-SMI): evaluating the first operational year of the South London and Maudsley (SLaM) demonstration site for psychosis. *Behav. Res. Ther.* 64, pp. 24–30.

Juhan, D. (1993) *The Physiology of Hook-up: How Trager Works*. Mill Valley, California: The Trager Institute

Jung, C. J. (1933) *Modern Man in Search of a Soul* New York: Harcourt Brace Jovanovich

Jung, C. J. (1940/1969) Psychology and Religion In *The Collected Works of C. J. Jung Volume 11*, pp. 3-105 London: Routledge & Kagan Paul

Jung, C. G. (1960). Synchronicity: An Acausal connecting principle'. In *The structure and dynamics of the psyche*, vol.8 of *The collected works of C. G. Jung*, (Trans. R.F.C. Hull). Princeton, N.J: Princeton University Press.

Jung, C. J. (1968) *The Collected Works of C. J. Jung Volume 9 Part 1 Archetypes and the Collective Unconscious*. London: Routledge & Kagan Paul

Kabat-Zinn, J. (2003) Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice*, 10(2), 144-156.

Kabat-Zinn, J. (2013) *Coming to your own Front Door: 108 Lessons in Mindfulness*. New York: Hyperion

- Kahn, M. (2001) *Between Therapist and Client: The New Relationship*. New York: First Owl Books
- Kapleau, P. (ed) (1967) *The Three Pillars of Zen; Teaching, Practice & Enlightenment* Boston: Beacon Press.
- Karen, R. (1998). *Becoming attached*. New York: Oxford University Press.
- Keleman, Stanley (1985). *Emotional Anatomy*. Berkeley: Center Press
- Kember, D. (2001) *Reflective Teaching and Learning in Health Professions* Oxford: Blackwell
- Kepner, J. I. (1993) *Body Process: Working with the Body in Psychotherapy*. San Francisco: Jossey-Bass.
- Kepner, J. I. (1997) *Body Process: A Gestalt Approach to Working with the Body in Psychotherapy* San Francisco: Jossey-Bass
- Kepner, J. I. (2003) The embodied field *British Gestalt Journal* 12(1), pp.6-14
- Kepner, J.I. (2008) "Towards a more deeply embodied approach in Gestalt therapy Studies in Gestalt Therapy. *Studies In Gestalt Therapy*.2(2), pp.43-56
- Kertay, L. & Reviere, S. L. (1998) Touch in Context. In E.W. L. Smith, P. R. Clance & S. Imes (Eds.) *Touch in Psychotherapy: theory, research and practice*. NewYork: Guildford press
- King, A. (2011). When the body speaks: Tummy rumblings in the therapeutic encounter. *British Journal of Psychotherapy*, 27(2), pp.156-174.
- King, A. (2012). More Than Words: Moments of Meaning in Relational Psychotherapy. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis*,6(2).
- Klockner, K. D., & Hicks, R. E. (2008). My next client: Understanding the Big Five and positive personality dispositions of those seeking psychosocial support interventions. *International Coaching Psychology Review* 3, pp.148 –163.

Klein, M (1930/1988) The importance of symbol-formation in the development of the ego In *Love, Guilt & Reparation* London: Virgo

Knox, R., Murphy, D., Wiggins, S. & Cooper, M. (eds) (2013) *Relational Depth: new perspectives and developments*. Basingstoke, Hampshire: Palgrave Macmillan

Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology*, 44, pp.274–283.

Kogan, G (1980) *Your bodyworks: A guide to health, energy and balance* Berkeley: Transformation Press

Krantz, A. M. (2012). Let the body speak: Commentary on paper by Jon Sletvold. *Psychoanalytic Dialogues*, 22, 437–448

Kryka, K. (2007) Thinking at the Edge: where theory and practice meet to create fresh understanding. *Journal of Indo-Pacific Phenomenology* 6, pp.36-41

Kryka, K. (2011) Embodied Knowledge: the role of the implicit in qualitative research. Masterclass notes Bournemouth University, UK. July 25 & 26th

Kurtz, R. (1990) *Body-centred Psychotherapy The Hakomi Method: The integrated use of mindfulness, nonviolence and the body*. Mendocino: Life Rhythm

Ladkin, D. (2012) Perception, Reversibility, “Flesh”: Merleau-Ponty’s Phenomenology and Leadership as Embodied Practice. *Integral Leadership Review* 9 (1), pp.31-41

Lambert, M., J. & Barley, D., E. (2001). Research Summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy*, 38 (4), pp.357-361.

Lantz, J. (2004). Research and Evaluation Issues in Existential Psychotherapy. *Journal of Contemporary Psychotherapy*. 34(4), pp.331-340.

Lamgmuir, .J.I., Kirsch, S.G.. & Classen, C.C. (2012) A pilot study of body-oriented group psychotherapy: adapting Sensorimotor psychotherapy for the group

treatment of trauma. *Psychological Trauma: theory, research, practice and policy* 4(2), pp. 214-220

LeCompte, M. D., and J. Preissle (2003) *Ethnography and Qualitative Design in Educational Research*, 2nd. ed. San Diego, CA: Academic

Lee, M. Y., Ng, S., Pui, P., Leung, Y & Chan, C. L. W. (2009). Integrative Body-Mind-Spirit Social Work: An Empirically Based Approach to Assessment and Treatment. New York: Oxford University Press.

Leung, P.P., Chan, C.L., Ng, S. & Lee, M. (2009) Towards Body-Mind-Spirit Integration: East meets West in clinical social work practice. *Clinical Social Work Journal* 37, pp. 303-311

Lee, D. (2012) *The Compassionate Mind Approach to Recovering from Trauma: using Compassion Focused therapy*. London: Robinson

Lehman, O. V. (2014) Towards dialogues with and within silence in psychotherapy processes: why the person of the therapist and the client matters? *Culture & Psychology* 20 (4), pp.537-546

Leijssen, M. (2006). The validation of the body in psychotherapy. *Journal of Humanistic Psychology*, 46, pp.126–146.

Leijssen, M. (2009). Psychotherapy as search and care for the soul. *Person-Centered & Experiential Psychotherapies*, 8(1), pp.18-32.

Lewis, T.F. & Osborn, C.J. (2004) Solution-Focused Counselling and Motivational Interviewing: A Consideration of Confluence *Journal of Counselling and Development* 82(1), pp38-48

Lietaer, G. (2002) The United Colours of Person-centred and Experiential Psychotherapy. *Person-centred and Experiential Psychotherapies* 1 (1-2), pp. 4-13

Linnington, M. (2014) The body I want: a psychotherapy for a disabled man. In Kate White (Ed) *Talking Bodies: How Do We Integrate Working with the Body in Psychotherapy from an Attachment and Relational Perspective?* London: Karnac (pp. 125-142).

Liskin, J. (1996) *Moving Medicine: the Life and Work of Milton Trager*. New York: Stanton Hill Press. Luborsky, L., Singer, B. & Luborsky, L (1975) Comparative Studies of Psychotherapies: Is It True That "Everyone Has Won and All Must Have Prizes"? *Arch Gen Psychiatry*. 32(8), pp.995-1008.

Lowen, A & Lowen L (1977) *The way to vibrant health*. New York: Harper & Row

Luborsky, L., Crits-Christoph, P., Alexander, L., Margolis, M., and Cohen, M. (1983) Two helping alliance methods for predicting outcomes of psychotherapy: A counting signs versus a global rating method. *Journal of Nervous and Mental Disorders* 171, pp.480-492

Madden, S. Fogarty, S. & Smith, C. (2014) Alternative and complementary therapies in the treatment of eating disorders, addictions and substance use disorders In T.D. Brewerton, A.B. Dennis (Eds.), *Eating disorders, addictions and substance use disorders*, Springer, New York, pp. 625–647

Maher, A. R. (1996) *The Complete Guide to Experiential Psychotherapy*. New York: Wiley

Mahalik, J. R., VanOrmer, E. A. & Simi, N. L. (2000). Ethical issues in using self-disclosure in feminist therapy. In M. M. Brabeck (Ed.), *Practicing feminist ethics in psychology* (pp.189-201). Washington, DC: American Psychological Association.

Main, M. (1990) Parental aversion to infant-initiated contact is correlated with parents' own rejection during childhood: The effects of experience on signals of security with respect to attachment. In K.E. Barnard & T. Brazelton (Eds.), *Touch: The foundation of experience*. Madison, CT: International Universities Press.

Mallow, A. J. (1998). Self-disclosure: Reconciling psychoanalytic psychotherapy and Alcoholics Anonymous philosophy. *Journal of Substance Abuse Treatment*. 15, pp.493–498.

Malson, H. (1998) *The Thin Woman*. London: Routledge

Manford, B. (2014) Insecure attachment and borderline personality disorder: Working with dissociation and the 'capacity to think' *Body, Movement and Dance*

in Psychotherapy: An International Journal for Theory, Research and Practice 9 (2), pp.93-105

Martin, D., J., Garske, J., P. & Davis, M., K. (2000) Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. 68(3), pp. 438-50.

Martin, P. (2010). Training and professional development. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of counselling psychology* (3rd ed., pp.547-568). London: Sage.

Maslow, A. (1962) *Toward a Psychology of Being*. New York: Van Nostrand

Matano, R. A. & Yalom, I. (1991) Approaches to chemical dependency: chemical dependency and interactive group therapy – a synthesis. *International Journal of Group Psychotherapy* 4 (3), pp.269-294

Matthew, M. (1998). The body as instrument. *Journal of the British Association of Psychotherapists*, 35, pp.17–36.

May, R. (1997). *The Meaning of Anxiety* New York: Norton

McCabe, G. (2008). Mind, body, emotions and spirit: reaching to the ancestors for healing. *Counselling Psychology Quarterly*, 21(2), pp.143–152.

McCluskey, U. (2005). To be met as a person: The dynamics of attachment in professional encounters. London: Karnac.

McDougal, J. (1993). Counter transference and primitive communication. In A. Alexandris & G. Vaslamatzis (Eds.), *Countertransference: Theory, technique, teaching* (pp. 95–135). London: Karnac.

McDougall, J. (1995) *The Many Faces of Eros* London: Free Association Press

McGuire, J. 1995 *What Works: Reducing Reoffending Guidelines from Research and Practice*. Chichester: Wiley

McLeod, 1997), McLeod, J. (1997) *Narrative and Psychotherapy*. London: Sage

McNeely, D.A. (1987) *Touching - Body Therapy and Depth Psychology*. Toronto: Inner City Books.

Mearns, D. & Cooper, M. (2005) *Working at Relational Depth in Counselling and Psychotherapy*. London: Sage

Meekums, B. (2002) *Dance Movement Therapy: A Creative Psychotherapeutic Approach* London: Sage

Meissner, S.J. (2007) Mind, Brain and Self in Psychoanalysis: therapeutic implications of the Mind-Body relation *Psychoanalytic Psychology* 24(2), pp.333-354

Merleau-Ponty, M. (1962). *The Phenomenology of Perception*. London: Routledge.

Merleau-Ponty, M. (1968). *The Visible and the Invisible*. C. Lefort (Ed), A. Lingis (trans.). Evanston: Northwestern University Press.

Merry, T. (2004) Classical Client-centred Therapy In P. Sanders (ed) *The tribes of the Person-centred Nation: An introduction to the schools of therapy related to the Person-centred Approach* Ross-on Wye: PSSC Books pp.21-44

Metha, N. (2011) Mind-body Dualism: a critique from a health perspective. *Mens Sana Monographs* 9 (1), pp. 202-209

Milakovich, J. (1998) Differences Between Therapists Who Touch and Those Who Do Not. In E.W. L. Smith, P. R. Clance & S. Imes (Eds.) *Touch in Psychotherapy: theory, research and practice*. Guildford press: New York

Miller, A. (2005) *The Body Never Lies: the lingering effects of hurtful parenting* (trans A. Jenkins) London: Norton

Miller, A. (2006) *The Body Never Lies*. New York: Norton

Miller, A. (2012) *Healing the Unimaginable* London: Karnac

Miller, S., Hubbis, M. & Duncan, B. (2007). *Supershinks: What's the secret of their*

success? Available from: <http://www.psychotherapynetworker.org> [Accessed 18 April 2015]

Mitchell, S.A. (2000) *Relationality: From Attachment to Intersubjectivity*. Hillsdale, NJ: The Analytic Press.

Mitchell, A. & McCormack, M. (1998). *The Therapeutic Relationship in Complementary Health Care*. London: Elsevier

Moch, S.D. & Gates, M.F. (Eds) (2000) *The Researcher Experience in Qualitative Research* London: Sage

Mollen, P. (2014) Attachment and energy psychology: explorations at the interface of bodily, mental, relational and transpersonal aspects of human behaviour and experience. In Kate White (Ed) *Talking Bodies: How Do We Integrate Working with the Body in Psychotherapy from an Attachment and Relational Perspective?* London: Karnac (pp. 65-88).

Morrow, S. L. (2005) Quality and trustworthiness in qualitative research in counselling psychology, *Journal of Counselling Psychology* 52(2), pp. 250-260

Mulhauser, G. (2014) *An Introduction to Existential Counselling*. Available from: <http://counsellingresource.com/lib/therapy/types/existential> [Accessed 18 April 2015].

Muller, J. P. & Tillman, J. G. (Eds) (2007) *The Embodied Subject: minding the body in psychoanalysis* New York: Aronson

Nasar, J., & Devlin, A. S. (2011). Impressions of psychotherapists' offices. *Journal of Counselling Psychology*, 58, pp.310-320.

Nelson-Becker, H. (2010) Integrative Body-Mind-Spirit Social Work: An Empirically Based Approach to Assessment and Treatment, by Mo Yee Lee, Siu-man Ng, Pamela Pui Yu Leung, & Cecilia Lai Wan Chan, *Journal of Ethnic And Cultural Diversity in Social Work*, 19 (2), pp.171-173.

Norcross, J. C. (2002) (ed.). *Psychotherapy relationships that work*. New York, NY: Oxford University Press.

Norcross, J.C. (2011) *Psychotherapy relationships that work: Evidence based responsiveness* (2nd ed.) New York, NY: Oxford University Press

Oerton, S. (2004) Bodywork boundaries: power, politics and professionalism in therapeutic massage. *Gender, Work and Organisation*. 11 (5), pp.544-65.

Ogden, P (2014) Wisdom of the body lost and found: the nineteenth John Bowlby Memorial lecture. In Kate White (Ed) *Talking Bodies: How Do We Integrate Working with the Body in Psychotherapy from an Attachment and Relational Perspective?* London: Karnac (pp. 11-40)

Ogden, P (2015) Proximity, Defence and Boundaries with Children and Care-Givers: A Sensorimotor Psychotherapy Perspective. *Children Australia*, 40, pp 139-146 doi:10.1017/cha.2015.10

Ogden, P. K. & Fisher, J. (2015) *Sensorimotor Psychotherapy: Interventions for Trauma and Attachment* New York: Norton

Ogden, P., & Minton, K. (2000). Sensorimotor psychotherapy. *Traumatology*, 6(3), 149–173.

Ogden, P., Minton, K. & Pain, C. (2006) *Trauma and the Body: A Sensorimotor Approach to Psychotherapy* New York: Norton,

Ogden, T. H. (2001) *Reading Winnicott*. Psychoanal Q. 70 (2), pp299-323.

Ogden, T. H. (2004) On holding and containing, being and dreaming. *International Journal of Psychoanalysis* 85, pp.1349-2364

Ogrodniczuk, J. S., Joyce A.S. & Piper W.E. (2009) Development of the Readiness for Psychotherapy Index. *Journal of Nervous Mental Disease*.197(6), pp.427-33.

O'Neill, P. (2002). Tectonic change: The qualitative paradigm in psychology. *Canadian Psychology*, 43, 190-194.

Orbach, S. (2003) Part 1: There is no such thing as a body. *British Journal of Psychotherapy*. 20(1), pp.3-16

Orbach, S. (2004) What we can learn from the therapist's body. *Attachment and Human Development*, 6(2), 141-150.

Orbach, S. (2006) How can we have a body? Desires and corporeality. *Studies in Gender and Sexuality*, 7, 89-111.

Orbach, S., & Carroll, R. (2006) Contemporary approaches to body in psychotherapy: Two psychotherapists in dialogue. In J. Corrigan, H. Payne, & H. Wilkinson (Eds.), *About a body: Working with the embodied mind in psychotherapy* (pp 63-82). London: Routledge.

Orlinsky, D.E. & Howard, I. (1986) The Psychological Interior of Psychotherapy: explorations with the therapy session reports. In L. Greenberg & W. Pinsof (Eds) *The Therapeutic Process*, New York: Guilford Press.

Orlinsky, D. E., Grawe, K. & Parks, B. K. (1994) Process and outcome in psychotherapy: Noch einmal. In Bergin & S. L. Garfield (Eds) *Handbook of Psychotherapy and Behaviour Change* (4th ed) (pp. 270-376). New York: John Wiley & Sons

Orlinsky D. E., Rønnestad, M. H. & Willutzki, U. (2004) Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed), *Bergin & Garfield's Handbook of Psychotherapy and Behaviour Change* (5th ed) (pp. 307-389). New York: John Wiley & Sons

Owen, A. (2004). *The Therapeutic Relationship*. Research thesis.

Painter, J. (1986). *Deep bodywork and personal development*. Mill Valley: Bodymind Books

Park, C. (2013) Mind-Body CAM Interventions: current status and considerations for integration into clinical health psychology. *Journal of Clinical Psychology* 69(1), 45-63

Patton, M. Q. (1990) *Qualitative evaluation and research methods* (2nd ed.) CA: Sage.

Patton, M. Q. (2012) New Directions for Evaluation pp. 97-108

- Petersen, C. (2002). More than a mirror: The ethics of therapist self-disclosure. *Psychotherapy: Theory, Research, Practice, Training*. 19 (1), pp.21-31.
- Pelham, G. (2008) The Relational Approach. In Haugh, S. & Paul, S. (Eds) *The Therapeutic Relationship: perspectives and themes*, (pp.104-116) Ross-on-Wye: PCCS Books
- Perry, D.B. & Szlavitz, M (2010) *Born for Love* New York: Harper Collins
- Pert, C.B., Dreher, H.E. & Ruff, M.R. (1998) The psychosomatic network: foundations of mind-body medicine. *Alternative Therapies in Health and Medicine* 4(4), pp.30-41
- Pescitelli, D. (1996) An Analysis of Carl Rogers' Theory of Personality. Available from: http://pandc.ca/?cat=carl_rogers&page=rogerian_theory [Accessed 17 December 2014]
- Pietroni, P. (1991) *The Greening of Medicine*. London: Gollancz
- Plakun, E. M. (2007) Perspectives on embodiment: from symptom to enactment and from enactment to asexual misconduct In J.P.Muller. & J.G.Tillman, (Eds) (2007) *The Embodied Subject: minding the body in psychoanalysis* New York: Aronson (PP. 103-116).
- Ponterotto, J.G. (2005) Qualitative Research for Counselling Psychology: A Primer on Research Paradigms and Philosophy of Science *Journal of Counselling Psychology* 52(2), PP. 126-136
- Porges, S. (2011) *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation* New York: Norton
- Pressly, P. K., & Heesacker, M. (2001). The physical environment and counselling: A review of theory and research. *Journal of Counselling & Development*. 79, pp.148-160.
- Prisoners' Advice Service (2014) *Male categorisation Information Sheet* [online]. London: PAS Available from: <http://www.prisonersadvice.org.uk/information/advice-sheets/> [Accessed 14 February 2015].

Prochaska, J. O. (2006) How do people change, and how can we change to help many more people? In M. Hubble, B. Duncan, & S. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 227-255). Washington, DC: American Psychological Association.

Prochaska, J. O. & Norcross, J. C. (2007) *Systems of psychotherapy: a transtheoretical analysis*. 6th ed. Australia: Thomson/Brooks/Cole

Reason, R. & Rowan, J. Eds. (1981) *Human Inquiry: a sourcebook of new paradigm research*. Chichester: Wiley

Reich, W. (1972) *Character Analysis*, 3rd Edition. New York: Farrar, Strauss & Giroux.

Reicher, S. (2000). Against methodolatry: Some comments on Elliott, Fischer, and Rennie. *British Journal of Clinical Psychology*, 39, pp.1-6.

Rennie, D. L. (2004) Reflexivity and person-centred counselling. *Journal of Humanistic Psychology*. 44, pp.182-203

Rennie, D. L., Watson, K. D. & Monteiro, A. M. (2002) The Rise of Qualitative Research in Psychology. *Canadian Psychology*. 43, pp.179-189

Reis, B. F., & Brown, L. G. (1999). Reducing psychotherapy dropouts: Maximizing perspective convergence in the psychotherapy dyad. *Psychotherapy*, 36, 123-136

Rindfleish, J. (2007) The "Death of the Ego" in East-meets- West Spirituality: Diverse Views from Prominent Authors. *Zygon*. 42, (1) pp.65-76

Rizq, R. (2012) The perversion of care: Psychological therapies in a time of IAPT. *Psychodynamic Practice: Individuals, Groups and Organisations*. 18 (1), pp7-24

Roberts, J. (1997) History of the Therapeutic Community In E. Cullen, L. Jones & R. Woodward (Eds) *Therapeutic Communities for Offenders*. Chichester: Wiley

Robitschek, C. (1998). Personal growth initiative: The construct and its measure. *Measurement and Evaluation in Counseling and Development* 30, pp.183–198.

Robitschek, C., Ashton, M. W., Spering, C. C., Geiger, N., Byers, D., Schotts, G. C., & Thoen, M. A. (2012). Development and psychometric evaluation of the Personal Growth Initiative Scale—II. *Journal of Counseling Psychology*, 59, 274 – 287.

Robitschek, C., & Hershberger, A. R. (2005) Predicting expectations about counseling: Psychological factors and gender implications. *Journal of Counselling & Development*. 83, pp.457– 469.

Rogers, C.R. (1951) *Client Centred Therapy*. London: Constable.

Rogers, C.R. (1957) The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology* 21, pp.95-103

Rogers, C.R. (1959). A theory of therapy, personality and interpersonal relationships, as developed in the client-centered framework. In S. Koch (ed.). *Psychology: A study of science*. (pp. 184-256). N.Y.: McGraw Hill.

Rogers, C.R. (1961) *On becoming a person*. London: Constable

Rogers, C.R. (1965). A humanistic conception of man. In R.E. Farson (ed.) *Science and human affairs*. California: Science and Behavior Books Inc.

Rogers, C.R. (1977). *Carl Rogers on personal power*. NewYork: Delacorte Press.

Rogers, C.R. (1980). *A way of being*. Boston: Houghton Mifflin.

Rogers, C.R. (1992) The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology* 60 (6), pp. 827-832

Rolef Ben-Shahar, A. (2008). The Woodpecker. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis*, 2(2), 216-224.

Rosenberg, J. L., Rand, M. L. & Asay, D.(1985) *Body, Self and Soul*. Atlanta: Humanics.

Ross, M. (2000). Body talk: Somatic countertransference. *Psychodynamic Counselling*, 6, pp451–466.

- Rossi, E. (1986). *The Psychobiology of Mind-Body Healing*. New York, NY: Norton.
- Roth, A. & Fonagy, P. (2004) *What Works for Whom? A critical review of psychotherapy research*. New York: Guildford press
- Rothschild, B. (1993) *Transference & Countertransference: A Common Sense Perspective*. Available from: <http://home.webuniverse.net/babette/transference.html> [Accessed 14 May 2012].
- Rothschild, B. (2000) *The Body Remembers: the psychophysiology of trauma and trauma treatment*. New York: Norton
- Rothschild, B. (2002) Body psychotherapy without touch: applications for trauma therapy. Chapter in Staunton, T. (2002) *Body psychotherapy*. London: Brunner Routledge. pp. 101- 115
- Rothschild, B. (2003) *The Body Remembers Casebook: Unifying Methods and Models in the Treatment of Trauma and PTSD* New York: Norton
- Rothschild, B. (2010) *8 Keys to Safe Trauma Recovery: Take-Charge Strategies to Empower Your Healing* NY: Norton.
- Rowan, J. (1993) *The Reality Game : a guide to humanistic counselling and therapy* London: Routledge & Kagan Paul
- Rowan, J. (1998) Linking: Its Place in Therapy. *International Journal of Psychotherapy*. 3 (3), pp.245-254
- Rowan, J. (2005) *The Future of Training in Psychotherapy and Counselling: Instrumental, Relationsl and Transpersonal Perspectives*. London: Routledge
- Rowan, J. (2012) Mind, Body and Soul. *Therapy Today* 23 (10), pp22-25.
- Rumble, B. (2008). Knowing the brain, unknowing the body. *Counselling Psychology Review*, 23, 70-73.
- Rumble, B. (2010). The body as hypothesis and as question: Towards a concept

of therapist embodiment. *Body, Movement and Dance in psychotherapy*, 5, 129-140.

Rumble, B. (2014). Review of Koch et al. *Body, memory, metaphor and movement*. Amsterdam: John Benjamin's Publishing Company. In *Body, Movement and Dance in Psychotherapy*, 9, 53-56.

Ryan, S. (2008). Mindful supervision. In R. Shohet (Ed.), *Passionate supervision* (pp. 70–85). London: Jessica Kingsley

Ryle, G. (1949, 2002) *The Concept of the Mind* Chicago, IL: University of Chicago Press

Samuels, A (1985). *Jung and the Post-Jungians*. London: Routledge & Kegan Paul

Samuels, A. (1985). Countertransference, the “mundus imaginalis” and a research project. *Journal of Analytical Psychology*, 30(1), 47–71.

Sampson, E. E. (1998) Establishing Embodiment in Psychology In H. Stan (Ed) *The Body and Psychology* London: Sage (pp. 30-54).

Schmid, P.F. (2002) 'Knowledge of acknowledgement? Psychotherapy as “the art of not-knowing” – prospects on further developments of a radical paradigm' *Person-Centred and Experiential Psychotherapies*. 1 (1-2), pp.56-70

Schiff, J. et al (1975) *The Caihexis Reader: Transactional. Analysis Treatment of Psychosis*. New York: Harper and Row

Schilling, A. (2012) Stillness and awareness from Person to Person. Available from <https://www.focusing.org/spirituality/stillness.htm> [Accessed 24 March 2015]

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

Schore, A. (2003) Early relational trauma, disorganized attachment, and the development of a predisposition to violence In *Healing Trauma: Attachment, Mind, Body, and Brain*, D. Siegel & M. Solomon (eds.), NY: Norton, pp. 107-167.

Schore, A. (2014) The right brain is dominant in psychotherapy. *Psychotherapy*, 51, pp. 88-397.

Schore, A.N. (2012). *The Science of the Art of Psychotherapy*. New York: Norton.

Schore, A. & Shore, J R. (2014) Regulation theory and affect regulation psychotherapy: A clinical primer. *Smith College Studies in Social Work*, 84, pp. 178-195.

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

Sedgwick, D. (2001) *Introduction to Jungian Psychotherapy: The therapeutic relationship*. Hove: Bruner-Routledge

Seigel, D. J. (2007) *The Mindful Brain: Reflection and Attunement in the Cultivation of Well-Being*. New York: Norton

Sharma, U. (1994) "The equation of responsibility: complementary practitioners and their patients." pp. 82-103 in *The Healing Bond: The patient practitioner relationship and therapeutic responsibility*, edited by S. Budd and U. Sharma. London: Routledge.

Shaw, R. (2003) *The Embodied Psychotherapist: the therapist's body story*. London: Routledge

Shaw, R (2004) The embodied psychotherapist: An exploration of the therapists' somatic phenomena within the therapeutic encounter. *Psychotherapy Research*. 14 (3), pp. 271-288

Shaw R.L. (2010) Embedding Reflexivity Within Experiential Qualitative Psychology. *Qualitative Research in Psychology*, 7(3), pp.233–243.

Shaw R.L. (2011) The future's bright: celebrating its achievements and preparing for the challenges ahead in IPA research. *Health Psychology Review*, 5(1), pp.28–33.

Shapiro, F. (2001). *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures* (2nd edition.). New York: Guilford Press.

Shemmings, D (2011) Attachment in Children and Young People. (Frontline briefing) Dartington: Research in Practice <https://www.rip.org.uk/research-evidence/research-briefings/frontline>

Siegel, D.J. (2007) *The Mindful Brain: reflections an attunement in the cultivation of wellbeing*. New York: Norton

Sills, F. (2011). *Foundation in Craniosacral Biodynamis: the breath of life and fundamental skills Volume 1*. Berkley: North Atlantic Books.

Simon, R. I. (1994). Transference in therapist–patient sex: The illusion of patient improvement and consent, Part 1. *Psychiatric Annals*. 24, pp.509–515.

Smith, E.W. L., Clance P. R. & Imes S. (Eds.) (1998) Touch in Psychotherapy: theory, research and practice. New York: Guildford press

Smith, E.W.L. (1998) A Taxonomy and Ethics of Touch in Psychotherapy. In E.W. L. Smith, P. R. Clance & S. Imes (Eds.) Touch in Psychotherapy: theory, research and practice. New York: Guildford press

Smith, E. (1985) *The body in psychotherapy*. Jefferson, NC: McFarland & Co.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health*. 11, pp. 261-271.

Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*. 1, pp.39-54.

Smith, J.A. (Ed) (2008) *Qualitative Psychology: A Practical guide to research methods*. (2nd edn) London: Sage

Smith, J.A. (2010) Evaluating the contribution of interpretative phenomenological analysis to health psychology. Keynote address presented at BPS Health Psychology Annual Conference, Aston, UK

Smith, J.A., (2011) Evaluating the contribution of interpretative phenomenological analysis, *Health Psychology Review*. 5 (1), pp.9-27

Smith, J.A., Flowers, P. Larkin, M. (2009) *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage

Smith, J.A. & Osborn, M. (2008) Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage

Smith, J.A., & Osborn, M. (2007). Pain as an assault on the self: An interpretative phenomenological analysis of the psychological impact of chronic benign low back pain. *Psychology & Health*. 22, pp. 517-534

Sointu, E. (2006) Healing bodies, feeling bodies: embodiment and alternative and complementary health practices. *Social Theory and Health*, 4 (3),pp.203-20.

Soth, M (2005) "Body Psychotherapy today - an integral-relational approach" In *Therapy Today*, November Vol 16 No 9)

Spinelli, E. (2008) The Existential Approach In Haugh, S. & Paul, S. (Eds) *The Therapeutic Relationship: perspectives and themes*, (pp.51-64) Ross-on-Wye: PCCS Books

Stake, R. E. (2000). Case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 435-454). Thousand Oaks, CA: Sage.

Stake, R. E. (2006). Multiple case study analysis. New York, NY: Guilford. Strauss, A. L. (1987). *Qualitative analysis for social scientists*. New York, NY: Cambridge University Press. Staunton, T. (Ed) (2002) *Body Psychotherapy*. London: Routledge

Stedmon, J. & Dallos, R. (2009) *Reflective Practice in Psychotherapy and Counselling* Berkshire: Open University Press

Stern, D.N. (1985) *The interpersonal World of the Infant*. New York: Basic Books

Stern, D. N. (1990) *Diary of a Baby*, New York: Basic Books

Stiles, W. B. (2009). Responsiveness as an obstacle for psychotherapy outcome research: It's worse than you think. *Clinical psychology: Science and Practice*. 16, pp.86–91.

Stiles, W. B., Barkham, M., Connell, J., & Mellor-Clark, J. (2008). Responsive regulation of treatment duration in routine practice in United Kingdom primary care settings: Replication in a larger sample. *Journal of Consulting and Clinical Psychology*. 76, pp.298–305.

Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice*. 5, pp.439–458.

Stiles, W. B., & Shapiro, D. A. (1994). Disabuse of the drug metaphor: Psychotherapy process-outcome correlations. *Journal of Consulting and Clinical Psychology*. 62, pp.942–948.

Stiles, W. B., Shapiro, D. A., & Elliott, R. (1986). “Are all psychotherapies equivalent?” *American Psychologist*. 41, pp.165–180

Stone, J. (2002) *An Ethical Framework for Complementary and Alternative Medicine* London: Routledge

Stone, M. (2006). The analyst’s body as a tuning fork: Embodied resonance in countertransference. *Journal of Analytical Psychology*, 51, 109–124.

Stone, J. & Katz, J. (2005) The therapeutic relationship and complementary and alternative medicine In T. Heller, (Ed) *Perspectives on Complementary and Alternative Medicine* London: Routledge

Stone, J & Matthews, J (1996) *Complementary Medicine and the Law*. Oxford: Oxford University Press

Stratton, P. (2009) A mediocre performance. *Mental Health Practice*. 3 (13), pp. 12.

Strawbridge, S. & Woolfe, R. (2003). Counselling psychology in context. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of counselling psychology* (pp.3-21). London: Sage.

Strawbridge, S. & Woolfe, R. (2010). Counselling Psychology: Origins, developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas & W.

- Dryden (Eds.), *Handbook of counselling psychology* (3rd ed., pp.3-22). London: Sage
- Stricker, G., & Fisher, M. (Eds.) (1990). *Self-disclosure in the therapeutic relationship*. New York: Plenum Press.
- Strupp, H. H. (1980) Success and failure in time-limited psychotherapy: Further evidence (Comparison 4). *Archives of General Psychiatry*. 37, pp947-954 5
- Strupp, H. H., & Binder, J. L (1984). *Psychotherapy in a new key*. New York: Basic Books.
- Sunderland, M. (2007) *What every parent needs to know: the remarkable effects of love, nurture and play on your child's development*. London: Dorling Kindersley
- Suzuki, D. (1997). *The sacred balance: Rediscovering our role in nature*. Vancouver, British Columbia: Greystone Books.
- Sykes Wylie, M. (2013). Somatic Therapy: Using the Mind–Body Connection to Get Results. *Psychotherapy Networker* [online] Accessed 18 April 2015
- Szasz, T. (1972) Reply to Goppelt, J.W., and to Blair, R.D., *American Journal of Psychiatry*, 128, pp.1588-9
- Taylor, C. (2006) Narrating significant experience: reflective accounts and the production of (self) knowledge. *British Journal of Social Work* 36, pp.189-206
- Teyber, E. (2000). *Interpersonal Process in Psychotherapy: A Relational Approach*. USA: Brooks/Cole
- Tischner, I & Malson, H. (2008) Exploring the Politics of Women's In/Visible 'Large' Bodies *Feminism & Psychology* © 2008 SAGE (Los Angeles, London, New Delhi and Singapore) <http://fap.sagepub.com>, 18(2), pp. 260–267 [Accessed 03 November 2014]
- Todres, L (2011) *Embodied Enquiry: phenomenological touchstones for research, psychotherapy and spirituality*. Basingstoke: Palgrave Macmillan

- Totten, N. (1998) *The Water and the Glass: Body and Mind in Psychoanalysis*. London: Rebus
- Totten, N. (2003) *Body Psychotherapy: an introduction*. Maidenhead: Open University Press
- Totten, N. (2005) *New Dimensions in Body Psychotherapy* Maidenhead: Open University Press
- Totten, N. (2014) Embodiment and the Social Bond. In K. White (ed) *Talking Bodies: How do we integrate Working with the Body in Psychotherapy from an Attachment and Relational Perspective?* London: Karnac (pp. 41-64).
- Totten, N. (2015) *Embodied Relating: The Ground of Psychotherapy* London: Karnac
- Totten, N. & Priestman, A. (2012) Embodiment and relationship: two halves of one whole. In C. Young (ed) *About Relational Body Psychotherapy* (pp. 35-68) Stow, Galashiels: Body Psychotherapy Publications
- Trevarthen, C. (2004). Intimate contact from birth: How we know one another by touch, voice, and expression in movement. In, Kate White (ed.). *Touch, Attachment and the Body*, pp. 1-15. London: Karnac
- Twigg, J., Wolkowitz, C., Cohen, R. L. & Nettleton, S. (2011) *Bodywork in Health and Social Care* (eds) Oxford: Blackwell
- Uphoff, A. (2008) "Touch in the Therapeutic Relationship: Shifting a paradigm" In S. Haugh & S. Paul (Eds) *The Therapeutic Relationship: Perspectives and Themes*. Ross-on-Wye: PCCS Books
- Van der Kolk, B. A. (1994) The Body Keeps the Score: Memory and the Evolving Psychobiology of Posttraumatic Stress. *Harvard Review of Psychiatry* 1, pp.1253-65.
- Van der Kolk, B. A. (2005) Developmental Trauma Disorder *Psychiatric Annals*, 35,(5) pp401-408

- Van der Kolk, B. A. (2015) *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma* Hammondsworth, UK: Penguin
- Vaughan, D. (1992). Theory elaboration: The heuristics of case analysis. In C. C. Ragin & H. S. Becker (Eds.), *What is a case? Exploring the foundations of social inquiry* (pp. 173-292). Cambridge: Cambridge University Press.
- Vick, P. (2002) *Psycho-spiritual body psychotherapy* In Staunton, T. (Ed) *Body Psychotherapy*. Hove: Bruner-Rutledge
- Wade, J. (1996) *Changes of Mind: a holonomic theory of the evolution of consciousness* Albany, NY: Suny Press
- Warnecke, T. (2009). The therapeutic modality of touch and statutory regulation *Self & Society* 37(2).
- Weerasekera, P. Linder, B., Greenberg, L & Watson, J. (2001) The working alliance in client-centred and process-experiential therapy of depression. *Psychotherapy Research*. 11, pp. 221-233
- Welwood, J. (2002) *Towards a Psychology of Awakening: Buddhism, psychotherapy and the path of personal and spiritual transformation*. London: Shambhala
- Wenzel, A., Liese, B. S., Beck, A. T. & Friedman-Wheeler, D. G. (2012) *Group Cognitive Therapy of Addictions*. New York: Guilford Press
- West, W. (1994) Clients' experience of bodywork psychotherapy, *Counselling Psychology Quarterly*, 7(3), pp.287–303.
- West, W. (2008) Spiritual Dimensions In Haugh, S. & Paul, S. (Eds) *The Therapeutic Relationship: perspectives and themes*, (pp.192-202) Ross-on-Wye: PCCS Books
- White, K. (2014) (ed) *Talking Bodies: How do we integrate Working with the Body in Psychotherapy from an Attachment and Relational Perspective?* London: Karnac

Whitehouse, T. (2006) Transpersonal connection within psychotherapy
Counselling Psychology Review 21(4), pp. 4-17)

Wilber, K. (2000) *Integral Psychology* Boston MA: Shambhala

Wilkinson, M (2010) *Changing Minds in therapy: emotion, attachment, trauma& neurobiology*. New York London: Norton

Willig, C. (2001) *Introducing Qualitative Research in Psychology: adventures in theory and method*. Buckingham: Open University Press

Winnicott D. W (1958). The capacity to be alone. In: The maturational processes and the facilitating environment, New York: Int Univ. Press. pp.29-36.

Winnicott, D.W. (1960). The Theory of the Parent-Infant Relationship. *International Journal of Psycho-Analysis* 41, pp.585-595

Winnicott, D, W. (1965) *The Child, the Family, and the Outside World*. London: Tavistock

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

Winnicott, D, W. (1971) *Playing and Reality*. London: Tavistock

Winnicott, D, W., C. Shepherd, R. & Davis, M. (1986) (eds) *Home Is Where We Start From: Essays by a Psychoanalyst* Hammondsworth, UK: Penguin

Wilson, G.T.& Shafran, R. (2005) Eating disorders guidelines from NICE *Lancet*, 365 (9453), pp. 79–81

Wolf, N. (1991). *The beauty myth: How images of beauty are used against women*. New York: Harper Collins

Counselling Psychology London: Sage

Wolfe, R., Dryden, W. & Strawbridge, S. (2003) *Handbook Counselling Psychology* London: Sage

- Wolger, F. J. (2002) Body psychotherapy and regression: the body remembers past lives. In *Body Psychotherapy*. T. Staunton (Ed) London: Routledge pp.172-201
- Wosket, V. (1999) *The Therapeutic Use of Self: counselling practice, research and supervision*. London: Routledge
- Wright, K. (1991) *Vision and Seperation*. London: Free Association Press
- Wright, S. & Sayre-Adams, J. (2001) *Therapeutic Touch : Theory and Practice* NY: Wiley
- Wyatt, G. (2001) Congruence: a synthesis and implications In G. Wyatt (ed) *Congruence* Ross-on Wye: PCCS Books
- Yalom, I. (2003) *Existential psychotherapy*. New York: Basic Books
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15, 215–228.
- Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J.A. Smith (Ed.) *Qualitative psychology: A practical guide to methods* (2nd edn, pp.235–251). London: Sage
- Yin, R. K. (2003). *Case study research: Design and methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Yontef, G. (2002). The Relational Attitude in Gestalt Therapy Theory and Practice. *International Gestalt Journal*. 25 (1), pp15-34
- Young, C. (2005) Doing effective Body-Psychotherapy without touch. *Energy & Character*, No. 35, *Article revised and updated for EABP Conference, 2010*.
- Young, C. (2007) The Power of Touch in Psychotherapy. *International Journal of Psychotherapy*. 11(3), pp15-24
- Young, C. (Ed.) (2011). *The Historical Basis of Body Psychotherapy*. Galashiels: Body Psychotherapy Publications.

Young, C. (Ed.) (2012a). *About the Science of Body Psychotherapy*. Galashiels: Body Psychotherapy Publications.

Young, C. (Ed.) (2012b) *About Relational Body Psychotherapy*. Galashiels: Body Psychotherapy Publications.

Yousef, N. (2010) Romanticism, psychoanalysis and the interpretation of silence. *European Romantic Review* 21(5), pp.653-672

Zur, O. (2006). Therapeutic Boundaries and Dual Relationships in Rural Practice: Ethical, Clinical and Standard of Care Considerations. *Journal of Rural Community Psychology*. 9. (1), pp.

Zur, O. (2007). *Boundaries in Psychotherapy: Ethical and Clinical Explorations*. Washington, DC: APA Books.

Zur, O. (2008). The Google Factor: Therapists' Self-Disclosure In The Age Of The Internet: Discover what your clients can find out about you with a click of the mouse. *The Independent Practitioner*. 28 (2), pp.82-85.

Zur, O. (2011). *Self-Disclosure & Transparency in Psychotherapy and Counselling: To Disclose or Not to Disclose, This is the Question*. Retrieved 04/04/2014 from <http://www.zurinstitute.com/selfdisclosure1.html>.

Appendix I **Research Project Outline Information Sheet for Participants**

Working Title of Project: Mind and Body in psychological therapy: a qualitative exploration of the role of the therapeutic relationship.

Name of Researcher: Sharon Mayer **e-mail:** sharon.mayer@uwe.ac.uk

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Name of Research Institution: University of the West of England at Bristol (UWE).

Name of Qualification Course: Professional Doctorate in Counselling Psychology

Background Information

Counselling Psychology combines knowledge of psychological theory with the skills of counselling and therapeutic intervention. The Professional Doctorate course at UWE adopts a relational approach to the study and practice of counselling psychology. The importance of the therapeutic relationship is central to this in that the presenting issues client's bring to therapy are considered to have developed 'in relationship' and can be changed by the therapeutic experience of relationship, including centrally the relationship between the counselling psychologist and the client.

Historically there has been a lot of interest in finding out more about what happens when clients and therapists meet and enter into a therapeutic relationship for the duration of the therapeutic intervention or encounter. Previous research studies have repeatedly indicated that the quality of the therapeutic relationship between a therapist and their client to be key to successful outcome in therapy.

Much of this research has focused on the field of psychotherapy, counselling and counselling psychology or what are often described collectively as 'talking therapies' rather than in more holistic therapies that often include bodywork in their therapeutic practice. As a consequence of this the therapeutic relationship has largely been studied in terms of thoughts and feelings in what appears to be a disembodied approach to what might be happening within the relationship.

Purpose of this Research Study

The purpose of this research study is to investigate the possibility that the importance of the therapeutic relationship in talking therapies in general, and counselling psychology specifically, may be broadened by the inclusion of the role the body may have in establishing and maintaining the therapeutic relationship.

The primary aim of the study is to explore how bodies and embodiment contribute to our understanding of the therapeutic relationship by eliciting the views and experiences of body-work practitioners from the traditions of body-focused complementary therapies. The secondary aim of the study is to critically consider these findings in relation to the existing theory and practice of counselling psychology.

How the Study is to be carried out

In order to obtain the necessary information to complete this study I intent to interview a selection of body-focused practitioners and apply qualitative analysis to explore the accounts they give regarding the nature of the therapeutic relationship and attendance given to the body within the specific therapeutic orientation. Each interview will be audio recorded and the audio tapes will then be transcribed word for word and analysed using a research technique called Interpretive Phenomenological Analysis (IPA).

The Role of the Participant

Therapists who work with the body in some way are invited to be participants in the study; those expressing initial interest will all receive this written information sheet. If having read this information you decide you would like to be a participant in the study, I will request to have a brief meeting with you in order to explain the role more fully, to answer any questions you may have and to obtain your written consent to becoming a participant.

All participants will be requested to take part in an interview with me at a time and date of your convenience. This may be at the location where we share therapy rooms or at an alternative suitable venue to suit the participant. It is envisaged that the interview will last for approximately one hour; however, as each participant will be encouraged to discuss their personal experiences as opposed to being required to answer set questions the time many vary according to the individual.

All interviews will be audio taped by me and the tape recordings will then be transcribed word for word to produce a written transcript of each interview carried out. Participants'

names will be substituted with a pseudonym and any other personally identifiable details within the transcripts will also be coded to protect confidentiality. All data will be kept secure.

When I begin analysing the research data this process will be closely monitored by my research supervision team. In order to gain maximum benefit from this, participants will be requested to give their permission for the audio tape of their interview to be heard and their transcripts seen by the researcher's supervisors.

The use of extracts from the transcripts is a crucial part of the chosen qualitative analysis technique of IPA and participants will be requested to give their permission for these to be used in the written research thesis in order to convey the findings of the research study to the optimum. As a participant you may be requested to take part in a subsequent interview to review your transcript and consider its analysis and interpretation before it is included in the write up of the research thesis.

Following completion of the research thesis I will be looking to publish the findings for review by the other researchers, professionals and / or the general public. In the event of this happening participants are requested to permit me to use extracts of their research data in the publication of the research project, publication of further papers and / or within the compilation of conference materials.

Pro and Con's of being a Participant

As the researcher I am unable to offer any financial payment to participants for taking part in this study. I am however; very appreciative of the time and commitment you as a participant are prepared to give in contributing to the exploration of this research. It is hoped that all participants may benefit from reflecting upon their experiences within therapeutic relationships to gain a deeper self awareness of how these relationships have in the past and will in the future contribute to the therapeutic process within their practice. It is envisaged that practitioners may seek to utilise this knowledge in their continuing practice and professional development. Having taken part in this research study it may be that some participants will have been encouraged to take part in further studies or to embark on their own research projects. All participants will be offered the opportunity to be informed of the research outcomes and given feedback on how their participation in the study contributed to this.

It is not anticipated that by taking part in this study you as a participant will be harmed or adversely affected in any way. However, I would like to reassure you that during the course of your interview, you will be monitored for any signs of distress should any sensitive issues arise when you are talking about your experiences. In the event of this happening participants will be reminded that the nature of the interviews are research based as opposed to therapeutic encounters and that when answering questions or discussing issues you can give as much or little detail as you please; you will be offered the opportunity to break at your request and given a de-briefing of the research process after the interview has been completed. It is envisaged that as a practitioner you may be in receipt of your own supervision or personal therapy at the point of your involvement in this study and this being so I will respectfully encourage you to use these resources should you feel in danger of being adversely affected by any aspect of your participation in this study. Alternatively I will seek to signpost you to potential sources of support to suit your needs.

The Participant's Rights

Having agreed to be a participant in this study does not mean that you are obliged to remain a participant if you decide that you don't want to be. Any participant has the right to change their mind at any point during the study and for any reason without being penalised or disadvantaged in any way, and you are not obliged to tell me why you have made this decision.

If you wish to contact me or a member of my research supervision team at any point during your participation in the study you will be able to make contact via telephone, e-mail or written correspondence; I will make these contact details available to you at the point at which you agree to take part in the study.

And Finally....

If having read this information sheet you share my interest in finding out more about the role the body may play in developing our awareness of what the therapeutic relationship is all about, and you haven't been put off taking part in this research study please complete the 'prospective participant slip' below indicating when and how I may contact you and return this to me in the stamped addressed envelope provided. ***Thank-you***

If you have decided that this is not for you, many thanks for expressing your initial interest.

Prospective Participant Slip

I.....would like to be a participant in your research study.

[

Please contact me in person or via e-mail / letter / telephone:

Signed

(Participant)

Date

Signed

(Researcher)

Date

Appendix II **Informed Consent Form for Research Project Participants**

Working Title of Project: Mind and Body in psychological therapy: a qualitative exploration of the role of the therapeutic relationship.

Name of Researcher: Sharon Mayer **e-mail:** sharon.mayer@uwe.ac.uk

Name of Research Supervisors: John Waite **e-mail:** john.waite@uwe.ac.uk

Helen Malson **e-mail:** helen.malson@uwe.ac.uk

I confirm that I have received and have read the project outline information sheet for the above study, which I may keep for my records.

I have had the opportunity to consider the information, and have met with the researcher who has discussed the project outline with me; I have had the opportunity to ask questions of the researcher and have had these answered satisfactorily.

I understand that my participation in this study is voluntary and that I am free to choose not to participate in the research project, and that I can withdraw at any stage without being penalised or disadvantaged in any way.

I understand that agreeing to take part in the project means that I am willing to:

- be interviewed by the researcher on one or more occasions
- allow the interview to be audio taped and transcribed word for word
- allow the researcher to use extracts of the transcript within the project thesis
- consent to the audio tapes being heard and transcripts seen by the researcher's supervisors
- allow the researcher to use my data in the publication of the research project thesis, publication of further papers and / or within the compilation of conference materials

I understand that the information I provide will be held and processed in accordance with Data Protection Principles:

- I understand that any information I provide is confidential
- No information that could lead to the identification of any individual will be disclosed in any reports on the project or to any other party
- My personal identifiable data will be replaced with a coded research identifier that will be used throughout the study
- All research documentation and materials will be kept securely

I agree to take part in the above research study.

Name of Participant

Date

Signature

Appendix III

Interview Schedule

Question: - What does the term 'therapeutic relationship' mean for you in your bodywork practice?

Question: - Could you briefly tell me a little bit about the therapeutic relationships you have had with client's you have worked with?

Prompts: Could you give me some specific examples?

Question: - In what ways is the body a crucial part of the therapeutic relationship for you?

Prompts: Physically (touch *, movement, reactions)
Emotionally (sense, expression)
Mentally (thoughts, perceptions)
Holistically (mind / body process)

*Question: - How do you gauge when or how much to touch a client?

Question: - How much are you aware of your own body when you are with your clients?

Prompts: Physically (touch, movement, reactions)
Emotionally (sense, expression)
Mentally (thoughts, perceptions)
Holistically (mind / body process)

Question: - What indications do you have to tell you whether you've got a good or maybe not so good relationship with a client?

Prompts: Could you give me some specific examples?

Can this change over the sessions?

Question: - How much do your clients discuss with you how they are feeling when they are with you?

Prompt: *Physically*

Emotionally

Question: - What do you think 'talking therapies' could learn from body-focused practitioners about the role of the body in the therapeutic relationship?

Question: - Is there anything you think bodywork practitioners could learn from 'talking therapies' about the therapeutic relationship?