CHAPTER ONE

INTRODUCTION

My purpose is not simply to tell my story but rather to use that story to understand what's going on ...
(Gallop, 1997, p.7)
CHAPTER ONE

INTRODUCTION

From my first desire to become a counsellor some thirty years ago, I have found myself on a journey, discovering and learning how to work with people in ways that were caring, respectful and effective. This work that I am now introducing to you is about the latter part of this journey where I was faced, yet again, with not knowing what to do or how to be helpful.

This gap occurred in my individual therapy work, and was related to clients who were seeking to understand what had happened to them in order to create more satisfying and authentic lives. Difficulties arose in their therapies when they began dealing with their childhood experiences. Some felt overwhelmed or paralysed with feelings while others withdrew or dissociated in-session, often without understanding what was occurring and being unable to take control of their reactions.

When I did not know how to deal with these reactions, I reviewed the previous sessions. I recalled the content of each session and what happened in the exchanges between us, and I attempted to assess the difficulties from the theoretical framework I was using. A
theoretical framework can be likened to a map,¹ where a therapist can read the situation in terms of symptom development, significant phases in the therapy journey, and options in terms of pathways to outcomes. I discovered that the map I was using appeared incomplete, either inaccurately describing some of the landscape or having no record of the territory in which I found myself. I explored other therapy maps, gathered a few useful landmarks and then tentatively placed them on my map. I continued working in this landscape and progressed the therapy with these clients by charting a therapeutic pathway that involved extensive physical holding during the course of treatment. As a result, instead of becoming overwhelmed or paralysed, dissociating or withdrawing, these clients regressed to the difficult places in their childhoods, to times of trauma, neglect, and abuse. I accompanied them, helping them stay in their emotional experiences where appropriate, finding my role as an enlightened witness,² and eventually becoming a nurturing therapist to the child and baby aspects within my clients.

I have revisited that journey for this research in order to investigate what happens when a therapist physically holds a client. My aim was to revisit the therapies of my former clients and attempt to find the emerging themes from their various accounts, and to develop an explanation for what happened. I want to begin by establishing the therapeutic and research contexts that have been woven together throughout this work as well as commenting on the presentation of this research document.

1.1 Positioning the Therapy

In the late seventies the family therapy movement in Sydney offered a new therapeutic map, an alternative discourse to the orthodoxy of the psychodynamic and psychoanalytic psychotherapies. Like the field of individual psychotherapy, family therapy was not unified and could best be viewed as an encompassing term for a number of different and competing approaches.³ Notwithstanding the significant differences between these

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¹ A map is "a representation, on a flat surface, of a part or whole of the earth's surface" (Delbridge, 1986), and generally has a legend to identify the landscape in terms of altitude, distance, territories, roads and other significant landmarks.

² The phrase 'enlightened witness' is a term Alice Miller used to refer to a therapist being a "supportive and corrective witness" (Miller, 1990, p.171).

³ Family therapy has been generally described as having three divisions: structural family therapy (Minuchin, 1974; Minuchin & Fishman, 1981); strategic family therapy with three approaches - Haley, Madanes, and MRI (Haley, 1976; Madanes, 1981, 1984; Fisch, Weakland & Segal, 1982; Watzlawick, Weakland & Fisch 1974; Watzlawick, 1978); and systemic (Milan) family therapy (Selvini-Palazzoli, Boscolo & Cecchin, 1977, 1980). Narrative therapy (White, 1984, 1986a, 1986b) was situated as a strategic therapy by some and systemic by others (Munro, 1987; Cade, 1987).
approaches in terms of theory and practice that were well documented\(^4\) at the time, family therapy broadly offered a new perspective on thinking about and working with clients. Generally, the client was regarded as the family, located in a gendered, cultural context, and the primary focus in therapy was the interaction between the family members. There was an emphasis on intervening to interrupt and change repetitive interaction patterns.\(^5\) The languaging\(^6\) and orientation to the assessments and technical interventions was novel in comparison to the individual therapy field, where the primary focus was the intrapersonal; the experience and inner world of the individual. In psychotherapy, changes were viewed as outcomes of interpretations that were primarily developed from assessing the therapeutic relationship. External behavioural change was regarded more as a by-product of the client experiencing themselves differently.

The family therapy maps appealed to me as a clinician because they offered ways of thinking combined with practical clinical application for couple work. Like many practising psychologists, my early academic training had not been oriented to professional practice, and my postgraduate studies could loosely be described as humanistic and client-centred, introducing me to an array of therapeutic modalities in individual and group work without specialisation or technical competence in any specific approach. Apart from the formal academic study, I had completed some introductory training in experiential therapies involving art therapy, sensate focusing and sculpture, and some intensive training in Gestalt Therapy and Transactional Analysis. However, the application of Gestalt Therapy and Transactional Analysis to couple work was not well developed and was difficult to apply,\(^7\) and so I gratefully became immersed in family therapy, eventually leading a training team to develop a systems and cybernetics


\(^5\) Each model of family therapy had its own set of action-oriented and problem-focused techniques: structural family therapy used in-session interactions, assessing them and then intervening directly to alter them; the strategic approaches used reported behaviour, hearing the family members' accounts and then developing rituals and prescriptions between sessions; and the Milan approach used the invariant prescription as well as providing opinions, linking behaviours to relationships.

\(^6\) While Carmel Flkas (1990) listed the definitional words in family therapy as reflexivity, recursiveness, circularity, systemic and cybernetic, practising therapists also had to be conversant with a more technical language specific to each family therapy approach, such as first and second order change, first and second cybernetics, homeostasis, punctuation and deviation amplifying feedback. These terms can be contrasted with terms such as unconscious, defences, ego, id, superego, energy, libido, introspection, transference, countertransference and projection, which were used by some of the psychodynamic and psychoanalytic therapies.

\(^7\) Eric Berne (1961) argued that couple therapy using Transactional Analysis was problematic and recommended Group Therapy for them. It was difficult to reconcile life scripts (Steiner, 1974) used for assessing each partner's childhood decisions about how they would conduct their life with assessing and intervening in interactional patterns, such as a common pursue-withdraw pattern (Watzlawick, Beavin & Jackson, 1967, p.57).
approach to couple work for the Marriage Guidance Council, NSW.\(^8\) However, my move to private practice in the mid-eighties and my working more with individuals required me to draw more intensively on my earlier training in Gestalt Therapy and Transactional Analysis. I struggled to blend the interpersonal and the intrapersonal orientations, finding the differences in language, assumptions and clinical practice difficult.\(^9\)

It was during this time that I discovered Emotionally Focused Therapy. This therapy modality acknowledged its links to both client-centred and Gestalt therapy (Greenberg, Watson & Lietaer, 1998), and positioned itself as an intra-interpersonal approach (Webster, 1998), being essentially focused on the intrapersonal aspects of the individual without losing focus on the interpersonal influences. This modality focused on feelings in therapy; classifying, researching and outlining methods of working with the emotional content in-session (Greenberg & Safran, 1987; Safran & Greenberg, 1991; Greenberg & Paivio, 1997). The aims and principles underlying Emotionally Focused Therapy initially felt congruent with my own thinking and desires for clinical practice. By its positioning, the therapy began to provide me with a framework to bring together the intrapersonal and interpersonal assumptions and principles in a manner that afforded me clinical flexibility and freedom. Further, there was an acceptable space for the therapist to be authentic in relationship with the client, and like the family therapy field it eschewed the symbolic aspect of the therapeutic relationship found in terms such as transference and counter-transference in the more traditional individual therapies.

As my private practice continued, some of my work with individuals and couples developed into long-term therapy. It was here I found that a number of the aims and assumptions of Emotionally Focused work were not consistent with my experience as a therapist. Contrary to the idea that Emotionally Focused therapy was a brief therapy, I found that clients were not easily able to resolve couple matters, let alone deal with adult and childhood trauma, in eight to twenty sessions.\(^10\) I found that clients wanted more than a resolution to their relational and personal difficulties. They wanted to understand

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\(^8\) This afforded me the opportunity to write about training couple counsellors (Webster, 1985), changing theoretical orientations (Webster, 1986), as well as my struggle with the place of feelings (Webster & Kamsler, 1985), ideas of power (Webster, 1987), and couple therapy (Webster, 1989).

\(^9\) The language in Gestalt therapy and Transactional Analysis involved very different terms from those of family therapy, such as figure/ground, ego states, body splits (top/bottom), injunctions and life scripts; and that games were complex scripted interactions that need to be restructured and reorganised (Berne, 1961, p.224), challenged and reworked (Steiner, 1974). While there was a commonality with Gestalt Therapy in respect to working in the present, moving between the intrapersonal and interactional perspectives proved too difficult for me.

\(^10\) Generally, writers in Emotionally Focused Therapy have emphasised the here-and-now focus and its brevity as a therapy (Greenberg & Johnson, 1988, p.62; Johnson, 1996, p.10; Greenberg, Watson & Lietaer, 1998, p.242), although one reference (Greenberg, Rice & Elliott, 1993, p.287) has been made to long-term treatment of fifty sessions or more for chronic personality or interpersonal difficulties.
how the difficulties had occurred so that they could be avoided in the future. They wanted to understand the origins of their patterns of relating and ways of being. Further, I found that clients were not easily able to consider or re-experience painful adult and childhood traumas. Instead they became emotionally reactive when close to the site of a trauma, becoming confused, incoherent, emotionally paralysed, or dissociating in the session. I struggled with these difficulties in clinical supervision\(^\text{11}\) and with further reading. Although I knew that there were theoretical inconsistencies by incorporating the unconscious aspects into the intrapersonal experience as well as investigating the interactional experience in the current events and past traumas, I began drawing on the ideas from the psychodynamic therapies or talking curing,\(^\text{12}\) taking some landmarks for my map, especially those connected to the symbolic aspects of therapy.

In the psychotherapies, therapists work towards creating an environment, constant and consistent in place and relationship, where clients will feel safe enough to remember their experiences or to symbolically re-enact them in the therapy relationship, and then be assisted to integrate these aspects using the therapists' interpretations. The development of this therapeutic space as a holding environment\(^\text{13}\) was considered to be vital to the success of therapy, and was understood to be experienced symbolically. The client was metaphorically held by the constancy and regulatory nature of the sessions and the consistency of the therapist's behaviour. In my clinical work, I discovered that symbolic holding and interpretation was not enough for my clients. I discovered that the therapeutic process was positively facilitated through actual physical contact, by physically holding my clients. Physical holding helped my clients feel safe enough to experience their unfelt and unshared feelings in experiential and expressive ways.\(^\text{14}\) Physical holding also facilitated the development of the symbolic aspects of the therapeutic relationship in terms of the clients experiencing the regressive parts of themselves and experiencing me, as therapist, as a maternal figure. Actual and symbolic enactments were possible with the clients re-experiencing events with their mothers, fathers and significant carers, as well as experiencing me as a significant carer. In this manner, I found that physical holding helped my clients heal.

\(\text{11}\) I sought clinical supervision in various therapy modalities: gestalt therapy, psychodynamic psychotherapy and bio-energetics analysis, not only to support my clinical practice but also to begin helping me connect to the broader psychotherapy traditions around long-term therapy.

\(\text{12}\) In using this renowned descriptive phrase, I am distinguishing therapies that were primarily verbal from the body-oriented therapies, such as somatic therapy and bio-energetics therapy, where the therapist works with the physical body as an integral part of the therapy process.

\(\text{13}\) The term 'holding environment' was developed by Winnicott (1963, p.89) and referred to the therapist's creation of a facilitating environment, which was spoken of as a 'holding environment'.

\(\text{14}\) By experiential, I mean the process of experiencing a feeling physically and emotionally; and by expressive techniques, I mean using drawing, baton work or cushion work to aid overt expression.
Cognisant of the theoretical inconsistencies prevalent in my therapy, I continued my journey, working in the landscape and endeavouring to incorporate the symbolic and the actual, the physical within the verbal arena, and the experiencing and expressive with interpretation. This was also done knowing that the prevailing therapeutic climate regarding physical contact in the verbal therapies oscillated between a cautious pessimism to a clearly negative attitude, fuelled by the theoretical assumptions underpinning the verbal therapies and the attention given to complaints of professional misconduct against health care professionals that ranged from inappropriate relationships to sexual assault. Notwithstanding this, I continued to employ physical holding in my therapy following the ethical guidelines available for psychologists using physical contact in their clinical practice.

1.2 Situating My Research

Revisiting this therapy was a different kind of journey. My first journey was as a therapist, finding my way in a somewhat uncharted landscape, holding professional responsibilities for both the therapy and the welfare of the client. This second journey, where I revisited the therapy journey, was as a researcher. This time I invited my former clients to describe and discuss their experience of therapy. It was an opportunity for me to re–search, to look for emerging themes and explanations for what had happened. This time I had researcher responsibilities for the design of the research, and to the research participants.

One factor that wove a connection between the therapy and the research was my involvement as both therapist and researcher. This involvement arose out of my desire to research physical holding that had been an integral part of a verbal therapy, in contrast to that of a therapist making physical contact or physically holding a client on a one-off or infrequent basis. As I have written about in chapter three, actual physical contact as a means of creating a facilitating environment had been consistently regarded and widely

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16 In 1997, the Australian Psychological Society developed formal guidelines regarding physical contact in treatment, as follows: When a therapeutic procedure entails some level of physical intimacy with a client, informed written consent must be obtained from the client or the client's legal guardian prior to the introduction of that procedure (Australian Psychological Society, Code of Ethics, 1997, Section B: Relationships With Clients). Prior to this recommendation, I sought verbal permission for ongoing physical contact.
17 The welfare of the clients is regarded as paramount, and psychologists are responsible for, and aware of the consequences of their actions (Australian Psychological Society, Code of Ethics, 1997).
18 David Russell’s (1999) comments about viewing research as re–searching; not just seeing but looking again into a matter, seemed appropriate to my revisiting the therapy.
19 I was required to conduct ethical research, primarily being mindful of the welfare and dignity of the participants, and establish confidentiality against any identifying information, as set out by the National Health and Medical Research Council Guidelines on Human Experimentation (1995) and the Australian Psychological Society (1997).
accepted as perilous, and contrary to the principles inherent in psychotherapy and psychoanalysis. I found that little had been done to investigate these widely accepted assumptions. Little had been done to examine the accuracy of the prevailing attitude that physical holding was dangerous or inconsistent with the aims and processes within a psychotherapeutic frame. The seemingly consensual agreement against physical contact in psychoanalysis and psychotherapy also appeared to be contrary to the experienced and perceived benefits shown in research, ranging from studies exploring clients’ subjective experiences of therapy to surveys of attitudes and behaviours of practising therapists regarding physical touch and therapy. The results in experimental research, both in analogue and animal studies, have revealed that physical touch is a powerful nonverbal means of communication and can have powerful effects on attitudes and outcomes. In this research, I wanted to attempt to find some explanation for the experiences I had been involved in, where my clients had benefited from sustained physical holding in their psychotherapy.20

The metaphor of a journey also felt right for the research and captured some of the essence of this experience.

... traveller metaphor understands the interviewer as a traveller on a journey that leads to a tale to be told upon returning home. The interviewer-traveller wanders through the landscape and enters into conversations with the people encountered. (Kvale, 1996, p.4)

This idea of entering into conversations was applicable to the research. I wanted to engage in conversations with my former clients, to discuss their experiences of physical holding, in order to investigate what physical holding did to them as well as for them. What were the opportunities within the physical holding process and how have these been experienced and understood? How did physical holding become positive and therapeutic? Although the clients’ experiences of being held were in the foreground of the research endeavour, the researching journey also enabled me to reflect on my experiences as the therapist who physically held them. While both the process and effects of physical holding had been constantly discussed during the therapy and had formed the basis of the next session’s physical holding, the research afforded me a place where I could listen again to what the clients were saying and compare this with my experience and understanding. From this re-searching of physical holding in therapy I have attempted to elucidate the feelings and processes that were involved, in order to begin to chart possible landmarks for a therapy map that involves physical

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20 For the beginning ideas about this verbal and expressive psychotherapy that blends the actual and the symbolic, the verbal and the physical, with the experiencing and expressive, see Ariadne’s Thread (Webster, 2001c), where I introduced some of the principles underpinning long-term Emotionally Focused Psychotherapy.
holding, and to develop what may need to be known for a therapist to respectfully, safely and appropriately use physical holding in their psychotherapy practice.

James Hillman spoke about explanation as plot-making; how therapists construct plots to explain their clients’ accounts of what happened to them in-session.

In our kind of fictions the plots are our theories. They are the essays in which we put the intentions of human nature together so that we can understand the ‘why’ between the sequence of events in a story.
(Hillman, 1983, p.9)

From my former clients' accounts I have attempted to understand what happened in the sequence of events surrounding physical holding. I have attempted to develop an explanation; what happened to them as they were being physically held, and following that experience. James Hillman (1983, p.10) articulated some of the definitional terms in Freudian theory which were elaborated in his case studies as transference, repression, symptom formation and psychotherapy. In this research I have endeavoured to synthesise my clients' accounts into the telling of a story with a plot that involves healing through emotional contact, regression, and a mothering experience through physical holding. In doing so, I propose that the positive therapeutic effect of physical holding makes necessary a re-examination of some of the principles and practices underpinning psychotherapy.

The similarities between the philosophical and ontological assumptions underpinning phenomenology and Emotionally Focused Therapy, as outlined in chapter four, wove another connection in my research. This allowed me an opportunity, in a research context, to hear my former clients' stories in ways that were compatible with the therapy they had experienced. I have used the methodology of phenomenology, drawing from aspects of descriptive, existential and hermeneutic phenomenology, in my attempt to discover the essence of the phenomenon of physical holding, and develop an explanation for the experience. I chose qualitative methods as a way of obtaining these stories and collecting the data. I employed a non-standardised interview format to conduct intensive interviews with my former clients, as research participants, on two occasions. I listened to the first interview and read the transcription, noting parts of the conversation where I would invite elaboration or clarification in the next interview. I also used my clinical notes; a record of comments made in the session and my observations and analysis following a session. I reviewed them for discussion in the second interview.
Don Polkinghorne described the need to attend to experience when he spoke of a phenomenological map.

... locates geological features of human awareness and reminds us that the research journey needs to attend to the configurations of experience before moving on to assumptions about independent natural objects. (Polkinghorne, 1989, p.41)

Attending to the research participants' experiences formed another connection with therapy, as I have endeavoured to privilege their experiences in both contexts, working always to listen and understand what was happening, and to find ways to help them experience their histories in ways that were authentic. After all the interviews were completed and transcribed I listened to the tapes and read the transcripts again. I also reviewed the summaries from the clinical notes, in order to develop a sense of each research participant's experience in terms of bodily experience, effects and ascribed meaning. I applied the QSR Nud*ist program\(^\text{21}\) to the data in my attempt to bring together common descriptions for the emergence of patterns and themes. By drawing on these methods I began a process of reflection, moving between the emerging themes and the individual transcripts in my exploration of physical holding.

### 1.3 Presenting the Research

While keeping in mind the academic purpose\(^\text{22}\) of this research, a number of desires informed me about how I wanted to present this journey. There are many varieties of touch in our society; the acceptable and unacceptable touch in families and wider networks, the supportive and erotic between adults, the forbidden and the abusive, and the diagnostic and empathic touch in nursing and other helping professions, that can form part of our experience. The topic of physical holding can also touch a reader at an experiential level because we have all been physically held in some form, in infancy and childhood, as well as adulthood. A reader's conscious and unconscious memories can be perturbed, becoming part of the background, informing and influencing one's ability to consider the information as it emerges through this research journey. It is not just the notion of physical holding that can start this resonance but also the concept of regression in therapy and its attendant process of dependency on the therapist.

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\(^{21}\) QSR Nud*ist is the Non-Numerical Unstructured Data Indexing Searching and Theorising computer package for handling unstructured data in qualitative data analysis (QSR Nud*ist User Guide, 1995).

\(^{22}\) Bob Hodge (1995) stated that a research PhD was about 'the assessment of a person's relation to the dominant system of knowledge and dependent on the academic institution, 'must contribute to the knowledge of a subject' to various degrees.
Max Van Manen (1995) used the distinction between the (dia)gnostic and (em)pathic hand in physical touch in nursing to elaborate this resonance created by the pathic ability of words; complicated ideas reverberating at prediscursive and precognitive levels. This is what I have wanted; for readers to be touched, to experience the pathic power of words at these deep prediscursive and precognitive levels. Martin Stanton, using more psychoanalytic descriptors, wrote about positive and negative transferences, when he cautioned readers of the effects of these during the reading process.

Some of the most positive and the most negative transferences occur in reading, and some of the most subtle forms of censorship operate through intellectual debate. So those embarking on a critical exposition of a person's written work should be careful to check their own response ...
(Stanton, 1990, p.xiii)

Notwithstanding these cautions, I would like readers to be self-involved, noticing and reflecting on what happens internally as they read the therapy stories and the research participants' accounts of their holding experiences.

Further, Stanton suggested that the reader becomes involved in a manner similar to that of a therapist with a client.

You read everyone's work in the same way as you read the patient on the couch. You do not try to categorise and enclose them from the start with set theories and interpretations. You try as best you can to appreciate what gives them space; you follow their language and movement ...
(Stanton, 1990, p.183)

I have put together the research document with this possibility in mind: the reader becoming involved with the text and letting the emerging themes and patterns envelop them. While many writers23 have discussed the importance of writing in phenomenological research, it was Van Manen who summarised the essence of the writing process for me; the integration of the textual expression of the lived experience with the essential involvement of the reader.

The aim of phenomenology is to transform lived experience into a textual expression of its essence - in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful; a notion by which a reader is powerfully animated in his or her own lived experience.
(Van Manen, 1990, p.36)

As I explored the emerging themes through the investigation of the transcripts, I continued reflecting on the data, noting my identifications and reactions, and asking myself questions about what I was reading and beginning to perceive in individual transcripts and across all the transcripts.

It was my desire that through its readability, this work would become accessible to practising clinicians. In keeping with Peter Willis's (1997, p.3) comments about writing with immediacy and vividness, I have sought to develop a writing style which allows for the rigour of academic research as well as being an interesting reading experience for both the academic and the practising clinician. I have endeavoured to blend a storytelling quality with a comprehensive discussion of the current literature on physical contact, as well as detailing both an overview of the methodology of phenomenology and an outline of the research method for the inquiry. In doing this, I have wanted to provide the reader with an opportunity to reflect on the lineage of physical contact in therapy and its connections with traditional psychoanalytic and psychodynamic psychotherapies, as well as the current status of physical holding in therapy and its appropriateness as a holding technique during regression work in therapy.

Van Manen's (1995) suggestion, that the reflective writing in hermeneutic phenomenology required attention to the expressive as well as the interpretive dimension, followed his earlier acknowledgment of Merleau-Ponty's comments about the evocative nature of phenomenological writing.

So phenomenology, not unlike poetry, is a poetizing project; it tries an incantative, evocative speaking, a primal telling, wherein we aim to involve the voice in an original singing of the world.

David Smith (1997, 1998) has also written about the elegance of phenomenological writing, the richness of the text with the emphasis on evocativeness, intensification and tonalism, and suggested that this genre of writing could ultimately become elitist. I have tried not to be daunted by these descriptions. Instead, I have been encouraged by the discussions on the researcher's voice and personal signature.

This struggle for research voice is captured by the analogy of living on a knife edge as one struggles to express one's own voice in the midst of an inquiry designed to capture the participants' experience and represent their voices, all the while attempting to create a research text that will speak to, and reflect upon, the audience's voices.
(Clandinin and Connelly, 1994, p.423)
Jean Clandinin and Michael Connelly’s exploration of the researcher’s voice helped me consider the complexity of voice in this research. I have two predominant voices in this work; a therapist’s voice and a researcher’s voice. These voices can be recognised throughout this document, at times linked together when each voice has commented on aspects of the research. Throughout the writing process I have struggled with which voice needed to speak and what each voice wanted to say. At times I have resolved this by using my therapist’s voice to comment on the clinical material in the footnotes. At other times both voices are available sequentially in the main text, or as in chapters five and six, the therapist’s voice sets the context for the clients’ conversations and my researcher’s voice.

_The goal of situating ourselves in our work and acknowledging our limited perspectives is not to overcome these limits - an impossible task - but to reveal to readers how our research agenda, political commitments, and personal motivations shape our observations in the field, the conclusions we draw, and the research reports we write._

(Kirsch, 1999, p.14)

In accordance with Gesa Kirsch’s comments it has been my intention to locate myself in this work and identify my values, my ideas and my personal and professional histories so that the reader has access to the influences that have shaped my work in this research. I have given an account of the therapy journey around physical holding; my intentions and emotional reactions as well as my professional activity around ongoing physical contact. The discoveries during the therapy journey were the motivating force behind my researching activity, and here again I have written about my doubts and reactions in my endeavour to make available the circumstances surrounding the decisions that I made along this journey.

It has also been my desire that, where possible, the research participants can become known by their own voices, through their own words in this research. In addition, I have acknowledged the subjectivity of other authors by using their Christian names, where available, when they first appear in the text before moving to the more traditional methods in subsequent referencing. In according them this subjectivity I have wanted to provide the reader with the opportunity to hear the many gendered voices contained in the text: other authors, the voices of the individuals as clients and research participants, and my voices; and then for the reader to develop their own ideas, while reading and considering mine, as the research account unfolds.

24 I have used a more inclusive practice of using ‘their’ or ‘them’ in reference to the singular in place of the accepted usage of ‘his’ to represent his or her, or his/her.
While Clandinin and Connelly (1998, p.173) cautioned on the risks of a signature being too flimsy or too thin, and wrote of developing rhythm, cadence and expression that will identify the writer's own mark, Sally Borbasi's (1996) account of her writing style alerted me to consider the nature of my writing and my involvement in it. In this introduction, where I have commented on the therapy and research contexts as well as how I have structured this document, my personal signature will have already started to become apparent. It has been my practice to write in an uncomplicated and straightforward manner, a style where a reader can easily access and relate to the ideas that I am discussing. I have endeavoured to do this here, writing in a clear and uncomplicated manner to allow the reader to draw on the emotional elements in the therapy and research stories as well as understand the comprehensive ideas of this investigation.

Using David Abram's example of having two introductory chapters,25 I have begun chapter two by telling my story of physically holding a client in therapy. I have written an account of the therapy journey and its different facets; what happened to myself as therapist and to my client as physical holding became part of the therapy process. I have provided an account of possibly the first time I physically held a client and what happened to her and to me. I take the reader along the therapy journey for a few more sessions, and have reported what happened and how I dealt with the various matters. My professional contemplations and my own personal reflections have been included to make accessible the journey I had in dealing with physical holding. The more technical aspects to beginning a research project, the examination of the literature and the maps for therapy, can be found in chapter three. While I acknowledge that physical contact has been used by therapists working with the physical body, and frequently or sporadically by therapists of eclectic orientations, I have focused on physical contact, and physical holding in particular, with respect to the main psychodynamic and psychoanalytic therapies. In chapter three I have outlined the principles and practices of these verbal therapies, starting with Sigmund Freud's legacy of significant work in psychoanalysis and then moving to consider how the possibilities for the development of therapy incorporating physical contact have been dealt with.

In chapter four I have outlined my understanding and struggles with the differences between the methodologies of phenomenology that act as part of the backdrop to this research. I have described the method I selected for the research project, outlining the steps and processes to a qualitative inquiry involving interviews and other ancillary

25 David Abram had two introductory chapters in his book, *The Spell of the Sensuous* (1996), with a personal introduction of his adventures that led to his reflections and writing, and then a technical introduction outlining the philosophical underpinning of his work.
sources such as clinical case-notes, client material in the form of correspondences and drawings, and audio and video transcriptions. In this chapter the weaving of the therapy and the research has come together again as I have considered the issues for the former clients as research participants as well as for myself, the former therapist as researcher.

The results have been presented in two chapters. Firstly, in chapter five I have presented the more descriptive and existential phenomenological aspects of the research; the experience of physical holding and what happened in the therapy as a result. While I have made comments both as therapist and researcher, I have attempted to foreground the voices of the research participants describing their experience. In chapter six I have presented the second part of the results relating to their reflections on my conduct as the therapist and then the meanings they have attributed to physical holding. Again, the former clients' voices can be heard through their dialogue.

In accordance with Ruth Wajnryb's (2001, pp.310-311) description of an end chapter, I have reflected on what has emerged from revisiting the therapy journey in light of my desire to investigate what happened in the physical holding experience. Although a tidy process of drawing all the threads together and tucking away any unruly ones was recommended, I found that I continued to weave my clinical experience with my clients' experiences into an account of what happens when therapists physically hold their clients in therapy. In this account the landmarks of emotional contact, regression and a mothering experience have been described and elaborated. Drawing on theoretical principles, I have endeavoured to provide an explanation about how clients heal from past infant and childhood traumas through the process of being loved, cared for and nurtured in a mothering experience that is both real and symbolic in a verbal psychotherapy using sustained physical holding.
CHAPTER TWO

RECOLLECTIONS OF A THERAPY JOURNEY

The work to which psychotherapists dedicate themselves is about wakening life. It is about bringing life back to deadened psyches through the body, and to deadened parts of the body through the psyche. (McNeely, 1987, p.10)
CHAPTER TWO

RECOLLECTIONS OF A THERAPY JOURNEY

My interest in understanding physical holding in therapy was born out of my holding a client during a therapy session, and then progressively holding her as well as other clients over many sessions when they began dealing with their childhood. In this chapter I have shared my recollections of this journey, starting with the circumstances surrounding my invitation to physically hold this client and then what happened to both her and me. I have included my professional reflections and the steps I took to understand this phenomenon and my reflections on how my personal experiences of physical contact may have influenced the initiatives I took as a therapist.

2.1 Possibly the First Time

Carole,¹ an intelligent American woman in her mid-forties, had been referred to me by her partner’s therapist after she had attended a couple sessions. She had been experiencing tearfulness in inappropriate situations; in the middle of important business meetings or at commercialised displays of family warmth and connectedness depicted in some television commercials. Carole was distressed about this, feeling out of control and unable to understand what was happening.

¹ For ethical reasons, all names used in this work are pseudonyms.
In our early discussions, Carole described a childhood where her father worked hard but
was generally uninvolved in the family, and where her mother had responsibilities for the
home and the three children. Carole felt her home life was empty of maternal loving and
caring, as she had experienced her mother as emotionally cold, distant and disapproving.
She described childhood scenes where her mother had been unpredictably violent
towards her, both verbally and physically. On one occasion\textsuperscript{2} her mother burst into the
lounge room, shoved soap into Carole’s mouth and screamed that she was dirty and
needed to be cleansed of the foulness. Carole was absolutely stunned, having no idea
what her mother was referring to. Apparently, without knowing its meaning, Carole had
used a swear word often used by her father. Carole learnt to be still when she was
abused by her mother, willing herself not to feel the hand, the belt, the wooden spoon or
the words raining down on her. Her stillness was multi-faceted, generated by an
urgency to stop her mother being angry and to stop the abuse, and further activated by
her desire to be loved by her mother. Carole felt a deep sense of unfairness and
resentment at the unrelenting cruelty she experienced. Ultimately, her stillness became
an act of defiance against her mother’s rage.

Carole could not maintain the facade that her mother’s violence did not affect her, and
when she was alone would collapse onto her bed, hiding her head under the pillow. She
desperately wanted to make her mother happy or pleased with her. She usually had no
idea what provoked her mother’s rages and violence. She would cry uncontrollably,
feeling inconsolable and alone with the intolerable feelings of distress and pain. In time,
Carole discovered that she could stop the emotional pain by focusing on external pain.
She learnt that injuring herself, by digging or gouging her skin, usually with something
sharp under her fingernail, made things different. It enabled her to stop the feelings.
Physical pain replaced her emotional pain. She told me that physical pain was easier to
deal with because she knew where it came from and how to make it go away.

In these early sessions, Carole provided detailed accounts about what was happening in
her current situation; when she became distressed at business meetings and watching
television, and what was happening in her deteriorating relationship. However, there was
little emotion accompanying her accounts. Instead, they resembled stories about
someone else. Carole did not experience any feelings as she spoke, and was not moved
by her accounts of what had happened to her. When I asked her about her childhood
experiences, she talked again in a detached manner, as if referring to someone else.

\footnote{Session five, 17 May, 1988. This trauma was explored again at a later stage when Carole was able
to have her experiences in-session, to feel her feelings, becoming regressed and re-living the
trauma, and then re-integrating the different aspects of her child self with her adult persona.}
When I endeavoured to respond to her emotionally, or asked her about how she was feeling, or intimacy that what had happened to her would be distressing or upsetting, she appeared to become calmer and cooler. Much later, she was able to describe what was happening.

*Carole:* *You know, what I can’t tell you about is this. It’s like I could hardly think about it when I was little at home either, because something happens and everything closes up inside my mind. And I remember I used to listen to my mother sometimes and things would even really make sense. But mostly, I wouldn’t even make sense of what she was saying. Because I would freeze all up, my whole mind sometimes would just freeze over. And I would stop hearing and feeling anything ....*

Carole was describing what happened to her in the face of repetitive emotional and physical abuse. Initially, she willed herself to be stationary, enduring what was being inflicted on her, hoping that the stillness would mean that her mother would stop. She learnt to block her natural urge to protest. She would feel herself disappear. In other words, Carole learnt to divide herself, to remove a part of herself. Technically, she either numbed herself emotionally or dissociated, which is a common survival response when children and adults are experiencing life-threatening traumas; emotionally, physically or sexually. This way of coping became automatic, a conditioned response to actual or perceived threats of abuse and difficult emotional situations. Ultimately, she brought this way of being and relating to her adult relationships.

Carole’s dissociating from her emotional self was active in the therapy. Whenever she felt the therapy session becoming emotionally dangerous for her, whenever she felt any stirrings of an emotional nature, she would block any awareness of these feelings. I began to notice her easy, relaxed manner. A stillness. Over time, I realised that she was controlling herself. By my consistently noticing her actions and staying with her responses, she began to tell me about feeling a long way away. Sometimes she criticised what I said in order to deflect attention from herself. No matter what was said or what we did, Carole was unable to be emotionally present in the session. As I got to know Carole, I became empathic and sympathetic to her distress; sad and angry about her childhood experiences, and anguished at her inability to feel anything. In addition, I felt helpless because my therapeutic techniques were not helping her. The talking dimension of therapy appeared not to provide her with enough safety for her to have her feelings.

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3 Verbatim transcript from 16 July 1991. All transcriptions and quotes are a faithful reproduction of the client’s words and so include repetition, passing and various verbal utterances.

4 Emotional numbing or deadening and dissociation are recognised responses to physical, sexual and emotional abuse, part of the descriptors for a clinical diagnosis of Posttraumatic Stress Disorder (American Psychiatric Association, 1994; Matsakis, 1994, Van der Kolk, McFarlane & Weisaeth, 1996).
During my work with her, I constantly reflected on what I felt and what was needed to make a difference. I had many supervision sessions discussing what to do. I often requested extra sessions, especially when I felt out of control, not knowing what to do with what Carole had said or with how she deflected my questions and responses. One time, my supervisor suggested that Carole’s fears and reactions were more about her commitment than about a deep-seated mistrust of other people or terror at depending on another person, and recommended that I challenge her about her commitment to the therapy. However, this did not fit with me. I perceived her as being very committed and I felt that I understood what Carole was struggling with. As a therapist, I needed to make contact with her, to help her find a way to deal with her pain. But my words were not enough. I knew my words were not enough. My words could not contact her. My words neither achieved enough contact for her safety nor helped her with the painful feelings. As I sat with my reflections about what was not working and what was needed, I became aware of my impulse to make contact with her by reaching out, by wanting to ‘touch’ her, as if to take away the pain or make it easier for her.\(^5\) It felt instinctive. It was as if some part of me on the inside wanted to move towards her. I did not voice my desire: my wanting to make physical contact, my wanting to make an emotional connection through physical contact; or my wanting to comfort her. That desire felt so taboo that I could not put words to it, or allow myself to know what I was feeling.

About twenty months into therapy, Carole began grappling with her reaction of splitting off. In one session she described her body as alien to her.\(^6\) As she elaborated on this description she began to react, finding her feelings being more with her. As she began to feel sadness and aloneness, words stuck in her throat. Carole told me that if she could hold me away emotionally, in a metaphorical sort of way, she would stop herself from acting out her impulse to cry and scream. This was a very important moment. Carole had revealed something that only she knew about herself. She was telling me what was happening. She was losing her ability to split off. Carole was feeling. However, the session ended unsatisfactorily because she could not release those feelings. A sense of tautness that developed in the session remained. She went away from the session frustrated, full of unreleased feelings. I went away feeling unsatisfied with myself because the feelings were there and I had not been able to help her release them.

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\(^5\) This was around August-September 1989, some eighteen months into the twice-weekly therapy.

\(^6\) Session on 17 October 1989.
In the next session, Carole reported feeling that *something had opened up inside her* - *a sudden internal perception (not an intellectual one).* She realised the connection between the desperation she felt when a lover had left her and the desperation she felt when her mother left her in hospital as a child. Her lover had ended the relationship shortly after Carole told her that she wanted more from the relationship. Her partner had not been interested in meeting this need. Her lover spurning her paralleled her mother’s actions. When Carole, at four and a half years of age, was being left at hospital, she was scared and cried out for her mother to stay. Her mother turned away and left without saying goodbye and without giving her a hug. Carole became hysterical at her mother silently turning away and leaving her. She felt a pain so big that she thought she would die. A black cloud descended over her and the world became grey and bleak, without the hope of comfort. It was one of the defining moments of her childhood.

Carole: *This is what I put together after the session. There was a frustration of not being able to retrieve her. I was yelling for her to come back. I tried so hard. Whether the decision was made then I'm not sure - to never ask anyone anything that meant anything to me again. Something moved outside myself. I couldn't participate. I knew there was no connection with Mother for me. I had tried continuously. There had been a compulsion to continue. I had hoped that it would change.*

Therapist: What did you fear that made you make the decision - a life-saving decision?

Carole: *In the hospital, it happened. I thought I was going to die, but she didn’t care if I did. What else could I have felt? Nothing but blankness. I think when I calmed down, I gave up.*

Therapist: I had a sense just now that ... you allowed yourself to feel it.

Carole: *That first sensation.*

Therapist: What’s the sensation that goes with that?

Carole: *Something that went from inside me. Like a shell. A vacuum sucked everything out.*

Therapist: What was sucked out?

Carole: *Sounds funny. The first thing that came into my mind was that I didn’t belong to anyone. My self had been taken away.*

And a little bit further along in the session,

Therapist: When you get inside and look out through Carole’s eyes, what do you see?

Carole: *Anxiety. It’s not a good enough word. I only felt then: fear, panic, disbelief. That this person was leaving me there. She didn’t do anything. It was so easy, to turn around and give me a hug, and say that it will be alright.*

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7 Session on 19 October 1989.
8 Session on 21 October 1989.
Slowly, Carole came to realise that her unmet needs had been transferred from her mother to other people. She also became aware of what her reaction would be if this need was met by me, as therapist.

Carole: What I am avoiding is what I would be feeling if you don't get up and go. If you were the only person - who didn't get up and go - I'd find that unbearable. I don't know why. I've avoided putting you in a position of accepting a part of me that no one has ... your position would become too significant. I don't want anyone to be in that position.9

What worried her was her reaction if she discovered that someone could be there for her. Someone who would emotionally stay with her and not abandon her. Someone being there. Me, as therapist, being there. What would she feel if these needs were satisfied? In addition to feeling warmth and a feeling of being loved, she could also begin to feel grief at the earlier unmet experiences as well as anxiety and fear about needing another person for her well-being and psychological health.

In the next session, our one-hundred-and-thirty-seventh session, she reported a dream where she saw herself as a small child. Carole had tried to drag her up some stairs to a destination that she was anxious to reach. But the child was being hurt by the dragging, and so Carole stopped and began to see what the child had experienced.

Carole: ... I went and saw what she had experienced. Nothing changed, nothing to do but sit there.

Therapist: What happened to the little girl when you were doing that?

Carole: I think she was relieved because I wasn't fighting with her any longer. I wasn't trying to pull her up the stairs, I wasn't trying to convince her that it was okay, I wasn't trying to ignore how she felt. For the first time, I just decided to try and understand what was going on for her and, phew, I went into her same feelings. And since then I don't see that either of us has moved again.

A little later in the session, Carole went on to describe the greyness and desolation of her child's world.

Carole: Silent ... Nothing in particular to colour and warm it.

Therapist: What happened to you when I asked you that?

Carole: "What happened to you when I asked you that?" When you ask me questions like that and I try to really understand what you are wanting me to understand.

Therapist: What is the first thing that came to your mind?

Carole: I started to have the bleakest feelings. It's like opening a trapdoor and you slowly start falling through it, so it is then building platforms so you don't fall in.

Therapist: Can you stay with the bleak feelings?

9 Session on 24 October 1989.
Carole: It's a very dense and heavy and private place or world or whatever. I can't give it up.
Therapist: (I lean forward) Tell me some more.
Carole: It's such a string of unpleasant feelings that I don't want to come up. Feels like being sick and you can't stop. And why don't I want that to happen? But I do, but I can't. And in my head I know it would be okay... and you would understand and...
Therapist: No one ever understood before. People very actively closed you down. They told you, "We don't want to see it. Close down." It was part of you. It was the most lovable part of you.
Carole: What an odd thing to say.
Therapist: It's the part that makes me want to hold you. That's the part.
Therapist: That little girl at four and a half closed off back then. The only way she can come back is with all of her.
Carole: You start saying that, this chair is moving back.
Therapist: Do you want me to stop?
Carole: No.
Therapist: Can you stop your chair moving back?
Carole: Yeah.
Therapist: What do you want to do when you see that little child? ... I want to hug her. What do you want to do?
Carole: I want to disappear. I don't want to have to deal with it.
Therapist: It's okay to deal with it. I haven't gone away.
Carole: No, I didn't think you would.
Therapist: What are you wanting right now? To help you against the struggle from disappearing?
Carole: Oh, I wasn't thinking about wanting anything. I was doing what I do as I said at the beginning... go blank. Until I can wait until it goes away. I know you don't think I should do that.
Therapist: Don't make it go away. Only if it is too much.
Carole: (Flounces. Deep sigh.)
Therapist: You are hanging on like mad.
Carole: (Laughs.)
Therapist: Talk to me. Talk to me. Keep contact with me. Stop trying to cut me off.
Carole: I'm not cutting you off.
Therapist: What's happening?
Carole: It's me that I'm cutting off.
Therapist: Do you want us to come closer?
Carole: No.
Therapist: Would you like me to hold you?
Carole: Of course I would.
Therapist: How would you like me to hold you?

Carole had split off, becoming more distant and remote from me. I experienced it as an interminably long time before I asked her if she wanted to be held. I asked her while sensing my stomach tighten, feeling my heart in my mouth and hearing my words quickly tumble out, mixed with my frustration at her distancing, helplessness at not being able to help her, and anxiety at the unknown space I was inviting her to. I did not know at that moment if she wished to be physically held, or how I would achieve this, as my invitation - those words - were there within me and I gave way to their expression. I had not predicted the outcome, or the possible effects on her, me or the therapy. When she replied, "Of course," I moved to hold her. I held her clumsily at first. I moved out
of my chair that was opposite hers to sit on my haunches beside her chair. I reached over and held her. I rocked her a little. She came off her chair onto the floor and collapsed in my arms. I held her as you hold another person, chest to chest, my arms around her, and her head buried in my neck. I stroked her back. I rocked her some more. As I held her, I said,

*Therapist:* It's been a horrible, lonely world. You are safe now. You are safe now. It's okay. You can let it out. You can hang onto me. I'm not going anywhere.10

Carole began to sob and sob and sob. Later, she told me that I had been the first person to ask her if she wanted to be held. The first person in forty-six years. It was a very powerful moment. My asking. Her accepting. My holding. Her letting go and feeling.

### 2.2 Tripping over Myself

At the next session Carole said she was astounded at her agreeing to being held. She told me what happened to her.

*Carole:* ... when you were holding me, I felt an internally calm feeling, something very peaceful. Everything sort of disappeared. Every once in a while, something would hit me inside, like a blunt instrument. It kinda shakes you inside.11

I was pleased to hear this as I believed that the physical holding had stopped Carole from distancing herself from her emerging feelings. By remaining emotionally present, Carole had been able to cry, and the holding had also been a soothing experience for her. Carole spoke of going to bed that night and being disturbed by a reverberating phrase, *"Don't hit me, don't hit me."* She reported that although being hurt physically by her mother had disturbed her more than she had realised, she did not understand the connection with the physical contact. I was not expecting these reactions, although I understood some of what was happening. Carole's early experience of physical contact had been negative. Physical contact meant being physically assaulted and abused by her mother. Therefore, any physical contact had the potential to unconsciously12 arouse

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10 Session on 26 October 1989.
11 Session on 31 October 1989.
12 The association of physical contact with her mother hitting her in the subsequent dreams can be regarded as a characteristic of people who have experienced severe childhood trauma and abuse. These people experience somatic memories, hypervigilance, nightmares and flashbacks in connection to events occurring in the present, as described by Matsakis (1994), Van der Kolk (1994) and Van de Kolk et al (1996).
fear in Carole. Physical holding in other situations could make her aware of these negative experiences and her subsequent associations with physical contact.

Carole recalled the dream she had that night. She had lost her footing when a bookshelf she was leaning on broke. She did not want to clean it up, but her mother told her to, because it would be "a really good thing psychologically." Carole replied by yelling, *Shut up. Quit being sarcastic. If you don't want to help, shut up. It's my stuff.* As Carole yelled, her mother turned on her with violence.

*Carole:* *She wheeled around, her face a mask of anger, lips curled. She reached out and grabbed me and clenched me. I took her arms - they were two bands of steel. I hit her ... to release them. She said, "Stay away from me, don't touch me." I replied, "I'm not."

Carole felt that her mother was angry with the mess and wanted her to fix it. Carole, resentful of her mother's interference, walked away into the kitchen. Her mother came after her.

*Carole:* *Then I found myself at an empty place in Annandale.*13 I don't know whether we bumped into each other. Mother took a washtub and beat me over the head. Then her fists. And then with big metal spoons. Finally I grabbed her wrists and I backed her onto the wall. There were knives. We had better stay away from there. But the spoon turned into a carving fork. That's what she had. Her fury doubled ... I knew she wanted to kill me. We were in this struggle. Then the scene ended. Mother was lying on the ground. I thought she was dead. I went to sit down. The dead body kicked me. I looked at her. She had a leer on her face. I told the doctor she was not dead. I picked her up. She wasn't my Mother. She was a child. And that was the end.

A number of things occurred in this dream. In walking away from her mother, she felt disoriented and experienced an apprehension that she had felt before. It was an apprehension about where home was. Then she experienced her mother's fury and violence as well as her own resentment and anger towards her mother. She physically fought her mother. She then found that her mother was not dead and when she picked her up, she discovered that her mother became a child. Carole interpreted her dream around the violence. The reference to knives related to her mother's attacks when she was preparing food. She told me of an incident where part of her thumb was chopped off when her mother slashed at her with a kitchen knife. Carole was disturbed at her previous lack of reaction to this event and now reported feeling, ... *shaky on the inside, feeling bad that I have been treated that way and disturbed that I have not been able to think about it that way before.* This was a dramatic shift in Carole's perception and

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13 Annandale was the suburb where Carole lived and I practised as a therapist.
reaction. Previously, she talked about the violence as if she was telling a story. A story about anyone, without reference to herself and without reaction to the experience or to herself. Her change of heart was wonderful to hear.

Carole did not comment on the last part of the dream where she picked up her mother to find the child. Was it the child in the mother or the child in Carole? Both ideas were plausible. As so often happens, most adults in therapy look for benevolent ways to explain their parent's neglectful, rejecting and annihilating behaviour, and often end up being more empathic to and understanding of the parent, and neglectful and critical of themselves. The question of the child was confusing for me as I did not fully understand this aspect. It was many years later that I fully understood that when she picked up her mother, Carole had found her own child. Her fighting her mother was like her adult self being on her child's side for the very first time.

Carole's sense of an empty place in Annandale could have been interpreted as her own domicile in Annandale being empty or not home for her, or as the therapist's place being empty and not safe or like home. In the session, I was not able to interpret this information either for myself or for her. Again, I did not fully understand until many years later, that regardless of what Carole had done in her adult life, or how long ago she had left her home in California and lived far away, she had not emotionally or psychologically left home. Our human need for attachment can mean that no matter how bad that attachment might be, the emotional and psychological leaving can only successfully take place when the attachment issues are dealt with. Often it can only be done when another attachment or another emotional connection or 'home' is found. Maybe the physical holding gave Carole the hope of a healthy attachment or that a new psychological home could be found with me.

How had the experience of being physically held affected Carole? From that next session, it appeared that Carole had felt stronger, as she had argued and struggled against her mother. Did holding provide her with that strength? Did the physical holding show her something that was now available to her? Did the holding make her

14 Alice Miller (1984, 1985, 1990) used the term 'poisonous pedagogy' in her outlining of socially sanctioned yet abusive child-rearing practices, how they shield the parent and make the child responsible, and how this has been replicated in psychoanalytic practice. In her book, Thou Shalt Not Be Aware (1985), she made recommendations for a psychoanalysis free of these difficulties.

15 Carole, in reading this, confirmed that the child was both in the mother and in Carole, and that her mother leeried at her because Carole would never be rid of her. Like Alice Miller (1986), the adult that was being on the child's side for the very first time was full of fear of who that child was.

16 It was John Bowlby (1988) who argued that attachment was a basic component of human nature. From his seminal work (1969, 1973, 1979) there has been much research about how the infant-mother attachment acts as a prototype for adult attachment throughout the life cycle of the adult, and of the ongoing need for relatedness (Peeney & Noller, 1996; Holmes, 1993, 1996; Josselin, 1992; Parkes, Stevenson-Hinde & Marris, 1991; Sperling & Berman, 1994).
feel reassured enough about herself to allow her to find her reaction to the violence? While I could not answer these questions, I was pleased with what had subsequently happened. I felt delighted at the information about the physical holding, as well as the dreaming experience, and that Carole was now locating herself differently in her history. What I did not fully understand until later was that physically holding Carole not only enabled her to feel safe, it allowed her to feel the pain, and it enabled an unmet need to be satisfied. Physical holding communicated to Carole's adult aspect that she could let go, as the therapist was present and available for her. Physical holding further communicated to her child self that someone felt for her. Her feelings were being held by the therapist. The therapist, like a mother, made her feel safe, so that the past could make itself known to the client and the therapist.

The next few sessions went well. In addition to dealing with some day-to-day matters, including her forthcoming hospitalisation for minor surgery, Carole began to talk more about what was happening to her in the therapy. Carole was afraid that I would not like her. It made her anxious and active in the sessions. She was worried that she might not do the right thing in the sessions. Carole felt confused. Her adult relationships were characterised by her looking after other people, observing and dealing with them. She did not know how to behave in the role of client when someone else was in charge, looking after her and responding to her. A couple of times, Carole asked to be held and reported feeling good when she heard my breathing. Carole reported feeling loving towards me and was pleased that she was not required to give herself up in return. She began to intimate that she was beginning to know more about what she wanted from me but was reluctant to elucidate that to me in those sessions. Her desire to be held was increasing. She wanted to be held each session.

It was about this time, as I was attempting to understand the information Carole was telling me, as I was attempting to understand what had been revealed in terms of the actual as well as the symbolic, that I began to feel afraid. I was afraid that I might have been doing the wrong thing. Holding a client briefly in a session was one thing. On that original occasion it felt like the right thing to do. But now, five or so sessions down the track, I had a client who wanted to be held, who was asking to be held and whom I was holding. At the same time, Carole was talking about feeling loving towards me,

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17 Traditional psychotherapies have viewed the direct meeting of needs in therapy as gratification and have cautioned against this practice, as is discussed in Chapter Three (see Anzieu, 1984a; Freud, 1924; Goodheart, 1984; Schwartz-Salant, 1984; Sempe, 1989).

18 Carole can develop both a positive and a negative transference with me as the therapist, reacting and responding to me as a child to a mother, where she would both want the attention and acceptance from me yet fear the negative reactions that she had experienced with her mother (Reber, 1995, p.810; Rycroft, 1968, p.183).
indicating that she knew what she wanted from me, and was talking about the 'real' in me. I feared what she was not able to say to me, worried that there might be an erotic element in her loving that I was responsible for, that she had misinterpreted my motives for holding her and that I was misguided in my interpretation of what physical holding was doing for her as a client. In addition, I was worried about what she saw as the 'real' in me, fearing that I might be in denial about my own motives or other crucial aspects of my personality and behaviour as a therapist. In my case-notes, I speculated that "if I give her space, she has to face the space inside her." I had theorised that Carole had to experience the emptiness inside her and access the unfelt feelings of her past. What was happening for me that I had noted this in my clinical notes? I believe that I was writing out, both for myself and to myself, my explanation about what needed to happen to help Carole and what my role was in that process. I was writing to work it out because I was apprehensive about ongoing physical contact, worried that it was not working, and anxious about being misinterpreted.

In reference to physical contact, the Code of Ethics for psychologists was concerned with sexual contact between a psychologist and client, specifically prohibiting personal and sexualised relationships. It was recommended that for other physical contact, described as 'so-called body therapies', a third party be present or in the immediate location. Where did this leave physical holding in therapy? Physical holding was not a body therapy or a therapeutic massage. It was a treatment technique, used in conjunction with a verbal therapy. It seemed that there was no appropriate measure for dealing with physical holding therapy. I was worried about where that left me. It was also around this time that there was a great deal of media coverage of a number of renowned psychiatrists and psychologists who were charged with having inappropriate relationships with their current and former patients. I wondered what would happen if Carole became unhappy with the therapy and made a complaint that involved my physically holding her. While I worried that the physical holding would not stop her dissociating or make her feel safe and cared for, I worried about her other, undisclosed feelings. I also became worried that there might be a counter-transference reaction occurring, that I was physically holding her either from my need to rescue or protect her or from my own unconscious need to be held.

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19 Carole read this chapter and added, I know that more clearly now. I wanted you to replace my mother inside me. I wanted a closeness, and intimacy so powerful that it would smother the bad seed.

20 Case-notes for the session on 9 November 1989.

21 If so-called body therapies are employed (eg, therapeutic massage), it is always necessary that a third party be present or in the immediate vicinity. The psychologist and client must reach the agreement on the identity of the third party: partner, friend, relative, nurse (Australian Psychological Society (1995) Code of Professional Conduct, Appendix B: Guidelines Relating to Client/Psychologist Physical Contact). The Code was amended in 1997 (see Ch 1, Footnote 16).

22 There are two major definitions of countertransference: the traditional, which refers to a therapist's transference onto the client, described variously as unresolved issues (Limentant, 1986; Eagle &
Following my speculations about what needed to happen and my increased agitation and worries, I withheld physical holding from Carole. I verbally bypassed her request to be held at the end of the next session. Immediately, I knew it was wrong. As the session finished and we got up to leave, I knew in my heart that I had made a mistake. In that moment, Carole felt absolutely rejected, taking personally my declining to hold her, and that her fear of losing me was coming to fruition. As we walked down the stairs and as I said goodbye to her at the front door I felt bad, intuiting her reaction and the struggle she would have between sessions, and agitated about the unknown space I was cast into. At the next session I apologised to Carole for my oversight. I avoided fully explaining what had happened as I didn’t fully understand it myself. However, I resolved within myself to keep physically holding her and to observe carefully and deal with each nuance of reaction between us, while I continued to search for other ways to help her feel her feelings.

2.3 Taking the Next Steps

Physical holding was powerful for both of us. Carole began to examine her childhood history more seriously, exploring the effects of feeling unloved and uncared for in a more intensive way; more openly and emotionally. She also began to consider the nature of her relating in adult relationships. As a therapist, I began to reflect on physical contact more deeply. I began talking about physical contact in supervision. I looked for material on physical contact and therapy. I reflected on my own experiences in therapy as well as my personal experiences of being held.

2.3.1 The Professional Landmarks

2.3.1.1 A Supervisory Beacon

When my supervision contract expired, I sought supervision with a female psychiatrist who was an experienced humanistic psychodynamic psychotherapist. I was looking for

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Wolitzky, 1992), or the unconscious complex-determined reactions (Stein, 1984), or the analyst's own wounding; their shadow response to a transference (Woodman, 1984), or the contamination of therapy by the therapist's needs (Nichols & Paolino, 1986), or an analyst's inappropriate behaviour (Gill, 1982); and the holistic, which includes any and all therapist's emotional reactions (Heimann, 1950; Stein, 1984; Eagle & Wolitzky, 1992; Reber, 1995). I was using the traditional definition and an outmoded view that countertransference was a hindrance (Freud, 1910; Reich, 1966) when I was worried that I was responding to Carole from my own transference or my own unresolved needs originating from my personal experiences or lack thereof.

23 Session on 21 November 1989.

24 In 1991, I began a Diploma in Clinical Hypnosis, a course to provide me with other techniques for working with repressed feelings.

25 Supervision (Webster, 2000) for the helping professions is aimed at helping an individual increase their capacity to perform effectively within their organisational setting and carry out their professional function in an integrated way. The orientation of supervision can be both administrative; reviewing the service provided and assessing clinical standards, and educative;
someone who could support me in exploring these difficult aspects of my clinical work; encourage me to reflect on my process and practice, and facilitate my learning more about therapy. In particular, I wanted help in making the therapy process transparent, as I wanted to explore how the therapeutic relationship influenced the therapy, how to work with clients' resistances to deeper and more painful work, and how to understand the dynamics of psychotherapy that made it such a long-term process.

I spoke about Carole in the second supervisory session as I was still reverberating from withholding physical contact. I wanted to understand what had happened because I had feared that my action might be connected to my own counter-transferential processes. Following my initial case presentation and without mention of the physical holding, my supervisor discussed the process of internalisation; how a child's pain is dealt with by their mother's intuitive response, and that only through basic trust can this be internalised and the child's sense of fragmentation healed. An intuitive response! Those words resonated through me. Yes, that was what happened to me! My inclination to hold Carole was my intuitive response. I felt relief. There was an explanation, a theoretical explanation for what I had done. Maybe it was not because of my own personal limitations or my professional shortcomings in not being able to hold the client symbolically, that I had resorted to physical contact. Maybe the physical contact was an intuitive response that I allowed to be expressed.

My supervisor's words allowed me to confess that I had physically held Carole. My supervisor did not receive this information as a confession, but instead she spoke about understanding my actions in the context of a mother holding a child. Further, she suggested that physically holding a client in a mother-child position can enable a client to experience their bodily space, their sense of self, and connections to other people. She argued that when the touch was genuine, the client would introject the positive effects of touch. It is the intuitive response that can be internalised, as authenticity can be felt by the client. I left that supervisory session feeling energised. Feeling good. There was a basis to my desire to hold my client, a basis that was external to my own personal process and one that was deeply important for the client.

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helping develop clinical skills by working with emotional reactions, developing integrative clinical assessments, and linking case management with conceptual ideas (Bradley, 1989; Hawkins & Shohet, 1990; Kadushin, 1988; Shipton, 1997; Webster, 2000).

26 Supervision session on 30 January 1990.

27 For further reading on healing a child's betrayal and the process of internalisation I was referred to The Child and the Family (Winnicott, 1975a) and Loose Ends (Hillman, 1975).

28 The supervisor connected this to Carole's dream images of a motor vehicle. She interpreted that by having a damaged car, Carole was telling me that she was damaged. The car represented her damaged ego, telling us her original 'holding' was impaired. Carole used her dreaming to bring her injury of the past to the therapist as she needed that damage to be acknowledged and validated. In bringing herself to the therapist in this manner, she was enabling me to repair the connection, to restore the facility for continued self-growth, and to develop the capacity for intimacy.
Further, my supervisor suggested that it could be more therapeutic to invite the client to work on the floor, as compared to the lounge. She suggested that I would minimise any erotic arousal because a lounge could invoke memories or associations around bedroom scenes. Although I did not have a lounge in the therapy room at that time, I did offer for Carole to work on the floor, which she readily accepted. It was easier to physically hold her and we both found that it was a more intimate space.

I presented Carole again in supervision after she talked of her fears about me, where she suggested that I was using physical holding as a technique, and that I was impatient with her and did not like her. My supervisor said that a number of complex things were happening. Carole was frightened that I did not have an intuitive emotional response towards her and that my physically holding her was a technique devoid of feeling. She also theorised that Carole was feeling positive feelings towards me but was fearful of them. She felt that Carole needed to feel her emerging feelings of love towards the therapist, like those child feelings of love towards a mother, in order for her self to emerge. However, I was cautioned that these loving feelings were complicated by feelings of fear and pain. Carole had not experienced any form of unconditional love from her mother and had lost her father’s when she reached puberty. She feared that as an adult she would not be loved for who she was and that, similar to her relationship with her mother and her lovers, there would be impossible conditions to be met. This transference fear would be enacted in the therapy. As she felt loving towards me, she would fear the impossible conditions about how she would have to be or behave in order to obtain my love. Further, she would fear that I would become disinterested in her, like her father. In addition to these transference fears, there would be other feelings as Carole realised her pain of not being loved for herself, her grief at being unloved by her mother, and her reactions to the physical and emotional violence she had experienced.

I could not digest all the ideas about the transference love and fear. However, my supervisor’s discussion enabled me to not fear Carole’s worries and accusations. I read them as fear and began to get to know them. Slowly I came to understand what my supervisor had been saying as I connected Carole’s childhood experiences to her

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29 Supervision session on 26 March 1990.
30 Again, these childlike feelings of love towards the therapist as mother are regarded as transference feelings.
31 Carole’s loss of her father’s unconditional love when her mother told her father that Carole was too old to sit on his knee, brought a second transference to the therapy. She feared that I would stop loving her, as her father did.
32 I assessed her fear as being constructed of mainly primary maladaptive fear originating from past traumatic events, as well as some secondary anxiety due to catastrophic expectations (Greenberg & Paivio, 1997, pp.194-228).
emotional reactions. I learnt to sit with them, to explore them and consider the part I might be playing by my actions and through the symbolic enactments and transferences. As I continued working with Carole, I presented the therapy in supervision whenever I needed to deal with any aspect of the process.

2.3.1.2 Holding onto the Written Word

I looked for what had been written about physically holding clients, and found a book, *Touching: Body Therapy and Depth Psychology* (McNeely, 1987). I read it avidly, searching for any comment about physical holding. A comment that would soothe my anxiety about what I had done. A comment that would give me a rationale or support for what I had done. I found a sentence that did just that.

*Every session someone goes into preverbal material and I do as much holding as necessary.*

(Marion Woodman, quoted in McNeely, 1987, p.57)

As much holding as necessary. It was a joy to read. I was unable to contemplate Deldon McNeely’s integration of body therapy and Jungian Psychology, or to see how her ideas on the meaning of touch in terms of mirroring, amplification, de-armouring and gratification, fitted. What fitted was that Marion Woodman, a renowned therapist, said that she physically held her clients as long as necessary.

Sometime later I found another book, *The Basic Fault* (Balint, 1989), where Michael Balint suggested that problems for difficult patients lay at the level of the basic fault and in the domain of two-person psychology,33 as compared to the Oedipal situation. Balint argued that some problems were of a more primitive nature, that it was the child and not the adult in the patient who was endeavouring to deal with the world.

*But the gulf separating us adults from the 'child in our patient' of the age of the basic fault - the 'infant' in the true sense of the word, i.e. one who cannot speak, at any rate, the language of adults ...*

(Balint, 1989, p.90)

Further, he argued that interpretations requiring adult comprehension were then experienced as an attack, and evoked pain and rage within the client.

*... that interpretations given by the analyst are not experienced any longer by the patient as interpretations. Instead he may feel them as an attack, a demand, a base insinuation, an uncalled-for rudeness or insult, unfair treatment, injustice, or at least as a complete lack of consideration ...*

(Balint, 1989, p.18)

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33 Michael Balint (1989, pp.18-23) argued that it was the basic fault because it lay in the domain of the early formative phases of an individual and his bio-psychological needs and psychological care. It was a two-person psychology because only the infant mattered as the other was there to gratify and attend; and it was in this arena, when the patient was an infant, that there were difficulties.
Balint's words gave me further explanation for what was happening: that clients in a regressed place were unable to comprehend the interpretations that were made about their processes. I began to think about the nature of Carole's splitting off and how it related to her child aspect. Until my understanding was fully developed, I considered that Carole's way of protecting herself, her splitting off the emotional self, could not be dealt with by sitting and talking with me in therapy. It came from my holding her. It was this intuitive knowledge and my desire to help her that encouraged me to continue to work with her in this manner.

In addition to supervision and reading, I met with my colleagues and used some of our monthly meetings to share and reflect on our experiences of physical contact in therapy in order to gain clarification and develop our thinking about physical contact. In 1992, the topic of physical contact that included physical holding was taught in an advanced course at the Institute. Listening to the students' discussions and reflections about their personal and professional experiences gave me confidence to continue developing my ideas about physical holding. I began developing guidelines for all aspects of physical contact and holding, ranging from introducing the idea of physical touch to actual contact and then debriefing. As I continued to work with physical contact I began to experience clients regressing to infantile places, and I began to get to know the transferences that were being enacted.

The result of this immersion in physical holding in the context of Emotionally Focused therapy led me to consider a number of important ideas for individual therapy. Some ideas related to the clients, encouraging them to deal with their unacknowledged and unfelt feelings, and helping them face both the unlovable parts of themselves and their need to be loved and accepted. Other ideas related to the role of the therapist, where I explored the concept of nurturing in therapy and my role in the mothering and re-parenting processes. However, what I was accumulating felt somewhat unmanageable. I did not perceive these ideas as a map for the journey with the next client. Instead, I felt I had a number of ideas about physical holding and a loosely-woven framework for individual therapy. A loosely-woven framework was not a map. Maybe it was some of a map.

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34 Monthly staff meetings at the Institute for Emotionally Focused Therapy; a private educational institution, accredited under the NSW Higher Education Act, to provide postgraduate programs in Emotionally Focused counselling and therapy.
35 In the Individual Therapy 2 course, physical contact was taught, where students were required to consider physical contact by reflecting on their personal experiences as well as their own therapy experiences before considering the application, usage and contraindications of physical contact and holding. This was developed into a specialised workshop in 1999 (Webster, 2000a).
2.3.2 The Personal Landmarks

2.3.2.1 Signs From My Personal Therapy

By remembering my personal experiences of physical holding, I was able to understand Carole's feelings of rejection at my not holding her. Two pivotal experiences stood out for me. In the late seventies, I attended an introductory workshop on experiential work\(^{36}\) where a number of different experiential modalities were demonstrated. On the second day, during a centring exercise, participants were requested to locate their inner self in the pelvic region, and then find a visual image to match the sensations being experienced. One person immediately became very distressed and began wailing. I was affected by their anguish and became noticeably agitated and started rocking myself backwards and forwards, as if experiencing stomach cramps. A support facilitator\(^{37}\) bundled me up in her arms, first supporting me by sitting behind me and having her arms around my body, and then moving me to a holding position, as a baby to a mother. As she rocked and spoke soothingly to me, I became very little\(^{38}\) and very distraught. I cried and repeatedly asked, "Why don't you love me?" in reference to my mother. During this experience, I moved between being aware that the facilitator was holding me, and feeling very young. When I stopped crying, nothing much was said about what I had experienced, and I felt very tired and washed out.

Ten years later I contacted that support facilitator for individual psychotherapy. In the early stages of the therapy, she did not make any physical contact with me, and it did not seem appropriate for her to do so. In fact, she did not remember the incident of physical holding that was pivotal for me. However, on one occasion when I was leaving a session, she reached over and spontaneously hugged me before I walked out the door. I experienced a number of sensations. It activated something inside me that reached back to my first experience with her in the workshop. I experienced both an emptiness inside and a sense of longing for that to be filled. In the next breath, I experienced myself being out on the street, as if I had been torn away or pushed out from that feeling of being held. In the next session, nothing was said by either myself or my therapist about what had occurred. However, I found myself waiting to be hugged again when I got up to leave the session. It did not happen. I left the room feeling stunned, as if I had been

\(^{36}\) Introduction to Experiential Therapies Workshop (1977), conducted by Dr Barry Blickarsky, Beth Stone, Beverley Mackenzie.

\(^{37}\) The support person had facilitated a psychodrama for me on my family of origin issues on the first day. The activity finished without resolution and both the group and I were left somewhat unfinished and unsatisfied. My inability to express what needed to be said was due to primary maladaptive fear, originating in childhood and relating to fear of annihilation, that was triggered by current events (Greenberg & Palvio, 1997, p.196-197).

\(^{38}\) A regressed state is regarded as a psychological experience of being at a younger age than your actual age (Webster, 2001), a reversion to an earlier mode of functioning (Rycroft, 1968, p.153) or a reverting to an earlier and more primitive or more childlike pattern of behaviour (Reber, 1995, p.649).
dealt a body blow. The cold wind outside swept me along. I felt like a leaf bereft of the tree. I was unable to talk about it with her and it was never mentioned in our work.

Reflecting on these experiences in the context of my physically holding Carole, I began to understand the powerful effect of physical holding. I understood that physically holding a client required great sensitivity and required a therapist to consider the actual and symbolic aspects of the experience. I knew that once a client was held, a therapist needed to be prepared to continue to hold them, as physical holding makes contact with a more regressed aspect of the client. I also understood that it was important to debrief the experience, and the client’s reactions and understandings in the next session.

2.3.2.2 Physical Contact in Childhood
I also used my experiences of being held in my personal life as sources of information to help me consider Carole’s need to be held. It was around this time that an interaction pattern developed between my partner and myself. As my therapy practice often involved evening work, I would generally arrive home to find him reading or watching television, with the dinner ready. It was my custom to greet him and then drape myself over him, in order to hug and be hugged. He accommodated this, stopping whatever he was doing to put his arms around me, and then would continue reading or watching the television as I lay in his embrace. It was a wonderful feeling to be received so unconditionally; to be able to lie on him, to hear his heartbeat, to feel his warmth and smell his smells. I tended to drift off into another space. A space of being, without tending to the present and without self-consciousness. Ten or fifteen minutes later I would return to consciousness, get up to get changed and become involved in the evening’s activities.

It took about six months before I noticed what I had been doing and wondered what was happening. I realised that I was doing something akin to what a small child does to a parent: lying on them, feeling calmed and secure enough to drift off into dreaming without the need to be watchful over one’s immediate environment or personal space. Immediately, I felt self-conscious and embarrassed. Although my partner was nonplussed at my concerns and indicated that it felt wonderful for him as well, I felt that I needed to be watchful of this pattern, telling myself that I was an adult and not a child, and that I did not want to skew my relationship in this way.

On deeper reflection, my partner’s holding me was reminiscent of my relationship with my father. I have fond memories, prior to my parents’ separation when I was nine years of age, of being able to sidle up to him, and lean against him, regardless of what he was doing. I remember that I never felt rejected by him. These memories are contrasted with
my experience of my mother as being emotionally unavailable and critical. Following their separation and with my mother having to work to support four children, my next period of physical closeness came from my relationship with my youngest brother, who was born nine months prior to the separation. I looked after him, waking to his cries at night, having him sleep with me when he woke in the early hours of the morning and giving him lots of maternal hugs and comfort.\textsuperscript{39} In addition, I watched over him and protected him from our other brother when I thought he was being cruel.

I believe this experience of looking after him affected me in a number of ways. My nurturing him nurtured me, as it provided me with warmth and love to fill a space inside me. A space that had not been filled by my mother. A space that was left by my father leaving. I found I could not oust my little brother from my bedroom as a teenager when I needed privacy, as I could not bear seeing the rejection and hurt on his face. I learnt to be conscious of not hurting or being intentionally hurtful or cruel to others. In addition, I believe I learnt to become more attuned to emotional changes within individuals, although I did not consciously know this until later in my career as a therapist. My early style of relating as an adult did not demonstrate any overly nurturing characteristics. Physical contact with others was not evident. I was respectful of other people’s personal space. I believe I acted in ways so as not to hurt others and sought to clear misunderstandings as soon as I felt or intuited them. What I am trying to say by way of telling you my history is that my offer to physically hold Carole was somewhat at odds with my general behaviour, both personally and professionally.

From my personal experience of therapy, I realised that the regressed parts of my clients had attached or bonded with me, and that I could not haphazardly stop holding them, because an emotional process had begun. In addition, the experience with my partner provided me with important information about the process of being held that I believe enabled me to more fully understand clients’ experiences. I was able to draw on this experience of listening to a heartbeat to quieten and calm clients. I was able to invite them to listen to my beating heart when they were distressed and needed to be calmed. I also used my experiences of breathing. I found that I could use my breath to calm clients, by telling them to breathe with me.

However, I also struggled with whether my physically holding clients was a countertransferential process and was more related to my own unmet needs for physical and

\textsuperscript{39} These descriptors represent some of the characteristics of a parentified child, where a child takes up or mimics a parent’s role in terms of responsibility, caretaking, and protective behaviours (Jurkovic, 1997, pp.4-11). The term ‘parentified child’ is used by both systemic and psychoanalytic theorists (see Frano, 1965; Mahler & Rabinovitch, 1956; Minuchin, 1974; Minuchin & Fishman, 1981; Jurkovic, 1997; Schmideberg, 1948).
emotional contact from my childhood, or my own reactive patterns of relating that developed from my becoming a parentified child with my brother. It was difficult for me to look at these issues early in the holding work. Although I was beginning to explore the ideas about a client’s inner world, in particular about the Inner Child, and my understanding about the nature and existence of this aspect within a person, I was coming from a more interpersonal orientation, which prized clients for being reasonable and having an ability to make decisions without reacting emotionally. Initially, I held the assumption that the regressive aspect of an individual was indicative of unfinished business and was a sign of immaturity. It was not until much later, with a deeper understanding of Inner Child work, the place of physical holding, and the need to re-experience past emotional difficulties, that I could view my past conduct as a therapist without embarrassment. Then I was also able to reflect on whether I was acting from a counter-transferential reaction with respect to physical holding generally, and with each client specifically.

2.4 Exploring Further

I also made physical contact with other clients. Physical contact began with Derek when I offered him a hug at the end of a session. While he had numerous affairs himself, it was his wife’s affair and then her ending the marriage that sent him into a spin, feeling out of control and deeply angry. In the session when I helped him move the younger part of himself away from his wife, I discovered that he did not trust anyone and that he could only find safety for that littler part in a tree. I felt for him. His adult part could not look after a part of himself and he felt mistrustful of both his friends and of me. I also felt for that little part of him who could only be safe in a tree on his own.

In the previous month, Derek had brought flowers to a session, quipping that the session could be held in a restaurant. After informing him that the purpose of the

40 While the term ‘Inner Child’ refers to the regressed aspect within an individual and could be regarded as a metaphor, it is used more specifically in Emotionally Focused work, where a client in a regressed place is dealt with as the child of that age and not in a metaphorical way (Webster, 2001c), and is based on my clinical experience of regression, as well as experimental evidence showing that brain wave activity changes with regression under hypnosis (Cocker, Edwards, Anderson & Meares, 1994).

41 Session on 11 August 1988. His feelings reflected his grief at the ending of his marriage as well as deeper anguish and fear, as he had experienced his wife, or rather having sex with her, as his security. I believed that the part of him that needed security was connected to a younger aspect.

42 When clients find a regressed part of themselves, integration at the end of a session can occur by helping them locate a safe place for that aspect of themselves. When clients feel kindly towards that smaller part of themselves they can generally imagine putting it inside them. When they are denying or critical of that smaller part of themselves, they find it impossible to imagine putting that part within themselves. Then a therapist will help them find a safe place external to themselves for the interim and until integration can occur.

43 Session on 27 July 1988. In previous sessions Derek had been talking about his fear of being controlled because of his childhood experience of his father’s cruelty and his stepmother’s violence.
therapy relationship was psychological, Derek told me that he did have an affection for me and needed a relationship to get to know someone. In the following sessions, while Derek continued to deal with his postgraduate studies and being separated, he also spoke about wanting to be loved. He observed that the little boy inside needed loving yet felt mistrustful of him. I wrote in my case-notes that Derek needed some reassurance, which led to my offering a hug at the end of the session. I felt I gave Derek a hug of affirmation, telling him he was okay and maybe making contact with the regressed aspect in him that was now alone in a tree. Derek acknowledged this in a letter to me while he was visiting his children interstate, saying that he had a special friend in me.44

After this, Derek began to seriously examine his relationships with women and discovered that he was searching for love. His pattern of needing to please women became apparent to him. Once he had sexual relations he felt he controlled them, and would become disinterested. It was also around this time that Derek began to experience spontaneous regressions in the session, where he experienced himself in pits and caves,45 which facilitated his talking about his earliest memory of the motor vehicle accident he had been involved in as a small boy, where his mother died.

Frank came to therapy because of a long-standing problem with his marriage, coupled with a long-standing affair. In the first session, he revealed how he feared therapy, fearing what he might discover about himself. Frank's fear became known to me through his style of defensiveness, his attacking what I said or did. At times, he would accuse me of being defensive, being patronising or being very superficial in my comments to him. In the third session,46 he posed himself a question, What would happen if I let you in? How am I going to know whether I can trust you ... trust that I don't have to look after you? Frank was telling me a number of things. Firstly, he was beginning to react to me or to what I had said to him in the sessions. He was fearful of 'letting me in'; allowing himself to be affected or influenced by what I said or did not

44 I believe the letter of 14 August 1988 was his attempt to hold himself and connect with me. He sent me a copy of his wife's solicitor's letter, to which he was reacting, and he also wrote about reminding himself that he had a 'friend' in me after he faced both his father-in-law's stony silence and his wife shutting the door in his face.

45 Sessions on 7 October and 11 October 1988. A spontaneous regression is where a client is overcome with somatic reactions or feelings that originate from early childhood trauma, and can be contrasted with a directed regression, where a therapist facilitates the remembering and reliving of childhood experience (Webster, 2000a).

46 Session on 8 September 1988.
say. Frank was telling me about his emotional patterns of relating, where he looked to meet other people's needs, believing that his needs would then be met.

In one session, Frank reflected on his realisations that he did not belong with his wife, that his lover did not really know him, and that he might not stay with either woman. I felt for Frank and the possibility of him not having either partner. I felt at the end that there was nothing I could say that would be helpful in this painful moment. As he was leaving and when we were at the door to my therapy room, I took his elbow in my right hand and said to him something along the lines of, "Be gentle with yourself." In the next session I talked with Frank about my making physical contact with him. He told me that he had thought of nothing else in the week. He wondered whether I was manipulating him and what I wanted. He tried to discount the contact. I told him why I had touched him: that I felt for him and I wanted to make 'contact' with him, as I felt that words were not enough. Frank believed me, and relaxed. He then told me that he had noticed that when each session finished I never turned my back to him as we were leaving the room. In the next session, Frank told me that he felt good about coming to therapy. He pondered on this and wondered aloud as to whether he was feeling safe with me. Again, I noted in my case-notes that I touched him briefly. I noted, "I felt soft when I touched him." Again, I believe with Frank, as with Carole, that my contacting him physically was due to my sense that literal contact was required. I felt that I was not able to make contact verbally, or that the verbal contact was somehow insufficient for what was occurring. I was acting upon my intuitive sense of what to do.

I gave another client, Zelda, a hug at the end of the session on the same day as my offering to hold Carole. I had been seeing Zelda for twelve months. For nine months I saw Zelda and her partner about their long-standing relational and sexual problems. It was in July 1989 that I stopped the couple work and recommended that each partner attend individual therapy. Zelda, who had seen me for the first interview in 1988, commenced long-term therapy with me. Immediately into her individual work, Zelda came to the session with a dream of a baby about to be hurt. Zelda felt flat and depressed, and had numerous dreams about being damaged and ugly. On one occasion, I helped Zelda become grounded and safe at the end of a session by putting blue light around her to keep her safe. In the next session, Zelda spoke of her difficult history: the problems with her former husband, her pregnancies and miscarriages, her psychiatric hospitalisations, and subsequent electric shock treatment and drug therapy. At the end

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48 Session on 12 October 1989. My putting blue light around her was a way of trying to help her take some of the therapy and her therapist away with her. My therapy room was blue and I invoked blue in the session. This can be regarded as a transitional phenomenon which acknowledges and follows the infant-mother symbiosis (Winnicott, 1950).
of this session, I gave Zelda a hug. Again, this hug was one of compassion - my feeling for her and her terrible history.

In time, I physically held these clients and others, as I did Carole. I regarded physical holding as a maternal form of holding; one of comfort, reassurance and safety. It was during these times that the Inner Child parts, the regressed aspects of my clients, revealed themselves to me. It was during these times that these clients allowed themselves to ‘become’ the regressed child that was within. It was as though their adult aspect stepped back to allow the Inner Child to come forward. As the child, they told me their experiences, they felt their feelings and they sought refuge and safety in my arms. As I continued, I developed protocols for developing and facilitating regressions as well as procedures for helping clients re-emerge to their ‘adult’ state. Rituals were created for each and every client according to our work, who they were, and the nature of the therapeutic relationship. Each client developed their own way of working with the material. Some worked through the verbal medium, others through dreams, drawings and other experiential techniques. Some clients developed names for their different inner aspects while others detested any naming, fearing artificiality, manipulation, or the work being ‘programmed’ or protocol-based, without individuality or realness. What became consistent in the therapy was the holding, the symbolic and the physical holding. Clients began to make contact with or find clues to their Inner Child and slowly began to trust me enough to allow deeper regressions to the baby-self. As the therapist I worked hard, being a mother-figure and providing a maternal space to these child and baby aspects in my clients, while supporting their developing adults and de-powering their inner critical voices, as I helped them find authentic expression for their feelings and emotional experience.
CHAPTER THREE

LOOKING FOR MAPS IN THE LITERATURE

... que les techniques thérapeutiques ... s'adressent à un corps souffrant, envahi et débordé par l'angoisse, paralysé par la terreur, l'émotion ou les affects. C'est un corps justement qui ne peut servir d'instrument car il est embarassé de lui-même, de son inertie, de sa «paralysie» ou de sa maladresse. C'est un corps qui a coupé ses liens avec la réalité sociale mais aussi avec sa réalité psychique interne et sa capacité de parler, voire d'imaginer et de symboliser, c'est-à-dire de mettre un lien symbolique entre les mots et «les réalités psychiques» qui l'habitent.
(Sempe, 1989)

[... that therapeutic techniques ... are addressed to a body which is in pain, which is invaded and overwhelmed by anxiety, paralysed by terror, emotion or the affects. It is a body which cannot serve as an instrument because it is embarrassed by itself, by its inertia, by its "paralysis", or by its clumsiness. It is a body which has severed its links with social reality, but also with its own internal psychic reality - its capacity to talk, or even to imagine or to symbolise, that is to say, to put a symbolic link between words and the psychic reality which inhabits them.]
(Bruce, 1996b)
CHAPTER THREE

LOOKING FOR MAPS IN THE LITERATURE

A variety of methods have been employed in the investigation of physical contact in therapy, ranging from analogue designs, observations, attitudinal studies and surveys of clinical practitioners and clients, to subjective accounts of physical contact in therapy and anecdotal accounts of clinical practice. My desire to research physical holding in psychotherapy led me to these investigations and to the maps of psychoanalysis and psychotherapy. I was particularly interested in the traditions in psychoanalytic theory and practice as they formed the basis for other theoretical developments. Further, I was especially interested in how regression was described and understood from both the practitioner and client perspectives. In this chapter, I have attempted to provide an account from these works in terms of the theoretical explanations about clinical practice and what this has meant for the notion of physical contact in psychotherapy.

3.1 Defining Physical Holding in Therapy

Many terms have been used in researching physical contact, ranging from general descriptors such as physical contact, touch, non-erotic contact and therapeutic touch, to
specific types of touch such as hand contact, pat, brush, squeezing, affectionate touching, hugging, kissing, embracing, or holding.¹

Some writers (Bacorn & Dixon, 1984; Borenzweig, 1983; Suiter & Goodyear, 1985) defined physical contact by describing what parts of the body were touched. Christopher Bacorn and David Dixon’s (1984) definition of touch limited it to contact between the counsellor’s hand and the client’s body.

... physical contact between the hands of the counsellor and the hands, arms, shoulders, legs or upper back of the client...

Robert Suiter and Rodney Goodyear (1985) considered three levels of physical contact: touching the hand, the shoulders, and across the shoulders in a semi-embrace. While Beverley Willison and Robert Masson (1986) defined physical contact as therapeutic when the behaviour was non-erotic and ranged from simple hand contact to a full embrace, a broader description of physical contact using touching, kissing, hugging or holding was employed in the research that surveyed attitudes and clinical practice of practitioners (Holroyd et al, 1977; Kardener et al, 1973; Leggett, 1994a).

In this research, I have used the words ‘physical contact’ to refer to a counsellor’s hand touching a client’s body; their arms, shoulders, back, legs or knees, as well as bodily contact, such as a counsellor’s arm around the shoulder of the client, hugging and physical holding. While I was interested in all forms of physical contact, I was specifically interested in physical holding as depicted in a mother-infant embrace.² Physical holding in the form of a mother-infant embrace is an intense form of physical contact where a client is held by a therapist as a mother holds a child across her body, with a client’s head resting on the therapist’s left shoulder or the top half of the chest for a sustained period during a therapy session, generally ranging from ten to fifty minutes duration.³ This description of physical holding provides a picture of a client enclosed by and contained by the therapist, as they experience themselves in the holding process.


² While Mic Hunter & Jim Struve (1998, p.174) describe a hug as being when the therapist’s arms are around the client’s shoulders, and the client’s head is supported by the therapist’s shoulder, I believe describing it as a mother-child embrace captures the essence of the experience.

³ For this work the terms ‘physical contact’, ‘touch’, and ‘non-erotic contact’ will be used interchangeably. ‘Physical holding’ will only refer to holding as described, and not touch per se.
3.2 Experimental Research into Physical Contact

The experimental research into physical contact has used analogue research, observational techniques and surveys in order to investigate the effect and meaning of physical contact, and the possible implications for counselling practice. Joyce Pattison (1973), in the first published research on the effects of touch on self-exploration and the therapeutic relationship, found that touch positively affected verbal interaction, self-disclosure and self-exploration, but did not find a significant relationship between touch and perceptions of relationship, although informal comments lead her to believe that touch could enhance the counselling relationship.\(^4\) In an extensive review of the published research, Beverley Willison and Robert Masson (1986) argued that touch supplemented communication and could be viewed therapeutically because experimental research findings have indicated increased self-disclosure, deeper self-exploration and increased feelings of reassurance on the part of the client-subjects, as well as the counsellor being viewed favourably.\(^5\) Alongside these findings that physical contact affected clients' verbal self-disclosure and self-exploration, positive results have been found with respect to both counselling and the counsellor; with counselling being regarded more positively (Alagna et al, 1979; Fisher, Rytting & Heslin, 1976), and the counsellor being liked (Boderman, Freed & Kinnucan, 1972), perceived as being warm, loving and friendly (Breed & Ricci, 1973; Fisher et al, 1976; Kleinke et al, 1974; Major & Heslin, 1982), more expert (Hubble et al, 1981; Suiter and Goodyear, 1985), attractive (Boderman et al, 1972; Suiter and Goodyear, 1985) and trustworthy (Suiter and Goodyear, 1985).\(^6\) There has also been considerable discussion about touch communicating caring, intimacy, sexual attraction or dominance (Alagna et al, 1979; Burgoon et al, 1984; Kleinke & Williams, 1994),\(^7\) function and relationship types (Alyn,}

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\(^4\) Pattison used female undergraduate students seeking counselling at the university counselling centre, and male and female counsellors who were second-year graduate students in education, and employed a touch regime of four physical contacts: one on introduction, two touches in the interview and a final touch on terminating the session.

\(^5\) From their review of the research supporting counsellor touch, they noted increased self-disclosure (Jourard & Friedman, 1970), deeper self-exploration (Alagna et al, 1979), increased feelings of reassurance in female clients (Whitcher & Fisher, 1979), and more positive feelings expressed (Fisher, Rytting & Heslin, 1976), while the counsellor was viewed as being more expert, attractive and trustworthy (Suiter & Goodyear, 1985). These results are consistent with other findings by Aguilera (1967), Lomranz & Shapiro (1974), and others. Stockwell and Dye (1980) found that increased self-exploration by women was the only significant result and linked the lack of significant effects of counsellor touch to a greater internal validity in their study.

\(^6\) Robert Suiter and Rodney Goodyear (1985) found that while there were no significant differences on the evaluation of expertness and attractiveness, consistent with other results (Pattison, 1973; Bacorn et al, 1984), the significant result on trustworthiness was reversed in the semi-embrace vignette, which suggested to them that the semi-embrace may have violated assumptions of appropriate behaviour.

\(^7\) Touch has been found to mainly communicate intimacy and immediacy. Many variables affect intimacy, such as interpersonal distance, eye contact, body orientation, and smiling (Patterson, 1976; Burgoon et al, 1984). Burgoon et al (1984) found that touch followed proximity, smiling and eye-contact in the communication of intimacy and immediacy.
1988; Fisher et al, 1976; Heslin, 1974; Sutton, 1989; Thayer, 1988), and cultural and

Overall, the experimental research findings have tended to show that physical contact
positively affected the clients' behaviours, perceptions about the counsellor, and the
counselling process. However, some researchers (Fisher et al, 1976; Burgoon et al,
1984; Hill & Gormally, 1977; Hubble et al, 1981; Patterson, 1976, 1982) have been
circumspect when considering their results. While Clara Hill & James Gormally
(1977) commented on the advantage of using analogue research, with the control over
the independent variables, they also noted the dissimilarity to real counselling.

... the lack of similarity to real counselling clients as well as the imposed
artificiality and possible inappropriateness of the counsellor statement in
response to the client's immediate message.

Comments had also been made about the touch regimes that were employed in the
studies, ranging from being too random or on a time schedule (Hubble et al, 1981), to
being too artificial (Burgoon et al, 1984), or too brief (Fisher, Rytting & Heslin, 1976).
Most analogue designs involved 'helping-related' situations but not counselling, and
vocational as compared to counselling interviews. The counsellors used in these studies
were undergraduate students or postgraduate students in education, who were given up
to six hours counselling training in the experimental design. The subjects for the
studies were mainly undergraduate students who received credit points for participating
in the research, although some designs invited self-selection on the basis of being
vocationally undecided or feeling anxious. The experimental situations ranged from a
single vocational session to rating acting vignettes of interpersonal physical contact, an
individual counselling assessment session of undergraduate students, and genuine
clients at a recognised counselling centre.

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8 Richard Heslin (1974) classified types of touch with five different relationships: professional-
functional, social-polite, friendship-warmth, love-intimacy, and sexual arousal. Miles Patterson
(1982) suggested that in a professional relationship where touch was involved because of a
functional task, touching could be viewed as a means to an end in treatment, which could explain
Bourque & Ladouceur's (1980) results.

9 Nancy Henley (1973b), in an observational study of reciprocal and non-reciprocal touch, found that
higher status individuals are more likely to touch lower status individuals across sex, age and socio-
economic status, with men more likely to touch women. Deborah Stier and Judith Hall (1984), in a
review of touch and gender, suggested that women appearing to respond more positively to touch
than men may reflect different preferred ways of non-verbal affective expression, or different
interpretations of touch as an affective expression, or power relations. Gender differences have
been found with helping behaviour, where men were more likely to help regardless of where they
were touched, whereas women were affected by where they were touched, and a cross-sex finding of
women receiving more help than men, and more help from men than women (Alagna et al, 1979;
Hornik, 1987; Kleinke, 1972; Nannberg & Hansen, 1994; Paulsell & Goldman, 1984; Willis &
Rawdon, 1994).
These studies have not been able to address some of the factors involved in a counselling situation, let alone a psychotherapy situation. For instance, the nature of emotional distress and its effect on individuals seeking help of their own volition, as compared to ‘testing’ undergraduate students, needs no further comment. Similarly, acceding to a request to attend a vocational session can not be equated with seeking help for personal problems such as relationship difficulties, depression, low self-esteem, or a history of sexual abuse, neglect or trauma. How these complaints affect individuals, how they become vulnerable to deeper emotional forces, cannot be underplayed, let alone their desire or need to talk with a professional about their distress. Further, the interplay of physical contact with the verbal exchange, the counsellor’s rapport and the counsellor’s intention provide the situational and relational context for evaluating any physical contact. What was also outstanding was an explanation about why physical contact affected an individual. Can it be explained from Joyce Pattison’s (1973) suggestions of safety, reward, lowering of defences or anxiety, or are there other possibilities that require consideration?

3.3 Surveying Attitudes and Experience in Clinical Practice

The investigation of attitudes, experience and clinical practice has mainly focused on clinical practitioners, until Pamela Geib’s (1982) phenomenological study and Horton, Clance, Sterk-Eliason and Emshoff’s (1995) survey of psychotherapy patients.

3.3.1 Attitudes and Practice of Clinical Practitioners

A number of researchers investigated physical contact by exploring the attitudes and practices of practitioners from a variety of professional backgrounds, ranging from social workers, psychologists and medical practitioners to medical specialists and psychiatrists.

Sheldon Kardener, Marielle Fuller and Ivan Mensh (1973) surveyed medical practitioners’ attitudes and practices regarding erotic and non-erotic contact with patients. Although physicians of different medical specialities such as psychiatry,

10 In a survey of patients’ experiences the problems most often listed as the presenting problem were relationship issues (48%), sexual abuse; incest, rape, unspecified sexual abuse (34%), and depression (29%) with a history of physical abuse, neglect, or trauma (PTSD, MPD) (28%) and low self-esteem (28%) and family of origin issues (22%) being the other main issues (Horton et al., 1995).


12 Four hundred and sixty respondents (46%) responded to a 32-item questionnaire rating their attitudes and conduct on a scale by circling “0” (never), “1” (rarely - defined as less than 5% of professional experience or opinion), “2” (occasionally - less than 25%), “3” (frequently - more than 50%), or “4” (always). Six questions were used to ask about their beliefs and practices regarding non-erotic touch. For example, “Do you believe non-erotic hugging, kissing, and affectionate touching of patients
general practice, internal medicine, obstetrics-gynaecology and surgery were used in this research, the psychiatrists in this study interested me as they were the group most likely to be involved in psychotherapy. Although twenty-eight per cent of psychiatrists thought non-erotic touch may benefit the patient, only fifteen per cent regularly engaged in such practices. Sixty-nine per cent of psychiatrists believed that non-erotic touch would occasionally, frequently, or always be misunderstood. In response to questions of, 'Who initiates non-erotic behaviour?' the majority of medical practitioners stated that frequently or nearly always the patients initiated such conduct. With respect to erotic behaviour, while twenty per cent of psychiatrists thought that erotic behaviour rarely and occasionally may benefit the patient, eleven per cent rarely or occasionally engaged in such practices.

In contrast to Kardener et al's study, Judith Perry's (1976) survey of female physicians revealed that female psychiatrists held different views and engaged in different behaviours to male psychiatrists. Whereas twenty-eight per cent of male psychiatrists thought non-erotic touch may occasionally and frequently benefit the patient, sixty-three per cent of female psychiatrists did; and forty-three per cent frequently or always engaged in non-erotic contact, as compared to only fifteen per cent of male psychiatrists. In both surveys, the most common circumstance for physical contact was providing comfort, which was acknowledged as reassuring, empathising and giving tangible support to a patient, although Perry's respondents also suggested crises such as bereavement as well as schizophrenic, agitated, depressed, or passive-dependent patients. Whereas twenty per cent of male psychiatrists thought erotic contact with patients rarely, occasionally or frequently may be beneficial, only two per cent of female physicians thought similarly. In contrast to Kardener's study, where eleven per cent of male physicians had been involved erotically with their patients, with five per cent involved in sexual intercourse, only one female practitioner had engaged in erotic activity, without sexual intercourse. These results led Perry (1976) to conclude that,

*Physicians have definite and sometimes opposing viewpoints regarding non-erotic and erotic involvement with their patients. Male physicians do not believe in erotic involvement but in practice do become involved, while female physicians consistently oppose erotic involvement.*

Andrew Leggett (1994a, 1994b) conducted a similar survey of male and female psychiatrists with the Royal Australian and New Zealand College of Psychiatrists. The disparity between attitude and practice was again apparent, with forty-one per cent of
respondents agreeing with the statement that non-erotic contact may benefit the patient and sixty-seven per cent thinking that the psychiatrist's intentions about non-erotic contact would be misunderstood. Non-erotic practice was harder to compare to the earlier studies, as the results were organised under type of contact: shaking of hands, brief touch in non-genital areas, hugging or holding, and kissing. Gender differences were noted; thirty-six per cent of practitioners would touch, hug, hold or kiss male patients, forty-one per cent would do so with female patients.\textsuperscript{14} With respect to physical holding, as in needing to be held like an infant being physically held by a parent, twenty-five per cent agreed (with four per cent strongly agreeing) that sometimes patients need to be held in this manner. Although approximately ninety-eight per cent of respondents agreed with the statement that erotic contact may not be beneficial, four per cent of male psychiatrists indicated that erotic contact sometimes occurred with female patients, with two having erotic contact with male patients.\textsuperscript{15}

Jean Holroyd and Annette Brodsky (1977) replicated Kardener et al's survey with psychologists.\textsuperscript{16} Four main categories for classifying non-erotic touch were suggested by the practitioners: for socially or emotionally immature clients (children, schizophrenic, patients with maternal deprivation); for periods of acute distress such as grief, trauma, severe depression; for general emotional support, including warmth, reinforcement, contact and reassurance; and for greeting and at termination.\textsuperscript{17} Gender differences in attitudes and behaviours were discovered. While fifty-three per cent of male psychologists perceived that the opposite-sex client may benefit from non-erotic contact, only forty per cent of female psychologists thought so. The figures for non-erotic behaviours were only given across gender, with twenty-seven per cent of psychologists occasionally engaging in non-erotic hugging, kissing or affectionate touching with opposite sex patients, and seven per cent doing so frequently or always.\textsuperscript{18}

\textsuperscript{14} The percentages were similar for brief touch, around thirty percent. It was in the areas of hug/hold, and kissing that the major gender differences were noted; whereas 8.2% would hug or hold a female patient, only 4.7% would hug and hold a male patient, two percent would kiss a female patient, and less than one percent would a male patient.

\textsuperscript{15} In addition, Leggett (1994b) found that 50.3% had reported that at least two patients had given a history of prior therapist sexual contact with therapist per se, including non-psychiatric therapists.

\textsuperscript{16} Holroyd and Brodsky had a 70% return rate involving 347 male and 310 female licensed psychologists. The psychologists were grouped according to primary therapy orientation; ranging from psychodynamic, behaviour modification, humanistic and rational-cognitive to eclectic. While a figure of fifty per cent of psychologists classifying themselves as eclectic could be worrisome, a survey of clinical social workers (Borenzeig, 1983) also found a similar figure of fifty-three per cent reporting themselves as eclectic.

\textsuperscript{17} Hunter et Struve (1998, pp.127-135) considered the many therapeutic options of touch ranging from reorienting a client and accessing memories to communicating empathy, providing safety, enhancing ego strength and working with past traumatic experience.

\textsuperscript{18} The difference between attitude and actual non-erotic practice was also found in Herman Borenzeig's (1983) survey of clinical social workers, with 85% having a positive attitude to touching but only 50% engaged in any physical contact.
As in the other studies, the rates were similar for believing that non-erotic contact could be misunderstood by the opposite-sex client; more male than female psychologists reported that the contact was initiated more often by the patient than themselves; and female psychologists engaged in more same-sex non-erotic contact than men.

Judy Milakovich (1998) interviewed eighty-four therapists, with approximately equal numbers of humanistic and psychoanalytic practitioners, and found that where a therapist had explicit permission to make physical contact from a supervisor or teacher, seventy per cent touched their clients. In addition, she found that eighty-three per cent of the female and fifty-five per cent of the male practitioners had received some touch in their personal therapy and were significantly more likely to touch their clients.

These survey results consistently revealed a number of things. There were gender differences in attitudes and practice of physical contact in counselling and therapy, with male psychiatrists, psychologists and social workers perceiving female patients as benefiting more from non-erotic touch and having more non-erotic contact with them than male patients. Generally, female practitioners perceived that physical contact would benefit their patients, and that they would make more contact than the male practitioners. While the most common reason for physical contact was to provide comfort, reassurance and empathy, only one survey (Leggett, 1994a) alluded to regression, in a specific question about physical holding in a manner similar to parent-child contact. The orientation of the psychiatrists or psychologists was indicative of the attitude of taboo against touch, with the psychodynamically-oriented practitioners less likely to perceive that non-erotic contact was beneficial to the patient and less likely to have engaged in non-erotic touch, as compared to the humanistically-oriented practitioners. Regardless of orientation, I also queried the reliability of the ratings by practitioners as I considered how the practitioners determined their responses. I reflected on how I would answer such a survey as a practitioner. Would I answer by taking a typical working week, tabulating how many patients or clients I touched, hugged, or held? Would I list the reasons why I made physical contact? Or, Would I respond by using a 'gut' feeling response?

While the survey work revealed that many practitioners held liberal views towards non-erotic physical contact and condemned erotic touch, their practice was not consistent with their attitude, with only some actively making physical contact in their clinical work. A number of factors may contribute to this difference, ranging from the pervasive influence of psychoanalytic theory to fear of censure and complaint, fear that making physical contact would be misunderstood by patients, and fear of crossing the boundary into a more erotic arena. The concern about erotic touch was evident as the discussions
of the research findings focused on the erotic aspects, although only Leggett (1994b) stated that there were no causal associations between attitude and practice of non-erotic physical contact with a move to sexualised activity.

3.3.2 Client Experiences of Physical Contact

In a singular study, Pamela Geib (1982, 1998) explored clients' subjective experiences of touch in psychotherapy. Ten women who had been in therapy of at least ten months duration with a male therapist were interviewed about their experience of physical contact in therapy. Six women found the experience of touch in therapy positive. Geib outlined four themes that emerged about the function of touch: preventing clients becoming lost in pain, providing a link to external reality, communicating acceptance, and allowing clients to experience new modes of relating. The four women who were ambivalent or negative in their reaction to physical contact reported that they experienced the therapist and not themselves as being in control of physical contact, that the therapist was responding from his own needs and not theirs, and that the therapist avoided any discussion about contact.

Geib used an unstructured interview and, while acknowledging phenomenology as a perspective that qualitative methodology can adopt, her results did not provide descriptions of the respondent clients' experiences to physical touch. The results relating to how the therapist touched or held them and when touch occurred, were presented under the subheadings of the incidence, themes and meaning of therapeutic and counter-therapeutic touch. The study failed to reveal to me the essence of the clients' subjective experiences. The different client summaries; talking about a therapist embracing her in saying goodbye, contact taking the form of sitting beside the therapist and holding on to him, reporting that a client asked the therapist if she could touch him, and the first physical encounter, did not give me a sense of what happened for the client in the physical contact. What happened when the therapist reached out to make physical contact? What did they notice about the experience? What did they feel and think?

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19 Whereas Kardener, Fuller and Menah (1973) devoted their discussion to considering erotic practice, Holroyd and Brodsky (1977) discussed reliability and the practitioners' responses to the erotic questions. Perry (1976), by showing how male attitudes and behaviour were different to female practitioner attitudes and behaviour, concluded that female physicians consistently opposed erotic involvement. Leggett (1994b) concluded that Australian psychiatrists who viewed non-erotic contact as beneficial were more likely to engage in sexual contact.

20 Of the six women who spoke positively about physical contact, one had only received a hug on terminating her therapy, three had physical contact when upset, in the form of sitting beside or hand held or hand on shoulder or back patted, five were hugged during the session when upset, and three were hugged at the end of the session.

21 Each was touched; one on shoulder, two on hand, one hair-stroking, three during and at the end of session, and one for lengthy physical holding during the session for the child part of her, for four months. In addition, one experienced the therapist as having an erection; two spoke of therapists revealing their relationship difficulties and impending divorces.
How did they respond? Then and afterwards? What did they feel afterwards and at the next session? In my experience, I found being spontaneously hugged by my therapist at the end of the session, something that unknowingly I was seeking, was both warm and regressive. I experienced a real sense of 'littleness' within myself at the very moment of having to leave the session and go into the street. However, at the next session, I found myself wanting and waiting, ever so subtly, for another hug, only to find myself without one. I was unable to ask for that physical contact and I was left stunned at not having received another hug and shocked by my internal feeling of desperation at not being given another hug.

In a survey of patients' experiences (Horton et al., 1995; Horton, 1998), Geib's identification of factors associated with positive and negative touch - clarity of boundaries, congruence of touch, patients being in control, and touch for clients' benefit - were used to investigate physical contact in psychotherapy. Congruence of touch accounted for twenty-one per cent of the variance of the patients' evaluation of touch in psychotherapy, with the therapists' sensitivity to the patients' reactions and the patients' ability to communicate about feelings towards their therapists increasing the variance to twenty-nine per cent. Whether patients thought the touch was for the therapists' benefit, and the therapists' potential sexual attractiveness, were not significant variables. In terms of narrative themes, sixty-nine per cent of the group stated that touch created a feeling of closeness, that the therapist really cared, and forty-seven per cent perceived that touch communicated acceptance and enhanced self-esteem. While twenty per cent found that touch was reassuring and they felt comforted and healed, only ten per cent felt that touch facilitated a breakthrough in the therapy by permitting regression or a move to more painful feeling work. Only ten respondents described negative experiences, six around the therapist's discomfort and four stating that touch was not their expressed need. While they found support for Geib's findings of the positive and negative identified factors around physical contact, they also found that many patients have difficulty requesting physical contact and expressing negative reactions about the therapy, and recommended judicious use of touch in therapy, to be based on a patient's history and innate temperamental difference, and how these affect their need-states and relational styles.

Suzanne Imes (1998) provided an account from a survey taken primarily of her clients in group therapy and selected individual therapy clients. She divided the respondents

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22 Two hundred and thirty-one respondents, 193 women and 38 men, with an average length of therapy of 3.8 and 2.8 years respectively, were analysed. 94% of patients were seeing private practitioners, mostly with doctoral level psychologists (95%).

23 The number of clients surveyed and the reasons for selecting the individual clients were not made available.
in terms of the extent of touch and childhood experiences: extensive usage (extreme abuse or touch deprivation in childhood), moderate usage (moderate abuse, physical invasion in childhood and adequate childhood touching), and minimal to no touch (extreme abuse, unmet dependency needs). In each category, Imes gave a narrative account of the therapy and the physical contact she made with a number of patients, accompanied by a description of the touching experience or a recommendation by the patient. She concluded that touch can be a pathway to unexpressed feelings or action that was against the body. Like Horton (1998) and Horton et al (1995), she recommended the individualised use of touch in therapy, citing a patient's history, verbal and non-verbal cues in-session, developmental and functioning levels of a patient, and available support systems external to the therapy, as issues to be assessed.

3.4 Anecdotal Accounts of Physical Contact in Therapy

In contrast to the taboo on touching (Forer, 1969; Freud, 1924; Menninger, 1958; Older, 1977; Wolberg, 1954) in early psychoanalytic history, the expulsion of analysts developing and considering views different from the mainstream acceptable or orthodox practice (Roustang, 1982), or the reticence of psychoanalysts, like Winnicott, to say directly what they meant, some clinicians24 have provided anecdotal accounts of physical contact in their individual and group therapy practices.

Richard Robertiello (1974) wrote about his clinical work, where he had been touching and holding his clients for the past three years. He related touch to object-relations theory, where a therapist-patient relationship is viewed as replicating a mother-child relationship, with the patient wanting to be held or touched.

> When the patients were asked what their fantasies or wishes were, they rather uniformly came up - after analysing enormous resistances - with the feelings of wanting to touch and be touched and to be held like a baby.

Peter Lomas (1973, p.143) gave an account of his physically holding a patient after successfully interpreting his patient's falling to the floor and having her hands stretched out above her as a request for physical contact. His ambivalence towards continued contact was noticed by the client, who informed him that it made her feel unsafe. His continued contact as well as his own self-disclosures enabled her to feel safe, and her symptoms of agitated disintegration became contained. Similarly, Peter Bruce (1984), a bio-energetics therapist, described his experience of working with a difficult, regressed

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24 See Bruce, 1984; Lomas, 1973; Glatzer, 1972; McNeely, 1987; O'Hearne, 1972; Older, 1977; Rabinowitz, 1991; Robertiello, 1974; Spotnitz, 1972; Wilson, 1982
borderline patient, where he responded to her yelling for a 'bottle' at the end of a session by providing and then feeding her from a baby bottle filled with warm milk.

And, finally, it was she who came up with the direction. "Bottle" she would start to yell, at the end of the session. "Bottle, bottle, bottle!"

Indirectly, Bruce noted the transference relationship as being around good and bad mother, with the patient struggling with her loss of mother in infancy, and her attempts to integrate these losses in her inner world and grow up from being a suckling infant.

Jules Older (1977) described a couple session where he grabbed a patient's hand to reassure her, and found that she began to talk about deeper feelings. Rather than describe this 'embarrassing' situation in supervision, Older repeated it using a one-way screen. His supervisor admonished him,

... that what I did was good, but that now I should learn to touch without physical contact...

which resulted in his refraining from making further physical contact with his patients.

Jean Wilson (1982) cited two examples, one where she touched a patient on the shoulder as she left the session, and another where she took the patient's hands to circumvent the patient's verbal guardedness and to empathise with the patient's emotional burden. In addition, she put her arm around her shoulder on leaving the session.

The more verbal interventions I made, the less she talked about her feelings and responsibility in the incident. Since she responded to my verbal questioning with such guardedness, I stopped, took her hands in mine, and reflected to her that she was feeling much pressure and was carrying a heavy burden. Her eyes filled with tears, she squeezed my hands, and nodded her head in agreement.

John O'Hearne (1972) gave a number of examples from group psychotherapy; participating in a dyadic enactment of deference by placing a foot on the patient's shoulder, inviting a patient to sit on the floor beside him with his hand on her shoulder, and hugging a patient after a significant self-discovery.

As she seated herself on the floor by my chair, I put my hand on her shoulder, letting my forearm rest on her back. Her quiet tears immediately became loud sobs. When she stopped, she looked at me without her usual forced smile and said, "Thanks, I couldn't stop myself."

Fredric Rabinowitz (1991) gave anecdotal accounts of group members and facilitators hugging during and at the end of men's group therapy sessions; a group member talking about his desire to receive a hug and receiving one, and a young man, who was hugged
by each group member during one piece of therapeutic work, responding by crying for his father.

After completing the round, he spontaneously returned to one of the men who had given him an especially full and powerful hug. Burying his head in this man’s chest, and weeping uncontrollably, he cried out, "Dad, why did you have to go? You were the only one to love me for just being me."

These anecdotal accounts informed the therapeutic community that there were benefits from physical contact in individual, couple and group therapy. Therapists (Older, 1977; Wilson, 1982; O’Hearne, 1972; Rabinowitz, 1991) generally conceptualised physical contact along a communication dimension, concluding that some form of physical contact reassured their clients when they were feeling pain, conveyed empathy when words were inadequate, facilitated a deeper contact and release of feelings, and facilitated therapeutic abreacts. Both Robertiello (1974) and Bruce (1984), while coming from different theoretical orientations, emphasised that physical contact facilitated the regressive space that allowed for grieving as well as symbolic mothering, and held similar views about the usefulness of physical contact to meet or gratify a client’s expressed needs or wants.25

3.5 Maps about Physical Contact in Therapy

Although different theoretical positions have informed clinicians about the desirability or taboo of physical contact, there has not been much consensus either across or within theoretical maps. The greatest influence has undoubtedly been the psychoanalytic writings, beginning with Sigmund Freud, although the developments of somatic therapies with a history dating back to Wilhelm Reich (1948, 1972, 1975) and Alexander Lowen (1967, 1975), have been slowly pervading the work of more traditional therapies. In this section, I have drawn out the different accounts explaining the taboo on touching in psychoanalysis and the influence on the development and practice of contemporary psychotherapy.26 Further, I have elaborated the positions of three influential psychotherapists, Sandor Ferenczi, Michael Balint and Donald Winnicott, who have challenged the taboo on physical contact in psychoanalysis.

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26 Notwithstanding the complexity of psychoanalysis, and the extensive discussion of every aspect of psychoanalysis and the endeavours to differentiate analysis from other psychotherapies (See Blum, 1992; Cooper, 1992; Dryden & Feltham, 1992; Frank, 1975; Gill, 1994; Nemiah, 1975; Patterson, 1986; Pine, 1992; Tarachow, 1962; Wolberg, 1977), I have only considered psychoanalysis and psychotherapy as they pertain to physical contact and holding in therapy.
3.5.1 The Psychoanalytic Map

In the analysis of an adult, the reconstruction of childhood is an essential process.
(Sharpe, 1950, p.14)

Psychoanalysis was developed by Freud as a psychological theory on human nature, with an accompanying map for the treatment of neuroses. The theory of mental development and subsequent disorders was based on the oedipal organisation, with particular attention given to the unconscious, defences and resistance. Within the therapeutic treatment, the map marked the cornerstones of the approach as being free association, transference and interpretation. The term transference was developed to explain a process occurring in Freud's analysis of the patient, Dora, where her perception of her analyst was substituted for that of her father and Herr K.

... new editions or facsimiles of the tendencies and phantasies which are aroused and made conscious during the progress of the analysis; but they have their peculiarity, which is characteristic for their species, that they replace some earlier person by the person of the physician. To put it another way: a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the person of the physician at the present moment.
(Freud, 1925, Reference footnote 2, p.139, quoted in Wolstein, 1954, p.53)

The analysis of the transference\(^{27}\) became a cornerstone of the analytic procedure, focusing on the analysis of the repetition of the forgotten past memory that had been transferred to the analyst. During analysis, patients would develop transferences to the analysts, projecting their unfinished business by way of their earlier attachments, to the analysts, whose task it was to receive, understand and then use interpretation to feedback the communicated emotional messages. Freud (1912b) made a number of general recommendations for physicians practising psychoanalysis, such as putting aside their feelings, evenly suspended attention, being a neutral instrument of reception, not taking notes, having patients lie on a couch, and not using patients as scientific material until after analysis.

Freud postulated that transference had at its basis or foundation an erotic source, which can be traced to his theory of the libido.

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\(^{27}\) The analysis of transference was the third revision in the technique of psychoanalysis, following hypnosis and catharsis, and after free association and interpretation. The aim of psychoanalysis shifted with each development; from the analyst facilitating remembering and abreacting, or reproducing and facilitating discharge; to encouraging the patient to freely associate so that memory could be recovered through the analyst's interpretation; to finally giving up a focus on particular or specific moments or problems to focus on whatever was present and available to the patient in the analytic session. Descriptively speaking, it is to fill in gaps in memory; dynamically speaking, it is to overcome resistances due to repression (Freud, 1914, p.148).
Positive transference is then further divisible into transference of friendly or affectionate feelings which are admissible to consciousness and transference of prolongations of those feelings into the unconscious. As regards the latter, analysis shows that they invariably go back to erotic sources. And we are thus led to the discovery that all emotional relations of sympathy, friendship, trust, and the like, which can be turned to good account in our lives, are genetically linked with sexuality and have developed from purely sexual desires through a softening of their sexual aim however pure and unsensual they may appear to our conscious self-perceptions. (Freud, 1912a, p.105)

Freud's theory of transference, together with his ideas about the repressed erotic impulse, led him to two important tenets of psychoanalysis: the abstinence of gratification, and the position of the analyst as the blank screen. Freud made recommendations for dealing with the development of transference love in treatment, cautioning analysts against gratification of any kind, from declarations of love to comments of feeling affection, and physical expressions or contacts, as he argued that it would interfere with the treatment. It was the treatment of the transference, the interpreting of the symbolic relationship contained in the transference, that brought about the cure.

... that he should deny to the patient who is craving for love the satisfaction she demands. The treatment must be carried out in abstinence. By this I do not mean physical abstinence alone, nor yet the deprivation of everything the patient desires, for perhaps no sick person could tolerate this. Instead, I shall state it as a fundamental principle that the patient's need and longing should be allowed to persist in her, in order that they may serve as forces impelling her to do work and to make changes, and that we must be aware of appeasing those forces by means of surrogates. And what we could offer would never be anything else than a surrogate, for the patient's condition is such that, until her repressions are removed, she is incapable of getting real satisfaction. (Freud, 1914, p.165)

Jean-Claude Sempe (1989) drew on the narrative of Christ in the Eucharist and Shakespeare's King Richard to elaborate the honouring of the symbolic and argued that physical contact took the analyst out of the 'untouchable status', making the relationship real and not symbolic or imaginary.

... le protéger contre un acte qui le fait chuter, déchoir, démystifier, ce qui ramènerait la position consacrée d'un homme hors d'atteinte, au destin d'un homme ordinaire avec le risque qu'il en perde la tête avec laquelle il est tellement nécessaire qu'il fonctionne.

[... to protect him from an act which causes him to fall, which dethrones and demystifies him, which would take the consecrated position of the man out of reach back to the destiny of an ordinary man, and along with it the risk of him losing that head which is so necessary for him to function.] (Bruce, 1996b)
Didier Anzieu (1984b) used the literary narratives of Shakespeare, Sophocles and Diderot which employed the oedipal complex. He also drew on the Christian narrative of the resurrection of God and his words to Mary Magdalen, "Touch me not" (John 20:17), to support the psychoanalytic arguments against physical contact in analysis.28

Sidney Tarachow (1962) commented on the surrogacy angle by suggesting that in treating a patient's requests as real and not interpreting them to show the transference, analysts were using the patient for their own counter-transferential concerns of loneliness and abandonment.

*The principal temptation is to play the role of mother.*
(Tarachow, 1962)

Patrick Casement (1982) had also argued this when he explained that his offer to hold a patient was due to his counter-transferential fear of losing the patient just before presenting her as a case-study at a psychoanalytic meeting. Casement maintained that by retracting his offer to physically hold the patient and restoring the psychoanalytic principles, the transferential feeling from the original trauma could be felt.

*Had I resorted to the physical holding that she demanded, the central trauma would have remained frozen, and could have been regarded as perhaps for ever unmanageable.*

The patient's request for physical contact in analysis has also been labelled as seductive, with touching determined as detrimental, serving the patient's wish fulfilment and avoiding the original trauma (Hunter et Struve, 1998, p.54; Smith, 1977). Sidney Smith (1977) described the patient's wish fulfilment as 'the golden fantasy', where a patient wants all their needs to be met in the therapeutic relationship in order to defend against the feelings of real loss and pain activated by the fear of, or actual separation from, the original mother. He also argued that the patient was resisting growing up and that all requests for physical contact needed to be assessed and interpreted in that light.

*He is convinced that his only hope in the analysis was to regress to the position of the baby to be taken care of. His wish to touch me was not an instance of*

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28 Anzieu used these ideas to firm up his argument that there should be no touching because of the symbolic nature of the analyst, similar to Jesus in his transformation to the mythical. However, touch did occur with Thomas, in the Gospel according to Saint John (20:27), when Jesus said to Thomas (John 20:27), *Reach hither thy finger, and behold my hands; and reach hither thy hand, and thrust it into my side: and be not faithless, but believing.* More interestingly, this touch to obtain faith was then excluded in the comments, *Thomas, because thou hast seen me, thou hast believed; blessed are they that have not seen, and yet have believed* (John 20:29). However, God's touch was described as "a healing touch" in the Gospel according to Saint Mark (1:41): *And Jesus moved with passion, put forth his hand, and touched him, and saith unto him, I will; be thou clean," and in the ordaining of twelve apostles (Mark 3:15), "to have powers to heal sickneses, and to cast out devils." (Holy Bible, 1975)
identifying with me as the analyst, nor was it an expression of his wish to learn from the analytic situation. Rather it was the expression of his desire not for analytic interpretations but for unstinting care.

Some therapists (Ellard, 1991; Sharpe, 1950) differentiated the social aspect of physical contact, namely, shaking hands at the beginning and end of session and physical contact derived from the payment of fees, from other requests of touch. An eminent Australian psychotherapist, John Ellard (1991), excluded these activities from his endorsement of the position that it was never permissible for physical contact to occur between patient and therapist.

There are some, I suspect, who would take the position that it is never permissible for there to be physical contact between patient and therapist, except perhaps a formal handshake at the beginning and ending of therapy. I accept that this is an excellent principle and that much harm and mischief have arisen from departing from it.

However, Ellard elaborated some exceptions: hands on shoulder or some similar acts, showing a patient how to take wrist pulse, removal of some clothing for medical emergency, allowing a client to pat his arm on leaving, a patient sitting in his lap, and being on all fours having head-to-head contact. In the situation where a patient may have experienced catastrophic events such as bereavements or fatal diagnoses, he suggested that this might require something more than verbal exploration. He recommended that therapists conduct themselves as 'an acquaintance' and concluded that nothing adverse occurred when he did this by putting his hand on a patient's shoulder or some other similar act. Clare McKenna (1991) challenged his minimisation of the physical contact interventions and alluded to the potential of infantilising and patronising behaviour. However, McKenna did not comment on Ellard's recommendation that the therapist should act like an acquaintance and not a therapist, or that Ellard adhered to the therapy principle on the taboo of touching, by denying the place of physical contact in the therapy setting, while simultaneously using touch to help his patients.

Ella Sharpe (1950, p.28) agreed with Freud's argument that the couch permitted the patient to think and talk aloud, and the analyst to listen more freely. Sharpe recommended that the analyst be guided by the analogy of a 'formal guest' and treat the patient with tact and courtesy when dealing with physical contact.

If my patient looks for the ceremony of shaking hands, I shake hands. If he, or she, is of the type who compensates by an assurance that the object knows "it is all right" then I should shake hands ...

(Sharpe, 1950, p.30)
However, Freud (1913, p.139) stated that while the patient may divide the treatment time into 'official' time and 'social' time when talking while sitting up, the analyst should not, and instead should regard the latter as part of the transference-resistance. Limentani (1986), in his presidential address at the thirty-fourth International Psychoanalytic Congress, argued that any variation along the physical dimension should be regarded as an attack on the psychoanalytic setting.

It is very easy, though, for psychoanalysts to introduce harmless parameters still compatible with the development and continuations of the analytic process, such as prolonging the session a little, inviting the patient to sit up; offering a tissue to a patient in distress; taking an occasional telephone call, etc. It is another matter to introduce parameters in the form of holding a patient's hand; touching her or her forehead, or any other physical contact. We do know that an infant needs contact with mother, but it does not follow that an analyst should act it out with his patients.

Anzieu had been in agreement with Limentani by arguing that the taboo on touching was the minimal psychoanalytic requirement.

L'interdit de se déshabiller, de s'exhiber nu, de toucher le corps du psychanalyste, d'être touché par sa main ou toute autre partie de son corps est maintenu; c'est le réquisit psychanalytique minimum.
(Anzieu, 1984b)

[The taboo of undressing, of showing oneself naked, of touching the body of the psychoanalyst, of being touched by his hand or any other part of his body is maintained; it is the minimal psychoanalytical requisite.]
(Bruce, 1995b)

By regarding physical contact as an attack on the analytic setting, a boundary based on the verbal medium was established, making psychoanalysis the talking cure, while demarcating physical contact as a forbidden zone\textsuperscript{29} that did not belong with the analytic work. Goldberg (1979), whilst acknowledging that analysts can feel the projection of feelings from a psychotic patient in their own body, argued that this can be discharged through language.

... language, or rather speaking, can function as a substitute for action and is an alternative for discharge of affect as well as mental contents.

Similarly, Anzieu (1984a), while admitting to the serious consequences of a premature or harsh taboo of touching on a child's life - the risk of sensory castration, communication failures and difficulties with closeness - still concluded that rigid

\textsuperscript{29} The phrase the 'forbidden zone' was also used in WW1 and WW2, when aircraft pilots were supplied with a silk escape map, one that they could use functionally as a handkerchief or scarf as well as a map. There were clear demarcations of territory and the legend indicated by a blue line the 'Northern Boundary of the forbidden zone', the enemy territory.
enforcement of the taboo was required in psychoanalysis, and that interpretation must replace unmet physical contact.

*La psychanalyse n’est possible que dans le respect de l’interdit du toucher. Tout peut se dire, à condition de trouver des mots qui conviennent à la situation transférentielle et qui traduisent des pensées appropriées à ce dont souffre effectivement le patient. Les mots de l’analyste symbolisent, remplacent, recréent les contacts tactiles sans qu’il soit nécessaire de recourir concrètement à ceux-ci: la réalité symbolique de l’échange est plus opérante que sa réalité physique.*

*Psychoanalysis is only possible within the respect of the taboo against touching. Everything can be said as long as the words can be found which suit the transferential situation, and which translate the thoughts that are appropriate to the patient’s actual suffering. The analyst’s words symbolise, replace and recreate the tactile contacts without it being necessary to return to them in a concrete way: the symbolic reality of the exchange operates better than physical reality.*

(Bruce, 1995a)

The psychoanalytic theory, which informed the analyst about human nature and psychological problems, provided a map for the analysis of a patient’s psychological oedipal issues through the interpretation of the transference. By privileging transference, the importance of the symbolic world was established and, in conjunction with Freud’s recommendations regarding analyst behaviour, analysis became the site of symbolic communication. The analyst was positioned as an objective figure who interpreted a patient’s psychological world, without contamination. By being the blank screen and by abstaining from reactions and comments that would involve them personally, the ‘real’ aspect of the patient-anaust relationship was considered to be removed, allowing the analyst to regard all communication from the patient as relating to their issues and to be interpreted as such.  

However, there were many other contextual, professional and personal factors that may have influenced the taboo on touch. Writers (Gay, 1988; Geib, 1982, Older, 1977; Parker, 1997a) have also drawn attention to the historical and contextual influences on

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30 Theorising the analyst as external to the situation and not affecting the interaction between patient and analyst has been described in family therapy as first-order cybernetics (cybernetics of observed systems), in contrast to second-order cybernetics (cybernetics of observing systems), where each participant is viewed as influencing each other in interaction (Fishman, 1983; Howe & Foerster, 1974; Keeney, 1983; Keeney & Ross, 1985; Sluzki, 1985; Tomm, 1984; Watzlawick, 1978; Watzlawick et al., 1967, 1974). Anna Freud (1956, p.618) commented on this exclusion of the real relationship: *I feel still that we should leave room somewhere for the realisation that analyst and patient are also two real people, of equal adult status, in a real personal relationship to each other.*

31 Jules Older (1977) speculated that the taboo against touching was only one of a number of other taboos in psychotherapy: discussing embarrassing topics, such as fatness, ugliness, bodily smells, sex, and feelings about death; having or encouraging noisy emotions, such as loud moaning, writhing and yelling behaviours or beating fists on the floor or furniture; and having longer individual sessions, and were related to the cultural rules prohibiting touching as well as Freud’s own cultural and familial background.
the development of psychoanalytic therapy and practice, suggesting that the era of Victorianism, characterised as a narrow-minded and sexually repressed community, was also an important influence in the taboo on touch in psychoanalysis. Further, Roustang (1982) considered that the taboo on touching in psychoanalysis derived from Freud's desire to establish psychoanalysis as a new medical practice, aligning it with science and differentiating it from other modalities such as hypnosis, that were viewed sceptically as being part of magical acts or religiously connected healing practices. In aligning with science, Freud wanted to give psychoanalysis the characteristics of objectivity and coherence, with the analyst recommended to a posture akin to one of a surgeon modelling detachment.

*I cannot advise my colleagues too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible.*

(Freud, 1912a, p.115)

Freud was suggesting that the analyst must operate without being influenced and affected by the patient, putting aside any personal reactions or feelings, and that it was the analyst's mental ability that was required in analysis. Here again, Freud was differentiating psychoanalysis from other healing practices where it was accepted that the personality of the healer was crucial to the process.

Finally, Freud's own personal preferences influenced the taboo on touch in his recommendation to continue using the couch, a remnant of the hypnotic method, which was borne out of his dislike of patients gazing at him.

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32 Freud did make physical contact in his early hypnosis and catharsis work, touching or massaging his distraught patients or those suffering somatic symptoms, or stroking the head or neck of patients in psychotherapy to stimulate them, and holding a patient's head to help them find an answer (Ball, 1999, 2000; Freud, 1904; Freud & Breuer, 1895; Gay, 1988; Hunter & Struve, 1998, p.53; Totton, 1998, p.47).

33 Ferenczi (1928) commented on the basis of Freud's second fundamental rule, that the analyst should have had their own analysis so that the importance of the personal element could be eliminated, and that the same tactical and technical methods can be used regardless of the analyst.

34 Contrary to Freud's consistent positioning of the analyst as the detached medical practitioner, the research in psychotherapy has consistently demonstrated that the therapeutic relationship is one of the crucial factors in the success of the therapy and that it is the personal characteristics of the therapist that enable the therapeutic relationship. See Frank & Gunderson, 1990; Gurman & Razin, 1977; Lambert, 1989; Luborsky et al. 1988; Mahoney, 1991; Orlinsky & Howard, 1986; Sexton & Whiston, 1994; Winstead & Derlega, 1994.

35 Anzieu (1984b) suggested that Freud's move to have his patients lie down or close their eyes and concentrate on their thoughts and images may have also been motivated to minimise the risk of erotic feeling. However, this is not borne out in Janet Malcolm's (1981) investigation. Sempe (1989) explored the two German words for body: 'körper', the anatomical male body, and 'leib', representing the interior or woman's body, bringing with it meaning and life. Freud apparently employed the word, 'körper', and in doing so, Sempe argued, made the body real. Sempe suggested that Freud had his patients lie down not because of his tiredness at their gaze or his need for analytical space, but because he wanted to move from the körper body, his masculine and phallicised body to a more maternal and symbolic body, represented by the term, 'leib'.
I hold to the plan of getting the patient to lie on a sofa while I sit behind him out of sight. This arrangement has a historical basis; it is the remnant of the hypnotic method out of which psycho-analysis was evolved. But it deserves to be maintained for many reasons. The first is a personal motive, but one which others may share with me. I cannot put up with being stared at by other people for eight hours a day (or more).

(Freud, 1913, pp.133-134)

Freud was also concerned about having any personal reactions to clients. When he considered himself to have had an 'erotic' dream about Frau Emmy May, he understood this as a warning about touch. As Freud perceived that all affectionate feelings have an erotic and transferential basis originating from infantile issues, he understood Anna O's embracing him as her feeling erotically towards him as analyst. Anzieu (1984b) supported Freud's arguments renouncing touch by providing an example from his work, of a patient dreaming of kissing him on the lips. Again, this fear of the erotic accompanying touch can be understood against the backdrop of the cultural time, as well as remembering that the majority of patients in analysis were women with neurotic states of hysteria and paralysis.

3.5.2 Attempted Revisions to the Psychoanalytic Map

Informal conversations between practitioners about physical contact have been documented, revealing that physical contact has occurred between therapist and patient. D. W. Winnicott commented on his touching a client in his correspondences with Mr Scott.

Il m'a été nécessaire pendant une longue période de tenir les mains d'une patiente d'un bout à l'autre de la séance ... Cela lui a permis de pour-suivre, d'exprimer amour et haine ....


[It was necessary for me once, over a long period, to hold the hands of a [female] patient from the beginning to the end of the session ... That allowed the patient to keep going, to express love and hatred.]

(Bruce, 1996a)

James McCartney (1966) chronicled that Ernest Hadley and Harry Stack Sullivan informed him that they allowed their patients physical contact, in spite of their writings to the contrary. He thought that all psychiatrists would have seen some patients who needed to show affection, and suggested that ten to thirty per cent of patients required some overt expression of affection.36 Jean-Pierre Lehmann (1989) referred to Michael

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36 McCartney, in his paper, Overt Transference, explicitly discussed physical contact, in which he included full sexual intercourse, as being acceptable behaviour in therapy. However, McCartney was
Balint's speech at Melanie Klein's seventieth birthday; about his patient's desire to be allowed to touch or stroke, or be touched or stroked by the analyst, and his coming to an agreement with his patient to satisfy some of these primitive desires. Lehmann himself informed spoke of holding, cradling and hand-touch with his patients in analysis.37

The incongruity between some analysts' writings about theory and practice versus their conduct can be understood within the development of analysis. History has revealed that analysts such as Rank, Jung and Ferenczi, to name a few, were expelled from the analytic society for challenging the practice of psychoanalysis (Roustang, 1982). Roustang observed that the theory of psychoanalysis and Freud were being inextricably linked, to such an extent that unless Freud approved or developed aspects of theory, other developments were not accepted.

### 3.5.2.1 Sandor Ferenczi and the Analytic Relationship

One of the early murmurings in the psychoanalytic circles regarding physical contact came from Sandor Ferenczi, known as Freud's greatest follower, closest friend and analysand (Symington, 1986, p.190). In her introduction, Judith Dupont noted Ferenczi's disagreement with Freud's therapeutic stance on patients.

... developed an overly impersonal, pedagogic technique giving rise to a much too exclusively paternal transference.
(Dupont, 1988, p.xxiv)

She (Dupont, 1988, p.xix) also noted Ferenczi's idea that a therapist's task was to find the most appropriate response to a patient to the problems presented.

In describing Freud's therapeutic stance as overly impersonal and pedagogic, Ferenczi suggested that analysts have ended up being intellectual in approach, devoid of human warmth and concern and sympathy.

*A tacit or seldom expressed basic principle of psychoanalysis is that in contrast to other forms of psychotherapy it does not wish to operate by means of sedation, soothing, stimulation, encouragement (that is, by directly emotional and suggestive measures), or with compassion, tenderness, friendly concern, sympathy, or genuine participation in any of those waves of emotion, such as hate, indignation, despair, or shared joy over positive excitements, the*

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37 Expelled from the psychoanalytic association over the sexual conduct that occurred in-session, as sexual involvement was, and still is, regarded as sexual abuse.

Following the translation of the articles by Anzieu (1984a, 1984b), Sempe (1989) and Lehmann, (1989) Peter Bruce interviewed Sempe and Lehmann in Paris in 1997. While both Sempe and Lehmann had argued that the taboo on touching was consistent with the principles of analysis, they also suggested that body practices could provide accessibility to early trauma, and may be beneficial for patients needing to regress to early dependence. Although Sempe informed Bruce that he was too phobic about touch to engage in it, Lehmann informed spoke with Bruce about hand-touch, holding and cradling in his own work.
happiness of love, etc. - but ultimately, and in the end, by intellectual means alone.
(10 March 1932, in Dupont, 1988, p.54)

Ferenczi also examined the position of the patient. Ferenczi took his patients' traumas seriously, regarding patients' reports of childhood abuse, rape, erotic play and seduction as actual abuse that caused childhood splitting, and not fragments of phantasy or desire by the child to be seduced by the parent (Stanton, 1990, p.109). In the remembering process through regression, Sandor Ferenczi (1933) discovered that his adult patients slipped into the child's place in terms of mannerisms, expressions, speech and other expressions, and so to analyse these memories as phantasy or transference in an impersonal manner, he believed, was neglectful and abandoning of the child in the patient.

The patient gone off into his trance is a child indeed who no longer reacts to intellectual explanation, only perhaps to maternal friendliness; without it, he feels lonely and abandoned in his greatest need.
(Ferenczi, 3, p.160. cited by Stanton, 1990, p.135)

In his work with patients, Ferenczi endeavoured to take a maternal position in the analytic relationship, showing warmth, friendliness and spontaneity. Ferenczi described his allowing a patient to kiss him, understanding this as the patient's need to be held and comforted and not as an erotic move.

See the case of Dm., a lady who, "complying" with my passivity, had allowed herself to take more and more liberties, and occasionally even kissed me. Since this behaviour met with no resistance, since it was treated as something permissible in analysis and at most commented on theoretically, she remarked quite casually in the company of other patients, who were undergoing analysis elsewhere: "I am allowed to kiss Papa Ferenczi, as often as I like."
(Diary, pp.2-3 cited in Dupont, 1988)

Ferenczi also spoke of love in the analytic hour. Martin Stanton (1990, p.138) understood Ferenczi's meaning of love as related to what patients might have needed to be nurtured and healed. Ferenczi himself asserted that the psychoanalytic cure was directly related to the proportion of the cherishing love given by the psychoanalyst to the patient, and regarded the withholding of love in analysis as abusive.

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38 In his paper, The Principle of Relaxation and Neocatharsis (1929), Ferenczi reverted to attaching significance to the repressed incestuous affection of adults, which masquerades as tenderness. Ferenczi suggested that considering early childhood abuse as phantasy was unhelpful, as it was a re-enactment of the parental emotional abuse (Diary, 7 January 1932, in Dupont, 1988, p.2).

39 The underlining in quotes replaces the author's original emphasis of using italics in the text.
Psychoanalytic "cure" is in direct proportion to the cherishing love given by the psychoanalyst to the patient; the love which the psychoneurotic patient needs, not necessarily the love which he thinks he needs and therefore demands. (de Forest, 1954, p.15, quoted in Stanton, 1990. p.139)

In Ferenczi’s efforts to find more appropriate ways to work with his patients, he developed the ‘active’ technique where he encouraged patients to enact forbidden or desired things in the analytic hour - for example, singing a song or playing the piano - so that the unconscious desires could become conscious. While realising that when he (1931) urged his patients into deeper relaxation and to surrender to emotions and impressions, his patients became more naïve and more childish in their forms of expression, he also found that his patients were jolted out of this reverie when he asked typical analytical questions. However, when he responded to his patient in a manner that was consistent with the childlike state, when he adapted to a child’s comprehension, a dialogue was entered into. Instead of a stereotypical question of, “Now, what comes into your mind about that?” he responded to a man who threw his arms around his neck, whispering, I say, Grandpapa, I am afraid I am going to have a baby! with a similar whisper of, "Well, but what makes you think so?"

In another example of active therapy, Ferenczi described how he was required to help the traumatised child in the patient with suggestive machinations of taking away the pain, covering it and soothingly telling the patient that it was gone. From this, he suggested that it was not abreaction alone that healed trauma, but a different situation as well.

What is fundamentally significant in all this is the fact that an abreaction of quantities of the trauma is not enough; the situation must be different from the actually traumatic one in order to make possible a different, favorable outcome. The most essential aspect of the altered repetition is the relinquishing of one’s own rigid authority and the hostility hidden in it. (12 May 1932, in Dupont, 1988, pp.106-108)

In other words, the analyst was required to respond in a manner that was different from the original response to the trauma. Ferenczi (1931) suggested that the analyst’s behaviour should be like that of an affectionate mother and that the analyst should be available to reassure, explain, soothe and comfort. Indeed, Ferenczi was arguing for an intermediate step between association and interpretation. In contrast to Freud, who

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40 Ferenczi’s initial elaborations on the active technique occurred in an address to the Sixth International Congress of Psychoanalysis, titled The Further Development of An Active Therapy in Psycho-analysis(1920). In a later paper, Present-Day Problems in Psycho-Analysis (1926a), delivered at the Midwinter Meeting of the American Psychoanalytic Association, Ferenczi argued that the active technique was a continuation of Freud’s technique of moving the repetitious behaviour to recollection. While he acknowledged Freud’s concern at the technique and the breaking of abstinence in analysis, Ferenczi still emphasised his concern about analytic technique, Exaggerated intellectualization of the analysis is no less wrong than its one-sided emotionalization (1926a, p.38).
believed in acting out, he argued that patients cannot recollect what they do not remember, and that it is only re-experiencing and recognising the past that enables material to become conscious and then recollected.

*It is unjustifiable to demand in analysis that something should be recollected consciously which has never been conscious. Only repetition is possible with subsequent objectivation for the first time in the analysis. Repetition of the trauma and interpretation (understanding) - in contrast to the purely subjective 'repression' - are therefore the double task of analysis.*

(Ferenczi, Notes and Fragments, 1932, 26.10.32, p. 261)

### 3.5.2.2 Michael Balint and Regression

Maybe encouraged by Ferenczi's thinking about the principles behind analytic therapy, the analytic relationship and the reality of childhood trauma, as well as being an analysand of Ferenczi, Michael Balint also questioned analytic practice. In contrast to Ferenczi's starting with the therapist, Balint started with the patient. Balint (1989) began by asking why some patients were more difficult to treat and less rewarding for the analyst. Although Freud desired classical analysis to be considered from a first-order cybernetics perspective, Balint argued that analysis should be regarded from a second-order cybernetics perspective, based on the object relationship, where changes in patients evolved from what happened between them and the analyst. His main point of interest was understanding why some patients were not able to use the interpretations given by the analyst, regarding them instead as an attack or demand.

*... that interpretations given by the analyst are not experienced any longer by the patient as interpretations. Instead he may feel them as an attack, a demand, a base insinuation, an uncalled-for rudeness or insult, unfair treatment, injustice, or at least as a complete lack of consideration, and so on ...*

(Balint, 1989, p.18)**41**

He understood his patients' struggles as belonging to the pre-oedipal stage. He defined this as the *basic fault*, where the patient felt that there was a fault, that something was missing, belonging to the early failure in the environment, and belonging to a two-person psychology of mother-child relations.**42**

*In my view the origin of the basic fault may be traced back to considerable discrepancy in the early formative phases of the individual between his bio-

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**41** While Balint's explanation was based on problems with interpretation, Stephen Post (1980) suggested that a patient's reaction was due to a premature move from primary processes to secondary processes of empathic perception and interpretation, where the therapist talks to the patient about the patient.

**42** The benign regression aimed at recognition, which Balint referred to as belonging to the basic fault, was in contrast to the malignant regression aimed at gratification. Pedder (1986) suggested that this connects to Bowlby's work on attachment, where the main aim of the child's tie to the mother is protection.
psychological needs and the material and psychological care, attention, and affection available during the relevant times.
(Balint, 1989, p.22)

Suzanne Kirschner (1996, p.18) suggested that Freud displaced the pre-oedipal fears of annihilation of the self by transforming them into oedipal ones, in order to evade the centrality of the pre-oedipal mother-child relationship. Roustang suggested that Freud's avoidance related to his desire to maintain an image of his mother as pure and unegoistic.

It is simply because he wanted to preserve, through this exception, not so much the relation between son and mother, but the mother herself, who was meant to be wholly pure and tender, untroubled, and unegoistic. It is as though the founder of psychoanalysis, who had done so much to demystify parental ideology, was determined to preserve a small corner in which all small boys could dream of their unchangeable mother.
(Roustang, 1982, p.101)

In viewing patients' problems as being connected to early childhood failures in the environment, Balint, like Ferenczi and Winnicott, came to believe that some level of gratification of the patient's request for physical contact, and the recognising and understanding of this, was an appropriate part of analytic therapy.

... that some of these primitive wishes belonging to such a state should be satisfied in so far as they were compatible with the analytic situation.
(Balint, 1985, p. 246)

He revealed that his patients informed him of their desire or need for some physical contact. Balint found himself understanding this especially in the contact of pre-oedipal work, where the patient had regressed to very early childhood trauma.43

... to give a present to the analyst or - more frequently - to receive one from him; to be allowed to touch or stroke him or to be touched or stroked by him, etc.; and most frequently of all to be able to hold his hand or just one of his fingers.
(Balint, 1985, p. 245)

Balint revealed that patients then came, although shyly and timidly, to expect, and some to demand, some physical contact or gratification.

... my patients began - very timidly at first - to desire, to expect, even to demand certain simple gratifications, mainly, though not exclusively, from their analyst.
(Balint, 1985, p. 245)

43 Balint's notion of regression, related to a primitive form of behaving and experiencing, was different from Freud's usage of regression, which referred to a mechanism of defence and a form of transference resistance (Stewart, 1996, pp.53-54).
Balint remonstrated against the idea of pitting the traditional analytic stance against physical contact but suggested that the consideration of physical contact needs to be therapeutic and relevant to the patient's dilemmas, and therefore part of an analytic stance.

*The question is, therefore, not friendly objectiveness plus correct interpretation versus hugging and kissing the patient ... but how much and what kind of satisfaction is needed by the patient on the one hand, and by the analyst on the other, to keep the tension in the psycho-analytical situation at or near the optimal level.*

(Balint, 1985, p. 231)⁴⁴

Balint (1986) was arguing that a therapist needs to accept the regression and that a therapist offers to be the 'primary object', which he stressed was not the giving of primary love but behaving as a primary object to be invested with primary love. In doing this, being a provider of time and context, patients can then find themselves and continue the growing-up process.

### 3.5.2.3 Donald Winnicott and Holding

Donald Winnicott (1945) used his paediatric experience in the development of his ideas about touch and therapy. Winnicott theorised about the development of the infant child, that the mother's actions in infant care, her holding, rocking, soothing and being intuitive about the infant's needs, facilitated the integration of the infant's unintegrated 'bits and pieces.'⁴⁵ He used these ideas about mothering, the task of providing an integrating experience for the infant through physical holding, in his analytic work. Winnicott compared the need of the regressed patient with the need in infant care; that the patient who was regressed to primary trauma needed a similar type of care to that required by infants.

*Sometimes we must interpret this as the patient's need to be known in all his bits and pieces by one person, the analyst. To be known, means to feel integrated, at least in the person of the analyst. This is the ordinary stuff of infant life and an infant who has had no one person to gather his bits together*

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⁴⁴ Interestingly enough, Balint's thoughts on physical contact have appeared to be de-emphasised. Stewart (1996, p.59), in reference to physical contact, placed Balint's touch at the other end of Ferenczi's contact. He also suggested that Balint eschewed all physical contact and that occasional finger-holding was the final remnant of touch in this therapy and any connection with Ferenczi's work. Stewart himself concluded that although physical contact may be therapeutically useful it may conceal too much, and used Case's example of refusing physical contact in conjunction with Balint's earlier comments (1959) that he mistook the patient's need to touch or cling to the therapist as primary love instead of a reaction and defence.

⁴⁵ Problems in infant care that led to Winnicott's notion of the false self have some similarities to Balint's basic fault (Morse, 1972), as well as Masud Khan's concept of breaches in the role of mother as a protective shield (Khan, 1986).
starts with a handicap in his own self-integrating task, and perhaps he cannot succeed, or at any rate cannot maintain integration with confidence. The tendency to integrate is helped by two sets of experiences: the technique of infant care whereby an infant is kept warm, handled and bathed and rocked and named, and also the acute instinctual experiences which tend to gather the personality together from within.
(Winnicott, 1945, p.150)

Jean-Pierre Lehmann (1989) suggested that the 'theory of holding' was seeded in this quote, as it was articulated that the position an analyst must maintain in the transference was a mothering one for patients who were in the primitive stage of development; in order to actually assure the holding of the little child, a therapist needs to be like mother to hold the situation. Winnicott alluded to physical contact in his discussion on the facilitating environment required in analysis and its comparison to infant care.

This can only be reached of course in an environment that is of the special type that I have called primary maternal preoccupation, where the mother (analyst) who holds is identified to a high degree with the infant held. At this point in an analysis, some patients do seem to need to be actually held, in some token form, with a modicum of physical contact.
(Winnicott, 1956, p.32)

Winnicott (1954) wrote about regression to dependence, where he suggested that the problem in regression for patients was not in the issue of regression per se but in the handling of it. Regression became problematic for the therapy when the analyst was not 'ready' for dealing with or meeting the regression and the concomitant dependence that goes along with early childhood needs that surface in the regressive episodes.

It is commonly thought that there is some danger in the regression of a patient during psycho-analysis. The danger does not lie in the regression but in the analyst's unreadiness to meet the regression and the dependence which belongs to it.
(Winnicott, 1954, p.261)

However, Winnicott's consideration of actual physical contact or holding in his analysis was not one that came easily to him, because of his acceptance of the analytic boundaries and the importance of interpreting the transference. In his paper, Withdrawal and Regression (1954), he began by telling the reader,

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46 Winnicott regarded the function of holding as being natural to the mother because of her primary maternal preoccupation, and [that it] was based on maternal empathy rather than on understanding (Winnicott, 1975a, p.xxxviii).
47 Goldman (1993b, pp.41-42) commented that Winnicott's use of the term 'mother' was related to the maternal function, as compared to the woman as mother. Further, Goldman suggested that Winnicott regarded the father as another mother in the early infant phase.
I have had forced on me the experience of several adult patients who made a regression in the transference in the course of the analysis ...

and providing an example of where he connected the need for physical contact with an interpretation,

... the pain represents your need to have your head held as you would naturally have it held if you were in a state of deep emotional distress as a child.

and another where he understood the couch to be the symbolic mother's lap and the patient's withdrawal as his going away "from my lap". Here Winnicott did not report making any physical contact or it being requested, as he was talking about the symbolic mothering position he took with respect to the patient. His argument that it was the patient's need to be understood in the regression, and not physical contact that was required, can also be understood in the context of analytic practice. However, Winnicott did provide an example where physical contact occurred for a woman in her second analysis. Winnicott described how he was required to do exactly what the patient needed and ended up with her head in his hands. He described the rocking action that ensued and how he regarded this as a form of communication without words.

Eventually it came about that she and I were together with her head in my hands. Without deliberate action on the part of either of us there developed a rocking rhythm. The rhythm was rather a rapid one, about 70 per minute (c.f. heartbeat), and I had to do some work to adapt to this rate. Nevertheless, there we were with mutuality expressed in terms of a slight but persistent rocking movement. We were communicating with each other without words. This was taking place at a level of development that did not require the patient to have maturity in advance of that which she found herself possessing in the regression to dependence of the phase of her analysis.

(Winnicott, 1969, p.258)

While Winnicott was generally unable to talk directly about physical contact in analysis (Lehmann, 1989), his patient Margaret Little did comment on his practice of physical contact in reference to her analysis with him.

... grabbed his hands and clung tightly till the spasms passed. He said at the end that he thought I was reliving the experience of being born; he held my head for a few minutes, saying that immediately after birth an infant's head could ache and feel heavy for a time.

(Little, 1993, p.124)

She referred to two phenomena, the regression to dependence and holding, stating that Winnicott used the word 'holding' both metaphorically and literally.
Metaphorically he was holding the situation, giving support, keeping contact on every level with whatever was going on, in and around the patient and in relationship to him. Literally, through many long hours he held my two hands clasped between his, almost like an umbilical cord, while I lay, often hidden beneath the blanket, silent, inert, withdrawn, in panic, rage, or tears, asleep and sometimes dreaming.
(Little, 1993, p.125)

Little reported Winnicott’s comments to her that he understood her situation as one of bodily surviving a psychic annihilation, such that in her analysis the split-off aspect within her was becoming integrated with herself, and that to do that required not only intellectual interpretation, but the emotional reliving of the experiences.

I had been annihilated psychically, but had in fact survived bodily, and was now emotionally reliving the past experience.
(Little, 1993, p.135)

It was here that what Winnicott was saying about holding the client in the regression to dependence was clear. A patient who is reliving an experience requires a way to be made safe in the totality of that experience. The patient has surrendered a level of control to allow the process of regression, in order to relive the actual trauma with the emotions that had been denied, as well as being in the presence of the therapist, who acts as a supportive and soothing mothering person. In reflecting on the holding aspect, Little spoke of the responsibility the analyst was required to take; to supply ego strength or, more informally, to be the adult person in the room who would take charge and deal with whatever matters arose while the patient was in another space, the regressive trauma space.

... taking full responsibility, supplying whatever ego strength a patient could not find in himself, and withdrawing it gradually as the patient could take over on his own, i.e. providing a ‘facilitating environment where it was safe to be’.
(Little, 1993, p.125)

Little felt Winnicott’s practice was ‘human’. She reported the overall sense of caring she experienced with Winnicott, from how he generally treated her, calling it token infant care; for example, he always opened the door to her, gave her coffee and biscuits, saw that she was warm and comfortable, provided tissues, etc. She described the events during her spell in hospital, how she was put into an open room in a locked ward and bathed, fed and cared for like an infant and how she settled (Little, 1993, p.134).
3.6 **Landmarks in the New Terrain**

The ideas that Ferenczi, Balint and Winnicott had about physical contact developed out of their experience with patients and their study of the principles underlying psychoanalysis and psychotherapy. Balint and Winnicott, as part of the object relations school, perceived that all relationships were elaborated from the primary relationship with the mother. Winnicott’s thesis was that the self emerged in the course of maturational development, out of the human environment that holds and cares for the infant and growing child. It was the experience of mothering, the ability of the mother to be there and intuit the infant’s needs, that allows infants to develop a psyche that represented their own inner and outer bits. Winnicott positioned the relationship between the mother and infant as being crucial to the infant’s emotional and mental development. The communication between them was physical, as the infant experienced the rocking and the presence of the mother, while the mother intuitively elaborated the infant’s needs via heartbeat, breathing, warmth and movements. It was what occurred between them, and what was communicated in the contact, that counted. Winnicott was articulating the importance of physical contact to the crucial emotional, mental and psychic development of infants.48

Like Winnicott, Anzieu explained that primary touch provided an infant with a sensorial basis, a common skin and an identification with the mother, an identification with a tangible object which then allowed the impulse of attachment to be satisfied, leading to the security of self. Didier Anzieu (1984a, 1990) developed the term, ‘skin ego’, in this argument for the importance of the skin,49 with primary tactile communication being the background upon which was written the inter-sensorial systems. He suggested that sensory castration, communication failures and difficulties with closeness related to problems of touch in a child’s life.

Le toucher primaire, corps contre corps, n’est pas important que pour la communication. Il fournit la base sensorielle du fantasme d’une peau commune entre le tout-petit et sa mère (ou la personne en tenant lieu), fantasme nécessaire à l’appareil psychique pour se représenter son Moi naissant comme Moi-peau et pour développer les fonctions du Moi par étayage sur les fonctions de la peau. Le contact corporel érotit sous-tend également l’identification à cette mère, non pas l’inclusion fantasmatique du sein nourricier, mais l’identification primaire à un objet tangible contre lequel l’enfant se serre et qui le tient. Ici c’est plus la pulsion d’agrippement ou d’attachement qui trouve

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48 The need of human contact in a physical way has been clearly documented in both foundational experimental work (Harlow et al., 1963) and studies of short-term and long-term effects of maternal deprivation in childhood (Rutter, 1981).

49 The many functions of the skin have been articulated, as an organ active in biological functioning, the cloak or boundary to the environment and the active receptor of human contact (Montagu, 1986, pp. 8-9), and as the foundation for touch (Munzer, 1972).
satisfaction que la libido. La réussite de cette identification primaire fonde le sentiment primaire de sécurité du Soi.
(Anzieu, 1984a)

[Primary touch, body to body, is not important for communication alone. It provides the sensorial basis of the fantasy of a common skin between the tiny baby and its mother (or the person in that place), a fantasy that is necessary for the psychic apparatus to represent his nascent ego as a skin ego, and to develop ego functions through the processes of the functions of the skin. Close body contact also subtends identification with this mother, not the fantasised incorporation of the mother's breast but a primary identification with a tangible object that the child holds and is held by. Here it is more an impulse of clutching or of attachment which is being satisfied, rather than the libido. The success of this primary identification is the foundation of the primary feeling of the security of the self.]
(Bruce, 1995a)

What happens when the original place at the maternal breast was not secure, or was laden with emotions and actions that were not appropriate for an infant? How can premature and inappropriate breaches in this attachment be healed? What does this mean for therapy? Is the uncovering of this history through reconstruction and interpretation enough? Does reconstruction heal, or does the infant self within the patient require something more to satisfy the unmet need of infancy? It was here that difficulties arose between theoretical ideas and analytic practice. Even when circumstances made primary identification in childhood difficult for a patient, the thesis of psychoanalysis and most psychotherapies was that the symbolic relationship in therapy must establish primary identification through transference and interpretation.50

While some of this could be understood as a gap that may occur where the treatment practice may be ahead of the theory, there was controversy with the idea of regression and the implication of the therapist relating in a maternal way towards the client.

The notion of regression, conceived by Freud as a defence, was regarded by Ferenczi as a therapeutic agent in psychoanalysis (Stewart, 1996, p.7).

_We talk a good deal in analysis of regressions into the infantile, but we do not really believe to what great extent we are right; we talk a lot about the splitting of the personality, but do not seem sufficiently to appreciate the depth of these splits._
(Ferenczi, 1933, p.160)

50 Freud (1924) also commented on the patient's desire to see the analyst as a transference-resistance and recommended that permission should not be given. However, Anzieu discussed some exceptions to this double taboo of the visual and physical registers. There were some patients who were not able to use the analytic context, such as the obsessive neurotics who favoured distance, the borderlines and narcissists, whose avoidance of pain was greater than the search for pleasure, and so these patients were regarded as unanalysable. Anzieu (1984b) explained that these patients needed to develop a boundary around the self or 'introject a skin self' and so were required to sit up and have visual contact with the analyst, arguing that the visual contact facilitated the reinstatement of the sound register and that this register must 'double' for the physical register, and that in this way the patient was encouraged, even required or demanded, to move to the symbolic register.
Balint elaborated on regression, explaining the process and reasoning behind it. The child in the adult, at the level of the basic fault, was an infant, one who cannot speak the language of adults. He spoke about the aim of allowing regression, to have a new beginning so that maladaptive patterns of relating could be broken with the creation of new ways of relating and loving.

*These mistrustful people must learn in the course of treatment to be able again to give themselves up to love, to pleasure, to enjoyment, as fearlessly and innocently as they were able to do in their earliest childhood.*
(Balint, 1985, p.162)

This required patients to give up or set aside their functioning ability or the 'caretaker' services of their false ego (Balint, 1989, p.111) and allow the therapist to act in that capacity. Winnicott also perceived regression as a process of healing, with the therapist providing the continuity of beingness, both symbolically and in actuality (Goldman, 1993b, p.xxiii). He wrote of regressed patients being in a place of need, requiring and demanding aspects from the environment, including the therapist, for their emotional development.

*It is proper to speak of the patient’s wishes, the wish (for instance) to be quiet. With the regressed patient the word wish is incorrect; instead we use the word need. If a regressed patient needs quiet, then without it nothing can be done at all. If the need is not met the result is not anger, only a reproduction of the environmental failure situation which stopped the processes of self growth.*
(Winnicott, 1992, p.xxiv)

Treatment involving regression, where the therapist acted as a care-taker meeting the needs of the child in the patient, meant that the patient became dependent upon the therapist both developmentally and therapeutically (Goldman, 1993b, p.50; Van Sweden, 1995).

*Eventually, the false self hands over to the analyst. This is a time of great dependence, and true risk, and the patient is naturally in a deeply regressed state .... This is also a highly painful state because the patient is aware, as the infant in the original situation is not aware, of the risks entailed.*
(Winnicott, 1992, p.xxix; 1955-56, p.297)

Ferenczi and Winnicott used the adjectives soothing, compassion and tenderness, and phrases such as maternal friendliness, affectionate mother, and being like a mother in their portrayal of what was required from the therapist to meet the regression. They suggested that a patient needed to be loved and attended to as a child.
Furthermore, no analysis can succeed if we do not succeed in really loving the patient. Every patient has the right to be regarded and cared for as an ill-treated, unhappy child.
(Ferenczi, 12 June 1932, in Dupont, 1988, p.130)

These descriptions, along with Winnicott’s ideas about meeting the need in the patient and Ferenczi’s recommendations that the patient should be offered the love and tenderness of which they had been deprived, are encapsulated by Ferenczi’s phrase maternal friendliness. A therapist needs to be a mothering therapist, attending to the child in the patient, and providing what is needed in the environment that allows a patient to come back into themselves and begin again the developmental steps that had been blocked by earlier interactions. Some of these mothering actions by the therapist are contained in the concept of the corrective emotional experience.

The parental intimidation is corrected by the more tolerant and sympathetic attitude of the therapist, who replaces the authoritarian parents in the patient’s mind. As the patient realizes that his modest self-assertion will not be punished, he will experiment more boldly. At the same time, he can express himself more freely toward persons in authority in his present life.
(Alexander, 1960, pp. 286-7)

Sandor Ferenczi, Michael Balint and D.W. Winnicott developed some important ideas about the possibilities of physical contact in therapy as a result of their clinical practice. By exploring the practices of these psychotherapists, a new psychotherapy that incorporates physical contact, where verbalisation and physical contact stand in sympathetic relationship to each other as a method of working with clients in therapy, can acknowledge its genealogy.
CHAPTER FOUR

REVISITING THE TERRAIN

Phenomenology is about redeveloping this 'capacity to see and feel what is there'. It is an attempt to regain a childlike openness in our encounter with the world.
(Crotty, 1996, p.158)
CHAPTER FOUR

REVISITING THE TERRAIN

My decision to revisit the therapy journey as a researcher and investigate physical holding encapsulated my desire to contemplate what happens in the experience of being physically held over a sustained period of time. I wanted to attempt to extrapolate the essence of the physical holding and consider what could be the essential components in a therapeutic context. Further, I wanted to consider how physical holding in a primarily verbal therapy enhanced the therapeutic journey, with the view to considering the possibility that physical holding could be recognised as a legitimate landmark in the unacknowledged and uncharted parts of the therapy maps. To achieve this necessitated the exploration of clients’ subjective experiences of being held in therapy as well as the perceived effects on them, and the meaning they ascribed to the holding experience.

4.1 The Methodology of Phenomenology

From a phenomenological point of view, to do research is always to question the way we experience the world, to want to know that world in which we live as human beings.
(Van Manen, 1990, p.5)

I chose the methodology of phenomenology to revisit the therapy terrain. I was particularly drawn to the phenomenological field because my research aims
encompassed the desire to access both the subjective experience and the constructed meanings of being physically held. However, I struggled with a number of differences within the phenomenology movement, which I will endeavour to draw out in my discussion of the methodology for this research endeavour.

Phenomenology is regarded as the investigation of experience, with a focus on the lived experience (Polkinghorne, 1989; Spiegelberg, 1982). The aim of phenomenology is the articulation of a philosophy of experience through the use of description to detail the structures of experience.

... to describe the structures of experience, in particular consciousness, the imagination, relations with other persons, and the situatedness of the human subject in society and history.
(Groden & Kreiswirth, 1994, p.562)

The different varieties of phenomenology within the phenomenological movement have been described and labelled according to their common features, sometimes as two types: intuitive and hermeneutic (Smith, 1997); the mainstream, authentic or ‘traditional’ and the ‘new’ phenomenology (Crotty, 1996, 1998); or as three types: the intuitive or transcendental, hermeneutic and the new phenomenology (Smith, 1998); and finally as four recognisable types: transcendental, interpretive or Heideggarian, existential and heuristic (Lawler, 1998). While each phenomenological type had the common aim of exploring the lived experience, they focused on different elements. Whereas the original phenomenology of Edmund Husserl, also labelled as the authentic, intuitive or transcendental phenomenology, focused on accessing the essence of the experience, the ‘new’ phenomenology noted by David Smith (1998) and described by Michael Crotty (1996, 1998) focused on the subjective experience of the participant without articulating or attempting to describe the essence of that experience. Heuristic phenomenology (Douglas & Moustakas, 1985; Moustakas, 1981; Lawler, 1998), also called reflexive phenomenology (Colaizzi, 1978; Giorgi, 1975), had the researcher’s personal reflections as the basis of the research endeavour, which can be contrasted with the traditional inquiry that may use the researcher’s original desire to research as a backdrop but not as the centre-piece of the research. Finally, hermeneutic phenomenology (Aanstoos, 1987; Spiegelberg, 1975; Van Manen, 1990) examined the experience in its textual form, attempting to draw out the hidden, deeper and wider meanings that are embedded in the textual discourse.

Phenomenology is considered to be the study of the process of consciousness, or the stream of consciousness; what happens internally, both emotionally and cognitively, and how this organises activity and meanings (Giorgi, 1985; Misiak & Sexton, 1973;
Packer, 1985), as it is assumed that what happens internally is not observable or readily available for observation.

*Human action is a complex and ambiguous phenomenon. An observer of a social interaction does not have direct, unproblematic access to the unambiguous "meaning" of the acts taking place, because people act in a situation that an observer does not share fully...*  
(Packer, 1985)

Amedeo Giorgi (1985, p.viii) suggested that phenomenological research provided a researcher with a process that could access these inner reactions and bring forth hidden meanings that could not be discovered by other approaches. How people experienced the world was called the ‘lived experience’, and Kenneth Shapiro (1985, p.29) suggested that research provided the possibility of returning to or accessing that *lived edge of the phenomenon*, as described.

*If I can only know something in or through my experience of it, I must begin with and build my understanding of it on an understanding of experience, of how I know in and through experience, of the relation to things that experience constitutes and that constitutes experience.*
(Shapiro, 1985, p.21)

Max Van Manen suggested that researching using a phenomenological framework means that we are exploring the way people experience the world with particular interest in what the experience was like.

*I must recall the experience in such a way that the essential aspects, the meaning structures of this experience as lived through, are brought back, as it were, and in such a way that we recognise this description as a possible experience, which means as a possible interpretation of that experience.*
(Van Manen, 1990, p.41)

It was recalling the experience through thoughtful and reflective grasping as summarised by Van Manen (1990, p.32) that I desired for my research. I invited individuals, who had experienced physical holding in therapy with me, to recall their experiences in such a way that the essential aspects of this phenomenon could emerge, and be known and described.

Mainstream, authentic or transcendental phenomenology aimed to access and discover the essence of the lived experience, *to capture the thing itself as lived* (Shapiro, 1985, p.23). In working with the lived experience of events, phenomenology required an emphasis on subjective experience. It was the individuals’ descriptions of their experience, their experience of being-in-the-world, that was emphasised. To access being-in-the-world, phenomenology requires a participant to go past the reflected and
formed thought, back to pre-reflective experience. Maurice Merleau-Ponty (1962, p.vii) regarded the lived experience as being a direct and primitive contact with the world. Crotty (1996, p.6) perceived that pre-reflective experience was becoming open to the experience, to the phenomena in stark immediacy to see what emerges for us after putting the meaning system into abeyance.¹

_The underlying idea of this metaphor is that we are to detach the phenomena of our everyday experience from the context of our naive or natural living, while preserving their content as fully and as purely as possible. The actual procedure of this detachment consists in suspending judgment as to the existence or non-existence of this content._

(Spiegelberg, 1982, p.709)

A number of writers (Shapiro, 1985; Van Manen, 1990) commented that experiencing and then speaking about or reflecting on that experience were two sequentially distinct and separate activities. Shapiro believed that the aim in phenomenology, to capture the thing itself as lived, was ambitious because of the process of experiencing.

_Experience is ongoing. To know it as such we must participate in that immediate flow. It is not enough to return, for we must explicate that appearance - how it is in our unreasoned, immediate participation._

(Shapiro, 1985, p.23)

In these discussions on the difficulties of accessing a return to experience, Van Manen (1990, p.10) labelled the process as retrospection, arguing that individuals were unable to simultaneously experience and reflect on that lived experience. Shapiro argued that exploring lived experience meant a return, a reverie to the bodily experiencing, and a rediscovery of that experience. He suggested that a posture of reflection must be effected that could allow for both being and knowing in a simultaneous movement.

_... effects a return to a forgotten bodily sensitivity, to the presence of myself as an embodiment. It is not something I need to learn; rather I need both to rediscover, as it was an original possibility, and to uncover it, for it is hidden by the predominant visual and intellective modes._

(Shapiro, 1985, p.52)

The process of accessing a client’s emotional experience parallels phenomenology.² In Emotionally Focused psychotherapy, a therapist, by accepting that what happens internally organises meaning and behaviour, invites clients to remember their experiences. Clients are invited to move beyond ‘talking about’ the experience to

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¹ This process of pre-reflective experiencing, putting one's meaning system or beliefs into abeyance, is known as bracketing. For further details see Crotty, 1996; Ehric, 1996; Giorgi, 1985a; Hycner, 1985; Shapiro, 1985; Spiegelberg, 1982.

² The parallels between phenomenology and Emotionally Focused psychotherapy are similar to Donald Moss's discussion (1989) of common assumptions between phenomenology and the experiential therapies, such as being-in-the-world, the priority of empathy, the principle of the individual's story unfolding over time, and the authentic encounter of the therapeutic relationship.
taking a pre-reflective stance and reflecting on that experience. Therapists look for the moments in the process of reflection when the unfelt feelings re-emerge, when clients become caught in the situational context and begin to feel what they had started to feel, or had cut off from feeling, in an earlier instance. In these moments they are regressing, re-experiencing the feelings and reactions belonging to that experience. This is a cathartic process\(^3\) that allows for the feeling and expansion of feelings that have been avoided or denied. Many therapists\(^4\) advocated re-experiencing in regression, arguing that clients developed awareness and new understandings from the process of re-experiencing.

*The process of allowing and accepting pain therefore requires that it be evoked in the session and lived through, not talked about ... In addition, you are then opened to new possibilities and can attend to new information.*

(Greenberg & Paivio, 1997, p.96)

As a researcher I was interested in the clients’ lived experiences, how they experienced being physically held in Emotionally Focused therapy, and what it did to them in a subjective way. It was my aim to invite clients to take up a posture of reflection, by bracketing their formed opinion of their experiences in order to describe their lived experiences. Researching the clients’ experiences of being physically held would require clients to recall their sensorial and feeling experiences. Although I was interested in each person’s subjective experiences, I was particularly interested in attempting to access the essence of physical holding in therapy and explore the relationship between the subjective experiences and the essence that might emerge.

### 4.1.1 Existential Phenomenology

Phenomenology, as an investigation of human experience, is based on a number of ontological assumptions about how we experience.\(^5\) The aim of mainstream phenomenology was to take a fresh look at reality, to explore events in such a way as to access the phenomenon itself. In this manner, as Crotty (1996) described, it was moving beyond a subjective position to access the essence of experience, to using the subjective experience to know about consciousness, the object of Husserl’s philosophy.

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3. Catharsis is the description used in psychoanalysis to refer to the bringing of repressed material into consciousness, or more commonly, to the release of emotional experience (Reber, 1985, p.114). Michael Nichols, tracing the history of catharsis, stressed that catharsis was not, in actuality, the letting up of stored feelings but allowing the completions of “previously interrupted or blocked emotional expression” (Nichols & Paolino, 1986, p.99). He defined catharsis as *a strong expression of feeling about repressed or conflictual material in the presence of someone other than the object of the original feelings* (op.cit. 1995, p.81).

4. See Balint, 1985; Ferenczi, 1931; Greenberg & Paivio, 1997; Rogers, 1951; Sullivan, 1989; Winnicott, 1945.

... Husserl's enterprise may well be characterised as the triumph of objectivity over subjectivity, or better as the establishment of objectivity in the very heart of subjectivity.
(Spiegelberg, 1975, p.76 cited in Crotty, 1996, p.31)

Mainstream phenomenology aimed to explore the psychic process of experience but, as Henryk Misiak and Virginia Sexton (1973, p.13) argued, struggled with positioning the body in the explanation. They perceived that while Husserl accepted that psychic life manifested in bodily functions, he objected to, or rather avoided the idea or possibility that psychic life would be reduced to bodily manifestation. Existential phenomenology did not have this struggle, as Merleau-Ponty argued that the primary vehicle for lived experience was the body. His existential phenomenology emphasised embodiment, that individuals' experiences were related to their bodies, that they encountered the objects of the universe by their very bodily being-in-the-world.

I can only know the phenomenal body by living in it, for, not being an object, an in itself, it is me myself; it is what I am, me inasmuch as I am conscious of the world. 'I am my body ... and correlatively my body is as it were a natural subject'.

Crotty (1996, p.68) argued that Merleau-Ponty regarded phenomenological research as being directed towards the bodily aspect of human experience, and that he saw each of us as a 'body-subject' who is at all times 'situated' in concrete lived experience. Phenomenological research then would aim at exploring the unformed bodily action (Crotty, 1996, p.68), the pre-subjective realm in ourselves (Madison, 1981, p21), or as Merleau-Ponty said, a return to sensation.

Let us then return to sensation and scrutinise it closely enough to learn from it the living relation of this perceiver to his body and to his world.
(PhP, 208; PP, 241 cited in Madison, 1981, p.21)

Crotty (1996, pp.68-69) further elaborated Merleau-Ponty's position, that looking at immediate experience did not mean primordial cognition, but a return to unformed bodily actions that precede the formed, or the gesture that precedes the thought. With embodiment, the methodology of phenomenology allowed for the return to experience based on affective and sensorial experience. Merleau-Ponty (1962, pp.viii-x) argued that it was about placing a person's unique experience at the centre of any investigation, since all knowledge is gained from an individual viewpoint. Gary Madison (1981, pp.23-24), in his exploration of Merleau-Ponty's work, discussed the process or relationship the body has with the world and with itself. The body was the way an
individual was present in the world and knowing of both the world and itself. It was, he summarised, a strange mixture of being-in-itself and being-for-itself.

The body is first of all a way of viewing the world; it is at one and the same time the way a subjective attitude both comes to know itself and express itself. The lived, phenomenal body must therefore not be thought of as an object in itself, but as the way a subject is present in the world and is aware of it.
(Madison, 1981, p.23)

Encountering objects or people in the world in this sensorial manner by one's being-in-the-world was, in Husserl's words, encountering others in lived pre-reflective experience.

... we do not encounter objects only by way of perception or predication. We encounter objects by virtue of our very being-in-the-world.
(Crotty, 1996, p.68)

In my research I was interested in the lived experience of the clients, their immediate physiological reactions and sensorial feelings when they reflected on being physically held in therapy. It was my aim to invite clients to focus on themselves as a subject-body and describe at a physical, emotional and sensorial level what they noticed, observed and physically felt. I wanted to find out what they experienced in the physical holding, what they experienced in themselves, about the therapist, and what it did to them physically and emotionally. The deeply personal and intersubjective nature of physical contact is what Van Manen (1995), citing Merleau-Ponty's description of a kind of physical reflection, referred to as pathetic touch, with its effect of turning the person being touched back to themselves.

When I suddenly experience the touch of the other person, I do not only feel the skin of the other's hand, I also feel myself through my own skin.
(Van Manen, 1995, p.9)

In my research I wanted to explore the clients' experiences of physical holding, their physical experiences of the therapist as 'other', as well as their experiencing of themselves through the process of physical contact. These ontological assumptions, relating to the knower beginning to know via bodily affective and sensorial experience, or pre-reflective experience, are also connected to other ontological and epistemological ideas encapsulated by the methodology of phenomenology. Edmund Husserl, in transcendental or mainstream phenomenology, described knowing, an act of consciousness coming from an individual's ability to reach into the other, as intentionality, as knowledge developed in relation to the other.

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6 Giorgi (1985a, p.43) noted the distinction between Husserl's intentionality and Merleau-Ponty's operative intentionality; the former referred to the reflective act and attitude taken up with respect to an object, whereas the latter referred to the stance taken up towards a situation or event to be discovered only in the lived experience.
... gained through or constituted through the active relationship of the knower and the known or the subject and the object.
(Shapiro, 1985, p.28)

This has also been described as a process of in-dwelling, where the object of knowledge comes to dwell within the knower.  

... that the mind reaches out to the object and into the object and draws it into itself, at once shaping the object and being shaped by it.
(Crotty, 1996, p.38)

Crotty explained the idea of 'what is known is in the knower', in that there is a union of the subject with the object, and that to become knowing one has to become something other than oneself, to transcend oneself. Peter Willis described the process of intentionality and in-dwelling as allowing the mind to behold the object.

The mind does not seize on the object to analyse and subdue it but attempts to behold it, to allow its reality, its beauty and its texture to become more and more present.
(Willis, 1996, p.218)

The description of the mind reaching out to the object, drawing it into itself, is an active description of the role of consciousness. The existential phenomenologist's understanding of knowing and knowledge was different to these original assumptions. The idea of intentionality was that the universe was found in consciousness and not the other way around, a reversal of the original position held by Husserl.

... rather than finding consciousness in the universe, we find the universe in consciousness.
(Crotty, 1996, p.47)

Groden and Kreiswirth noted that Merleau-Ponty's locating consciousness in the body avoided the duality of mind-body, avoiding splitting the mind off from the body.

Merleau-Ponty situates consciousness in the body. His notion of "perception" as the situated, embodied, unreflected knowledge of the world rejects splitting the mind off from the body or treating the body mechanistically as a mere object.
(Groden & Kreiswirth, 1994, p.563)

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7 Crotty (1996, p.38) elaborated the Scholastic influence in phenomenology with Husserl's idea about knowledge, especially that the object of knowledge comes to dwell within the knower.
Phenomenology, with its focus on the subjective and personal nature of experience, was positioned with the interpretive/constructivist, as part of the new paradigm. The constructivist paradigm holds many assumptions that are contrary to those of the empirical and positivist paradigm, such as the non-detachability of theory and data, the construction of facts by relationship, the importance of the internal aspects of experience, and the inexactness of description and language (Guba & Lincoln, 1991, p.29; Heron, 1981). The constructivist paradigm acknowledges the inner aspects of experience and the influence of interrelationships in meaning and knowledge building, and emphasizes the involvement of people in the researching processes.

*Epistemologically, if the constructivist argues that the outcomes of any inquiry are a literal creation stemming from the interaction between inquirer and inguired-into, then there is no viable alternative to taking a subjectivist position.*

(Guba & Lincoln, 1990, p.146)

Within the interpretive/constructivist paradigm, reality is viewed as a process (Lincoln & Guba, 1985, p.84), constructed from personal experience: the felt feelings and meanings emerging from the social and gendered context. Consistent with the constructivist view that reality is a process constructed from interaction and relationship between the individual or knower and what is to be known (Reason & Rowan, 1981b, p.241), Shapiro commented on the relational and perspectival nature of knowledge.

*... phenomena as lived consist in and are constituted by a relation between experiences and experienced. Knowledge is relational in this sense and reality is perspectival. To recognise this is to accept that the posture we seek can neither stay in itself, external to things, nor lose itself or leave itself behind in some self-dissolving relation to things.*

(Shapiro, 1985, p.28)

These ontological and epistemological assumptions contained within the methodology of phenomenology were relevant to the researching of physical holding in therapy. Emotionally Focused psychotherapy is based on a process of inviting and helping clients to access their experiences.

*We do this by encouraging and facilitating clients to explore their childhood and early adult memories and then discover and recover their emotional experiences. Further, we give them permission and help them feel their disallowed and unfelt feelings.*

(Webster, 1999)

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The therapy has a phenomenological underpinning of reflection, description and re-experiencing, allowing clients' experiences and narratives to stand as truth, accepting, in doing so, the relativist and perspectival nature of knowledge and reality. The therapy involves helping clients attend to previously disavowed and unowned emotional experiences, by attending to bodily cues - sensations, feelings, moods, passions - so that they can rediscover their emotional experience.

_Important therapeutic processes involve attending to feeling and bodily sensation, and symbolising these in awareness._
(Greenberg & Paivio, 1997, p.85)

In addition to acknowledging and working with the symbolic aspects of the therapeutic relationship, Emotionally Focused psychotherapy especially emphasises the authentic aspect of the therapy encounter, as it is this aspect that allows the therapist to in-dwell, to become knowing of their clients and their inner emotional worlds.

_Therapists become the client by hearing their client's story, how they feel and what they make of their feelings, so we can walk in their journey, walk in their story, and in so doing experience what it is like. Being them. In this manner there is a real entering into the life of another. And this is where realness is crucial. Therapists must put themselves as a person into the client's shoes in order to deeply feel with their most inner self the experiences shared with them by their client._
(Webster, 1998)

The respectful and authentic encounter with the therapist is also regarded as a second source of change. It is a new interpersonal experience that, when accepted by clients, allows them to make contact with their fundamental or primary emotional responses.

_New interpersonal experience, the second source of change, comes from contact with a therapist who is being genuinely caring, empathic, validating, and respectful, and is a source of new genuine interactions that are emotionally corrective._
(Greenberg & Paivio, 1997, p.84)

The importance of the therapeutic relationship in Emotionally Focused psychotherapy resonates with Merleau-Ponty's ideas about psychoanalysis and his prerequisite requirements for healing. Dreyfus and Wakefield (1988) argued that Merleau-Ponty's ideas created a breadth psychology, as he was talking about individuals having become constricted in an earlier experience, losing the possibility of options for relating and experiencing, as the constriction in experience had also meant a bodily freezing in that experience. Therapy then was viewed as a process of expanding the content and differentiating the context in order to release the bodily structure for broader relating in current relationships. Merleau-Ponty emphasised the relationship between the therapist
and client, that the past was dealt with and a new awareness of the past was formed in the context of the therapeutic relationship.

*Psychoanalytical treatment does not bring about its cure by producing direct awareness of the past, but ... by binding the subject to his doctor through new existential relationships ... It is a matter of reliving this or that as significant, and this the patient succeeds in doing only by seeing his past in the perspective of his co-existence with the doctor.*
(Merleau-Ponty, 1962, p.445)

The philosophy and methodology of phenomenology, in particular, the ideas from existential phenomenology, fitted with both my therapeutic experience and the research endeavour. I wanted to access former clients' experiences in the unreflected state, as I wanted them to remember and recall their experience in their own manner so that patterns and essence could emerge from within and not be superimposed upon their dialogue.

4.1.2 Hermeneutic Phenomenology

*Hermeneutics ... is based on the assumption that the manner in which someone gains an understanding of the lifeworld of another and is then able to describe this so that others can understand it, is through language and text.*
(Smith, 1997, p.76)

Language and texts are required in the process of communicating the phenomenological descriptions and this in itself brings hermeneutics to the horizon for discussion. It is through the interpretations of the way individuals experience life and through the researcher's interpretations that hermeneutic phenomenology can be distinguished. The central thesis of hermeneutic phenomenology, as I understand it, is that we can begin to understand someone, we can come to understand some sense of their being-ness and hence their view of reality, by engaging with what has been spoken or written.

Hermeneutics is about examining what has been put into language. The tradition of hermeneutic phenomenology has its basis in the study of biblical texts, which has allowed the researcher to study the structures and meaning that can be realised through the work. Martin Heidegger, who was regarded synonymously with hermeneutic phenomenology, viewed hermeneutic phenomenology as the phenomenological explication of human existence itself (Palmer, 1969, p.42 cited in Crotty, 1998, p.97), as the revelation of phenomenological seeing (Crotty, 1998, p.96).

Aanstoos (1987, p.15) wrote about the difference between phenomenology and hermeneutics, where hermeneutics was more concerned with the *larger social context of*
meaning in which it is embedded, more interested in the social and cultural meanings, as contrasted with the individual meaning of actions or the discovery of the essence of the subjective experiences. Hermeneutics was about interpretation of the text, the exploration of the hidden (Spiegelberg, 1982) or deeper meanings embedded in the text as a whole and within the language used in the textual endeavour.

Unlike phenomenology, hermeneutics is not concerned with the experienced intentions of the actor but takes action as an access through which to interpret the larger social context of meaning within which it is embedded.
(Aanstoos, 1987, p.15)

Martin Packer (1985) suggested that Heidegger was arguing that we need to understand human action against a background of practice; bodily, personally and culturally. He suggested that hermeneutic method employed a detailed progressive description of episodes in order to gradually articulate more and more of the organisation of human action. Writers (Lawler, 1998; Smith, 1998) have emphasised Heidegger's focus on being or what it is to be, as compared to consciousness, which was the focus in the traditional and existential phenomenology; and as Smith suggests, beingness is conveyed through oral and written text.

The subject does not step out from his being in order to discover things; rather he returns to himself and becomes conscious of his being by associating with them.
(Madison, 1981, p.55)

What did interest me in hermeneutic phenomenology was the notion that the different relationships to the text needed to be acknowledged and investigated. Jocelyn Lawler (1998) argued that researching using a hermeneutic lens required the exploration of individuals' meanings of their experiences, as well as an explication of how they arrived at them. In addition to the relationship between the individual and the text, the relationship of the reader or research to the text needed exploration. Crotty (1998, p.95) noted Wilhelm Dilthey's acknowledgment that an author's historical and social context was essential in the understanding of the texts.

Account tends to be taken, for example, of features such as the intentions and histories of authors, the relationship between author and interpreter, or the particular relevance of texts for reader.
(Crotty, 1998, p.91)

What also came with hermeneutic phenomenology was the ongoing debate about the place or significance of language. A number of theories, such as constructivism and social interactionism, contain the assumption that reality is determined by language. Crotty (1998) wrote about how reality has been regarded as language-determined.
An older, more traditional view of language has it representing and articulating our concepts of reality, which in their turn reproduce or reflect reality .... It is now language, the way we speak that is considered to shape what things we see and how we see them, and it is these things shaped for us by language that constitute reality. (Crotty, 1998, pp.87-88)

The place of language within phenomenology initially made me shy of considering hermeneutics. It was the privileging of language, the making of experience language-bound, that did not sit well with me. I experienced these ideas as ignoring the existential phenomenologist’s notions about the subject-body and the place of embodiment in experience.

Shapiro (1985, p.41) argued that lived experience was meaningful prior to languaging, prior to a reflective explication. In accord with Shapiro, Parker also argued for bodily experience as being meaningful prior to languaging.

The body as living flesh is a metaphoric way of understanding the spaces between the discursive imprints upon the body. It is a way of understanding the a textual body. The body as living flesh is an embodied space from which creativity and new understandings can emerge. (Parker, 1997b, p.12)

Here, the languaging of experience was regarded as following pre-reflective experience. Languaging was the articulation of experience. In other words, what became language-bound was the ability to express the experience as expression via languaging, coming as it does after the physiological, sensorial and affective experiencing. This was accurately expressed by Prescott.

I sense meaning affectively with my bodily being. Articulate, verbal meaning usually arises for me if I allow myself to stay with this sensing, this felt meaning. As I read over what I eventually do write, attempting to see if it "makes sense"... I actually find I am trying to see if what I have said harmonizes with the sense of meaning, that is, the bodily knowing I feel (Prescott, 1974, p.172, cited in Valle & King, 1978, p.11)

With existential phenomenology's belief that the body is the vehicle for meaningful experiencing: a site that was regarded as a textual, not a mechanical object or a flattened text or communication field (Parker, 1997b, p.25); Shapiro argued that hermeneutic phenomenology did not deal with the lived experience aspect and its implicit meaningfulness prior to cognition.

It does not deal with the fact that my immediate lived experience is implicitly meaningful prior to my assumption of a relation to it of linguist to language or reader to text ... Not only do I know the situation that I am in (and hence how to
act in it) without disengaging from it, without reflectively explicating it, at any moment I know more than I could tell. (Shapiro, 1985, p.40)

Hermeneutic phenomenology has not seen the place of languaging as problematic but rather as a natural part of human existence. The placing of language in this manner appears to minimise the aspect of bodily experience and the denial of the secondary sequential place it naturally has in relation to experiencing.

On the hermeneutic account, communication does not seem as difficult, mysterious, or mystical as is the case for the humanists; it is viewed as a necessary, natural, and constitutive aspect of human existence rather than as a problematic and ultimately distorting transformation of a more primary private human essence. (Messer, Sass, Woolfolk, 1988, p.249)

Writers (Madison, 1981; Rudge, 1997) have argued that language is not independent of bodies, as it is two bodies that ‘couple up’ or experience, as compared to two thinking aspects.

... involves not two Cogitos which infer each other’s existence, but two knowing-bodies which ‘couple up’ ...
(Madison, 1981, p.39)

I have struggled with the positioning of language, initially as a therapist and now as a researcher. There has been ongoing movement towards the privileging of words, both the symbolic and the narrative within the therapy field, beginning with Freud by his privileging of the symbolic in psychoanalysis through to psychoanalytic psychotherapy and the current systemic therapy discourse in narrative therapy. Within the less traditional and mainstream therapies, such as Emotionally Focused Therapy, Somatic Therapy, Bioenergetics and other Experiential therapies, there is a different value given to the place of the experiencing and the physical site of the body. In Emotionally Focused Therapy, emphasis is given to the nature and expression of the emotional response in its bodily form and to the fact that following the emotional experience, clients symbolise or use language to speak the experience.

It is the thoughtless image, the wordless automatic sensorimotor response, and the felt meaning of the look or touch of another or of the sound of her or his voice that often governs emotional response, rather than an explicit thought. (Greenberg & Paivio, 1997, p.65)

As a researcher, I was particularly drawn towards existential phenomenology due to its focus on bodily experiencing and the process of knowing and because I also perceived that these ideas were the philosophical foundations for Emotionally Focused work.
However, as a researcher I was looking for more than a descriptive phenomenology. Notwithstanding that I wanted clients to communicate their reflections on their experience of being held, I also wanted to investigate the meanings that the participants gave to physical contact and to understand the effect this may have had on them during therapy. As I was exploring meaning, and wanting to investigate these meanings both independently and in concert with the descriptions of the experience of physical holding, I wanted to also draw on the hermeneutic aspect of phenomenology. My initial hesitancy and shyness about approaching hermeneutic phenomenology related to the privileging of language in the determination of experience and reality. Van Manen expressed what I had been grappling with in working with the lived experience and meaning.

*To do hermeneutic phenomenology is to attempt to accomplish the impossible: to construct a full interpretative description of some aspect of the lifeworld, and yet to remain aware that lived life is always more complex than any explication of meaning can reveal.*
(Van Manen, 1990, p.18)

Van Manen also grappled with putting experience into words, and used the term poetising.

*Poetising is thinking on original experience and is thus speaking in a more primal sense .... We must engage language in a primal incantation or poetising which hearkens back to the silence from which words emanate.*
(Van Manen, 1990, p.13)

Crotty (1996) argued that because language was the verbal mode of communicating, *phenomenology is inescapably a hermeneutics*, and that language could be used in the service of phenomenology. Van Manen suggested that the writing must have a phenomenological quality to it, as it must reveal the nature of human experience. He argued for a style of languaging that would reflect the phenomenological endeavour and also resonate with the reader in an expressive manner. Language that would attempt to reach the pre-discursive and pre-cognitive aspects that were less accessible in conceptual intellectual thought. In other words, using words to touch us, to move and inform us pathically, and leave an effect on us.

*The writer must arrange the words and create textual tonalities that are just right, that provoke pensive passions, that evoke reflective responses, and that invoke unforeseen insights.*
(Van Manen, 1995)

Crotty (1996, p.158) used the description, *childlike*, to capture the openness and naivety of an encounter with the world, and Herbert Spiegelberg (1982, p.693) suggested that
attempting a phenomenological description using metaphor and analogy might allow the description without forcing a classification on the experience.

In summary, the methodology of phenomenology, by drawing on some of the ideas of descriptive, existential and hermeneutic phenomenology, was an appropriate vehicle for researching physical holding in therapy. Exploring participants’ experiences could possibly enable the coming-to-know of the essence of physical holding in therapy. The philosophy of phenomenology, in particular, the ideas from existential phenomenology, fitted with both my research aims and the therapeutic endeavours that were being researched. Some of the assumptions and ideas in the methodology of phenomenology were similar and complementary to some of the methods of therapeutic practice in the Emotionally Focused approach. Both were systematic, using particular forms of interviewing through questioning and responding; explicit, endeavouring to discover and deal with the lived experience; self-critical, reflecting on methods and processes; and intersubjective, working with the relationship between the individual and the world, and between the client and the therapist.\textsuperscript{9} By acknowledging the primacy of bodily experiencing, by working at the site of subjective experience in my attempt to draw out the essence of the experience, and by accepting the sequential relationship between existential phenomenology and hermeneutics, I felt that I could then explore the subjective elaborating of the clients’ experiences, their meanings and understandings of their experiences, and then how they arrived at these thoughts and conclusions.

\section{4.2 Phenomenological Methods of Inquiry}

\textit{Qualitative methods can be used to uncover and understand what lies behind any phenomena about which little is yet known.} (Strauss & Corbin, 1990, p.19)

There is no singular method for phenomenological research. Writings on phenomenological method have ranged from outlining the possible methods\textsuperscript{10} to discussing the processes involved in the researching.\textsuperscript{11} The idea from Guba and Lincoln (1990, p.138) about a researcher investigating aspects of human behaviour being required to restore humanness to the inquiry, guided me in my design of a method for the research inquiry. To me, restoring humanness to research spoke of individuality, allowing each person to narrate their experience in their idiosyncratic manner so that patterns and themes could be found from within the story and not superimposed upon

\textsuperscript{9} The descriptors systematic, explicit, self-critical and intersubjective were listed by Van Manen (1990, p.11) as part of phenomenology’s claim to be scientific in a broad sense.
\textsuperscript{10} See Polkinghorne, 1989; Crotty, 1996; Stone, 1979; and Patton, 1990.
\textsuperscript{11} See Polkinghorne, 1989; Colaizzi, 1978; Rowe et al, 1978; Van Manen, 1990; Mann, 1976; and Spradley, 1979.
their dialogue. It is the experience (Clandinin & Connelly, 1994) that then stands as the focal point for the research. To achieve this in my method required me to adhere to the principles of the interpretive/constructivist paradigm, which does regard the subjective and individualistic nature of experience as the starting point for social inquiry (Clandinin & Connelly, 1994; Guba, 1990).

The methods I employed for the data collection and then the analysis were developed to fit with the research investigation and with the particular characteristics of this research study. As little was known about clients’ experiences of physical holding in therapy, a research method was required that allowed individuals an opportunity to speak about their experiences, to allow for different experiences, understandings and interpretations. I chose qualitative methods12 because it fitted with the ontological and epistemological assumptions underlying phenomenology and because it could allow the possible emergence of the essence of the phenomena in physical holding. I investigated physical holding using an interview format with a number of respondents who had experienced extensive physical holding during the course of their individual therapy with me as their therapist, in conjunction with other data sources, such as clinical case-notes, client correspondence during the process of their therapy, and transcripts of clinical interviews where available.

4.2.1 The Interview Format

The interview formats used in phenomenological research have been well documented. Crotty (1996), in his review of nursing research, discussed the varied ways researchers gathered data, ranging from unstructured to semi-structured interviews, from employing open-ended questioning to asking only one question in an interview. He argued (1996, p.159) that the phenomenological method involved participants being open to the experience and describing what comes into view for them. Van Manen (1990) provided guidelines for obtaining the lived experience that ranged from having respondents describe experiences as lived, describing experiences from the inside, and focusing on a particular incident, to attending to bodily feelings, smells and sounds. In heeding his caution (1990, p.66) not to have the method rule the research question, I reflected on what I hoped to gain from the interviewing process together with a review of the different interviewing formats.

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12 I am using the term ‘qualitative’ at a methods-level as compared to using qualitative as a paradigm-level term (Guba, 1990; Bogdan & Biklen, 1992; Bryman, 1984; Strauss & Corbin, 1990). Foddy (1994, p.14) referred to qualitative researchers as having procedures based on prolonged, intimate immersion in the social interaction in question or the use of non-directive, open questions that respondents answer in their own words rather than in terms of pre-set response categories.
An interview is a meeting where there is a purposeful conversation between an interviewer seeking information from another, using various format techniques. Van Manen (1990, p.66) described the interview as a means for exploring and gathering experiential narrative material and as a vehicle to develop a conversational relationship about the meaning of the experience. Norman Denzin (1989, p.102) viewed an interview as the place where the research act comes alive. Denzin classified interviews by type, structure and method as schedule standardised, non-schedule standardised and non-standardised, where the non-standardised interview has no specified set or ordered questions.

... stressing the interviewee's definition of the situation; encouraging the interviewee to structure the account of the situation; and letting the interviewee introduce to a considerable extent his notions of what he regards as relevant, instead of relying upon the investigator's notion of reference.

While Lindesmith (1947, p.6) likened a non-standardised interview to an informal friendly conversation, a non-standardised interview is similar to an unstructured interview (Guba & Lincoln, 1991, p.155; Fontana & Frey, 1998), a depth interview (Lincoln & Guba, 1985), a rapport interview (Massarik, 1981), or the examination of 'areas' (Becker, 1962, p.592). In a non-standardised interview the sequence of questioning is determined by when and how respondents talk about the subject (Richardson et al, 1965, p.51). It was the non-standardised interview that felt congruent with my research, as information is obtained from the respondent in a manner that recognises the individuality of each person. By that, I mean the interview would proceed and be guided by the respondent's responses and exploration of the area being discussed. I felt that this kind of freedom was crucial for the allowing of a space for information to surface. It would allow me to obtain the first-person descriptions of an experience.

... to attain a first-person description of some specified domain of experience, with the course of dialogue largely set by the respondent, the interview begins with few prespecified questions concerning the topic ...
(Polloio, Henley & Thompson, 1997)

Acknowledging and attending to the process of gathering the research data in this way is also part of the non-positivist paradigm.

... concerned with exploring the relationship amongst different factors, also leading to multiple truths, involving the researched as active participants in the research process, and the research process itself as being of equal importance to the outcome.
(McDermott & Carter, 1995, p.31)
Many researchers have commented on the importance of the process of researching. Van Manen (1990, p.2) argued for consideration of the relationship between the research method and the question. Judd, Smith and Kidder (1991, p.253) argued that it was important to think about the processes needed to generate good data, described as complete and valid. They suggested considering a positive atmosphere, asking the questions properly, obtaining adequate responses, recording the responses and avoiding biases. These views required an interviewer to be competent in grasping the meanings each person was attempting, as well as communicating through skilful questioning and responding. This meant developing a positive atmosphere to allow a dialogue to develop primarily from the respondent's conversation. I also considered how to introduce different areas in the interview, how to use the range of open-ended questions, how to respond to each respondent and do so in a manner consistent with a phenomenological approach, that encouraged a respondent's reflection of their experiences.

I was also mindful of privacy and sensitivity because therapy is generally regarded and prized for its confidentiality. It affords clients an intimate space where they can consider and experience aspects of their lives, both real and imagined, within the safe confines of a consulting room. What happens in that room is generally not open to public scrutiny and often is only available to a mentor or supervisor through the process of recalling a session. Not only do the topics of conversation and the client's processes remain confidential, but the therapist's actions also remain private. Physical contact in therapy can be controversial for more traditional or mainstream therapies and has been discussed within a context of boundary violations\(^\text{13}\) on the part of the therapist. Physical contact is an area of therapy that clients may or may not have discussed with their partners or friends. Talking about it in detail in a research endeavour opens that door to the therapy process.

Claire Renzetti and Raymond Lee's exploration of sensitivity (1993) alerts researchers to their responsibilities to the wider community, exploring not only the psychic costs to the participants but also the costs to the researcher in relation to the dissemination of the research data. Consistent with other feminist researchers, they recommend (1993, p.179) self-disclosure and reciprocity on the researcher's part as promoting that "true dialogue" rather than "interrogation" in the interview situation (Bristow & Esper, 1988). I considered the hierarchical nature of interviewing. I thought that self-disclosure was appropriate when the respondents asked me to comment or when they invited a more

\(^{13}\) Boundary violations in therapy are generally related to dual relationships, sexual involvement and the development of personal relationships (see Austin et al. 1990; Bersoff, 1999; Carter, 1993; Daniel, 1998; Francis, 1999; Koocher & Keith-Spiegel, 1998; Pope & Vasquez, 1998; Rutter, 1990).
dialogical process during the interview process, especially as the respondents were talking about physical contact with me when I was their therapist. Overall, I felt that the hierarchical nature of an interview would avail, as I was positioned as the interviewer without equal rights in the conversations. The balance and movement between the hierarchical and non-hierarchical elements of a research interview would be familiar to the respondents because this had existed in the therapeutic relationship previously, moving from when I had directed the client's attention to their processes to when I had self-disclosed in the session. To develop a non-standardised interview that could accommodate these issues required me to consider how to question or invite discussion on a subject area as well as how to respond appropriately.

I was also mindful of the process of remembering. By asking respondents to talk about their experience, I was seeking their retrospective account of that experience. The process of remembering can begin in many ways.

"... that remembering begins in vague feelings, in sensuous rather than conceptual matters - an embodied remembering which is, so to speak, continuous with one's existence as the person one is, and a remembering which is dependent upon 'traces', 'representations' or other 'external signs' of some kind."
(Bartlett, 1932, p.122 cited in Shotter, 1990, pp.120-138)

Some suggest that a number of factors can influence accuracy in remembering, such as recency (Foddy, 1994), retroactive interference (Baddeley, 1979), salience (Foddy, 1994), novelty of task (Morris, 1981), intentionality of the behaviours, and the acceptability of material to be remembered (Edwards, 1942). I also considered the limits of memory and the type of information that can be expected (Foddy, 1994; Morris, 1981) alongside Baddeley's caution,

Memory is essentially a reconstructive process, and subjects will try to make sense of a given incident, often recalling their interpretation rather than what they actually literally observed. Bearing this in mind, it is particularly important to avoid leading questions.
(Baddeley, 1979, p.23)

Sudman and Bradburn (1982, p.222) suggested a backwards or forwards sequence for recalling events in interviews using a chronological order. William Whitten and Janet Leonard (1981), examined autobiographical memory and found that the probability of recalling was primarily a function of recency, and that a backwards search was better than either a forward or a random search. They recommended starting with recent events and moving backwards. Further, Cannel et al (1981) noted the importance of questions and how they can act as a stimulus to recall the relevant event, suggesting that
a single dimension variable for the researcher may not be relevant for the respondent. In researching physical holding, there could be different elements that would be recalled by the former client as respondent, as compared to the therapist as researcher. For example, whereas I may consider the issues around regression, emotional work, containment issues and feeling one's experience as a researcher, a former client may be prompted to recall other associations, such as emotional distress, personal evaluations of where they were in life generally, as well as other feelings of warmth, care and sensuality.

From a phenomenological perspective, it would be advantageous to ask open-ended questions or open up the area in a general way, to allow respondents to find their associations to the topic, to create their own cues to reactivate memory, in order to describe their experiences. Lazarsfeld (1944) suggested that open-ended questions should be used initially before closed ones. Open-ended or descriptive questions (Spradley, 1979; Pollio, Henley & Thompson, 1997) were recommended to help respondents talk and allow them to apprehend the area, while further exploration could be aided by repeating or restating what respondents were saying. They were also regarded as useful for clarifying the meaning of answers, discerning the dimensions of topics and personal motivations, and clarifying the nature between variables. Further, answers to open-ended questions (Lazarsfeld, 1944, p.132) can provide the interviewer with information about how respondents have interpreted the question, the underlying motivation influencing the respondent's orientation to the topic, and the frame of reference that the respondent has employed. Similarly, Judd et al (1991, p.237) recommended short and simple questions to simplify the respondent's task. They recommended the funnel principle, starting with general questions, followed by increasingly specific and detailed questions. This would enable respondents to begin in the research inquiry wherever the topic touched them, and an interviewer would then follow their lead with increased specificity in questioning.

Fowler and Mangione (1990, p.41) suggested questions when meanings were unclear or ambiguous, "How do you mean that?"; when the information was not specific or detailed enough, "Tell me more about that?"; and for seeking additional points to the information already given, "Anything else?" Fran Peavey (1994) examined the levels of questioning, how the power and depth of a question could make a difference. The first level of questioning that opened an area for discussion was very relevant for my interview. She classified question types into levels: description questions, "What aspects?" and, "What are you most interested in?"; observation questions, "What do you see? hear?" and, "What have you heard or read?"; analysis questions to obtain meaning attributed to events, "What do you think about?" and, "What are the reasons for?";
feeling questions, "What sensations do you have in your body when you think or talk about this situation?" and, "How do you feel about the situation?"; and consequence questions, "How has the situation affected your own physical or emotional health?" These questions and responses were familiar to me as a therapist (Webster, 2001a), yet it was helpful to consider them in the research arena.

Based on a phenomenological framework and with consideration of interview formats and the nature of questioning and responding, I developed a format based on broad areas of inquiry that related to the research. In my initial telephone contact with the respondents, where I sought their interest in being involved in the research, I informed them of both the area of inquiry and the broad research question. Further, I asked them to consider or reflect on this question and their experiences of being physically held in the therapy prior to the actual interview. I gave no further instruction around considering the research question, as I wanted them to find their own pathway into the area, or revisit their experience in a contemplative mode (Crotty, 1996a).

The dimension of their involvement was also given in these telephone conversations. I planned on two interviews. The first interview would be of one to one-and-a-half hour's duration, where I talked with each respondent about their experience of being held in therapy, and the effects and meaning of these experiences. A second interview was scheduled a month later. Between meetings the interview was fully transcribed,¹⁴ then listened to and read to obtain areas where further information was sought or current information clarified or further explained. In addition, my clinical notes as a therapist were summarised in relation to physical holding and other relevant information. Other data sources - notes, letters, drawings or poetry from each respondent - were reviewed for areas of information that I would explore with the respondent in the next interview. The areas for further inquiry were listed and taken to the next interview.

I began the first interview by reiterating the research question. In the interview, I followed the respondent, using different open-ended, descriptive, exploratory and other questions and responses, encouraging their descriptions of their lived experiences and then helping them consider the effects and meaning of the experiences. I developed a set of information areas with general questions that guided me in the interview when required. Three major areas were used: description of physical holding, "Describe your experience of being held" and, "Describe an experience that felt typical of the physical holding for you"; inner reactions, "How did it make you feel?" and, "What sense did

¹⁴ The interviews were fully transcribed verbatim, in line with McCracken's (1988, p.41-42) recommendations that each utterance needs to be examined for its connection to the text as a whole.
you make of the experience of being held?"; and specific incidents, "Can you remember the first time you were held in the session?" and, "How were the other experiences of being physically held similar or different?"

In the second interview I began by reminding them what I had done between meetings and then how I thought this interview would proceed. Firstly, I invited them to give me their reactions to the first meeting in terms of how they felt after the meeting, and any further thoughts and comments, before going through the areas of inquiry from the first interview and then the other data sources. This meeting also was of one to one-and-a-half hour's duration.

I used William Foddy's (1994, p.185) recommendation for piloting the research questions. I invited one participant to act as a pilot study and to review her interviews with me. Following each interview, I recorded her immediate reactions and comments about the interview. The participant then took a tape-recorder home and continued to comment as further reflections emerged. I transcribed this material and used this in conjunction with my own review to modify the interview process. Further, I reviewed the research interviews in a number of ways. Firstly, I noted to myself where I was meta-communicating to myself in the interview. This was where I would think something about the interview or question the material that was being discussed. After the interview I recorded this and reflected on what was happening. Secondly, at the end of the interview, I reviewed the whole interview by asking myself, "What did I gain from listening and being part of the interview?" "How did I find asking and responding with this person?" and, "How do I understand the type of conversation that developed between us, both as a researcher and as their former therapist?"

4.2.2 Ancillary Data Sources

Methods are like the kaleidoscope: Depending on how they are approached, held, and acted toward, different observations will be revealed.
(Denzin, 1989, p.235)

In using qualitative methods it is important to use triangulation,15 in the form of different methods, data-sources or researcher. Triangulation has been viewed as an alternative to validity (Denzin & Lincoln, 1998), allowing for the possibility of the development of in-depth understanding (Denzin, 1989, p.235), enhancing trustworthiness (Belcher, 1994), the emergence of better descriptions (Mathison, 1988),

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documenting convergent findings (Grbich, 1999; Sandelowski et al, 1992), removing personal biases (Denzin, 1989, p.236) and confirming conclusions (Huberman & Miles, 1998, p.200). Denzin (1989), like Lincoln and Guba (1985) and Merriam (1988), argued that it was unlikely that one method could reveal all relevant features and that a number of methods could provide a rich source of information for data analysis and understanding. Further, Lincoln and Guba (1985) and Merriam (1988) suggested that multiple data sources might be a stable source of information as they may accurately reflect a situation and be contextually relevant and grounded in the contexts they represent. Triangulation can also be problematic, providing inaccurate generalisations or theoretical justifications, or legitimising personal views (Sarantakos, 1993, p.156). However, Sandra Mathison (1988) argued that triangulation can aid the development of meaningful theory by the convergence of perspectives achieved with data triangulation and with the understanding of any inconsistencies and contradictions. By exploring any convergences, inconsistencies and contradictions, a researcher is provided with another means to avoid researcher biases that might not be detected using a singular data source.

In my research I employed multiple methods by using the research interviews, clinical case-notes and client correspondences, in the form of emails, faxes and letters made during the process of therapy, as well as transcripts of these therapy sessions where available. These ancillary data sources\(^1\) were introspective and also retrospective, as they predated the research inquiry.

4.2.2.1 Clinical Case-Notes
The main ancillary data source or field text (Clandinin & Connelly, 1994) was the clinical notes\(^2\) I made during the process of the therapy. After each clinical session, it was my practice to write notes about the session. I would write about what occurred in the session (for example, "conducted an affect bridge technique" and, "explored childhood messages"); observations about the client's feelings or reactions or movements in the session (for example, "client appeared distressed when we spoke about ..."); my assessment and ideas about what I thought was occurring; my personal reactions, such as distress, frustration, warmth or feeling pleased towards the client; and finally, my tentative plans for the next session (for example, "... must explore client's

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\(^{1}\) The clinical case-notes and the client correspondences in the form of emails, faxes and letters are what Webb et al (1971, p.88) described as archival records that are more discontinuous and generally not part of the public record, and are often unobtainable unless there is an affiliation between the researcher and the organisation or person with the materials.

\(^{2}\) To date, the Australian Psychological Society does not have any recommended or prescribed forms for clinical note-taking available for psychologists. I developed my forms (see Appendix 1) in conjunction with recommendations from Austin, Moline and Williams (1990) and my own history of note-taking, with consideration of the ethical and legal obligations for clinical practice.
reaction to what I said, need to follow-up reaction to task, and explore regression further").

I reviewed these clinical notes for any comments about physical holding in therapy. Comments or notes that I had physically held clients or comments about their or my reactions to physical holding were extracted. In addition, I noted where clients were in their process of the therapy in order to consider the situational and contextual aspects that may be relevant background to the holding process. After each clinical file was reviewed, the extracts were read again, and I listed some entries in order to ask the respondents in the second interview for their comments or reactions to the events.

4.2.2.2 Client Material

Another ancillary data source or field text was client material. This was correspondence in the form of notes, letters, faxes and e-mails, drawings,\(^\text{18}\) or poetry that came into my possession during the time of the therapy. During the process of the therapy, clients had spontaneously written to me or shared their own writings, or at times had been requested to keep a diary or written contact with me between sessions. I reviewed this data for any reference to physical holding.

I hoped that these ancillary records might provide another source of data that could be used to review the perceptions and recollections made during the research inquiry, and might deal with Foddy’s concern (1994, p.97) that there was a tendency of respondents to underestimate the frequency of mundane events and overestimate the frequency of rare or sensational events. Further, these data sources were developed in the spirit of phenomenology, created by the process of in-dwelling in the experience, at times the clients writing out pre-reflective experience and at other times writing reflected comments; hence the introspective and retrospective nature of these records. These texts were created during therapy by clients, who were aiming to develop their own understanding or to work out what was going on within their own processes, may reveal both inner experience and the inconsistencies that can emerge with the interference of a research inquiry.

4.2.2.3 Audio and Video Tapes

The other data source was the audio and video tapes\(^\text{19}\) of the therapy sessions. Where permission had been given by the client, it had been my practice to record the sessions

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\(^{18}\) Drawings would be reflected on and investigated similarly to Murphy’s process, in Gilgun, Daly and Handel (1992, p.155): Visual data were analysed like observational field notes, without predetermining the codes and categories.

\(^{19}\) My practice of recording sessions had developed initially from my role as a trainer at the Marriage Guidance Council (NSW), Counselling Training Centre (NSW) and the Institute for Emotionally
for ongoing clinical review. I had held a number of these tapes during the life of the therapy. During the investigation and reflection of the interviews in conjunction with my clinical notes, I then explored the transcripts of what was said at relevant times.

4.2.3 Respondents

Nine people were invited to participate in this research inquiry. They were former clients who had experienced physical holding in their therapy with me. I wanted to work with them for a number of reasons. As their therapist, I had been an integral part of their experience. I regarded this as an asset that could allow for ease in the discussion of sensitive aspects of physical holding. Further, as a therapist I could have an increased understanding of their conversations and even another view of their understanding of the effects and meanings of being held. As therapy is so clearly such a private domain, I believe, similarly to Walker (1996), that the clients’ agreement to discuss physical holding and their experience of therapy came from their personal connection with me. While I agree with Robert Bogdan and Sari Biklen (1992, p.32) that phenomenological researchers should not assume they know what things mean to the people they are studying, but rather should emphasise the subjective aspects of people’s behaviour to gain entry into the conceptual world of their subjects, my being part of their experience could add depth to the intersubjective experience. Respondents may be able to discuss sensitive aspects of the process or struggle to find words to convey either description or meaning, because I was the other person present in the holding experience.

Further, through my being part of each respondent’s experience, I believe I can bring all the clients into conversation with each other. By this, I mean that I can consider physical holding both within each clinical case-study and between multiple case-studies, in terms of what happened for each respondent in the holding, what happened within me as the therapist, and finally, what happened between us. Citing George Rosenwald's (1988) synthesis of images, Tracey and Robin Burgess-Limerick (1998) described how phenomenological research can bring each clinical story, reflecting different perspectives, into conversation with each other and develop a shared reality or meaningful theory.

If psychological phenomena are located within socially constructed, multiple, dynamic, and potentially contradictory realities, then investigation of these phenomena requires a method that permits the construction of theory at the phenomenological level of the individual while embracing the connections between individuals. Multiple-case research is grounded in phenomenology,

Focused Therapy. I would record sessions in order to review what was said between sessions or to play back tapes to help clients with processes occurring in-session; or to seek permission to use the tapes or edited transcripts in my role as a trainer at the end of the therapy; and finally, as a protection against any complaint about what was occurring in the therapy hour.
and brings individual cases into conversation with one another (through the researcher) to construct shared realities out of individuals' perspectives.
(Rosenwald, 1988)

Many researchers\textsuperscript{20} commented on the selection of the participants for the research; either the lack of attention to, or the selection of the best candidate.

... little attention is paid to establishing whether or not respondents actually have had the necessary experience upon which an assumed opinion or belief could be based.
(Foddy, 1994, p.101)

In Donald Polkinghorne's (1989) view, the best candidate for the research task was the person who demonstrates or has the capacity to provide a full and sensitive description of the experience under examination. In other words, it was respondents who could be articulate, who could speak from their pre-reflective experiences. Individuals who have been through long-term therapy that has a significant emphasis on the verbal component as well as consistent physical holding could be the ideal target group for this research inquiry. Psychotherapy using an Emotionally Focused approach was a therapy where there was the availability of consistent physical holding as well as a significant level of verbal exchange. As a senior trainer and therapist in this approach,\textsuperscript{21} my clients appeared to be the best candidates for being the research participants.

However, working with my former clients made me consider a number of ethical issues. In addition to privacy and confidentiality (Gilgun et al, 1992, pp.48-49), I considered a number of other issues relating to informed consent, dependency, and the effects of revealing sensitive information that may be distressing about the holding experience. The research inquiry into physical holding was inviting former clients to revisit and speak about their experiences in therapy. When there was physical holding in a therapy session, I sought their permission to make physical contact. After each experience of being held I would invite them to talk about this experience, and any issues or reactions were discussed. In other words, the areas that I wished to talk about in the research had been asked about in the therapy at some point in time. In addition, most had given their permission for the therapy sessions to be recorded by either audio or videotape, as part of my professional service.\textsuperscript{22}

\textsuperscript{20} See Foddy, 1994; Polkinghorne, 1989; Van Kaam, 1986; Colaizzi, 1978.
\textsuperscript{21} In my role as Director at the Institute for Emotionally Focused Therapy, I have written a number of articles dealing with different aspects of Emotionally Focused work, such as pain (Webster, 1999b); long-term couple therapy (Webster, 2000b); and the transferential aspects of therapy (Webster, 2001c), as well as writing manuals in Individual and Couple Therapy (Webster, 2001, 2001b).
\textsuperscript{22} Seven of the nine had their sessions video- or audio-taped. Three gave permission for the tapes, and six gave permission for their therapy journey to be reported for educational purposes.
However, I felt that there were a number of boundary issues that needed to be clarified. Firstly, I was advised that the contract for therapy ended and my duty of professional care ceased when therapy was successfully completed or by agreement between both parties. These individuals would then be legally free to decide whether they wanted to participate in a research study. Further, by inviting former clients, who had successfully completed their psychotherapy, I made an assessment that any vulnerabilities or dependency issues towards me as the therapist would have been worked through in the last phases of their therapy before finishing therapy.

The nine respondents were individuals who came to therapy either as self-referred clients, or on the recommendations of work colleagues, academic advisers, friends, or family physicians. They were six women and three men, aged between thirty-two and forty-eight years of age at the time of initial consultation. With the exception of two; one who had recently separated and the other single, all were in established relationships: three were in de facto relationships, one heterosexual and two lesbian, and four were married. Four had children. With the exception of one, who began tertiary education while in therapy, all held tertiary qualifications in a variety of fields, for example, science, law, engineering, psychology, arts and economics. All were working in these professional areas, six being self-employed and three being employed in the private business sector.

4.2.4 Therapist as Researcher

The position of the researcher is an important one in phenomenological research. By being positioned within the interpretive/constructivist paradigm, the description of the subjective aspects of experience in phenomenology is understood to be influenced by the researcher and the nature of the relationship that can be created.

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23 A legal opinion obtained in 1995 recommended that there were no legal problems that could be foreseen by using former clients who have successfully finished psychotherapy, who, with informed consent, decided to participate in a research project. A professional opinion was also obtained in 1995 around the issue of boundaries and it was thought that there would not be a breach in boundaries of a consulting relationship when a psychologist moves from being a therapist to being a trainer or clinical supervisor. It was agreed that when successful therapy was finished, a psychologist could move from being a therapist to being a trainer or clinical supervisor. Further, in the 1997 amendments to the Code of Ethics, it was recommended that twelve months elapse before any boundary or role changes.

24 I consulted with Dr Colin Wastell, Director of the Masters in Counselling Program, Macquarie University, regarding any difficulties that may have arisen from the treatment and termination aspects for the nine prospective participants.

25 For complete confidentiality, pseudonyms will be used and I will only describe the respondents in terms of generalities with respect to age, education and occupation, so that identification of specific individuals is avoided. Further, specific identifying information or descriptions about personal lives or storied content will be avoided. Where relevant to the research inquiry, only interactional processes and intrapersonal descriptions will be used.
... if the constructivist argues that the outcomes of any inquiry are a literal creation stemming from the interaction between inquirer and inquired-into, then there is no viable alternative to taking a subjectivist position. (Guba & Lincoln, 1990, p.146)

The researcher is involved in the creation of the data by their interactions with the respondents, an integral part of the research process. Van Manen argued that in order to enhance the research relationship, it would be helpful for researchers to reflect on their own experiences prior to exploring the phenomena with others.

... to be aware of the structure of one’s own experience of a phenomenon may provide the researcher with clues for orienting oneself to the phenomenon and thus to all the other stages of phenomenological research. (Van Manen, 1990, p.57)

This resonated with me, as I had reflected on my personal experiences of being held in my personal life, both with my partner and in my childhood, and then as a client in my own therapy. Initially, these reflections had helped me as a therapist when I held clients. I had been able to consider what reactions clients might have to being held and to consider how this could be understood therapeutically. These personal reflections also helped me as a researcher, orienting me to how people might talk about their experiences, how they might feel when invited to give their descriptions in a pre-reflected manner in addition to describing the effects and meaning.

Daly (Gilgun et al, 1992, p.108) suggested that being an insider with respect to her personal experience gave her a head start in the research. Her personal experience enabled her to know the kinds of things to say, how to say them, and when to bring them up in the course of the interview. Walker (1996) suggested that some matters might only be available to research where there was a personal connection. Both comments had relevance for this research. I was an insider. I had a personal connection as the therapist who had accompanied my clients on their therapeutic journey and had physically held them in the therapy. I was the one who had talked to them after each holding experience, dealing with their positive or negative reactions and the effects of the physical holding process. Having been the therapist, I was further along the dimension of lived experience, as compared to knowing the experience through being told; the generally accepted place of the researcher in phenomenological research (Giorgi, 1985a, pp.76-79). Further, I believed that this inside connection enabled greater cooperation (Reason & Heron, 1986, p.457) in the research. My having been the therapist could accord the respondents a greater sense of security and safety that could be translated into a greater sense of freedom of expression, less embarrassment in disclosing aspects of their experience, and a greater frankness in talking about aspects of being physically
held. I had already been proved trustworthy, as they had already spoken of their experiences and described their feelings and reactions. For them, they were doing this again, describing their experiences again, with the person who had listened to them originally. In this manner, similar to the former clients being the best candidates for the research task, I could be regarded as the best candidate for the role of researcher;\textsuperscript{26} being part of that experience, and being able to articulate aspects of that experience as a therapist.

I believed that my former clients could distinguish between the professional roles of therapist/psychologist and researcher. In my letter to them confirming my telephone call inviting them to participate in the research, I informed them that I was doing research as a post-graduate student with the School of Social Ecology, Faculty of Health, Humanities and Social Ecology, University of Western Sydney. I stated that there were a number of procedures available to them around the research if they required them. I was able to provide names of three other therapists who could debrief them, although I was also available if required. I also informed them that they could contact my supervisor, or the Human Ethics Committee at the University of Western Sydney, to discuss the project or any aspect of concern.

However, being the therapist, being the insider, could also have some negative consequences, such as interpreting a respondent’s meaning without thorough exploration, or assuming description or meaning because of my having being part of that same experience. In order to limit such negative effects, I reflected on the therapy journey with each person prior to the research interview. After each reverie I would put my reflections aside, as recommended in the bracketing process (Shapiro, 1985; Spiegelberg, 1982), in order to be with the respondents in an open and inquiring manner.

\textit{... an unusually obstinate attempt to look at the phenomena and to remain faithful to them before even thinking about them.}  
(\textit{Spiegelberg, 1982, p.717})

I felt that I was then able to orientate myself to the phenomena being described, without bias or prejudice. This orientation required a researcher to be empathic to the respondent in order to participate in their experiences. Van Manen (1990) and Daly (1992, p.108) suggested that a researcher become as familiar as possible with the events being investigated to facilitate this empathy, and then a researcher could easily use the

\textsuperscript{26} Michael Lambert (1989) recommended that individual clinicians become involved in research on their own work as a way of overcoming clinician defensiveness and patients' fears about being involved in research.
same terms as the respondents. The notion of empathy resonated within me. It was familiar to me as a therapist. Empathy is a crucial therapeutic skill (Webster, 1998a) to facilitate a therapist being able to participate in or experience a client's sensations, reactions and feelings. Considering using empathy in research gave me permission to be more involved in the research interview, to 'be with' each person as compared to being more distant or 'being away' in an emotional sense.

In phenomenological research, the voice of the researcher needs to be distinctly present.

... although a researcher's voice must always be distinct from the participant's, the researcher's voice can be grounded in the research participant's experiences and can reflect a shared understanding. (Burgess-Limerick & Burgess-Limerick, 1998)

McCutcheon (1990) spoke of the researcher's voice developing through drawing on partial autobiography as well as patient listening to the respondents and ourselves, as researchers.

... we need to be patient with ourselves, and realise that significant interpretations may be a long time in coming, and to give ourselves advice to tell the story of our research many times to other people but also to listen carefully to ourselves as we tell that story to hear our own focus and concern. We need to turn inward to try to involve our imagination and intuition. (McCutcheon, 1990)

In this research I have attempted to bring a number of distinct voices to bear; those of the former clients as well as mine as researcher, therapist, and myself personally. It has been my hope to allow each voice to emerge and be heard, braided with my researcher's voice throughout the inquiry.

4.3 Analysing the Data

Data analysis in phenomenological research27 has three broad steps: data reduction or putting the protocols into units; data display or transforming the units into meanings that are expressed in psychological and phenomenological concepts; and conclusion-drawing or developing a general description of the experience. I was guided by these steps in developing a method of analysing my data on physical holding to fit with the idiosyncrasies of the study, in particular, finding a way to allow myself as the researcher to investigate and dialogue with the transcripts in conjunction with listening to my therapist's voice.

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4.3.1 Data Reduction

Paul Colaizzi, Amedeo Giorgi and Adrian van Kaam are widely accepted (Polkinghorne, 1989; Crotty, 1996; Tesch, 1990) as providing three main ways to begin the analysis of the data in phenomenological research. Whereas Colaizzi read all the individual transcripts or protocols first, before extracting significant statements and formulating meanings, Giorgi worked on one transcript at a time, getting a sense of the whole and then identifying each meaning unit, and van Kaam categorised descriptive expressions then ranked them by frequency of occurrence before reducing these descriptive expressions to more precise terms. I decided to begin with data reduction, reading each transcript to classify the descriptive expressions and comments. A number of factors informed this starting point. I had collected eighteen interviews with accompanying clinical notes and felt overwhelmed by the mass of information. I also needed to immerse myself in being the researcher and find a comfortable place to contemplate the data I had collected. I decided to read all the transcripts and complete the data reduction by categorising the descriptions, phrases or conversation using the QSR Nud*ist qualitative computer package. I found that I began to relate to the words and descriptions within each text as well as across texts without reference to the research participants.

In contrast to using the conventional content-analytic methods (Lincoln & Guba, 1985, p.337) where the units are developed prior to the analysis, I developed the units as I categorised the texts. The Nudist program being an index system enables an index tree to be created with various units or nodes that can be modified during the data reduction. I began with four major nodes: data on respondents (1:1), experience (1:2), effect (1:3) and meaning (1:4). These eventually expanded into five to include process (1:5). Four child nodes were attached to experience, the second node: location (2:1), images (2:2), body (2:3) and frequency (2:4). These four child nodes were then further indexed. Whereas location had two sub-categories: floor (2:1:1) and lounge (2:1:2), the third node, body (2:3), had eight sub-categories: skin (2:3:1), smell (2:3:2), breasts (2:3:3), heartbeat (2:3:4), temperature (2:3:5), noise (2:3:6), kiss (2:3:7), and breath (2:3:8) (see Appendix 2). Any comments that were made that mentioned these bodily

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28 Data reduction is the term that refers to the reducing of the data into manageable units (Giorgi, 1985a, p.49). A meaning unit was defined as a part of the description whose phrases require each other to stand as a distinguishable moment (Wertz, 1985, p.165 cited in Tesch, 1990).

29 While the Nudist program assisted me with the mechanistic phase of categorisation (Drass, 1980), or the text management phase (O'Brien, 1982), I was still required to classify all words and phrases myself, as I found the searching aspect of the QSR Nud*ist program unhelpful because the searches for words or patterns did not provide any meaningful reduction into units.

30 Due to the small number of respondents and the need for privacy, I did not continue with the data node (1:1). I created the process node (1:5) during my reading of the transcripts to include comments about process such as comments about holding in the therapy, reactions to the end of sessions, and reactions to the research interview.
aspects were indexed under the nodes in body. This process was replicated for effects, meaning and process. I was guided by Strauss and Corbin's recommendation (1990, p.62) not to become overburdened with labelling and Richards and Richards's (1998) caution about the blinkering effect of theory. I allowed myself to discover the labels from the text, finding a name to encompass the description and then using it to see if it was appropriate. I did not use any psychological labelling but used labels that were faithful to the text. In line with Marshall's (1981, p.396) comments I let the units build up all the time or developed provisional categories (Lincoln & Guba, 1985, p.347), and during the data reduction process I reviewed them to see if they were still appropriate or needed to be divided into new ones.

4.3.2 Data Display

Data display is the second phase in phenomenological research analysis, where the units from the data reduction are expressed in psychological and phenomenological concepts. While Sharan Merriam (1988), Sotirios Sarantakos (1993, p.300) and Snyder (1992) spoke of the data collection and analysis occurring in a cyclical and continuous process through data reduction, data organisation and interpretation, I was unable to use this process. Instead, I read the various descriptions listed under each node after I had completed the data reduction across all the transcripts. I eliminated any irrelevant descriptions or surrounding conversations that had been included in the data reduction. In line with Merriam's (1988, p.131) comments about jotting down comments, observations and queries in the margins of the texts, I dictated mine and made comments such as "telling me about control", "experiencing fear" and, "holding and sexuality", as well as querying the categorised descriptions with questions such as, "What happens when you feel safe and relaxed?" "What did she fear?" "Why was the body important to them?" and, "Are there any other reasons?" I began asking myself questions such as, "What is this information telling me?" and, "What am I gaining from this?" and found myself initially responding from my position as therapist as I wrote out my story and

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Using the Nudist program, I classified the responses about effect around seven nodes: merging (3:1), positive (3:2), negative (3:3), beingness (3:4), regression (3:5), emotions (3:6), and adult (3:7) (see Appendix 3). Relevant conversation was categorised in either these major seven nodes or the child nodes. For example, from the second node, Positive Effects (3:2), there were seven nodes or children, ranging from soft (3:2:1), connection (3:2:2), nurturing (3:3:4) to gratification (3:2:6) and growing up (3:2:7). Some comments were placed in more than one category and I also found that some nodes could be integrated together, for example, beingness (3:4) and emotions (3:6) with positive effects (3:2).

The meaning node (1:4) had two child nodes: redress (1:4:1), that involved comments about what physical holding in therapy addressed for them; and family (1:4:2), to categorise comments made about their family or my involvement as a therapist in a family manner (see Appendix 4).

The process node (1:5) developed into six child nodes: sadness (1:5:1), that related to feelings they experienced in the process of being held; interview process (1:5:2), that related to this research; process in-session (1:5:3), comments about therapy process; between sessions (1:5:4), reactions between therapy sessions; ending therapy (1:5:5); and the Inner Child (1:5:6) that dealt with comments about their child selves (see Appendix 4).
understanding, weaving it between my comments, questions and explanations, and the respondents' quotes. Towards the end of the process of reading and commenting, I found myself less involved in the therapy journey as I became more detached and reflective on the descriptions each respondent developed and how they compared. Generalities started to emerge, as I discovered that many of the respondents had spoken of the idea of space in the context of physical holding as well as ideas such as experiencing feelings and re-experiencing childhood situations. This process, where I was discovering common elements and exploring these concepts, and the relationships between the categories, is regarded as the beginning phase of organising, abstracting and synthesising (Merriam, 1988, p.131), and theorising (Goetz & LeCompte, 1981, p.167).

Finally, following Kvale's (1996, p.47) usage of the hermeneutic circle, I read each interview through and reflected on each respondent's conversation, considering how they described their experience, what they emphasised and how I understood that as a therapist, and any gaps in descriptions that appeared relevant, while also noticing the differences between the interviews. I dictated my reflections on how the information was given in the interviews in accordance with the recommendations to be attentive to both the phenomenon and to how it was revealed, and the relationship between the two, as well as investigating each utterance and its connection or relationship with the text as a whole. My using a holistic and selective approach: holistic, by attending to the text as a whole and exploring a fundamental meaning of the text; and selective, by asking what the statements or phrases seem to be revealing about the phenomenon, can be regarded as the descriptive and interpretive analysis of the data (Pollio et al, 1997), where the descriptive deals with categorising the data and the interpretive or hermeneutic deals with the text in a holistic manner for overall understanding.

I then read my transcribed commentary on the interviews. For some of the interviews I noted that I read the whole transcript without dictating any comments, in contrast to the first three interviews, where I read and made notations as I went. In the latter three, I

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34 Kvale employed Radnitzky's (1979) canons of the hermeneutic circle: reading an interview to get a general meaning, then going back and forth between certain themes to develop their meanings, before returning to the text for more global meanings;

35 In addition to reflecting on each individual text or holding a conversation with the text (Kvale 1996, p.182; Merriam, 1988, p.131), I brought each individual text into conversation with each other (Burgess-Limerick et al, 1998, p.64). For instance, I commented that Carole's presentation felt very different to Robyn and I had to re-read Robyn's transcripts to discover that while Robyn talked about the order of how she thought about things and how physical holding was enabling, Carole spoke very specifically about the first time she was held and graphically described being "unconsciously propelled across the room." Whereas Robyn had spoken in a general manner about trusting the body and allowing emotions space, Carole initially spoke about her terrific inability to express herself, and Derek spoke of touching being a very primitive form of communication. These comments intrigued me as I contemplated the differences.

noted that I read both transcripts of a respondent before commenting, and it was with the last respondent's transcripts that I acknowledged being saturated. This is Yvonna Lincoln and Egon Guba's (1985, p.344) second stage, where descriptions and phrases from the interview transcripts became heuristic, and stimulated me to reflect and think further. Huberman and Miles (1998, p.186) spoke of analytic induction where there is the discovery of regularities by iterative procedures; a process of reflection through cycles of questions and answers and then considering the notes made in the margins, or summary sheets made. I found myself making comments on the commentary as well as schematic maps of each person's main points in their descriptions, in order to globally reflect on the meanings that were contained within.

4.3.3 Conclusion Drawing
The final third step of drawing out the conclusion was Giorgi's (1985, p.3) fourth step: the synthesis of the transformed meaning units into a consistent statement about the subject's experience. Many terms are used in considering the conclusion or the development of a general description of the experience. William Fischer (1989) termed the conclusion as the general structural description, where he explored what was happening and studied a subject's involvement in order to consider the unfolding global units, and then finally asked himself what was the psychological meaning. Polkinghorne (1989) commented that Giorgi developed a general transsituational description, using his words only after developing a situated structural description of the experience for each subject. Giorgi interrogated each meaning unit and its theme with questions such as, "What is the specific topic?" Finally, the meaning units were synthesised and tied together into a descriptive statement of essential, non-redundant psychological meanings (Polkinghorne, 1989). Wertz (1985, p.188) spoke about how the immanent meaning and structural knowledge transcends individual experience and that the researcher must determine which features of individual structures manifest a general truth and which do not. A way to do this was to read the individual experiences and check them against others. The researcher must language the general truths as they see them; the necessary and sufficient conditions, the elements and the relationships that constitute the phenomena in general.

It is here that I was most comfortable as the researcher. After I explored and commented on the data that was collected under each node in the Nudist program and then read and reflected on the transcript texts, I found, similar to Renata Tesch (1990),

37 'Saturation' is a term used in grounded theory to indicate informational redundancy (Morse, 1994, p.59) when the findings only replicate earlier ones without new categories emerging (Glaser & Strauss, 1967 cited in Adler & Adler, 1998; Sarantakos, 1993, p.141).

38 Giorgi (1985, p14) stated that the meaning units that are developed are known as 'constituents' and not elements and exist in relationship to the researcher as compared to existing in the text.
that the meaning units I had developed became transformed into a more professional, abstract language. The meaning units helped me interpret the text, enabling me to begin to consider each part within the context of the whole text as well as being able to contextualise it by placing the text in the personal circumstances of the respondent as well as the therapy process. Howard Pollio et al (1997) reminded a reader that an important aspect of the hermeneutic analysis was to understand the background context and to attempt to contextualise the descriptions as given.

The final aspect of the work was the writing up of the research, producing an analysis or plot that goes beyond the described experience. Denzin (1989) spoke of creating a text that stresses and emphasises the emergent designs and understandings, and emphasised using thick descriptions that outline the context of an experience, stating the intentions and meanings that organise the experience and reveal the experience as a process. It was my endeavour to develop a general description; a thick description that emphasised the emergent designs and understandings and showed the emerging story with the various plot elements.
CHAPTER FIVE

EXPERIENCING PHYSICAL HOLDING IN PSYCHOTHERAPY

Our hurts don't feel quiet to us and don't emerge quietly when we let them emerge at all. Pain hurts. Getting in touch with pain is a large part of the business of therapy. When we do get in touch with it, it must emerge as pain - with a groan, a whisper, a writhe, or a scream. Discussion of pain isn't expression of pain; it may be avoidance of it.

(Older, 1977)
CHAPTER FIVE

EXPERIENCING PHYSICAL HOLDING IN PSYCHOThERAPY

Physical contact was initiated by me in therapy either as a physical hug at the end of a session or as some form of physical contact, such as reaching out and touching my clients’ arms or shoulders. Five respondents referred to these various forms of physical contact leading up to being physically held in a therapy session.

Frank:    ... our relationship’s gone from not touching at all ... to having a hug on me going, to being touched - holding my arm and being hugged at various points during stressful times - then to going onto the floor and being held.

Derek:    I think for the first period, maybe the first six months or year, there may have been a holding at the end, as a goodbye or ... I remember very distinctly you taught me how to hug goodbye ...

Carole, Neil, Derek, Hilary and Frank recollected being given a hug at the end of the session. While this occurred at different intervals into therapy, ranging from one month for Hilary and three months for Derek to twelve months for Frank and two years for Neil.

Hilary:   ... I only saw you for about two or three weeks and you offered me a hug goodbye, and that alone flattened me. It knocked me around in the nicest ways of ... wow.
It was two years into Neil's therapy before I offered to hug him at the end of the session.

*Neil:* At the end of every session we exchanged hugs. Exchanged is probably a slightly misleading way of putting it, because at first I experienced that fairly passively ...

Although Ruby and Zelda had received hugs at the end of sessions they did not mention them. Whereas Ruby, like Neil, was offered a hug two years into her therapy, I offered a hug to Zelda in her first year of individual therapy, after she had been talking about her experiences of electric-shock treatment.¹ Hilary and Frank noted the physical contact in the forms of shoulder contact, arm and hand holding.

*Hilary:* And then as we moved into what you describe as physical contact, where you might have touched me on the shoulder or the like.

While the initial contact with Hilary occurred after two sessions,² I held her hand in the next session when she was distressed and later placed my arm around her shoulder for a side-on hug.³ She asked for a full hug, which I agreed to.

Twelve months into therapy, I initiated physical contact with Frank by taking his elbow as he left a session that had been painful for him, and when I felt that my words were not enough.⁴ Following this, I sat beside him and would reach out and touch his arm or shoulder at poignant moments in his work.

*Frank:* ... it was when you got the lounge that you were able to sort of, reach out and, and just touch me on the arm or provide support in that way, which I found awkward at first.

Later he said,

*Frank:* ... you hugged me when I was going, and building slowly from being hugged leaving, to occasionally, if I was becoming distressed, because I was starting to trust you enough, I realise now, trust you enough to feel distressed. Then you would either hold my arm, or just give me a hug, if I was particularly distressed.

Although this kind of physical contact occurred with everyone, it was not mentioned by all the respondents. Robyn reported being physically held very soon after the

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¹ See introductory comments on Zelda in Chapter Two, p.39.
² A hug was offered in the session on 3 December 1990, where Hilary brought some drawing work from her previous therapy to discuss. In the session, she was able to complete this drawing of herself as a little girl by giving her eyes.
³ Session on 20 December 1990 where she reported having a visual image of herself as a girl in a white dress that was stuck in mud up to her waist. We were unable to discern the significance of this in the session, due to her distress and inability to verbalise in a coherent manner.
⁴ See comments in Chapter Two, p.39.
commencement of therapy. However, it was ten months into therapy before physical contact was made by my reaching out and holding her hand when she was crying. Fourteen months prior to physically holding Carole, I had held her hand when she said that she felt she would be out of control. Following this, Carole, on a number of occasions, received a hug at the end of a session. With Neil, something different happened. Three months after being given a hug at the end of the session, I gave permission for him to follow his stated desire to sit at my feet and put his head in my lap, whereupon he asked me to hold his head.\(^5\)

While I felt that Carole’s not being able to speak had prompted the physical holding, both Neil and Brenda had accurately perceived that being physically held had occurred because progress was not being made.

**Neil:** And I think that we originally embarked on this kind of holding because we felt we’d reached the end, or I felt that I’d reached the end of that and couldn’t progress anymore. And perhaps that made it another technique that I was prepared to try.

**Brenda:** ... there was maybe three or four sessions that it almost seemed like you thought we weren’t getting where we wanted to go, there was a bit of a block perhaps, that we weren’t moving ahead perhaps ... At some point you had obviously made a decision that you were prepared to work in this way.

As with Carole, Neil and Brenda, physical holding was offered to every respondent according to their situation and circumstance. Physical holding in the form of an embrace was an intimate physical activity. It required physical contact between two bodies. I generally held my clients in the same way, similar to a mother holding a child across her body, with their head on my shoulder or upper chest area. When I held them I could feel them. I would feel whether they were allowing themselves to be held or not. If they were not letting themselves be held, I would encourage them to put their arm around my back in order to limit them holding themselves on their elbow or arm. Sometimes I asked them to hold me firmly, because I discovered that when they did this they could not remain detached and that they experienced themselves being held by me.

In holding my clients, I noticed their skin. Was it hot or cold, clammy or dry?\(^6\) I listened to their breathing. Were they holding their breath? Breathing shallowly or too

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\(^5\) Session on 5 February 1990 where he reported feeling like a cardboard cut-out. He said he felt there was a little him with no face, beside him, who wanted to be in his heart. I reported in my clinical notes observing sadness flicker across his face as I held his head in my lap.

\(^6\) I asked all my clients whom I was holding not to wear perfume or after-shave, as the smells remained with me after the session and then also could become problematic for the next client. I asked women not to wear make-up because crying stained my clothes. Most (Robyn, Carole, Derek, Fran, Ruby, Zelda) liked my using little towels over my shoulders, as they felt safer to have their feelings and not be concerned about staining my clothes. Brenda and Hilary found it unnatural and did not like it.
fast? I became attuned to their breathing and would often encourage them to focus on it, saying things like, "Allow yourself to breathe. Focus on your breathing." This allowed them to focus and relax, which in turn helped the emotional experiences to surface. I also used my breathing to help them to regulate their breathing, to calm down, or to activate their emotional state. Sometimes I would use noise to facilitate the client's process. If I wanted to encourage a client who was beginning to feel or express some emotion, I would make a little sound, sometimes sounding like a pained expression and sometimes a moaning sound. When I wanted to soothe the client, I would make little cooing, or tut-tutting, or mm-mm type sounds. And finally, heartbeat. When clients were distressed or when I wanted to help them finish the emotional work and return to an adult space, I asked them to listen to my heart. By listening to my heartbeat, they began to focus outwards, breathe more evenly and become more settled.

In summary, I began to get to know my clients in a completely different way. In addition to their words and use of language, and the way they sat and looked at me, it was the way they were in a bodily sense and what was happening inside them that I was experiencing and observing, and then using in my work with them. This occurred for my clients as well. They began to know me in a completely different way. They began to experience me in a bodily sense, which in turn focused them back to themselves.

5.1. The Bodily Experience

The respondents recalled the experience of being physically held in the therapy in terms of the physicality of the holding experience, with each person commenting about various aspects of the body, ranging from skin contact, breath, heartbeat and breasts, to clothes, smells, eyes, and noise.

5.1.1. Skin Contact

Five people, Robyn, Carole, Frank, Hilary and Neil, spoke about skin contact between us. They discussed how they could feel my skin, cheek, neck or chin, on their cheek, forehead or the top of their head, when they were held by me. With skin contact being a physical connection, they felt as if they were connected to me, and that they were in relationship with me. They reported that this heightened their experience of being held.

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7 I could slow clients' breathing down or calm them by telling them to breathe with me. Then I would breathe noticeably loudly and in a purposefully regulated way in order for them to follow me and regulate their own breathing. This encouraged them to lean on me by following my breathing pattern. Secondly, my change of breathing could activate them into an emotional state. When I stopped breathing on the outward breath, they also would stop, and this seemed to allow 'a space to develop' where clients found that they could no longer contain the feelings that were inside them.
Robyn felt a physical intimacy from being held. She commented on how she lost a sense of where she and I began.

Robyn: ... of being in the sensation of the skin contact, and I don't know whether you are familiar with it, but when you do hold somebody's hand or they hold yours, sometimes you don't have a sense of where your edge is and where their edge is.

She said she would move herself in order to experience skin contact and to get the feeling of connection.

Robyn: I know it made a difference to me, to the quality of the experience, if I could have my forehead - my cheek or my forehead - against your skin, that made the experience a lot more - nice - it was more than nice. It was that sort of sense of being connected.

Carol also spoke about the connection from having skin contact through her hand making contact with my skin.

Carole: ... it was nicer in the summer because I could feel your skin ... it would be right there [indicating with her hand resting on my neck], that's where I'd have my hand and it formed that kind of tactile connection, my nerves and your skin met, and there was this communication that I felt.

Carole reported that some of the most powerful experiences came from her being able to touch me. Carole described the longing she experienced when she touched my face. She reported that it transported her to a different place.

Carole: One moment when, I don't know what we were talking about, but I reached up and touched your face. And what I felt was that I had this little hand touching this face, and I remember I kept my hand on your face. And somehow or other, it formed such a strong connection for me. It was so familiar, or, there was a longing connection. That's what it was. I wanted that to be there. I wanted my hand to be there. I wanted your face to be there. The texture and feel of your face was really intense; it led me to all sorts of feelings and places and thoughts. I was just transported to a different place.

She elaborated on how her hand was not always around my neck but very often right next to her own face and sometimes resting on my chest. Carole commented on the fact that I kissed the top of her head, experiencing it more as maternal intimacy than a kiss per se.8

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8 While I allowed my clients to kiss me on the cheek if they were overcome with warm feelings in the therapy or when giving me a hug goodbye, I generally felt it to be taboo on my part to kiss a client because of the possibility of misinterpretation.
Carole: And I think that from time to time you would also reach down and touch me, sometimes, put your hand on the top of my head, or I think a couple of times you actually kissed me on the top of the head. It didn’t feel like a kiss. It just felt like maternal intimacy.

Hilary and Frank spoke of a number of different bodily elements coming together. Hilary talked about the permission she felt to move her head and rest it on my neck. Frank spoke broadly about the physical touch and the calmness and control he experienced from me.

Frank: ... but the way that you went about it was not to rush me. And, yes, I think you just did, as I’m starting to feel that, touch me on the arm or something as I went out, to create a contact; and that was okay. And then you just went slowly ... always with a calm about it, and always with control ...

Frank reported that the powerful experience came from the skin contact combined with sounds and warmth. He described how he felt skin contact from my chin touching the top of his head.

Frank: And it was very, very powerful, very warming to me. And I can’t really explain why. Particularly if you were also murmuring, sort of reassuring sounds, providing a cocoon of warmth and safety, nurturing, love, affection, however you would describe it. But I think because it was your skin that was against me, even though it would be against my hair, as opposed to against my own skin, that made a real big difference. It made a big difference.

Neil remembered when I put my hand on his forehead and he vividly recalled a blissful scene of his mother coming into his bedroom when he was sick and placing her hand on his forehead. He described it as having someone putting all the broken pieces together.9

Neil: ... when you put your hand on my forehead or on the top of my head, it was like letting a tightrope go slack. Which I found really wonderful.

In the second interview I reminded him of the different forms of physical contact that I made with him; rubbing his head, putting my hand on his stomach, or placing my hand on his forehead.10 Neil reported that the hand contact was not a strong part of the experience that he remembered, although he could recall the contact when I held his hand during hypnosis.11

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9 Session on 13 September 1994.
11 On 12 September 1991, I assessed Neil for hypnosis to enhance the exploration of his childhood that he had difficulty remembering in order for us to understand the cause of his emotional deadness.
Neil: I think that was really good. I think that because I was scared about hypnosis and it helped me to know I could come back. It was like an anchor, not an anchor, but a mooring rope.

Derek also briefly commented on connecting to a positive childhood experience. He spoke about his father who, in a rare show of affection touched the top of his head, which was very blissful for him.

Derek: Yeah, and my father used to stroke the top of my head as a little kid. It was the only affection I ever got from Dad. Not the only affection, but the one I remember most. And there wasn't a lot, so it's pretty dramatic. So if ever you touched the top of my head for some reason, sometimes you put your chin there, and as soon as you did, that was it, I was gone - I was in fairy land - I'm in some nirvana.

While Derek spoke of the positive experience of touch, he became fearful in therapy that he would be punished when he accidentally touched my skin on one occasion.  

5.1.2 Breath  
Five clients mentioned breathing. While Derek linked my breathing to the heartbeat, Carole, Ruby and Zelda discussed how my breathing helped them deal with emotional blockages and enabled them to find steadiness and calmness. Both Frank and Carole spoke about how I breathed for them.

Frank: ... one of the things we discovered here is that I actually didn't breathe. You used to have to keep me aware to keep breathing. And in a way, I suppose this was conscious on your part, but you actually breathed for me.

In addition to breathing for her, Carole reflected on her experiencing of the physical movement in her chest and how this satisfied something in her.

Carole: ... and feeling you breathing, your chest going up and down ... it was the physical going up and down in your chest. Most often I think it calmed me and soothed me, and it was really satisfying ...

and need for cognitive control. I found that with the trust that had developed over the two years of therapy, he was able to begin to access early emotional experiences.

12 On 8 July 1992, while I was holding Derek, he accidentally touched my back where my jumper had ridden up. He immediately became fearful that I had tricked him and he would be punished.

13 In a letter of 3 May 1990, Carole wrote about my breathing, Michelle is exactly right when she said the only time I really let go and entrusted myself to her was when she held me and I allowed myself to sink into darkness and warmth and comfort and (and this part makes me cry even before I write it) love. It may not have been coming from her, but it was close to what I was feeling ... That moment came back to me Tuesday morning (this morning) when I realised I felt such bliss then because I was released from a struggle - I had momentarily abandoned the battle to maintain some semblance of power. I was free and someone was there. Breathing with me. Heart beating with me too. Almost for me. Well, I was in another world. The pain was there too, but I didn't have to struggle with it either. I had turned power over to Michelle and she made it safe for me. My most constant battle was superseded.
Ruby talked about getting emotionally stuck and how my breathing helped her calm, which allowed her to be with her experience. She also referred to a certain thing where I would stop breathing on the outward breath to help her in her emotional experience.

Ruby: *Like, I remember initially you used to hold me and you'd actually just move, rock-move. It's like keeping the vibration going, and you'd tell me to keep breathing, and you'd say, "Breathe, Ruby, breathe," 'cause I'd get stuck. Then to help that, to shift that blockage or whatever it was, you - there's a certain thing that you do ...*

While Zelda, on the other hand, spoke about not knowing the difference between the breathing and the heartbeat, it was important to her that they matched.

Zelda: *... it was like the steadiness of your breathing, too, which I guess is connected to your heart, that somehow had a calming effect on me. And I guess that's what happens to babies when they are held by their mothers. That if they're distressed, that if they actually feel that in their mother, they calm down or they feel safe. So it was the breathing that was important. And I guess it's hard for me to say what was the heart and what was the breathing. It was all sort of the same, in a way, but it matched.*

While Neil did not comment on breathing in the interviews he had said in therapy that my breathing made me feel human, real and lovable,\(^{14}\) and on another occasion that he was fascinated by my breathing.\(^{15}\)

### 5.1.3 Heartbeat

Seven of the nine respondents commented that the heartbeat was crucial to the therapy. Derek and Robyn spoke about moving themselves so that they could hear the heartbeat. Carole spoke about listening to the heartbeat as well as feeling the pulse in my neck. The heart was a comfort to her, as it gave her warmth. My heart became her heart.

Carole: *I was often frightened and that once I understood about how comforting your heart was, it seemed to me like it was my heart. It was like, I would be sitting there, very cold and fearful and apprehensive and anxious, and it would be like, I didn't have anything myself. For a long time, I very much needed it. If I didn't have your heartbeat and I didn't have your warmth and I didn't have your contact, I would have none of my own, either.*

Carole talked further about the importance of both the heart and heartbeat for her.

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\(^{14}\) In a session on 20 October 1994, I held Neil for fifteen minutes without speaking. Afterwards he said, *my breathing made me human, real and lovable.*

\(^{15}\) Session on 27 October 1994.
Carole: Ah, the image that most comes to my mind when I think about it, is sort of curled up, nestled against your heart, because your heart played a really important part. Knowing that that was there, and hearing it, and hearing it so strong. It was like this strong central core of my life at that moment. Your heart, hearing it and feeling it.

Here, Carole spoke about the importance of my heart and how she would curl up and nestle against it. She described an image she had of my heart, not looking like a heart at all, but being this big pink thing that she would be sitting underneath with her knees up and her arms around her chest, feeling safe with the sound of the heartbeat. She felt taken care of.

Carole: ... it was that all-encompassing feeling of somebody totally taking care of me. Not in control of me, but taking care of me. For those moments I was totally safe.

However, the heartbeat took Carole further as she described the heartbeat as having a womb-like feeling. That it was warm, enfolding and organic.

Carole: I've said this I don't know how many times, it was so important to hear that and feel it and feel like it was around me. And, intellectualising, I suppose it was a very womb-like feeling. There I would be, enclosed in darkness because my eyes would be closed. Closed in darkness. Warm, enfolded, and hearing this steady, organic sound that was there for me.

The heartbeat became all-encompassing, such that Carole felt that she gave herself over to it, and then to me, her therapist. She felt that for a time she resided in me.

Carole: I completely gave all of that to you. Or it all ended up in you. I, for a while, resided in you. Your heartbeat, your warmth, your everything.

Derek also commented on the fact that when he could hear my heat pumping and could feel the rising and falling of my chest, he got into a different space, a rhythm.

Derek: ... I would wriggle my shoulders and for quite a long time I couldn't release all my weight. Remember, I'd always had an arm lifting myself off the couch because I didn't want to put my head and shoulder onto your leg or something. I think when my side of my head was on the side of your breast and I could feel, not your breath, but I could feel your heart pumping. I could hear the sound of your heart and I could feel it and I could feel the rising and falling of your chest, and I think then that I got into a rhythm.

He went on to talk about the powerfulness of being on someone's heart, that it was private, real, honest and intimate.

Derek: There's something very private about it [the heart], that's their inner workings and it's beyond the head and it's beyond. It's like it's real and it is
really what's making their life. And it's private, it's intimate, it's very real. It's not confronting, but it's very honest. To be able to listen to someone's heart, actually you get past all the persona. And then I would fall into some other place.

Frank felt that time stood still.

*Frank:* And time stood still. I can only remember putting my head and my ear to your chest, to hear the heartbeat. And I'd start to hear the heartbeat and that was it.

He reported that he was unable to describe the experience, because as soon as it started, he experienced it as an opening up where he also went away.

*Frank:* Everything would stop whilst I was there. As soon as that heartbeat would start, then I was aware of warmth, but ... I can't say any more than that, because I can't. I don't have any words to describe it, and I can't even ... I couldn't recreate that feeling, do you understand? Like, I couldn't consciously recreate the feeling. But I know that doing that produced so much warmth and love in me. And it accessed so much, it just opened everything else up.

Frank, like Neil, described the sensation as a state of wonderful paralysis and described himself as a big sponge, soaking up the warmth and love.

*Frank:* ... that was almost like a state of wonderful paralysis. You know, it was like I was transfixed by just warmth and love. The 'I' that was there would just be filled like a big warm sponge, I suppose.

He also described the effect of the heartbeat, that it provided safety and reassurance for the baby aspect within him to emerge.

*Frank:* One of the things that was extremely powerful in the safety and the reassurance for that baby aspect of me to come up, was actually for me to be placed in a position so that I could hear your heart.

Like Derek and Frank, Hilary also described the sensation of 'going' when she listened to the heart beating.

*Hilary:* No, I was just inside you, but I actually did hear your heart and that used to, I used to just go, I was gone. When I started listening to your heart, that was the end of me, I was gone.

She understood this process as the heartbeat being connected to her baby-self and the problematic issues associated with her.
Hilary: I don't really understand it. I can only surmise that because my issues, so much of my core issues have been about a baby and probably even in the womb, that the heartbeat was very significant to me.

Zelda commented that listening to my heart made her feel held. She felt that my letting her lie on my chest, hearing my heart and encouraging her to breathe, required something more than a technique, that it required realness on the part of the therapist in the holding experience. She felt that realness through my constancy and the steadiness of my heartbeat.

Zelda: Like, it was more than a technique. For you to be able to let me lie on your chest, your shoulder, and let me hear your heart and, in fact, encourage me by saying listen to your heart. I could feel you breathing. It was a sort of a constancy and a steadiness about that. I would have picked up something different if you weren't connected to me in this process.

Whereas Carole, Frank, Hilary and Zelda commented on the heartbeat facilitating the emergence of the younger or baby aspects of themselves, Ruby remembered the heartbeat most clearly at the end of the experiential work, when I invited her to listen to my heart in a soothing manner. Further, she found listening to the heartbeat and the synchronised breathing at the start of each holding experience difficult because it required her to open her chest and expose her heart.16

Ruby: It's a lot about coming out of it. I wouldn't perhaps become aware of your heartbeat until it was time or whatever, and then, I think on a number of occasions, you've said, "Listen to my heart beating," or something like that. And it would be like I'd tune into that and then I'd be aware that there was somebody there, and sort of come back into the present.

5.1.4 Breasts

Robyn, Neil, Zelda, Derek and Frank mentioned my breasts. Robyn and Neil spoke about the embarrassment17 or self-consciousness of the physical closeness.

Robyn: I have never experienced that type of holding in my memory before or since and certainly not as an adult. It was the embarrassment of being physically close. And just being able to experience your breasts, for instance, and your skin being so close and ... the smell of you. And just the intimacy of being like ... right beside, right against you.

Neil also spoke about feeling self-conscious and was distracted by both the proximity to my breasts and the sexual nature of them.

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16 I believe that opening her chest and exposing her heart meant that she was vulnerable to me and it also required her to trust and open herself to herself and to her feelings.

17 Embarrassment (3:3:2) was one of the sub-nodes under negative effects (3:3).
Neil: ... you always had a pillow on your lap and so that was alright. But I was always conscious of the fact that my face was very near your breasts. And initially I found myself very distracted by that, by its purely sexual nature.

Zelda, Neil, Derek and Frank spoke of their sense of experiencing their baby-self being breastfed by me.

Zelda: Well, I think that was probably round about the time that the breast stuff was coming up, about feeling like - a sense of my baby feeding at your breast ...

The idea of being breastfed by her mother was very uncomfortable for Zelda and she found that she needed to dissociate her baby-self in order to let her have this experience.

Zelda: I think on some level I was having it outside, because I had to. That was my baby, it wasn't me. It was to split it off, you know. And because, I think that was really important for me, a huge thing, because any image of myself being breastfed by my mother has always felt absolutely uncomfortable.

While Neil was distracted by his proximity to my breasts and the sexual nature of them, he found himself dealing with issues that involved his mother. Neil spoke about having an image of being at my breast as if he was being breastfed. Again, this image was mixed with both a maternal and a sexual element.

Neil: ... many times I felt and I actually said to you I had an image of my mouth on your breast, but I don't carry a sensory memory of actually taking in milk, and so I didn't actually have that part of it. So I had the image of my mouth at your breast, that was both maternal and sexual, sometimes together, sometimes separately.

Derek was also frank about the struggle between two parts of himself. He commented on the innate desire and urge to suck, and the looking for the connection between his mouth and a nipple when he was at the breast at the baby level. He also noted that he experienced another space when his adult came forward and was looking for something else, a much more sexual connection.

Derek: I suppose you want me to be frank ... for the vast majority of times all I would feel is a heartbeat and a chest, but sometimes I would feel a breast and I'd become very aware of it; and all I wanted to do in many cases was, was suck. I don't know if it was obvious, but I got to the point where I felt I was connecting with my mouth and then I vacillated between sexual and some other space.
Frank also experienced his baby-self being at my breast in therapy, but did not initiate conversation around that experience until after I mentioned it during the interview.\textsuperscript{18}

\textit{Frank:} ...is that my baby used to suckle from you. I - used to attach itself to your breast and to suckle from you ... as best as I can say, it was physical, it was a reality, and, because there was a - I'm not quite sure of the words for this, but there was a reality of - well, pleasure would be a word, but it's not pleasure in the sensual, it's only like an energy that I can tell you about.

What Zelda, Neil, Derek and Frank were describing were their experiences of being their baby-selves, experiencing themselves being at my breast as if I were their mother.

\textbf{5.1.5 Other body comments}

There were only a few comments on the other aspects relating to the bodily experience; clothing, smell, eyes and noise.

\textbf{5.1.5.1 Clothes}

Clothing was important, because the clients would feel the fabric and texture of my clothes as they leaned against me.\textsuperscript{19} Ruby and Hilary spoke about the significance of my clothing.

\textit{Ruby:} You always wear really nice things. I have really clear images of that first winter in 1989 when a lot of it happened. When I first started to be held and you had a lot of really beautiful, fluffy jumpers and stuff like that.

She didn't like anything tickling her nose and was fretful that she would soil my clothes, but was initially too embarrassed to tell me. Ruby connected the clothes to softness and was interested in the idea that I was comfortable in softness.

\textit{Ruby:} And there's a sense - I wonder whether it's about you - it was clear that you were really comfortable with that softness. I mean, there could be a technical term for it, transference or whatever, but you were really comfortable with your softness and that was something that I could model on. But also that [the softness] was there for me.

Similarly, Hilary spoke of softness. While she spoke of liking contact with my skin, it was feeling the fabric in my clothes that she craved. Hilary talked about the importance

\textsuperscript{18} In the session on 7 June 1990, I asked Frank to stay with the feeling of sadness, whereupon he saw a baby behind a fence, whom he said needed orange juice, breasts and milk. Later, in a session on 19 November 1992, Frank reported feeling bad and fearful of me rejecting him because he was having an image of his baby at my breast. I gave him permission to stay with the experience, which he finally found to be good. After many experiences of this, Frank took his baby-self to his own breast on 1st September 1994, saying that he would care for, protect and look after his baby-self.

\textsuperscript{19} While most clients noticed what clothing I wore, some would make comments on various aspects, such as style, fabric, colour and texture. Generally, I would just accept these comments, unless I felt required to further explore what they had said.
of colour and texture in the clothing. She recalled reacting to synthetics, their texture and odour. Further, she did not like bright colours, or mohair if it got up her nose. She liked white cotton. She thought that the colour and the fabric of white cotton helped her baby aspect come forward in her self when she was held.

_Hilary:_ Yeah, white really brings me forward. I think it’s because of the way in which white is used. It’s sort of used around softness and gentleness and yougness - babyness. There are no white fabrics that are harsh and horrible. They just don’t make them in white. And even if they did, they wouldn’t even be a harsh and horrible fabric. Yeah, it’s a baby colour. It’s a clean colour.

5.1.5.2 Smell

Robyn and Ruby spoke of smell. Robyn spoke of the embarrassment of the close physical proximity, and the sense of intimacy she felt from experiencing the therapist's breasts, skin and smell. Ruby remembered my smell and again associated it with softness.

_Ruby:_ It’s funny, I can remember the smell of you. You know, in that kind of flood of things of softness ...

Although Neil did not mention smell in the interviews, it was discussed in a session where he allowed himself to experience smelling me while being physically held.20

5.1.5.3 Eyes

Hilary spoke about eyes. For her, eyes were of great significance, as she felt that they told her whether her therapist was present to her. She contrasted this with her memories of her mother being turned away from her. She experienced her mother as rejecting her and not wanting to look at her, as if she should not have existed. She felt unwanted.

_Hilary:_ You have to have eyes. That’s what they [her inner girls] used to say all the time. Where are your eyes? Eyes tell you everything. The eyes say, "You are important. I love you. You are here. I’m here."

Although Derek did not mention it, I also recalled times when he was being held, when he would suddenly open his eyes and look at me intently and say, just like a four year

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20 In a session on 19 November 1992, Neil experienced himself as being very baby-like in the physical holding and I observed that he was actively smelling me, and gave him permission to be with me in that way. In the debriefing of the experience he reported that he saw the water on the desert and then said, I’m blessed from the experience of being able to give over to someone and feel accepted and emotionally naked.
old boy, *Do you love me?* When I said yes to this little boy, he would close his eyes and go back into experiencing.21

5.1.5.4 Noise

Frank and Robyn commented on the noises I made when I held them. They indicated that the sounds were very reassuring.

*Frank:*  *I think I should say that somehow, just the sound - it wasn’t that you were saying words, but just making a noise - was very reassuring.*

Frank felt that the noises were most important for his baby-self. He indicated that it was not only the verbal noise I made, but also the rumblings of my stomach, that made him feel reassured. He wondered whether it replicated the noise he might have felt in his mother’s womb.

*Frank:*  *I can relate it most to the baby, because that came up more strongly, and when I said - and of course, you couldn’t have talked to him. Like, you made sounds to the baby, you know; and that’s another thing, there were more sounds when the baby was around.*

Robyn also felt reassured by the verbal noises that she thought that I made to reassure her and let her know that I was connected to her. She felt she needed these verbal noises and grunts to feel okay.

*Robyn:*  *And that’s why I found it valuable, because the little “mmmmms” that you would make was a way of telling whomever needed that reassurance, “I’m still here,” without actually using the words, “I’m still here.” Somehow it was better to just hear “mmmm”.*

In summary, different aspects of the body held different significance for each person, according to their childhood history. Each person began to develop both a real and a symbolic relationship with me as their therapist. Within the symbolic relationship, different bodily aspects had significance according to how each person had been treated. At times, the significance of these elements was discovered by accident, as in the case of Neil and Derek with forehead and head contact, and Hilary with the colour white. These accidental discoveries opened each person to their early childhood experiences, allowing the positive to be re-enacted and the negative to be healed by the therapist’s caring and more appropriate response to the experience.

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21 I discovered the significance of eyes for him on 20 July 1990, where he spoke about his experience of his mother looking into his eyes.
5.2 The In-Session Effects of Physical Holding

The aim of Emotionally Focused psychotherapy is to help individuals develop a state of emotional well-being which involves both the intrapersonal and the interpersonal aspects, such as entitlement to have sentient experience and authentic relating to others. While the development of this therapy has included the classifying of feelings and emotional disorders, the psychotherapeutic developments have involved the classification of clients' emotional patterns; their process in terms of how they relate to themselves and others. Through classification, therapists can develop comprehensive intrapersonal and interpersonal assessments that then enable them to consider a therapeutic pathway that is appropriate for each client and their circumstances. While the therapy involves investigating and exploring current difficulties, much of the work involves remembering, revisiting and re-experiencing past disappointments and traumas in order to re-integrate aspects of the individual that have been avoided, denied or unexpressed, for fear of rejection, loss, or negative self-evaluation. Helping clients deal with these past events using Emotionally Focused psychotherapy involves a dialectic process between re-experiencing, expressing and finding meaning to the experience.

Initially, physical holding was offered to clients when they were in pain. I believe that how the pain was experienced and expressed evolved from the nature of the triggering event, what was underlying this, and each person's emotional patterns towards themselves and others. At the time of the offer to be physically held, seven of the nine respondents were dealing with issues that surrounded separation; having been left (Brenda and Derek), leaving a partner (Carole, Frank and Ruby), or contemplating separation (Neil, Zelda and Robyn). Everyone was at different points in this process. Brenda, sick with influenza, was in the immediacy of the separation, feeling the rejection as well as insecurity about her current studies. Derek's rejection had been two years ago

22 Initially, Greenberg and Safran (1987) classified feelings into four types: primary emotions, secondary emotions, instrumental emotions and maladaptive emotions. Later, Greenberg & Paivio (1997, p.36) elaborated the primary, secondary and instrumental categories, beginning with an internal division of adaptive and maladaptive emotions and moving to divisions into discrete emotions, bodily felt sense, complex feelings, bad feelings, and dysfunctional feelings. I have found this classificatory system unwieldy as a practising therapist. However, from reading the text closely, there is a simpler elaboration that was discussed in terms of exterior and interior experience (op.cit. p.33) but not really used in their work. Exterior experience (op.cit. p.33; Webster, 2001) relates to a client's feelings, thoughts and actions in relation to another person and can be further divided into primary and secondary experiences. Interior experience (op.cit. p.33; Webster, 2001) can be regarded as self-experience; a client's feelings, thoughts and behaviours about themselves.

23 In order to develop differential interventions, Greenberg & Paivio (1997, p.55) classified emotional disorders into five areas: inability to effect changes in relationships, avoiding or disowning feelings, problems in regulation, trauma, and dysfunctional meaning systems.

24 The story of the discovery of emotional patterns in Emotionally Focused psychotherapy was elaborated in the article, Mirror Mirror (Webster, 1995). A further elaboration of these patterns, in conjunction with the thesis of this therapy was described in Ariadne's Thread (Webster, 2001c).

25 Greenberg & Paivio (1997, p.47) described emotional pain as a complex feeling state that involves loss of relationship and damage to aspects of self.
and he was now dealing with understanding the loss of his mother in early childhood and the place of women in his life. Ruby was exploring the possibility of reconciliation after eighteen months of separation. While Carole, who had been out of her relationship for six months, was exploring why she was unassertive about her needs in relationships yet needing to be in control, Frank was exploring the matters of needs and control in his relationships with women. Neil, Zelda and Robyn were dealing with their ambivalence about their relationships that arose from feeling that their needs were not being met in their relationships. Only Hilary was different, in that she always felt secure about the future of her relationship.

In accordance with one of McNeely's (1980, p.73) motivations for physical contact, I initially used physically holding as containment, to support a client in either having the experience or staying in the emotional experience, and not attempting to abort it through fear of rejection, disapproval or abandonment. Whereas Brenda, Ruby, Robyn and Zelda were held because they were distressed and crying, Carole was held to stop her dissociating from her feeling self. Derek was held to contain his scaredness about his emotional pain, Hilary and Neil asked to be held because their talking made their pain surface, and Frank's pain emerged as a result of the physical holding process.

I discovered that after clients faced their fears of losing control or getting lost in the emotional experience, they could surrender their control to me, knowing that I was there to help them in the experience. I found that I could either enhance the process of feeling by encouraging their sentient experiencing and expressing behaviour, or stop the process by guiding them out of their experience and back into their more integrated self. As physical holding continued in-session, Geib's (1982) idea of containment as a soothing experience became relevant. I discovered from clients' feedback about being held in-session and about the hugs at the end of sessions that physical holding also became a soothing experience where clients felt calmed and cared for. Consequently, physical holding progressed from holding each person when they became distressed or pained to holding them every session, to either allow the pain to emerge and be experienced, or to soothe the client. Physical holding continued until it was no longer required.

26 In addition to physical contact being a soothing experience, Geib's notion of using physical contact to also help a client not to get lost or caught in the experiencing of pain is related more to clients' fears than to my goal as a therapist, of helping them experience the pain and not abort it prematurely. My goal is about encouraging them to stay in the experience, to feel all facets of their emotional experience in order to find completion, and then to help them emerge from that experience to process and integrate it in their emotional and mental framework.
All nine respondents spoke about the effects of being held. Some began by commenting on their having feelings in-session (Carole, Ruby, Frank), or how physical holding was a positive experience (Brenda, Neil), while others discussed the negative effects, such as embarrassment or mistrust, of the physical holding experience (Robyn, Zelda, Hilary, Derek). While I initially classified their responses about effect around the seven nodes and their child nodes, I discovered that the responses around effects could be differentiated into those relating to in-session effects, those relating to the overall effect of being physically held, and finally, those that referred to my behaviour as a therapist. In the area of in-session effects, I have ordered their responses into two main categories; identifying and feeling feelings, and remembering and re-experiencing past events. The comments about the overall effect of physical holding and those relating to therapist behaviour I have included in the next chapter, which deals with their experience and understanding of the therapeutic relationship, and its overall effect on them as clients.

5.2.1 Identifying and Feeling Feelings

Everyone mentioned or discussed discovering, identifying and experiencing feelings as a result of being physically held in therapy. Ruby, in particular, focused on this, and recalled how she went home after a session and thought to herself, I'm having feelings, I'm feeling something. I'm feeling. She said that the physical holding brought her back into herself, and enabled her to feel many feelings.

Ruby: \(\ldots \) I think I've probably felt some of my deepest pain. Fear. Like really allowed myself to feel it - and then actually going into this space of the feeling. And you know, for me that's sobbing often, and it kind of comes in waves \(\ldots\)

She described how she was rocked by me and continually reminded to breathe, which helped her get past her difficulty in feeling. It had been difficult to cry, and she described it as coming in waves and then feeling dizzy. Brenda was very emphatic that she would not have been able to access her feelings of pain if she had not been physically held. It was her being physically sick, combined with her fears about studying and the abrupt ending of her relationship, that catapulted her into feelings.

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27 See Chapter 4, footnote 31.
28 I found that the main effects appeared to be in four nodes: beingness (3:4) combined with emotions (3:6) for identifying and feeling feelings; and merging (3:1) combined with regression (3:5) for remembering and re-experiencing past events. The regression node had the most entries of all the effects nodes; 169 text units retrieved, or 2.4% of total text units in comparison to an average of 33 text units, 0.51% of total. The positive (3:2) node contained many comments that related to therapist behaviour, although growing-up (3:2:7) contained comments about the overall effect of the physical holding. Further, the negative effects node (3:3) contained comments that related to the clients' concerns about their own behaviour or their fears about the therapist's conduct in terms of trust, approval and abandonment.
Brenda: ... and I must have said to you something like, "Look, I just feel so sick, I just feel so terrible," and it just triggered something off about feeling sick and terrible and I just remember just collapsing on you and just something came absolutely almost from my pubic bone, just came absolutely from a very, very deep level - like it just ejected out somehow, it came and came and came and came, and I just remembered that sense of just feeling sick, I just felt so sick, I felt so awful, I felt so sick, just poured and rolled out and rolled out and there was an absolute change in me ...29

Brenda discussed how the physical holding started something off in her which led to her becoming very distressed and crying.

Brenda: ... I can say this really quite confidently, that I would not have made - had you not held me - I wouldn't have made the progress. No way in the world. I wouldn't have spewed out what I did. I wouldn't have got in touch with the feelings and the anger and the pain that I did. Absolutely no way.

Carole spoke about discovering feelings that she had not been able to identify or understand in her responses to situations. Feelings were identified when the holding broke down a barrier she experienced within herself, the barrier being her fear and confusion30 about not knowing what was wrong or why she was stuck. Carole saw the barrier within herself mirrored in the physical gap between us, with us sitting in chairs opposite each other. Physical holding removed that physical gap, which in turn removed the barrier within herself to herself. She poignantly says that it brought me inside.31

Carole: ... we sat across the room from each other, you were only sitting a few feet away, and I felt like there was this huge space between us. There was a huge space in distance. There was a huge space in contact. I'd look at you, and listen to what you were saying and yet I knew that there was this huge mushy gap between us, and I didn't know what it was. And once I was over there, not just next to you, but had your arms around me, it brought me inside and it removed that barrier.

29 Brenda's current predicament connected her to her past childhood trauma where her health had led her to be hospitalised as a child for a number of years. Not only did she experience the isolation and aloneness of hospital life, she experienced isolation and a sense of not belonging when she eventually returned to school, because she was not part of a peer group and was badly behind in her education.

30 Her fear and confusion was multi-layered. Her fear was both secondary, covering her primary feelings of anger and hurt, as well as primary maladaptive, relating to intrusive aspects from past events. Her confusion was secondary anxiety about catastrophic expectations and negative evaluation about expressing her primary feelings. Finally, her primary anxiety about self related to the loss or annihilation of self as a result of expressing primary experiences (Greenberg and Paivio, 1997, pp.194-228).

31 As a therapist, I understood the experience of coming back into one's body as an integration of the emotional and physical self. Reaching out to clients in a careful manner, allowing them to pull back or react when fearful, enabled them to develop trust, so that when they felt distress or pain, their adaptive need for physical contact was experienced and the feeling self naturally came forward to be acknowledged or soothed. Carole was describing her feeling-self integrating or coming back into the body.
In addition to identifying the feelings, the physical holding had two effects on Carole. Initially, physical holding soothed her.\(^{32}\)

\textit{Carole: } Most often I think it calmed me and soothed me. At first there was this hugely calming effect, and it continued to have that calming effect ... my surface level of anxiety, that I wasn't able to identify or solve, sort of went away.

After a while her mind turned to different memories and her more painful feelings emerged.\(^{33}\)

Frank said that the physical holding allowed his feelings to surface. He said that when these feelings appeared he didn't fully understand them, and that it took a few days to work out that he was distressed.

\textit{Frank: } And allowing them to surface with whatever it was they had to show or say or feel. You know, and it wasn't all showing the same. A lot of it was just feeling.

Frank also learnt to identify and have his feelings as a result of physical holding. Firstly, he said that physical contact built trust between us. He had described himself as a wounded animal\(^{34}\) capable of verbally lashing out, but the physical holding and the way that was done had the immediate effect of bringing him back into his body. He described how he controlled himself, by having a part of himself sitting in the corner,\(^{35}\) watching what was happening, censoring everything he said, listening to my words and watching my body language. As trust developed, Frank reported the effect of it taking away his control and, like Ruby and Carole, he experienced coming back into his body.

\textit{Frank: } Because I had totally suppressed - I didn't feel in my body at all. And, so when you touched me or hugged me, the very first thing it made me do was come back into my body. When you would touch me, I just had to fly back into my body. It had the actual effect of taking away that control by making me flow back in to my body. I was back in my body.

\(^{32}\) On 26 January 1990, Carole said in-session that when I held her, she felt an inner peace on the inside. On 12 April 1990 she said that during the holding she felt she was going down and floating in a safe place.

\(^{33}\) On 27 April 1990, Carole spoke about feeling like a slug on the inside and that this feeling would always be there. She felt as if there was a steel band around her head, and when I held her she began to feel angry, then felt cold and distant. In the research interview she remembered saying this and spoke further about feeling that there had been a black physical weight inside me.

\(^{34}\) Frank had used this metaphor in a poem, titled Trust, that he sent me on 11 July 1990. Angry, wounded, confused animal at bay, ready to strike and run away, you slowly calmed and gentled to stay. Not pulling away when it was tough. Slowly, not to startle, you came near, risking yourself to allay my fear, trusting me to see your motives clear, and not to attack or reject.

\(^{35}\) This is a phenomenological description of dissociation where individuals have split their emotional and physical self in order to survive physical and sexual abuse (Matsakis, 1994; van der Kolk, McFarlane & Weiss, 1996). This splitting process was first revealed by Frank on 26 April 1990 and then further elaborated over time.
Frank felt that returning to his body was the key to having feelings. He remembered how I asked him to look underneath his anger, the only feeling that he displayed, which was generally expressed in a verbally cold manner.

Frank: *I can remember a day when we were talking about something and you asked me where the pain was and it was in my stomach, and that was anger; and I'd been starting to recognise that if I was tight in the stomach, that actually meant I was feeling angry about something. But then I got to realise that pain was underneath that. But it came as a big shock to me one day - and we had a big laugh about the fact - that I could actually differentiate between different types of pain. I was actually having disappointment on that particular day. It was like getting in touch at the next level and starting to be able to differentiate the types of feelings, the types of pain, the subtler types of pain and disappointment. And being able to put a label on it and being able to understand it.*

Hilary and Zelda spoke about the emotional pain they experienced as they were held; and while Hilary felt steadied in her experience, Zelda reported that the physical holding helped her deal with current pain as well as allowing *all those years of pain locked away somewhere inside of me* to surface.

Zelda: *... I think what it probably allowed was all the pain to surface. The pain of my life, from my baby through to all my girls and my young woman, and right through.*

She described how the physical holding enabled her to be wherever she was in her reverie or in whatever feeling state she experienced.

Zelda: *I think there were many different aspects to that. Sometimes I'd just be with whatever the feeling was that was happening, with just the pain, or the loneliness, or whatever was coming up for me. Sometimes I was actually watching something that was happening, there was a drama going on inside of me, something was being leaked out inside of me - my girls were doing something or I was just observing them, and sometimes I was remembering things.*

Neil also noticed the process of what happened to him as he was physically held in therapy, and his moving from deep relaxation to observing currents of feelings.

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36 Frank is referring to a series of sessions, beginning on 15 February 1990, where I helped him identify his angry feeling as being located in his stomach. He identified his pain for the first time on 14 June 1990, after I asked him to look underneath the anger for other feelings. This is an Emotionally Focused technique: focusing and then locating the secondary reaction of anger and moving to access the primary feelings (hurt, pain, etc.) (Greenberg & Paivio, 1997; Webster, 2001a).

37 The pain about a difficult phone call with her mother only surfaced when she was physically held following the discussion on 28 November 1990.
Neil: I think that I was able to be more conscious in that exchange, to the point that I became acutely conscious. I became aware of physical and mental changes in myself during it ... I could trace an immediate sense of physical relaxation through to then observing currents of feeling in myself ... and often a sense of quite formidable relaxation.

Although he did not elaborate more specifically on his experience, my clinical notes contained comments he had made that reflected a view similar to Carole's, that the experience of being physically held moved between the emergence of pain and a soothing experience. Derek, like Neil, found that physical holding in therapy enabled him to let out his pain.

Derek: While I found the hug was a real invitation to be open ... it was like letting out the part of me that was in pain, which I don't normally expose - the part of me that is in pain. It has a space where it will come forward and be revealed.

He found that the physical holding also pacified him.

Derek: There were times, and I think they were only created through the pacification of me, through holding - my senses were pacified by holding and I felt the spot ...

In summary, physical holding had the effect of either helping clients identify and then deal with painful and difficult feelings, or helping them feel pacified and soothed when distressed and upset. All the respondents found that the physical holding experience connected them to their feeling self. Carole, Frank, Ruby and Neil spoke about the effect of physical holding on firstly bringing them back into themselves or their bodies in order for them to begin feeling. While Carole and Frank spoke about identifying feelings, everyone mentioned or spoke about the pain that was released and felt during the holding experience. In addition to the experiencing of feelings such as anger, hurt, loss and grief, Derek, Carole, Frank, Neil and Robyn mentioned or discussed the soothing aspect of the holding experience.

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38 On 26 March 1990, while he was being held, he spoke about becoming aware of his forehead hurting. On 25 November 1993, when he was feeling shame, I put my hand on his stomach and he reported feeling love flowing from him towards me. On 28 April 1994, he was debriefing from being physically held and said, Touch gives me wholeness. Words are not right for me - they fracture me.

39 On 23 March 1990, he experienced himself as a child in a corner, beaten and malnourished, whom he thought should be left to die. I offered to hold him and Derek experienced his pain surfacing in the session. On 14 April 1990, Derek arrived at the session feeling very scared, and hanging on only by knowing he was coming to the session. During the session, Derek again experienced the child, dirty and badly burnt. I entered his experience as described, bandaged the child and directed that he be taken to a hospital. This therapeutic entering into his imaginative world and becoming a participant acted to block re-traumatisation in experiencing, as I became the care-giver to look after the wounded part. My actions could eventually be internalised by the client.
5.2.2 Remembering and Re-Experiencing Past Events

Early childhood and adult experiences can contain difficult memories; memories of inappropriate actions, words or painful feelings that have not been dealt with, either because they were too painful to experience, or because no one was available to help the person through the difficulty. Memories, painful feelings, or reactive and defensive behaviour can be activated by cues in the present. These cues can take the form of action or inaction by others, or feelings, thoughts and behaviours that trigger earlier memories. One of the assumptions of Emotionally Focused therapy is that reprocessing events including those from childhood, by allowing the events to be fully experienced, enables a person to find better adaptive responses to situations. In this manner, clients who revisit developmental traumas and deal with them appropriately can find that they are more aware of the effects of others on them, are able to minimise reactive responses, and so become better equipped to deal with day-to-day living.

To help clients in Emotionally Focused psychotherapy revisit past adult and other childhood traumas involves a process of remembering and re-experiencing. Initially, a client is invited to remember these events by talking about them. During this process a therapist assesses the trauma in terms of its effect on the client back then and its current effect on the client in-session. By hearing the events of the trauma, a therapist is able to assess what happened to the client emotionally, in order to plan interventions to help the healing process. In addition, there are ongoing in-session assessments that involve working out how clients are affected by talking about the event; their reaction and relationship to that part of themselves involved in the trauma, and their behaviours, such as collapsing, crying, dissociating or becoming numb, in order to predict some of the difficulties that may arise in deeper exploration of the events. Deeper exploration is achieved by re-experiencing, through the process of regression to these earlier experiences. Regression\(^40\) can occur spontaneously or with direction. Spontaneous regressions occur when clients, talking about adult experiences, find themselves re-experiencing childhood scenes. Spontaneous regressions can also occur when clients, reminiscing on childhood matters, finds themselves overtaken by the feelings they had back in that situation. A directed regression is where a therapist invites clients to use the material of current events, such as their feelings, thoughts or actions, or the other person's comments and actions, as a point of exploration of early childhood matters.

In Emotionally Focused therapy, regression is initially directed by the therapist. However, as therapy progresses, clients will experience more spontaneous regressions

\(^{40}\) Regression has also been described as partial or complete. A partial regression refers to a client having a divided consciousness, both adult and child, and a complete regression refers to where a client loses this duality and only experiences the child perspective (Hammond, 1990, p.509).
as they begin to trust the therapeutic process and begin to feel more openly and spontaneously. A therapist, by getting to know the intricacies of their clients’ processes, can facilitate a regression subtly, by asking them to stay with any overt bodily sensations, feelings or thoughts. In Emotionally Focused therapy, a metaphorical language of the Inner Child[41] is used to talk with clients about the origins of their reactive responses, to help them develop a nurturing relationship to the child part of themselves that experiences loss or pain or hurt.

In my interviewing, all the respondents spoke about having visual memories or ‘flashes’ while they were being physically held. While many spoke of initially not understanding the significance, most commented on the experience becoming a feeling one, where they re-experienced pain and distress. Respondents spoke about their childhood memories, their reactive behaviours and their discoveries of their more childlike aspects, and spoke naturally of their Inner Child or Children. Further, a number of respondents spoke of regression experiences that took them back to baby-like sensations and experiences.

5.2.2.1 Childhood Experiences

Robyn talked about the effect of physical holding helping her acknowledge and deal with her grief about what she had not received as a child. She reported that because she had been unconscious of the presence and expectations of the younger part, she thought it was the physical holding that enabled her to stop her critical faculty and allow some part of herself to step back and allow a younger part to be present.

Robyn: *Somebody in me, sort of stepped away - the best words I can think of - allowing the unevaluative, trusting, almost like an innocent trusting of the relationship and of the process.*

She felt it was her girl, the more innocent part of her, who knew about the world of sensations and being in the body of touch.

Robyn: *My girl's always there. There's an inherent quality, I don't know whether some part of her has been silenced or she never got to speak, but certainly there is a part of my experience that relates to sensation. That is more her world than my adult world. My adult is in that world and knows that world and enjoys it, but it's that experience of being in the body of touch, of texture, of visual symbols or images.*

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[41] I say metaphorical language, as traditional therapy is against the usage of Inner Child language. Dr Greenberg (Webster, 1998) commented on the difficulty of this language from a theoretical position. I have also wanted to distance myself from the popular psychology of Inner Child work (Bradshaw, 1988, 1990; Capacechione, 1991), because of its lack of acknowledgment and understanding of the symbolic relationship, in terms of transference and countertransference, that develops in psychotherapy. However, it has been demonstrated that regressed adults have different levels of brain wave functioning in comparison to their adult functioning (Cocker et al, 1994).
Zelda discussed how the physical holding enabled her to acknowledge her childhood fears and insecurities, and the reasons for their existence. She recalled a therapy session where I had commented that her terror of the dark would have ceased if she had been physically held, not castigated.

Zelda: And I was just absolutely blown away by that, and I knew it was the truth, and it just kind of hit me. I thought, "Fuck," you know, it's like, "I needn't have had all that," if someone had held me instead of telling me, "Don't be silly, be a big girl," or, "There's nothing to be frightened of." So I guess, being held in therapy was actually being held through all my fears, the fears of my girls, and all the things that were surfacing, that needed to.

Carole emphasised that she was not remembering the pain or hurt but actually feeling it.

Carole: ... it was only when you were holding me that I was just completely one hundred percent back there again. I felt all those feelings that I didn't know that I had. At first it didn't seem like they were my feelings. Once I got used to it - that they were feelings - it made me feel what I think was everything. I don't know what everything was, but it would make me feel pain or hurt. Not remembering pain or hurt, but actually feeling it, and I could identify it with specific things.

Carole described a time as a very small child, being regularly collected from school by taxi. As she waited for a taxi she felt distant from her own mother and from the other children. She experienced isolation and sadness that she never wanted to show at the time but could feel when being held.

Carole: ... when you were holding me, I could feel myself being there, hanging onto a little tree or something like that, watching all the other kids being picked up by their mothers, and they were hugging, you know, and I was waiting for the bloody taxi, which was very often late, and I was just little ... it made me feel it again, how distant I was, not just from my mother, but from all the other kids. All the other family associations that were going on, mother-child associations, it just wasn't part of my life. And standing there made me feel terribly lonely, not lonely in the sense that I wanted other kids to come up and talk to me, but lonely, not having what they were having. And when you were holding me I could feel that isolation, and I could feel that sadness that I never wanted to show, either. 'Cause I didn't want to be a little kid standing there looking sad, so I'd always pretend I was doing something, and it was okay, and it wasn't okay.

Carole reported spontaneous regressions, where she would find herself back in a childhood experience while she was being physically held.

Carole: Because very often I would try and sit and talk to you ... and I couldn't, and that's when you would hold me, and then suddenly I'd be able to, because I would be back there again, I wouldn't be trying to talk about it from this distance, I would actually be back there.
She described having visual memories where she would see things from her past.

**Carole:** ... you're actually there again - visual memories, because my eyes were always closed, they were never open when you were holding me, and I would see things both from my past, in what I think is reality, and also distortion through fear or anxiety, and if I were to see myself in my mind's eye it would be as a child or a little girl ...

When I asked Carole, "How old do you feel now?" during the physical holding, Carole felt herself at different ages. She felt it was literal, an actual feeling that belonged to events she had experienced in childhood. She felt she could be that child again and have those feelings. Carole said that she could only experience herself back there so completely when she was being held.

**Carole:** That's how I spent, oh, God knows how many hours, crying and not having to be concerned about anything else, and being able to feel, wherever it was, that I was at that point for whatever reason I was crying ... and you'd sometimes ask me, "How old do you feel now?" and sometimes it would be four, sometimes it would be seven. It would be literal, because things would be going through my mind. They wouldn't be adult things and conversational things and explanatory things, they would be actual feelings, as if I were there ...

Brenda, in her discussion on regression and the effects of being held by the therapist, spoke about her time in hospital as a child. She had been required to spend three or four years in hospital, having to lie flat, often restrained by being tied down on a canvas frame with a metal frame on top. She described the joy and then felt the pain of making and then losing a connection to nurses who would be on duty for six weeks before moving to another ward. Further, Brenda dealt with a childhood memory of being in the kitchen where her parents may have been fighting. She was pushed away by her mother when she went to comfort her and experienced a black cloud descending over her. Brenda commented that the holding made her feel safer and not so frightened or overcome by the great cloud descending on her. She reported that when she experienced that scene again in therapy, she became that child again.

**Brenda:** I have just recalled that kitchen experience, because the memory is of Dad being this great big black figure ... Mum's sitting in this kitchen chair crying and me coming out - I must have been about two or three - and saying, "What's wrong?" and she pushed me away. I mean, I can't even say it absolutely happened, but it just did - then I turn around and walk away, this...

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42 On 6 February 1992, Brenda was rubbing her thigh as she talked about childhood matters. On inquiry, she said it felt sore, and I asked her to stay with that sensation. She began crying and punching the lounge as she remembered the painful time when she had to withstand both the pain and a limp for two years prior to being diagnosed.

43 In the second research interview Brenda reported that she felt the black cloud was her father. On 21 May 1992, Brenda did some drawings as her feelings had been overwhelming her, and these took her back to her parents fighting in the kitchen.
big, black cloud, like a big, black mat, being unrolled over the top of me and weighing me further down - but I remember you helping me sort of walk out from this mat, just holding me and walking through it.

Frank said that through the physical holding process he came back into himself and discovered younger parts of himself, namely, his boys.

Frank: ... we actually discovered my boys through that process. When I was held, particularly in the early stages, it was a signal for me somehow just to go right back into myself and contact aspects of me. They [the boys] seemed to come up of their own volition. Particularly the younger ones. And it was only through holding that that could ever have been done. But it was not only coming into myself, but somehow it contacted those deep parts of me that had been really cut off.

He said that he felt that it was not possible to dialogue with someone who could not speak, and therefore touch had been essential for him to go back into early experiences. Frank then discussed how his inner boys had different needs and that the therapist held him differently according to who was present in the session.

Frank: And, either intuitively or not, I don't know how consciously, but you would hold me in a different way, either closer or further away; both in a sense of being near to you, but also in a, the body position; so it would be out on the shoulder, or in under your chin, and, and you would respond in different ways ... and what I'm saying is that, there was something which happened, which communicated to that little person inside me, by way of touch, which was tailored to that person.

Hilary also spoke about physical holding bringing forth youngness in her.

Hilary: ... and it brought forward aspects of myself that I had no idea were there. And it would not have come forward in any other way - it brought forward youngness in me that I had only felt in very transient sorts of ways.

She commented on discovering memories about herself and her experience of banging her head in a corner of a room. She checked this out with her family, to find that she had spent her time from a baby to three years of age with her legs in plaster to her hips, and had laid or sat on a blanket in the corner from day to day. From her experiencing my heartbeat in the physical holding, and with her attempts to act out her head-banging reaction, she discovered the effect on her.

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44 It was a bit unclear as to whether Frank was referring to the difficulty of someone in pain talking, or whether he was referring to child aspects who were pre-verbal. I suspect he was talking about both.

45 When the distress and pain became unbearable for Hilary she could not avail herself of the physical holding but would leave the lounge and curl up on the floor in a corner and begin to bang her head against the wall. I would immediately stop this behaviour and hold her, talking to her and soothing that part of her that was in distress and wanting to disappear.
Hilary: ... I was uncovering memories about myself, that I was finding myself in a corner banging my head and experiencing things that weren't in my conscious memory. ... and having spent such an unbearably long time with both of my legs in plaster to my hips, sitting in a corner - that's what I did from day to day. From a baby to three, sat in a corner day after day. Two legs in plaster, unable to move and nobody around me. That's why I recall my mother's back so vividly. And the way I left the place was I banged my head. And it brought on, I realise now that rhythm, when I banged my head, it was like a heartbeat. I banged my head, not because I had a condition, but because that's how I left my pain.

Hilary found the interval of a week between sessions too long and often needed telephone contact to settle herself. She reported that she felt most dysfunctional during this time.

Hilary: But it actually sent me off into an almost terrible space, because it put me in touch with what I hadn't had. It wasn't that what I had experienced wasn't good, it was that it put me into a place of really knowing what I'd never had, and that was just terrible, just terrible.

Ruby found that the physical holding not only brought her back into herself, but it made her feel very little. Often when she was talking in therapy, she began to get flashes of the house she lived in as a little girl. She experienced it as if she was there. The accompanying feeling generally was heaviness, but she felt as if she was reclaiming herself.

Neil commented on the effect of being in an experience. In contrast to both a thoughtful remembering of childhood and to hypnotherapy, where he felt a return to childhood, the effect of physical holding was somewhere in-between. For him, it was finding an image and staying with it.

Neil: In the hypnosis, and even in conscious thought, I could go back to childhood scenes literally - I would walk through them, observing them, touching them, smelling them, sensuous while experiencing them. That kind of deeply sensuous inhabiting is not the same as what you're doing when you are thinking about it. You can still walk through it but you can't live it like that, or I can't. But this was neither of those things, and yet had aspects of both of them. But there was something more static about it too, it wasn't as lively, it was more seizing an image and staying with that image.

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46 Many clients, when feeling and re-experiencing both adult and early childhood pain, can often find it difficult to function easily in the world; they feel more vulnerable and exposed, their defences do not work as successfully, and they become more reactive to interpersonal and environmental cues. Many clients require more frequent sessions and/or medication during this time.

47 On 20 May 1992, I asked her where her girls were and she spoke about them being vulnerable and scared. In this instance she had remembered her favourite soft toy from when she was a small child, which had got lost when they moved house. She became very distressed.
However, Neil felt that while he could be either adult or child in hypnosis or thoughtful remembering, he could only be a child in the physical holding experience. Neil spoke about recognising emotional issues, and then his grieving process with respect to his mother, and what he felt he needed and hadn't received.

Neil: I mean, if you don’t understand it, well, first of all, if you’re not aware of it, it’s difficult to come to terms with. Second, if you don’t understand it, it’s even more difficult to come to terms with it. And I guess if you just say, yes, that happened, and look at that, it’s easier to move on and forgive and say, yes, we all have our failings. If it’s a great big sort of an amorphous cloud of grieving, that’s very hard ever to come to terms with it, because it’s got no names and it’s got no shape and it’s got no features. You can’t recognise it as part of human experience.

Neil, like a number of respondents, spoke about how my actions helped him to remember some caring from his family. Like Derek understanding the significance of his head being stroked or held, Neil found that when I inadvertently stroked his forehead, this was an enactment of his mother doing that when he was sick,48 and he experienced it as putting him back together again.

Derek’s pain originated in early childhood when he saw his mother tragically killed in an motor vehicle accident. When I identified his hurt around this tragic event, Derek commented on the accuracy of my words.

Derek: So then I knew what the thing that was being held was, I actually knew what it was to be cuddled. Before that, I didn’t know what it was to be cuddled, it was all just a big me. But when there was a special part of me that was very vulnerable, and I totally fucking knew what you were talking about when you said it, because it went back to when my Mum died. That was the part of me that was hurting. That’s the part I looked after.

He had felt guilty, responsible for his mother’s death, as he had been present at the accident. He found that the sensation he experienced in the physical holding enabled him to circumvent that guilt and go to his pain. He described how he could not be in his life in a way that felt right.

Derek: It [the rhythm] blocked out the feeling of guilt that I killed my mother. But I only know that now. My dynamic was that there was a bit inside me that was really, really rejected, or dis-empowered, or something, and it really did need to be held ... and there was a part of me that wanted to be in my life, but I just couldn’t find the vehicle. So you can, that was the day. That was the most important day of all the therapy we did.

48 At times, therapists trip over a significant feeling, thought or action, and can work with this in a session, whereas at other times, clients can tell the therapist what it is that is pleasurable or reminds them of either nice, soothing activities or painful and fearful ones.
5.2.2.2 The Baby-Self

Seven participants spoke about their baby-self that was identified in the experiencing process. While some mentioned the work with the baby-self or the feelings associated with that aspect (Zelda,\textsuperscript{49} Ruby\textsuperscript{50}), others talked in more detail about their experiences (Carole, Frank, Hilary, Neil, Derek). In both interviews, Carole spoke about her experience of feeling like a baby most of the time, feeling as if someone was holding her like a little baby.

	extit{Carole:} Most of the time when I've felt like a little baby and it was the warmth and comforting of that, I felt like somebody had me, holding me like a little baby. I felt like that little baby being held, and that was actually a good feeling, it wasn't like feeling like a little baby and feeling frightened or anything. When I felt most like a little baby, I mean a really little baby, it was because I felt this strong maternal presence.

When she was in this space feeling like a little baby, she'd want to put her hand up next to the therapist's face, and when she did, it always felt like a little hand.

	extit{Carole:} I'd want to put my hand up next to your face ... it wasn't like this big hand, it always felt like this little hand, and I loved touching you like that.\textsuperscript{51}

In the second interview Carole spoke about the little baby\textsuperscript{52} learning to try out her emotional experiences.

	extit{Carole:} That also starts with the being a little baby, and coming out into this cacophony of who knows what. But what I felt at the time with you, was that I did have a chance to, in safety, try out emotional responses ...

Frank said that through the physical holding he began to have a number of flashbacks, in terms of him as a baby, where he remembered and experienced his mother yelling or hitting him.

\textsuperscript{49} On 15 September 1992, she experienced an image of her baby in a suitcase. In her next session she reported this with great distress and we put the suitcase on my verandah until she was ready to deal with it. That took three years. At the time, she had been working on various incidents and traumas when she was three and also as a teenager. In the research interview, Zelda said that she felt overjoyed at her discovery, thinking that she was nearly there as she had found her baby-self. However, she also acknowledged that she was split off from that baby-self.

\textsuperscript{50} On 7 April 1993, using visualisation then drawing, she discovered her baby-self by drawing the barrier she has to other people. After drawing that barrier I asked her to look behind the wall, and she discovered a little baby curled up in the corner.

\textsuperscript{51} For Carole, in her baby-state, having the desire and enjoying touching her therapist's face can be regarded as a crucial healing moment. She had come from a family where her mother had been unpredictably violent, which led Carole to put her positive and negative feelings away. Deconditioning this process is difficult but was successful, as she began to trust that she could initiate an action without fear of any reprisal or attack.

\textsuperscript{52} On 27 May 1991, Carole said in-session, \textit{I just want to be held and to be little}. On 17 June 1991, Carole spoke about having a baby dream. On 24 June 1991, Carole spoke about some dreams where I was pregnant with a baby that she recognised was her.
Frank: ... I had a number of flashbacks during this time, but only in terms of me as a baby. And my mother yelling at me or hitting me - I'd done something. 53

He spoke about the sense of not feeling my body, or his own body, when he was being held as a baby.

Frank: ... but it was like I was a baby ... I would feel warmth and love and just general, very deep calm and happiness. I'd sort of be conscious of that, but at the same time not conscious of my body or yours. I was conscious of the 'being' but not the physical.

Similarly to Carole, who felt she resided in me for a while, Frank also experienced the baby part being inside me, going into my heart, to be fully inside me as if I was carrying the baby. 54

Frank: Well, there were two forms of things when we're talking about the baby. The baby is and was real in our connections. There were a number of times, where - how can I say this, because I was about to say physically - the baby actually went inside you. And would go into your heart and be fully inside you, as if you were carrying the baby. And that was the experience that I had. That I was actually inside you. There's a lack of consciousness and yet I could feel your warmth, and I felt that when I was being held I was being taken into a space.

Hilary felt that the greatest effect of physical holding was to bring forth her baby-self. She noted her reactions to my clothing, 55 only liking white cottons, and reacting openly in-session if my clothes were bright or synthetic. In discovering her baby-self through the physical holding, Hilary also realised that the need of the baby could not be

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53 When Frank was beginning to have these flashbacks, I suggested that we move to work on the floor and not on the lounge. On 7 June 1990, Frank felt sad and I asked him to stay with that feeling and an image emerged of a baby behind a fence. This was the first image of his baby-self.

54 In addition to feeling like a baby in my arms, Frank also experienced his baby being inside of me. On 10 March 1992, he said, The baby doesn't want to come out. He wants to stay in the womb. He is all pink and has fear. On 24 April 1993, Frank told me that I was carrying his baby-self and that he would be born. He wanted to know if this was alright with me. On 10 December 1993, Frank experienced his re-birth in-session.

55 Her reactions to my clothing are a form of acting-out. When I wore clothes she did not like, Hilary would react in the session by cutting off or dissociating. Similarly, her head-banging activity in therapy was acting-out. When she felt distressed she would attempt to soothe herself by head-banging. Similarly, Derek acted out his fear of being hurt. On 10 May 1990, Derek experienced his hands as bleeding during a regression. He held my hand and thumb as a baby does and said to me, You can take a piece, it will be okay. He was communicating that if I was going to hurt him, it would be better to do it now so he wouldn't be surprised. Neil was similar. On 4 March 1993, after some holding work, he was feeling angry, so I invited him to do some non-dominant writing (Capacchione, 1991) and he wrote, I still need to feel green. We all need joy but have to cap hurt to get it, okay. After writing this he felt very ashamed, and I reached out and held him, saying, "I like you." He began to smile and had tears, and said he wanted to feel closer to me. He said that he did not know that I liked him, and following this he began to hold onto me in the physical holding.

56 On 18 August 1992, Hilary had an image while being held: seeing herself as a little baby in a cot and being firmly grabbed by the shoulder by her mother, and feeling as if she was being choked.
filled for her, and her craving became overwhelming and very distressing, as she found herself acting out in many ways.

Hilary:  And it's a need, a craving, and no, it hasn't been filled, but it doesn't feel like it will swallow me up now, and I don't think it will ever be filled and I don't think it can ever be filled, just because I can't ever be a baby again.

Hilary described the emotional process as sinking into the therapist who was without anatomy or organs. Hilary was speaking about a cavity, an emotional space inside me as her therapist, where she felt safe enough to let go.

Hilary:  I just sunk. I sunk into you. Sometimes I felt like we'd become one and I'd actually moved inside your skin. All of that. Sunk into the need, let go of myself.

Derek spoke about the sense he had that the aspect of him being privileged in the holding process was the baby part of him.

Derek:  Sometimes I actually felt that the part of me that was being honoured in here was the baby, which is kind of like really special ...

Through being physically held, Neil discovered that he had not felt any bonding between his mother and himself, or much physical holding. This explained to him his absence of needing physical contact, which he discovered after being held in therapy. He began to understand the process of what was needed to be helpful for him and how he needed help to heal himself. He felt that he needed someone to do what was required for healing, the mothering of the baby.\(^57\)

Neil:  And there's this pain and anger that has to be experienced and let go. There's a sense to it, to me, that I don't find all that good. I mean, superficially it seems to me not very promising. There's almost the sense that I have to do all this myself, that I have to mother myself, that I have to heal myself, take the child, bathe the child myself. Whereas, in fact, I think that's something that while you have the responsibility for it, you have to ask somebody else to do it.\(^58\)

Whereas Carole, Frank and Hilary experienced their baby-selves sinking into or residing in the therapist, Neil used the term 'interpenetrate'. I believe that he was

\(^{57}\) On 18 July 1991, he spoke in-session of putting his mother in a steel box. In that session he alerted me to his having an inner boy. He said, He's in my chest, but he's not often there. Then he added, I also have a baby, but it is still embryonic.

\(^{58}\) After many sessions when Neil was regressed and working with painful material, he began to cry in-session on 14 April 1994. Although I didn't understand what was happening, I put my hand on his chest, on his breastbone, and asked him to feel the warmth. He reported feeling hurt and helpless anger and bitterness. Then he had an image of my hand crunching a black-winged bird that had been between my hand and his heart.
alluding to the same experience as the others, but found it difficult to speak about his
need, in a similar manner to his talking about *exchanging a hug* instead of *being
hugged*.

*Neil:* I lose a true awareness of who I was, where I was and separateness. That's a pretty nice thing to remember, actually. It's only after it stops, really, that you can talk about it, because while it's happening it's really unsayable. I suppose it is losing your body, becoming very light. What I'm about to say sounds sexual but it's not. It's sort of, though you interpenetrate, it's not sexual at all.

In reference to her younger aspects, Robyn spoke of *merging* being the best word she
could think of, but she didn't know whether it was really a coming into you as therapist.
In her discussion with me, she said that she felt an ambivalence, one voice within her
wanting to say merging, and another not wanting that to be said.

*Robyn:* And I think that this other comes from the other side of the brain that allows
you to be 'in being' rather than 'in doing'. In that sense, I think of it as a
sort of merging with life, a merging with livingness, when something is fully
whole and encompassed, whereas to then start to analyse it shifts it into
something else.

Brenda and Derek used words such as to *get as close as*, to *have an encompassing sort
of experience*, to be as nurtured by my mother as I could. Brenda supposed that it was
like getting back into the womb somehow.

*Brenda:* ... you just want to get as close as, as close as you possibly could - yeah, I
suppose it's like getting back into the womb, somehow.

Derek felt that on many occasions that he felt that he was little and trying to get closer to
his mother. Further, he said that what he was trying to do was to *burrow in, not to be
touched, but to be told, to be, to feel, to get a knowing*.

*Derek:* I just wanted to be as close and as nurtured by my mother as I could. I just
wanted to hear my mother say or wanted to feel for my own heart that I love
my mother and, I mean, that is easy for me to say now, but I think what I
was trying to do was burrow in, not to be touched but to be told, to be - to
feel - to get a knowing ... I was burrowing to be back with her. A little kid
trying to get closer to Mum.

Derek was commenting about being small and his desire to be nurtured by his mother,
to feel and get the knowing for himself. However, Derek was very clear that he was not
burrowing to be inside the therapist or his mother, but that he was burrowing to be back
with her. Derek spoke of beingness, a spot that was found between him and the
therapist, *soul to soul, heart to heart*, a place of unconditional love. In contrast to
Robyn, Carole, Hilary, Frank and Neil, whose experiences of their mother were negative, punitive or absent, and who were facing their baby-like feelings through being held in a caring manner, Derek lost his mother whom he experienced as loving, and was endeavouring to find her or have that experience again.

What emerged from the respondents' comments is that physical holding enabled them to experience and to be themselves, as compared to being in a more rational state. In this state there was a sense of boundary loss or a loss of a separate sense of existence. As a therapist, I understood their experiences to be ones where the therapist was there for them in such a way that they were able to stop attending to or thinking about the other person and stay with their own experiences more fully. The respondents commented on their experiences of feeling as well as their vivid remembering and re-experiencing of childhood memories and feelings. Further, seven of the nine respondents commented on experiencing regressions that allowed them to find images and experiences of when they were their baby-selves. In other words, while they were regressed, they discovered sensations or fragments of experiences or memories that enabled them to re-experience and also reconstruct narratives of what happened to them at that time. In addition, some experienced themselves being a baby, in-session, with me as their maternal figure, which also allowed them a pathway back to their earlier baby experiences that could then be dealt with in the therapy session. For some, it provided a loving and healing experience of being mothered.
CHAPTER SIX

EXPERIENCING THE THERAPY RELATIONSHIP

The lived body is the bearer of meaning.
(Shapiro, 1985, p.41)
CHAPTER SIX

EXPERIENCING THE THERAPY RELATIONSHIP

Physical holding is more than taking hold of or encountering another in a physical sense. Physical holding is an intimate encounter. I believe physical holding is about providing a particular type of relationship that would enable clients to be safe enough to have their feelings and to re-experience aspects of their adult and childhood history. Creating this type of contact developed out of my professional understanding of what I believed clients required and also from my feelings towards them. A therapist can feel many emotions for their clients during the course of therapy; sympathy, sadness, fear and anger as well as compassion, empathy and love. It was these feelings that fuelled my desire to provide an emotional experience via the physical holding experience, to facilitate remembering and re-experiencing, and to provide an emotional relationship to be experienced in itself for the internalisation of acceptance and worthiness.¹

¹ Larry Beutler and John Clarkin (1990, p.224) suggested that there are two general types of outcome in therapy: altering symptoms and resolution of internal conflicts, and that in contrast to behavioural and cognitive treatments, experiential and other psychotherapies would generally emphasise the latter. While Leslie Greenberg and Sandra Paivio (1997, p.4) outlined the goal of therapy as the integration of affective experience into a person’s existing organisation of their experience, the outcomes I have delineated for Emotionally Focused psychotherapy are positive self-experience or positive feelings towards oneself, and increased authentic relating. Further, a core proposition is that a client internalises the accepting, valuing and caring by the therapist into self-acceptance, self-worthiness and self-caring.
All the respondents spoke of how they experienced the therapeutic relationship during the physical holding; what happened between us, what it gave them and what it meant to them. In their discussions they used phrases that incorporated the word, space.

Ruby: ... in a space, like in an emotional space where certainly as an adult I've never been touched before.

Frank: ... your holding me was almost like you were providing the warm safe space for me to be me ...

Brenda: ... it really created a situation of trust ... 

Derek: No, the common space would have been the nurturing.

Carole: ... to go down into that kind of space ...

Robyn: ... it was sort of trusting the body and trusting the emotions and allowing them space, lots of space, to emerge.

These descriptions were about the space that had been created by the physical holding experience. The space between them and me, as therapist. This space felt tangible to me because I had been there as a participant. Their descriptions resonated with my memories of the therapy. At times, when they spoke of their experiences, I was fascinated by their descriptions, fascinated by the detail or the emotional content. At times, I felt transported back to the experience. At other times, I remembered what they felt like when I held them or what I felt like as I held them. The spaces they were describing were created by what happened in each session, how the holding occurred and was developed for each person, and what it did for them in their therapeutic journey.

In addition to how they experienced the physical holding and what they perceived the effects to be in-session, the final part of my inquiry dealt with the clients' understanding of the physical holding experiences. Initially, their understanding of the experiences began to evolve from what they said about my behaviour as a therapist, and how they experienced and interpreted this. In addition, some respondents were able to comment more directly about how they understood the physical holding experiences. I have presented these findings beginning with my comments as a therapist, and then the descriptions about how they experienced me, before moving to how they interpreted the

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2 Their responses about therapist behaviour were classified in both the child nodes under the positive effect (3:2): soft (3:2:1), connecting (3:2:2), reassurance (3:2:3), nurturing (3:2:4), safety (3:2:5), and gratification (3:2:6), as well as under the negative effect (3:3): fear (3:3:1), embarrassment (3:3:2), emptiness (3:3:3), expectations (3:3:4) and no time (3:3:5).

3 Using the nudist program I collected responses under two child nodes in meaning: redress (4:1), covering the respondents' comments about what they felt physical holding did for them, and family (4:2), including their comments about the sense of the maternal paradigm.
experience. Finally, I have presented what each respondent regarded as the overall outcome of the therapy.

6.1 Experiencing the Therapist

The respondents recalled my behaviour towards them during the physical holding, with some reflecting on what it meant to them and others reflecting on what it gave them. Their comments dealt with a variety of therapist behaviours ranging from non-sexual behaviour, providing safety and acceptance, to being loved and nurtured.

6.1.1 Non-Sexual Behaviour

It was my practice to be very clear that my behaviour was non-sexual. I demonstrated this by my conduct and processing of our reactions to each physical holding encounter. In addition to scrutinising my own sensate reactions, I also monitored my clients' behaviours and emotional reactions for any possible clues to erotic responses. Seven respondents spoke about the touching being non-sexual. Some discussed their experience of the physical holding as being non-sexual and others talked about experiencing sexual feelings in the physical holding.

Early in the first interview, Frank said that he knew straight away that the touch was non-sexual.

Frank: ... I always felt like there was a very clear set of messages from you about what you were doing and the fact that you were in charge of what you were doing. Do you understand? It wasn't like an invitation to go any further, it wasn't blurred edges, it was done and over. It was at your initiation, and your completion.

While this made him feel uncomfortable at first, because he did not know how to act in those situations, he became more comfortable with the physical holding and actively wanted it. Frank felt that the physical contact without a sexual component had the result of building his trust.

Frank: And it created another level of contact between you and I, and it did something ... because it had no other sexual contact or no sexual component. It allowed another level of trust to come into the situation.

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4 Although the comments on my behaviour being non-sexual were not prominent, I have included them because of recent concerns about the place of sexual and erotic feelings with physical contact.

5 My only concerning sensate reaction was a physiological surge when Brenda nuzzled her face into my neck. In ongoing sessions, I manoeuvred her face so that the sensations would not recur.

6 In addition to understanding that close physical contact in the form of physical holding could raise the topic of sexuality, I also understood that negative abstractions might occur, as six respondents had previously experienced various forms of sexual invasion, ranging from one episode of sexual violation to long-standing sexual abuse by family and other individuals.
knew straight away, as soon as you hugged me or held me or touched me, that it was non-sexual. I felt uncomfortable at first, but then I became comfortable, and then I actively wanted it.

He experienced physical holding in therapy as removing the power inherent in the therapy relationship.

Frank: ... you know, in the therapy situation there is an actual and an implied power structure. And what started to happen as you touched me - held me - was that, there was some sort of counter-balance to that hierarchical structure that’s inherent in the typical analytical setting. In a way, something about power was taken away.

Frank also had to deal with his urge to sexually touch me in the therapy. This was a re-enactment of his being sexually interfered with by his mother.7

Frank: You know that part of the reactions that I had when I regressed, or went back; at one stage I had a compulsion to touch you, but it wasn’t me as an adult, and it was a replication of something that had happened in my childhood. I was amazed at the whole process; I was amazed at just how the holding unlocked me, unlocked those memories, unlocked ... And I’m sure that it had to be in that way because it was so safe.

Hilary, in her second interview, said that she had not experienced my touch as being sexual in tone.

Hilary: There has never been an instance in which I have even had the slightest, remotest idea that your touch had any sexual or abusive or invasive tone to it.

Further, she reported that she herself had not experienced any sexual feelings as a result of being physically held, and remembered reflecting on this observation. She reported feeling healthy that she did not have an association between physical contact and sexual feelings.

Brenda and Ruby had been worried about my misinterpreting them as seeking sexual contact. Ruby reminded me of how she reassured me that her dream about my arm being around her was not sexual but rather one that reminded her of time with her mother in the kitchen as a small child.

7 On 23 November 1993, Frank realised that part of him wanted to touch me in a sexual way. I suggested that he allow the urge to be there in order for us to understand what was happening. He began to realise that the only time his mother’s touch was soft was after sexual abuse and that his inner boy of three years wanted to touch me in order to get love. I reassured him that I loved him not for what he did and that I did not want him to do anything for me. He then began to feel good.
Ruby: And for some reason we were having some sort of picnic in the courtyard there and you were there, and I spent the whole day almost like I was your baby or something, just being held, and can remember you were sitting up against this ... it was a lovely stone cottage and you were sitting with your back against the stone wall and I was just leaning against you and there was this whole thing around these tins of Canadian smoked salmon. And you had to open the tin with one hand because you had your arm around me at the same time. But it wasn't like a lesbian thing or anything; it was just like at the same time.

Brenda, who had been concerned that I might misread her need to be held as sexual because she was a lesbian, found that the holding provided her with an emotional connection that did not become sexual.

Brenda: ... I actually thought about, I was a bit apprehensive that it might, because I've been wary of sort of times in the past when I started to feel some sort of sexual - a physical turn-on. But it didn't, actually. It was interesting and I think it was just part of the process actually, because I was actually a bit surprised it didn't, but there was the emotional connection with it without that gistic over the top - where it becomes sexual, it didn't go over there.

Carole acknowledged that even though she had experienced sexual feelings on a couple of occasions, the predominant experience was warmth, and reminded me of a dream dealing with physical contact and how I was concerned at a possible sexual connotation.

Carole: There were probably a couple of times when we hugged when I had a sexual feeling - and those surprised me - but in the main it was just the warmth and being able to feel you.

Derek spoke about his mistrust of physical touch, and his not being able to differentiate between caring touch and sexual contact, and his having to deal with his own issues around sexuality.

Derek: When I was there, I didn't get an erection, I didn't get sexually aroused by it but I really got closer to you as a person and then I had to deal with a lot of my sexual stuff.

He acknowledged that at times there was another aspect of him participating in the physical holding.9

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8 On 23 March 1988 and prior to any physical contact in therapy, Carole had a dream where she was lying on the floor and I was literally tinkering inside her stomach. She reached up in the dream and kissed me. We discussed the dream at length. She felt that she was not frightened but comforted and felt warm towards me. She felt her kiss was an extension of the closeness, intimacy and warmth, in a non-sexual way. On 16 February 1989, she informed me of a dream with us touching heads and experienced a warm shock that woke her from her dream.

9 On one occasion, I experienced him stroking my upper arm in what I believed was an adult movement. I placed my hand over his and stilled him. In the next session I processed this.
Derek: There was a period when I was aware of another part of me participating in a hug.

Robyn and Neil struggled with the intimacy of the physical holding. Robyn, like Derek and Frank, acknowledged that this type of intimacy only occurred for her in a sexual relationship. Neil spoke of the disquiet that he had with respect to the holding process because, regardless of the professional relationship, he felt the personal nature of the exchange. Neil also commented that at times he had to deal with his sexual feeling from being held, because physical contact had meant sexual contact. As a result of therapy, he said he learnt that it was possible to have sexual feelings and not act on them, and to determine what he was responsible for in this area. Further, he reported that his sexual feelings vanished when he began to deal with issues around his mother.

Neil: ... it became non-sexual when I began to relate it [the breast] to my own stuff with my mother, which as we discovered during my therapy, was very early weaning, probably not either bonding, or not any decent bonding, between me and my mother and not a great deal of physical holding ... and being disempowered from actually having what I wanted, which was my mother’s breast.

The experience of my behaviour being perceived as non-sexual was important for a number of reasons. It assisted clients in developing their trust in me and also entrusting me with their bodies. Further, my conduct allowed them to explore and discuss the presence or absence of erotic sensations, and what they meant for them in the therapy.

6.1.2 Safety and Acceptance

One of the pivotal tasks of therapy is to provide a safe place for clients to explore their experiences. Acceptance is an important element that contributes to safety as therapists endeavour to communicate acceptance to clients about their circumstances and reactions. I found it easy to accept my clients’ experiences, and I provided them with constant reassurance about their reactions. Everyone spoke of the safety or acceptance they experienced from the physical holding, using phrases such as, made me feel safe, that sense of affirmation and reassurance, and affirmed me as a person and I got your support.

Safety provided clients with a space for their different needs. Whereas Brenda talked about safety to have her feelings, Carole spoke of safety in terms of being taken care of,

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10 On 11 November 1987, well before I made physical contact with Neil, he dreamed about coming into a church where there was a nun that he identified as me. In-session he commented on his need to make me into a non-person because of his anxiety about seeing me as a person, and the possibility of having sexual feelings towards me.
and Frank spoke about feeling he could be himself in that moment. Ruby felt
overwhelmed because the experience of being held was safe.\textsuperscript{11} She emphasised her
being able to stay emotionally open, and contrasted this to closing down and not feeling
when she was by herself.

\textbf{Ruby:} \textit{I simply don’t think that I can do it on my own. Because what happens
when I’m on my own, what I notice is that I go into foetal position where I
don’t stay open, and what we were doing [physical holding] by being like
that, even though I was tucked up and that kind of thing, I was at least
keeping my chest open. That matters.}

Carole described her longing for fulfilment, safety and protection, and how she
experienced this when she was being held.

\textbf{Carole:} \textit{And that longing is for that fulfilment, safety, protection, that I didn’t have,
and I was always wanting. I didn’t know what it was, and so I’d look for it
in other people. I didn’t know that all of this emptiness that I felt inside, and
sadness, was connected to something that was simply needed at one point
and never received. And I found that out. For those moments when I was
here - you holding me - it was being fulfilled, and even though I was upset,
or sad, or whatever, there was, it made my life seem whole …}

Frank, who had been fearful about safety initially, and concerned about whether I would
drop him, felt protected and safe when we worked on the floor, which enabled him to go
into early childhood memories.

\textbf{Frank:} \textit{… your holding me was almost like you were providing the warm safe space
for me to be me, whatever that was at that particular time. I can remember
not remembering where I was. I can remember just being where I was at
some time in the past. I can remember that you would hold me and it was
like going into a deep meditation. I would just go.}

Discussions around acceptance also involved comments about the clients’ fears of
disapproval and rejection. Neil described his experience as being wholly positive. He
experienced my acceptance,\textsuperscript{12} and felt gratitude\textsuperscript{13} about what he thought I was putting
myself through as a therapist.

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\textsuperscript{11} Ruby often felt ashamed after she dealt with her memories and experiences of sexual abuse. At the
end of the work in sessions on 20 February 1990 and 6 March 1990, I asked her to make eye contact
with me. In regression work, I believe it helps a client to make eye contact with the therapist in
order to be more grounded in an adult functioning place, and that the therapist can also assess any
lingering shame feelings that can be identified in the way the client can or cannot make open eye
contact. When eye contact is unable to be made, a therapist can talk gently with the client,
reassuring them, and help them make contact with the objects in the therapy room, such as the
flowers, or pretty objects the client likes, before requesting that they then make eye contact.

\textsuperscript{12} On 24 November 1994, Neil said about the holding, \textit{I feel more secure. I can let my feelings be there
and soak it up.}

\textsuperscript{13} Neil’s expression of gratitude was shown in a session on 26 March 1990, when he gave me a big hug
after I held his forehead when he was in pain and he felt that the evil was released. On 2 April 1990,
I made a note observing that Neil had held onto me tightly at the end of the session, a possible

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Neil: Powerful, I find a tremendous sense of release, warmth, deep acceptance, in the fact that I can surrender my entire physical being to somebody else.

Further, he described the sense of acceptance he experienced.

Neil: That feeling of being blessed I associate with that giving over experience ... to be able to feel yourself so accepted, so completely in, to be so naked [emotionally].

Whereas Derek said the acceptance blocked out his feeling of guilt, Neil felt forgiven when I placed my hand on his forehead.14

Neil: ... felt that if you put your hand on my forehead or on my head I felt in some way released and forgiven. And what all that had to do with, which was really nothing very much, but everything very much. I mean in a real sense nothing very much, because I'm just an ordinary person, no better or worse than most ordinary people.

He experienced a sense of surrender, feeling deeply relaxed and simplified.

Neil: I almost immediately felt a sense of relaxation. At a very deep level a sense of surrender .... I think I frequently expressed the feeling that I felt simplified. Everything that seemed complicated and hard became soft and open and easy.

Derek's experience of acceptance can be found in his description of finding the place similar to that his children sought in him as a father, where he could let go.

Derek: It's a place. You just go there and it's all gone white. It's a point. When I think about my kids, I guess they muzzled and burrowed and snuggled and really what they were after was to get in a comfortable place from which they could just let go.

Derek was also open about his concerns for approval, and how he struggled with getting what he wanted without feeling threatened.

Derek: ... I wanted what you had to give me. I wanted certainly your approval. So how can I get what I'm here to get without giving up what I came in here to give up? And if you hold me, and you expect me to act like a baby, how can I act like that and get what there is to get, but still feel not totally endangered?

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14 Clinical notes on 13 September 1994 about my placing my hand on Neil's forehead paralleling the hypnotherapy work where he recovered a memory of his mother putting her hand on his forehead and his primitive connection to her. It was my opinion that he experienced forgiveness because he no longer blamed himself for his mother's lack of physical and emotional care.
Zelda’s fear of disapproval evolved from her feelings of embarrassment and repulsion of her body.

Zelda: \(\ldots\) how I was embarrassed to start with, and I was very conscious of my body, and my weight, and \(\ldots\) how that would be for you holding me, and I felt like, obviously I had some repulsion, or some rejection of my own body, and therefore I was a bit scared that you would also feel that I'd be heavy, and I think that with all the stuff that happened to me in my childhood, I think I grew up not only feeling emotionally abandoned or rejected, but also very uncomfortable in my own body. I think I was rejecting of my body.

Zelda felt that my preparedness to hold her helped her begin to accept herself, physically and emotionally.

Zelda: Because somehow, if you were prepared to hold me, my body, then somehow that made a difference to me starting to feel okay about my body, and hold myself, not only emotionally, but also in my body.

Initially, Brenda feared my rejection around her need to be held, and it was my reassurances that gave her safety and predictability about the holding experience.

Brenda: \(\ldots\) a warm feeling, a safe feeling, there's a nice sort of feeling of predictability about it, and I guess that's safety \(\ldots\) I didn't have to be worried that you'd change your mind or go somewhere else or like someone better - that old thing [fear] that was forever - and it still does - bottles up in me \(\ldots\)

Although Robyn struggled with finding the words to express the essence of what it meant to her, she also found me safe, accepting and trustworthy in the holding experience.

Robyn: Unqualified \(\ldots\) that experience is an affirmation of me, of my existence. It was the beingness, the beingness through skin contact with another person's skin and that other person being trustworthy. It was the safety of the experience and the beingness through the skin.

Physical holding challenged Frank’s sense of badness, and allowed him to feel self-acceptance and hope.\(^{15}\)

Frank: \(\ldots\) I was judging myself extremely badly - and it [physical holding] connected me to you, it created something which allowed me to trust, but also to feel somehow that whatever we were doing, and whatever was

\(^{15}\) On 29 November 1990, Frank said, I have hope. Sitting beside me, he put his head on my lap and his arms around my legs. I stroked his head. He said, That's what I've always wanted to do and never have, and then cried. Afterwards, he reported feeling good, feeling at one with himself and with me, as if there was no separation between us.
coming out, whatever I was telling you, which to me was horrific - the content of what I was telling you was horrific and proved my badness - was okay, and that we'll get through it.

Like Frank, Robyn had experienced fear of being dropped.

Robyn: ... the only sense I can make of it was that it [physical holding] was getting to some part of me that was very young; who in fact may not have been held very much at all or may not have been held safely ... And I remember that several times that that's the sense that some part of my body had - that being dropped was imminent.

Robyn spoke of anxiety flooding her when she was distressed by intrusive self-talk. However, the physical holding created a safety which helped the internal chatter to quieten and then she began to notice what was happening inside her, in contrast to being overwhelmed.16

Robyn: ... like somebody comes up and is trying to either talk through what's happening or the speech gets faster and she's worried about something so she just goes quick, quick, quick. When I attempt to hold myself, I become her. I'd say that that's what my experience was and still is that when I am agitated - that part of me is flooding me. Whereas when I'm held by you, that part could be quieter even though she was lively, like somehow she was more contained. And there was a part of me, that more observing part, that was able to notice it rather than be fully flooded by it.

While everyone spoke of the safety or acceptance they experienced from the physical holding, I began to understand that each person needed different things to feel safe, reassured and accepted. The way I received and attended to everyone in the physical holding allowed them to find out what they needed. In addition, they had fears that related to their concerns about safety or being rejected around their needs for ongoing physical holding or around themselves, emotionally or physically. To receive the physical holding and to experience the safety and acceptance, they had to surrender themselves to the experience, open themselves or give up aspects of their defence and become vulnerable, both with me and to me.

6.1.3 Warmth and Love
My physically holding clients evolved from my clinical understanding of what was required in the therapy process, as well as my feelings towards them. As a result of hearing about their painful experiences and their efforts to keep themselves safe or to protect themselves, I felt protective towards them. I would feel warmth towards them,

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and as I got to know everyone more intimately and felt for them in their distress, I cared about what had happened to them.

The words warmth and love were used by some respondents to encapsulate the effects of the therapeutic relationship in the physical holding. Carole experienced warmth from the therapeutic relationship and interpreted this as love and understanding. She noted that it was not what was said, it was how she interpreted the experience from her bodily reaction.

Carole: Because there was something that I needed up close to me, a warmth that I needed. What I was surrounded with was coolness, and what I wanted was warmth, and that's what you provided. That's what touching and holding provided, was the physical warmth. The warmth that seemed to be love and understanding, which surrounded me. You didn't have to say those words, but that's just what I, my body, interpreted.

Zelda interpreted being consistently held and validated as being loved. She internalised being loved, which helped her deal with her fears and insecurities, and helped her to be able to love herself. She described her experience of being loved.

Zelda: ... I'd have to say it's not just about holding, it's about love. My sense was that in being held, consistently, and validated consistently, felt like being loved. The meaning that I have put on being held, not just being held, but being held in the way I've been held by you in therapy, in the process that we've gone through together, the meaning I've put on it is that I've been loved. And I've been able to internalise that enough, I think, to begin to love myself.

Zelda, like Ruby and Brenda, observed that it was not the physical holding per se that made the difference, but rather the relationship that was established and developed. Hilary also felt loved.

Hilary: I sat in a connection of feeling loved and valued, and that my experience was valid and important, and so that was the very wonderful and positive part of feeling the connection that I felt for you.

She found it challenging that I could hold her without expectation, and that she could experience being herself without any demands on her.

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17 On 16 July 1991 Carole asked me, Do you like me? Am I lovable? while being held.
18 Experiencing physical holding as being loved was traumatic for Hilary. On 19 July 1991 she asked me, Why did my mother not love me, not want me? as I was physically holding her. She broke from the physical holding and fled to a corner of the room and started banging her head, her childhood behaviour that she used to block her emotional pain. I stopped this activity and she said from her baby-self, I'm bad. As I restrained her physically she began to tell me about the plaster cast she used to wear on her legs as a small girl and how her legs were cold and itchy. On 6 December 1991, Hilary experienced her baby-self finding her mother’s milk being bad, and again she attempted to go to the corner and bang her head.
Hilary: ... and being held in such an innocent and yet powerful and loving way, is very challenging. That somebody could hold me without any demands or expectations ... and so I had always had in the back of my mind, “oh God, should I be doing something now; should I be crying or screaming or ... “ and you didn’t really have those sorts of expectations of me, and I think that’s what allowed my stuff to come up naturally - because there were no expectations; instead, what came up was me, just me. 19

Neil and Frank both felt loved by the process of physical holding. While Neil did not discuss this in the interviews, 20 Frank found it difficult to find the words to describe feeling valued and loved. 21 Frank used the image of being a big, pink teddy bear filled with a wonderful glow. Then he was able to say that it was love.

Frank: ... feeling valued. It’s hard to say, I can’t think of a better word just at the moment. Feeling valued and feeling comfortable that I was important, I suppose. It just filled me with this ... and again, I’m trying to put words to something ... but it was like I was a big, pink teddy bear. You know, just filled with all this wonderful glow. It was more like, that’s love.

Derek struggled with the fact that the person being honoured in the therapy was the little boy in him. He also struggled with his growing sense of becoming dependent on me as well as his experience of me as being caring and loving.

Derek: I was very dependent on you because of the holding. And you weren’t coming at me with sympathy, you were coming at me with love ...

Derek talked about seeking the unconditional loving he had experienced with his mother in order to love himself. 22

Derek: I wanted to be loved, and it didn’t really matter who it was. Unconditionally loved. And unconditional love is like the love of a mother, so it really didn’t matter who it was. That’s the love I’d been searching for with my lady friends. Of course, there was the part of me that didn’t love me, too. I couldn’t love it unless someone else did, and nobody else ever had. So I just

19 The demand Hilary was referring to related to her previous experience of therapy where she felt that the cathartic work demanded certain behaviours from her, such as crying or expressing anger. So when held, she was initially anxious about what was expected of her.

20 On 25 November 1993, Neil felt shame in the session. I held him and then placed my hand on his stomach. He reported feeling love flowing from him. On 8 December 1994, during the physical holding, he said, There’s a hand around my heart, and spoke of his learning about being loved and how everything inside himself slowed down.

21 Feeling loved frightened Frank. On 8 February 1990 he commented on feeling my love, I have to push it away. I’ll be vulnerable and you’ll see me. I replied, “I have already seen you,” and moved to sit beside him and gave him a hug. A barrier that he had felt between us went down then.

22 Derek spent many sessions discussing his relationships with women and finally came to understand that he was looking for mothering from them. For example, on 18 October 1991, Derek experienced his mother looking down at him angrily and scornfully, and pushing him away from the breast. He later realised the connection with women he was intimately involved with, I look at them in the same way my mother looked at me.
wanted someone in the big wide world to fucking love that part of me, enough for me to trust that it was okay to love it too.

Ruby also made reference to her mother, and how the physical holding helped her to find a space that brought back the experience of her mother's love.

Ruby: I wonder whether it's something about bringing back for me the purity of my mother's love. It's like no matter what happened, whatever I did, I was her child. And I think that was what I was taken back into.

It was the nature of the relationship between myself and my clients, how I felt towards them as well as their interpretation of that experience, that I believe was important in the physical holding experience. Rather than experiencing physical holding as a technique (although some were fearful that this was all it was), it was the relationship between us that coloured the experience. By feeling the warmth or valuing or the unconditional nature of my acceptance of them in the physical holding, they interpreted this experience as a loving one. They felt loved by me as their therapist.

6.1.4 Being Looked After and Nurtured
When the clients were regressed and experiencing painful emotions, it was my task to look after them so that they would be able to have their feelings without fear. At times, I would watch for the intensification of feelings, or a client's need for more reassurance or closer physical contact. I viewed part of my conduct as being nurturing, where I would support or emotionally nourish the clients in their distressed state. Although this could take the form of verbal reassurances, soothing sounds, and physical stroking, I believe it was the atmosphere that was created that clients experienced as nurturing to them. Many interviewees spoke about how they felt looked after and nurtured. Carole described the experience of sitting under my heart as a safe place where she felt taken care of.\textsuperscript{23}

Carole: It made me feel safe. It made me feel like I was protected and there was something strong. Because it always seemed to be strong, I took comfort in the fact of how strong this heart was, and how close to it I was. I wouldn't have said or used those words probably at the time, but it was that all-encompassing feeling of somebody totally taking care of me. Not in control of me, but taking care of me. For those moments I was totally safe. There was nothing I worried about, nothing I thought about.

Carole spoke about feeling satisfied by the experience, that she experienced something that she had missed in childhood.

\textsuperscript{23} On 27 May 1991 Carole said in-session, \textit{I just want to be held and be little.}
Carole: It was satisfying to be able to be there. It was like something I missed. It was like something that I needed and there it was, and I’d never known that that’s what I needed or wanted. I didn’t think about these things. I’m only saying that and analysing it afterwards, but it did satisfy something.\footnote{I believe that we do not know what we have missed until we have experienced it. Many clients find that they discover their need to be acknowledged, recognised or valued as a result of being acknowledged, recognised or valued in therapy.}

Frank spoke about the calmness and steadiness of my reaching out to him, and how he did not have to make any decisions. He reported experiencing this process as a nurturing one where he could be passive and receive.

Frank: ... it was set up so I didn’t have to make any decisions, it didn’t ask me to do anything, basically. And it was, very clearly, like a form of nurturing. It was something you were doing for me.

Further, he felt the nurturing not only by the cautious and gentle way I approached him but also because he always had a choice.

Frank: And I don’t think I could have gone on without having that approach, that feeling from you. But then you added another dimension by the very careful way that you approached touching me. Because it made me feel, firstly, I always had the choice - that just locked right into my mind - that it was clear what it was about, it was a nurturing thing - and I felt the word ‘appreciation’ of me came into it. It’s like you were appreciating and encouraging me. But also showing that you were connecting to me at some personal level, even though it was in, within a therapy context.

Like Carole, Frank experienced both the soothing and the nurturing and then the remembering and re-experiencing.

Frank: I think that I didn’t realise that something deep inside of me, which hadn’t been activated before, or ever since I was very young, which was that real need for nurturing, was being activated as well.

Derek spoke about the common space he experienced in the therapeutic relationship that he regarded as nurturing.

Derek: No, the common space would have been the nurturing. Your love vacillated for me between mothering, mother love (which is what I needed), and unconditional love. That’s what I felt, and I’m not saying that’s what you were doing.

Like Carole, Derek felt that he was looking for an experience that he could internalise. A space to experience being accepted, loved and nurtured. A mirror to see himself as an acceptable and lovable person.
Hilary spoke of the steadying and soothing she experienced when she was distressed. She regarded her experience of the therapeutic relationship as getting what she had not received from her mother.

_Hilary:_ You were giving me what my mother had never given me, could never give me and will never give me.

Robyn spoke indirectly of the nurturing that she experienced in the therapeutic relationship. Robyn felt that the therapeutic relationship was a positive internal resource for her at a sensorial and symbolic level, and provided her with a foundation for self-nurturing. Experiencing nurturing in the therapeutic relationship gave her the sense that she existed and that someone was pleased that she did.

_Robyn:_ ... I think it does provide a foundation, and it might be in more than one area, because I can go back and remember what it was like to be held by you and that is something that continues to be a positive resource for me. And that’s to do with the feeling level, and the sensorial level, and it’s both the niceness of those sensations, but also the symbolic meaning, like you exist. "I’m glad that you are here" is what I get out of them, anyway.

However, Robyn was also embarrassed at being held as if she was a child. Further, she found that she had expectations of the relationship that were not met, that she could not or did not discuss with me.25

_Robyn:_ Well, I think that my younger parts became too vulnerable and too exposed, in the sense that I then had expectations of my relationship with you. They then had expectations of my relationship with you and my adult wasn’t able to dialogue with them about what this holding meant for them and what this holding meant in terms of what my relationship with you meant.

Being looked after and being nurtured by me, as therapist, did a number of crucial things for these clients. They felt steadied, pacified and soothed, and taken care of.

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25 On 21 June 1995 Robyn spoke about having to ‘do it’ on her own as I was not there for her on the outside. Further, on 19 July 1995, Robyn expressed her dissatisfaction that she could not talk with me between sessions in the moment that she was experiencing difficulty. When she terminated therapy on 28 July 1995 she said that there was something she was unable to get from therapy, and she experienced talking about her unavailable mother as being replicated in therapy because of her perceived experience that I was not available enough.
6.2 A Maternal Experience

Physical holding facilitated the process of experiencing and regression, where clients not only felt their emotions but also re-experienced themselves in earlier childhood dramas. In each scenario, I took care of them as they encountered their pain. I treated them as they were in the experience: young, hurting and without defence or protection. When the episode was finished, I helped them become more adult-like so that they could process the experience and understand what had happened.

Seven of the nine respondents referred to understanding the experience of being physically held from a maternal paradigm. Derek and Neil spoke about how the actual positioning of themselves in relationship to me, as therapist, represented the maternal paradigm.

Derek: To curl up on the couch with the knees hooked up and to be held in a mothering position … What I felt was to disengage from Derek and bring up the little ones …

Neil: … quite late in our therapy we had what was almost like a Madonna and child holding, which was you sitting on the couch or on the floor and me with my head in your lap.26

Earlier, Neil had described how he moved from being distracted by the sexual aspect of the physical holding back to his own mothering experiences. He perceived the positioning of him in relationship to me as the maternal paradigm. He felt that even though he was held by his mother, he had been unable to have what he wanted, namely, his mother’s breast.

Neil: After a time I began to relate this to the maternal paradigm - obviously I would have been held by her because I was little, and children are held, because they can’t be other than held. And I would have been inarticulate and disempowered from actually having what I wanted, which was my mother’s breast. And in that nurturing, but still sexual way that we know infants and mothers bond, I began to see what we were doing as being repeating that.

Neil experienced himself as becoming bonded with me. While he felt that he had not had a satisfactory maternal experience, he understood his experience in therapy as being maternal, as well as acting to facilitate other things. He felt that the experience awoke a 'knowing' inside him about the experience.

26 On 20 August 1992, Neil said he wanted to lean over, which I encouraged, while I physically held him by having my arms around his folded body. He reported having a deep feeling of the smallest inner self and mothering. He then said to me that this was what he needed.
Neil: It awoke in me a knowledge and understanding of what I wanted. So it couldn't have been replacing it - it's almost as though it was a symbol, something that was both itself and stood for other things as well.

The experience allowed him to remember his mother's actions when he was sick. My spontaneously putting my hand on his forehead when he was lying with his head in my lap enabled a re-experiencing of his mother's palm on his forehead when he was sick.

Neil: I do remember being sick and I do remember the feeling of my mother's palm on my forehead, and probably that's one of the reasons why it feels like such a calming experience. And also very clear memories of a damp, cool face-cloth on my forehead when I had a fever, so it's probably a whole lot of stuff to do with cooling and calming and healing.

Carole also spoke about a mothering experience.

Carole: And looking at that rationally now and trying to rationally think about what this meant to me, I think it means that you gave me a mother experience, a warm and loving mother experience.

She related her not feeling whole to her early childhood experiences. Carole felt that I had provided her with a 'good enough' experience which addressed the gaps from her childhood. While she acknowledged that what she gained from the physical holding could not fill the original gap, it satisfied her enough and made her feel whole.

Carole: ... nobody's a perfect mother, but there's a good enough mother. So it didn't do what the original perfection would have done ... but it was enough to make me feel whole again.

She had talked about looking for a maternal intimacy, looking for this type of emotional fulfilment in her relationships, looking for warmth and oneness of an adult to a child.

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27 It was my practice to use a cushion so that clients avoided lying directly on my lap.
28 On 2 March 1995 he reported feeling like a timpani, and elaborated this in the research interviews, a bit like the acute sensitivity that a drum-skin has, it's just the slightest brush on it will reverberate - it's musical, highly sensitised, instantly responsive and fully aware. It made him feel healed and young.
29 One of her dream series related to her baby-self. On 17 June 1991 she dreamt about a baby, and on 24 June 1991 she talked about this baby being born and her fear that it was not with me.
30 'Good enough' experience relating to mothering is a phrase developed by D.W. Winnicott (1950) and referred to by many authors as one of the powerful metaphors Winnicott developed about the mother-child relationship (Balint, 1989; Goldman, 1993a; Casement, 1982; Kirschner, 1996). On her own initiative, Carole read extensively across the psychotherapeutic literature in her attempt to understand her therapy.
31 Carole reported my occasionally touching the top of her head, and remembering on a couple of occasions that I kissed the top of her head, as being signs of maternal intimacy.
Carole:  ... I would identify as being maternal, maybe it’s just parental, but I think of it as maternal, of that maternal figure and a child, that is a warmth and intimacy of adult to child, is what I was really looking for ...

After Carole discovered what it was that she had been searching for, she grieved for that missed opportunity with her original mother. The mothering she was experiencing in therapy then enabled her to emotionally mature.

Carole:  I think that I sort of grew up a bit. I emotionally grew up a bit, and I think that emotional input from parents, usually the mother, I suppose - or whoever it is that’s taking care of you - you have to have that emotionally to grow up. Not just instruction, or whatever it is, but that kind of feeling from somebody, and I had it for several years from you. And I think that my emotional maturing was because of that [physical holding], and I don’t think it could have happened unless that holding had taken place.

The gap inside her closed over, and the emotional maturing and growing up occurred. Carole had the opportunity to express her child emotions and have them responded to in appropriate ways. Then she found her adult feelings and responses to those difficult childhood situations.

Carole:  I was able to express child emotions and have them responded to, and I think that changes you. I think that being able to have those feelings, and having those responses, is part of growing up, and you have to experience those things, and experiencing that, then, with you, matured me emotionally, and gave me that opportunity to respond that I’d never had before.

In contrast to Neil and Carole speaking of the mothering experience, a number of participants (Frank, Zelda, Hilary) spoke about the experience in terms of my being their 'actual' mother, while others (Derek, Brenda, Ruby) spoke about the physical holding as getting them back to a mothering experience. Frank felt that it was definitely a form of nurturing, and experienced himself at times as a baby in a mother’s arms. He regarded me as his mother.

Frank:  Sometimes I felt like I was that baby in my mother’s arms. In my true mother’s arms. My true mother being the one that was here. Not the one I had naturally. I would feel warmth and love and just very deep calm and happiness ... And then at other times I would be somehow re-enacting things that had happened or feelings that I was having while things were happening, not conscious of being me or being here, or you being here.

He emphasised that his inner boys experienced me as being their actual mother. 32

Frank:  ... my boys were starting to make themselves heard, and then it just became very strong, that my boys said that you were their mother.

32 Frank had a fear of telling me in case I thought that it was not good or I would reject him.
Not only did the contact with me ease his pain or soothe him in-session, but my reassuring him that I was available in a mothering capacity on an ongoing basis was particularly helpful.

*Frank:* You know, I could give some comfort, but it was more a comfort to say, "This has happened, it can happen again," and that, "Michelle will be there, and is there". But that’s how it was. It’s like telling a little kid, "Yes, when you see your mother next, it’ll be fine," and, "Don’t forget that she’s there," and all the rest of it.

Frank acknowledged the difficulties of using the word ‘mother’, and found the term ‘mothering space’ to describe the nurturing. Brenda had a similar difficulty and used the phrase ‘mother-child thing’ when she talked about the nurturing aspect.

*Zelda* said that she felt I was the mother to her girls.\(^{33}\) By knowing that it was her girls speaking and not her adult self, she was able to express many infantile comments and requests.\(^{34}\) *Hilary* also felt that I was being her mother, and that her child parts referred to me as Mummy, although never to me directly.\(^{35}\)

*Hilary:* I used to think of you as my mother... You were just Michelle, even though sometimes some part of me did refer to you as Mummy.

In contrast to my being experienced as mother, Derek spoke about losing that mothering experience prematurely and his seeking that feeling again through physical holding. Derek, like Carole, reported realising that he had been attempting to get this experience with his lovers. When his partners wanted something from him, he felt resentful and could not trust their feelings for him. The role that I took, playing his mother, being accepting and unconditionally loving, eventually allowed him to re-experience that feeling he had been searching for. Earlier, he had commented on how *unconditional loving is like the love of a mother.*

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\(^{33}\) On 28 May 1991 her girls asked me in-session, *Will you be my mother?*

\(^{34}\) This was a difficult time for Zelda. When Zelda told another therapist, with whom she was doing some somatic work, that her girls would stay with me between sessions, the other therapist said that Zelda wasn’t able to carry me with her. Zelda felt this was a criticism. Then the therapist told Zelda in some body work that she could see Zelda’s baby frozen alive in her sternum. Zelda came to her session with me very distressed, and cried and cried. It was my opinion that the body therapist had been inappropriate in making comments and professing to ‘see into’ Zelda (Webster, 1992), who had been having her own beginning sightings of her baby-self. In Emotionally Focused Therapy, it is acceptable for clients to leave their child-selves with the therapist for safety and protection until such time as they can internalise the therapist and/or re-integrate and look after their own child self.

\(^{35}\) Hilary’s girls did ask me in-session on one occasion whether I was their mummy. Apparently, I responded by saying, *I’m sort of like that. I’m Michelle, but I’m sort of like that.*
Derek: That’s the role of the mother - stereotypically - and I didn’t give a shit who was going to play that role. I just wanted someone to love that me unconditionally.

As with Carole, it was the experience that informed him or gave meaning to the idea of mothering. He described both unconditional loving and nurturing as the space. Further, Derek spoke of the healing effect of mothering, that being loved unconditionally would allow him to love himself.

Derek: They say you see God through the eyes of your mother, and that’s the nurturing period. And I guess I was looking for some reflection of me in that reflection from someone else. If someone could love me, I could love me, and I call that the mother. Mothering might be a better word. It might not be the ideal word but it’s certainly a better word than mother.

Like Derek, Ruby spoke about finding the place that brought back the experience of her mother’s love. She felt that the holding experience enabled her to go back to that loving space that she had experienced with her mother. She did not feel that I was her mother or that she was projecting mother onto me. It was what the space represented for her, a space where she could be small and find completeness about a number of matters.

Ruby: And it’s not so much about you being an object [mother], it’s about me going back into that space where I could be small, where it was safe to be small and have that the way at some level it was. It’s like being in that place of feeling, a sense of completeness within it. It’s a felt thing.

Brenda thought of the mothering image because it felt logical to her.

Brenda: ... I mean, it’s the mother-child thing, isn’t it? Somehow I had experienced that sense of safety and the sense that it was okay for that to happen. As a child with a mother. I mean, that is what my logic tells me. If that can happen safely and I felt safe and good about it, therefore I must be okay - I can operate more safely out in the world.

On further elaboration, she felt that it was the qualities of safety, warmth and trust that are conveyed in the symbol of mother-child. However, Brenda did not feel comfortable about relating the mother-child image to her therapy experience. The idea of my being her mother felt remote to her. She felt that she had not been looking for a mother.

Brenda: ... it wasn’t my mother, it was never my mother, it never felt like my mother to me. I wasn’t looking to be mothered, I didn’t have the feeling that I was looking to be mothered.
Robyn spoke about believing that physical holding would redress something she had not had as a child. It was not that it reminded her of being held, because, like Frank, Hilary and Zelda, she suspected that she had not been held by her mother.

Robyn: And I think some part of me believed that it might redress what I didn't have as a child. It didn't actually remind me of being held by my mother. And I suspect that is because she didn't do it.

All the respondents made some comments about the meaning of the physical experience. They linked their understanding of the experience of physical holding to their early childhood experiences where they felt or realised that either there had been a lack in emotional caring or mothering, or they had been prematurely removed from that experience. Although phrases such as 'mothering', 'Madonna - child' and 'being mother' were used, it seemed to me that the phrase a 'mothering experience' captured the essence of what the respondents were referring to. Brenda, Derek and Ruby understood their early childhood experiences as ones where their opportunity to be mothered had been prematurely cut short by hospitalisation or death. Whereas Derek, Neil and Carole understood the therapy experience as being a maternal one that provided them with an experience that they had not had, or had been frustrated in, Frank, Zelda and Hilary experienced me as an 'actual' mother, providing them with a mothering experience they felt that they had never had.

6.2.1 A Mothering Experience for Regression to Infancy
The sensate experience of being mothered was evidenced when the clients were regressed to early infancy. Five participants (Derek, Frank, Hilary, Neil and Zelda) spoke of their regressive urge to suckle or be breastfed as they were being physically held. During the interview, Derek talked of his urge to search for a nipple, which had occurred in the therapy process.

Derek: I remember searching for your nipple. I suppose I have got nothing to lose by saying it, so I'll be perfectly frank - I remember I was there as a boy looking for a nipple. In my mind, I was sucking on your nipple.

He felt it gave him an extraordinary feeling of being connected as well as feeling very empowered. He reported feeling both separate and loved. In the second interview he spoke about his mouth searching for a nipple and I described to him how his mouth would pucker up and that I would give him the knuckle of my first finger to suck. Derek was surprised on two counts. Firstly, he knew the finger sucking had happened but had been unable to locate the experience - when, where and with whom. Secondly,
he had been very definite that he was sucking on my nipple in a session. Hilary also spoke of my giving her a finger to suck on and her feeling of being breastfed.

Hilary: Several times you gave me your finger ... I actually don't have a great recollection of that because I think I was very deep into that. Yes, certainly it was that sort of a feeling [being at the therapist's breast], it was a feeling of being suckled, yes. An image of it I don't recall ... it most certainly felt that I was breastfeeding.

The sensate experience of breastfeeding in therapy opened up her infant memories about breastfeeding and she came to understand the significance of her sucking her thumb as a teenager and her impulse to suck as an adult. In the second interview she acknowledged the intensity of her desire to suckle and related that to feeling that she may not have had enough physical contact with her mother, rather than being underfed.

Hilary: ... I think breast-fed babies, they respond to their mother, not necessarily to be fed, just when they want a drink, and I don't really think they're drinking for thirst's sake, they're drinking to suckle, because the contact, the sucking movement, etc., puts them in another space. Most babies, when they have extra contact with their mother outside of feeding, go to sleep, they go. And I didn't have that, I had other ways of going, I banged my head, or that when I was a child, I don't know what I did when I was a baby. But I don't really know it clearly - I just know that what was happening for me [in the therapy] was breast-feeding, but it wasn't actually about being fed, I think it was more about sucking.

Zelda, like Hilary, also had a sense of her baby feeding at my breast although she needed to dissociate from her baby self.

Zelda: I think on some level I was having it outside, because I had to. That was my baby, it wasn't me. It was to split it off, you know. And because, I think that

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36 On 25 January 1993 he had been held for a long time towards the end of the session. Following that he sent me a poem, titled, Michelle's Nipple. I felt her hand, curled. A finger bent to my lip, or was it? I drew my lip and let that finger enter. I sucked, I chewed, I sank. Deep contentment, Bliss and peace, Safety, Comfort, Love. Heaven to lie and suck one finger. One hand, one arm, one breast. No tiger can pounce, no car can crash. Peace. My tongue rolls in search of fruit. My saliva rushes waiting. No way to describe - bliss - it is where I came from and where I go.

37 On 1 November 1991 Hilary aborted in the session, saying, I'm sorry I'm bad. She went into the corner of the therapy room and said, Then I can be good. My mother couldn't feed me, she was sick and she put me away. I made her sick, I'm sorry. Her mother had referred to breastfeeding in terms of being like a cow. Hilary's memories of her mother having post-natal depression and being sent away to a woman down the street were verified by her family.

38 On 1 February 1990 Zelda said in-session, On the inside, she's wanting to yell, but she's crying more from the inside. I want my mother. Feed me with food. I've never been held. On 23 April 1991, I noted that Zelda was feeling well, and although her own physical care of herself as an adult was going well, she felt her baby wanted to suckle, and that she could not do it for herself. While she was held she experienced being breastfed by the therapist. Then, on 23 July 1991, Zelda told me that her baby-self was feeling okay and had a pink rabbit with her. She said, The baby's still being breastfed by me [therapist], and she's not ready to do it herself. Zelda reported that the baby opened her eyes the next day. Zelda had difficulties being regressed, being little or powerless, and initially felt very awkward about telling me that she was at my breast, and endeavoured a number of times to prematurely do that herself. In addition, I was unsure of my position and several times invited her to take back the baby prematurely.
was really important for me, a huge thing, because any image of myself being breastfed by my mother has always felt absolutely uncomfortable.

In addition, Zelda, like Robyn, was fearful of being seen as little.

_Zelda:_ ... it was like part of me didn't want you to see me being little, being a baby, because I have this need to be seen as strong and together, and all of that, and of course being held and becoming little often meant that that wasn't there, and yet I would often feel stronger then, after.

She was also fearful that in being regressed she might become too vulnerable and disintegrate.

_Zelda:_ ... but it was more a fear of falling apart. And so I didn't want to lose control, be out of control, and I was afraid, I think, that if I was too vulnerable or too little, that I mightn't be able to be in charge, or be in control. My fear was that I would become undone, fall apart, and not be able to really function.

Frank spoke in detail about the suckling experience. Like Derek, he made a strong connection with me.

_Frank:_ But there was a special connection that was made during that time. Everything was extraordinary, but a more than extraordinary feeling of being connected, of you loving this baby, and giving of yourself to it. And therefore, making it feel one, but also separate and loved.

Neil struggled with describing the experience of being at the breast. In contrast with Derek and Zelda but like Hilary, he did not experience breastfeeding per se, but rather described it as filling an emotional need, which I believe everyone else also felt, but maybe did not express as clearly as he did. The experience gave him great peace.

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39 On 29 June 1990, he experienced his baby-self at my breast during the physical holding. Later in the session he talked about how he had sublimated his desire for food and that he was able to go without food for days, without complaint.

40 On 21 October 1993, following Neil's comment, _I need to go back to the milk time between the three year old and him to find forgiveness_, I held him. He reported after being held that he was first aware of me as a woman and then he heard a voice say, _She won't go away_, and then he allowed himself to be there more. On 16 June 1994, Neil said that he needed a sarcophagus or the golden boat, as there was a lack of belief, a lack of nourishment. There was a wound that needed milk. Further, he said ... _it could happen but there are conditions_. _If I give myself more time and get deeper into it, I will feel the pain and the fear. I can't express it. I want to scream. It has a weight of shame and duty. With a touch, one central part of me can become a place of complete vulnerability, I will become helpless, I will become big, floating_. He went on to describe himself as a fully formed focus, very small, a curled-up person. It's all of me. It's all of me. In-session, I asked him, _What is he waiting for?_ He says, _The wound. The bathing of the wound with milk. Surrendering to that to get back._
Neil: Oh, no, no, no, I didn't censor it. My hesitation is only the milk part.\(^{41}\) Many times I felt and I actually said to you I had an image of my mouth on your breast, but I don't carry a sensory memory of actually taking in milk, and so I didn't actually have that part of it. So I had the image of my mouth at your breast, that was both maternal and sexual, sometimes together, sometimes separately ... it was sometimes just a feeling of emotional need. Desire of a different kind altogether.

While the perceived sensation of being at the breast was soothing\(^{42}\) and healing for some, it also produced many painful\(^{43}\) memories.

Being looked after and being nurtured by me, as therapist, did a number of crucial things for these clients. They felt steadied, pacified and soothed, and taken care of. These initial experiences led them to experience more primitive or deeper regressive urges, namely, having spontaneous images of being at my breast, as a baby with a mother. In disclosing these sensations, clients were encouraged to have and explore them, and many found themselves being nurtured as an infant.

### 6.3 The Healing Outcome

Although healing\(^{44}\) is a term not generally employed in psychotherapy to discuss therapy outcomes, I want to use this term to consider the outcomes in Emotionally Focused psychotherapy because there seems to be something active in its usage, a sense of aliveness for the client and for the process of the therapy. Healing can signify both the active journey of the client and also the active place of the therapist, and can bring to mind questions such as, "What heals?" and, "Who heals?" All the respondents spoke of the healing effect from physical holding; that the process of physical holding during the psychotherapy was an integral part of their healing.\(^{45}\) While everyone spoke about how they were different as a result of the therapy and the effect of discovering and satisfying

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\(^{41}\) Neil's first reference to the healing power of milk was made on 14 November 1991, when he felt he needed to be flat and washed by his mother's tears and milk. Ongoing references were between 21 October 1993 to 20 October 1994.

\(^{42}\) On 20 October 1994, Neil said that, It was like a hammock in childhood, a vessel filling up with love and going to the wound, a milk quality, a sexual feeling, intense, and it wasn't connected to me.

\(^{43}\) On 10 October 1991, during an episode of suckling on my finger, Derek regressed to a scene of his mother pacing the floor and then dropping him on the bed. On 24 September 1994, Neil had an image of a baby with a charred mouth that I understood as meaning that his mother's milk was not right for him - either the breast-milk or the bottled milk.

\(^{44}\) While healing means "to make sound or whole, to restore to health" (Delbridge, 1985), the current language used to describe therapy outcomes is often in terms of treatment outcomes or competencies measures. While Reber (1995, p.331) distinguished 'healing' from 'cure', with 'healing' being applied to less severe cases of trauma and 'cure' to more serious disease and disabilities, I prefer to consider cure using Michael Nichols and Thomas Paolini's (1986, p.60) comments in relation to interpretation, where a suggestion is curative because it aims to alter some psychic feature of the client, and to consider healing using a medical analogy of assisting a wound to get better.

\(^{45}\) It was the child node titled 'growing up' (3.2.7) that alerted me to the emergence of the healing outcome and the central place of each respondent's needs within that.
their needs, five respondents (Brenda, Derek, Carole, Neil and Frank) specifically spoke of becoming whole. Some spoke about the intrapersonal changes: becoming softer, feeling stronger, and being more accepting of self; while others discussed the interpersonal changes: being able to express their feelings, and relating differently with others.

6.3.1 Discovering and Satisfying Needs

Everyone commented about their discovering their individual needs and some commented on their experiences of having these needs satisfied in therapy. While most talked about the discovery of needs within themselves, Brenda elaborated on her loss of neediness, and Hilary and Robyn discussed how their needs had not being satisfied during the therapy process.

Carole spoke about experiencing her reactions to both positive and negative events in her childhood being neither acknowledged nor allowed. She reported experiencing me providing her with what she had needed back then and had not received. She described her need as having a quality of desperation.

Carole: ...because you'd ask me what I was feeling, and I'd say, and then I'd start talking about my mother, or a situation, and I'd see myself in that situation. I knew that I had this longing. There was something I wanted and there was a desperation that I had, inside myself, and a tension, and not so much an anger, but either a sadness or an insecurity, or, whatever it happened to be, at the time, because there was something that I needed up close to me, and it was at a distance.

She described how previously these unfulfilled needs had become longings that fuelled her inappropriate reactions and lead her into unhealthy relationships. Now Carole felt she could identify these needs, understand them and manage them.

Carole: ...it's led me to chase that longing, in inappropriate ways. Nearly all my relationships were formed in response to trying to satisfy that need, and of course always being disappointed. I would do anything. I would do anything to try and satisfy it ... the need of emotional fulfilment. Now, if I feel it, I recognise and understand it immediately. It's not as if it's wiped out. It's there and it's part of me and I understand it ... it doesn't drive me any longer. When it does come up it's totally manageable.

Like Carole, Zelda, who described her need to feel loved and held as a spiritual yearning, also found these to be met in therapy.

Zelda: It's about the, the feeling loved and feeling held. I think that for so long I had that need, that yearning in me around my own sort of spirituality or spiritual connection. I never had it with my mother, ever. I think that so much of what's happened has enabled me to feel spiritually held, as well.
Frank and Neil also discovered their needs for adult physical contact. Frank commented that he eventually became active in having those needs met in his personal life. Neil felt that he was reminded that he had a range of needs for warmth, comfort and physical contact that should be owned and not submerged in activity.

Neil: ... I had to overcome the shyness to learn to allow myself to own - that's a bit jargon-ish - to own the want. It's much easier to ignore the want. It was in actually allowing myself to have it, I have to recognise the want. And that was something I came across more than once - I kept having to relearn it - that I wanted touch, holding, skin-to-skin, or if not skin-to-skin, then at least person-to-person.

Neil reported that his awareness of his physical (not sexual) neediness was both positive and negative, as he realised he did not feel nurtured in his relationship and that he now wanted this.

Neil: For being held ... positive in the sense that it teaches me something, negative in the sense that I felt saddened and deprived because of it.

Like Carole, Derek and Brenda acknowledged that they had pursued relationships on the basis of their unmet needs. Brenda commented on how she stopped having inappropriate emotional connections as she moved beyond her need for approval and began feeling better within herself.

Brenda: ... I'm aware that just at around that time there was an absolute change in me, it was like I lost a neediness, somehow ... I just was aware what was making these quite irrational emotional connections - that just ceased. There was more a feeling of completeness within myself. I don't know whether it actually changed my life, but it was certainly a feeling within me that was better, healthier.

Similarly, Ruby spoke about feeling incomplete in some way, and her deep longing for someone to be with her around things that mattered to her.

Ruby: ... but I didn't know what exactly it was that I was longing for, I just knew that there was this really incomplete thing for me ... that comes back to the deep longing. That thing of recognition, I think, about part of me that was lost, part of me that I simply never discovered as an adult. It seems to matter, it seems to be absolutely critically important for me. It's like, without it I will die. Or without it I will continue to live life on the surface, and find that really not fulfilling.

While Carole, Derek, Frank, Brenda and Neil were now able to identify and manage their adult needs, Hilary felt that the need in her was a bottomless pit that had not been filled from her therapy experience, but one that would no longer engulf her.
Hilary: I just felt like I was entering a bottomless pit of need and it could never be filled. What can you say about a bottomless pit, it's bottomless. And it's a need, a craving. And no, it hasn't been filled, but it doesn't feel like it will swallow me up now, and I don't think it will ever be filled and I don't think it can ever be filled, just because I can't ever be a baby again.

Hilary spoke about always knowing both the need and the ache it caused her. She experienced the ache becoming bigger and deeper during her therapy. In contrast to Carole, who felt that the physical holding made her feel whole again, Hilary did not experience this, as she felt that while the physical contact took the lid off, it did not fill her need to be touched that she described as bottomless. However, she acknowledged in the second interview that the physical holding enabled her to discover and then face her neediness as well as helping her with the pain.

Hilary: And so then we moved into holding and the need became greater, and I felt like it was going to swallow me alive and I might not even survive. But the holding also had an effect of holding me, as well. It was like in some ways the need was actually being met, so even though, on the one hand, physically holding me was opening me up, physically holding was also meeting some of that need.

Robyn, like the others, discovered her needs but, as with Hilary, felt that her needs were not able to be fully satisfied, and felt incomplete as a result of her therapy.

The discovery that their needs for warmth, caring, loving and physical contact had been suppressed or denied because of unsatisfying childhood experiences surprised everyone. Some reflected on their past behaviour of pursuing these needs inappropriately in adult relationships, while others reflected on their new feeling of wholeness or their sense of entitlement to have these needs met appropriately in their intimate relationships. However, for Hilary and Robyn the discovery of these needs and their experience that I could neither satisfactorily meet these needs in therapy nor make up for the childhood deficit was difficult, although they acknowledged that both the recognising of their needs and the grieving for them being unmet in childhood had been productive.

46 On 14 June 1994 Hilary said, No one can be there for me. I have to do it on my own. I believe that her realisation that no one could fill her need or be there for her came from her disappointment in the therapy, where she struggled with matters such as my not being more available to her between sessions, my limiting this contact to helping her hold between sessions, and my reluctance to disclose too much personal information on questioning.
6.3.2 Intrapersonal Changes

The intrapersonal changes that were described ranged from developing softness and becoming less reactive to others, to a new sense of wholeness in their self-experience.

6.3.2.1 Softness

Brenda, Ruby and Hilary described their intrapersonal changes in terms of softness.

*Brenda: ... I’m not a different person but I’m just much more in tune with myself, with my own feelings and who I really am. It sort of cut away a sharp edge - it’s rounded me off somehow ...*

Brenda spoke about how she felt a more rounded person, more empathic and less judgmental, feeling better about herself and taking responsibility for her behaviour. She felt *more solid a person.* She also attributed this to the letting out of her anger, as well as her not being reactive but rather being able to reflect on situations.

*Brenda: ... but I feel better about myself, I take responsibility for my own behaviour, I just feel a nicer person really, and I think there is more quality in my life. I sort of make better connections. I have more empathy, and I think that was always there but I think I didn’t work with it, that I didn’t take advantage of it. I’m not so judgmental - no way in the world - I mean, I just cut that way away ...*

Ruby described the healing effect as a mini transformation, feeling that after each time she was held she was different. She reported that she was now able to feel her feelings and not brace or control herself. She felt softer and more real.47

*Ruby: It’s like I had this incredibly brittle, hard, tough, outer shell, and what was happening is that it’s become more full, it’s been filled up with more softness and tenderness and realness ... It’s like it [the holding] made it safe for me to be that open and vulnerable with somebody else there and I don’t think I was ever that open and vulnerable by myself either, since I was a little child.*

In asking Hilary whether the physical holding helped her, she reported that it helped her become softer, to grow up and be more accepting of herself and others.

*Hilary: Yeah, it did help me to grow. It helped me to grow in a more loving way, a more accepting way. I guess because I had been giving myself such a bad time, judging myself, criticising myself, putting labels on myself. So I felt that I started to become a lot softer in how I viewed people, that when I saw them acting out or being distressed or something, whatever it might be, I was able to actually understand more, it gave me wisdom. That’s how I grew.*

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47 On 11 October 1989, very early in her therapy work, Ruby dreamt of a dead body that came alive. A dead body that had been petrified into stone or wood. In 1991, Ruby began to explore the sensation of a band of steel around her forehead when her child part did not feel heard.
6.3.2.2 Wholeness

Whereas Brenda, Ruby and Hilary spoke of feeling softer and rounder, Carole felt that the effect of being physically held enabled her to heal from her childhood wounds. While it did not deny or remove what had occurred, physical holding enabled her to have her experience in different circumstances, and it released the emotional blocks within her.


Her experience of wholeness related to her earlier experiences.

Carole: I felt whole within myself. I didn't feel like I feel whole within myself now, sitting here talking with you, I felt whole within myself at whether I was four years old or seven years old, or whatever it was. There was something that I needed at those ages ... it would seem that you were now providing, and it was like being there again, and finally having this thing ...

The effect of experiencing the feelings, from identifying them to feeling them, enabled Carole to feel whole again and she felt that it gave her emotional maturity, as she could identify and have her feelings in adulthood.

Carole: And helped me through that point to go on beyond that need ... that's the emotional maturity ...

Similarly, Frank described the effect of physical holding on his emotional maturity as a process of growing him up.

Frank: ... I felt you were growing me by holding me. I mean, in a physical sense, as well as emotional. You know, I know that's not a possibility [growing up physically]. Having said that, I've just realised that my shoe size went up a couple of sizes during that period; you might remember I did tell you that. But I actually felt that you were growing me.

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48 On 4 August 1991, I asked her to find her baby-self using an internal visualisation and Carole found her crying on a bed. I asked her to go and hold the baby, which she did, and Carole experienced herself as adult, as well as the girl part. On 26 October 1992, a year or so later, Carole said in session, The fear has always been there ... there is a little baby with despair, lying there with no energy and no life, and is very fearful of touch. Carole commenced a series of fear dreams and finally, in therapy, uncovered an episode of sexual abuse when she was still an infant in a cot.

49 I understand that point as being the moment in each situation where her reactions, her feelings and thoughts, had been denied by herself or others, and by being in the experience again, and being interacted with or responded to in appropriate ways, the need to be acknowledged or soothed diminished.

50 In addition, Frank's asthma improved when I discovered that he was not breathing openly when I was physically holding him. I would often encourage him to breathe regularly and to follow my breathing.
Derek also felt the integration or becoming whole that Carole reported. He felt that he integrated the Inner Child aspects with his adult aspect and that rather than being and operating from a child place, he had found a new place upon which to stand.

**Derek:** ... I felt like I had integrated. I learnt to absorb my child - my children - into my life, and for a long time a lot of the writing that I did and a lot of the behaviour that I exhibited [were them] as they actually ran my life ...

While Carole, Frank and Derek spoke of wholeness and emotionally growing up, Zelda and Robyn spoke about an aspect of wholeness from the viewpoint of feeling internally stronger and less fragmented. Zelda spoke of feeling stronger, less fragile and fragmented. In addition, she became more accepting of her physical body as well as her emotional self as a result of being physically held. Robyn reported using her experience of being physically held as a protection of her right to exist when she was not feeling good about herself.

**Robyn:** ... And this is where I see holding fitting, if I can still remember positively the sensation of being held by you, and I don't know if I actually consciously do that if I am having my struggles, but if I could somehow conjure up that image it would sort of, like, help to put a barrier around me and my right to exist, which should be inviolate, and whatever stuff my mother was negatively laying on me.

Although the physical holding enabled her to continue to deal with these issues, Robyn felt that the therapy had not been successful in helping her erase the negative messages questioning her right to exist.

**Robyn:** It has allowed me to continue on my work with more confidence ... I still have a deep struggle with issues to do with my permission to exist. ... I now have more resources to challenge it and somehow know that it's just not mine; I know that somehow it belonged also to my mother, who was a wounded, limited human being.

Carole also used the holding experience to help deal with her anxiety between sessions.

**Carole:** I think it gave me the strongest tool outside, to be able to hold myself. Sometimes, especially if I couldn't sleep, or fears came up, or I had a bad dream, or thoughts were disturbing me, or I had those disturbing times ... at those kinds of times I could visualise and feel your arms around me, and that seemed to help me the most in getting through periods of anxiety.

**6.3.3 Interpersonal Changes**

While Carole, Brenda and Derek alluded to interpersonal changes by discussing how they were not reacting inappropriately in their relationships, Frank, Neil and Hilary
spoke about having more appropriate ways of relating to others. Frank described how his newly acquired ability to relate developed as a result of my relating to him.

Frank:  ...by touching me you allowed some form of emotional contact to flow between us. And it was like you reached out to me - there’s something else I’m trying to get to and it’s not coming easily - you created a new relationship with me, and a new ability for me to relate to you. As a person.

Neil reported that the effects of being physically held in therapy and addressing what occurred in childhood enabled an internal reconciliation around his mother, and a healing process in relation to his mother.

Neil: Did it help heal? It must have done, because I’m fairly sure that it’s been one part of a slow, gradual process of my coming into some kind of relationship with my mother. I don’t think it’s complete coincidence that that’s happened to the extent that it’s happened, and all that’s happened since then.

Similarly, Hilary commented on experiencing great anger towards her mother about her early childhood experience. Post-therapy, she felt more accepting and loving towards her mother.

Hilary: I went in and out of being very angry with my mother and lacking tolerance towards her and her ways ... And yet it’s interesting that since I’ve left therapy I’m far more tolerant and tender and loving towards my mother now, and far more accepting of who she was and the space she was in.

In summary, everyone spoke of the changes they experienced within themselves or how they related. Everyone discussed their discovering their own needs for physical contact as well as closeness, warmth and love. In addition, while some felt that their way of reacting changed, to becoming softer and less judgmental, and some perceived that their way of relating changed, most felt that they became whole as a result of their experience of being physically held in the therapy.
CHAPTER SEVEN

DISCOVERIES AND NEW LANDMARKS

_Psychotherapy advances only by regression, going back over the material one more time, re-writing its own history._

(Hillman, 1983, p.28)
CHAPTER SEVEN

DISCOVERIES AND NEW LANDMARKS

Physical holding, an intense form of physical contact, is an intentional activity that can be initiated by a therapist during the course of Emotionally Focused psychotherapy. As a therapist, I initiated and progressed physical contact to physical holding during the course of therapy with a number of clients, based on my clinical assessment and my relationship with them. This research has been a journey to revisit the therapy experience in order to investigate the clients’ accounts of what happened, in an endeavour to find the emerging themes and develop a coherent explanation for what occurred in the holding experience.

I began this project by establishing the context, telling you about how I became involved in physically holding clients, what I experienced and how this affected me as a therapist. I also considered the more technical aspects of the project by examining the literature and maps of therapy, as well as exploring and outlining the principles underlying a qualitative research inquiry. In my last two chapters, I commented on my activities as a therapist and then synthesised the clients’ accounts of physical holding, dividing their narratives into experience and effects of physical holding, and then how they experienced my conduct as a therapist. I have endeavoured to allow all the participants their subjective voices through their comments, as their descriptions and reflections throughout the document have provided a pathway to their experiences.
Revisiting the therapy was powerful for each person. Overall, the experience was positive; while most felt pleased and satisfied with what they said, some felt nostalgic, vulnerable, or distressed by the process of remembering the painful situations they had regressed to, the impact of the holding and, for some, the grief of no longer having the holding experience.\(^1\) I, too, was moved. Their accounts were compelling, drawing me into remembering their pain and anguish. At times, their honesty in speaking about their experiences, their comments on the bodily contact, how they were influenced by the physical holding, and the regression to their baby-selves, both encouraged and unsettled me. While I was encouraged that their clarity would allow themes to be revealed, I also felt vulnerable because it was my therapy and our relationship they were commenting on. In contrast to processing each episode of physical holding during therapy, where my primary focus was their reactions and how to adjust the regression work and my role in it, now they were reflecting on the physical holding experience per se, which involved a comprehensive commentary on my conduct for the purposes of this project.

In this final chapter I have continued to weave together our experiences as I return to consider what happens when a therapist physically holds a client in therapy. From my clients' accounts of revisiting their therapy journeys, a number of possible landmarks have been identified through description. In concert with theoretical principles, these landmarks have enabled a therapy journey to be charted that involves physical holding in a predominantly verbal psychotherapy in a landscape that involves emotional contact, regression, and an emotional experience of a mothering relationship. I have brought together both the theoretical principles and the descriptions of the landmarks in an account of what happens in a therapy that involves physical holding.

7.1 Emotional Contact

*When a person starts therapy, he isn't beginning a pale conversation; he is stepping into a somatic state of relatedness.*

(Lewis, Amini, Lannon, 2000, p.168)

The beginning stage of therapy is guided by the theoretical principles underlying that approach. In Emotionally Focused psychotherapy, therapy begins in earnest when the therapist makes an emotional commitment to the client. It is my experience that making

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\(^1\) Everyone spoke of reliving aspects of their journey, with Derek feeling lightened, and Frank feeling freed by being able to talk about the therapy experience. Carole, Brenda and Ruby felt nostalgic, vulnerable or washed out from the remembering process, and Robyn and Hilary became distressed during the interviews. Most (Carole, Hilary, Ruby, Neil, Robyn and Zelda) reported feeling positive about being able to provide a comprehensive account of their experience. Brenda, Hilary and Zelda commented on feeling good from realising what they had achieved.
an emotional commitment to a client, when a therapist decides whether they will accompany a client on a therapy journey in accordance with the principles underlying the therapy, is a requisite component in the decision-making process. I regard my commitment as deciding to be in relationship with the client, come what may, and to accompany them on their journey. It is a commitment to be in a therapeutic relationship with them. This commitment develops out of my feelings of warmth, compassion and connection towards the client's hidden real self, which I glimpse during the early sessions as a result of their narrating events that were painful or distressing, or as a result of an active intervention that moved the client past reporting their experience to their primary or authentic experience.²

Dan Ornish (1998, p.61) regarded commitment as a key to the healing process because it makes people feel safe and trusting, which helps them become open and vulnerable. As a therapist, I committed myself to the client's journey and opened myself up to relate with them and be vulnerable in that experience. I believe that this commitment was experienced by my clients through my seriously attending to them, endeavouring to understand their experiences, and my respectful stance towards their reactions and ways of relating. As a therapist, I developed a relationship with each client that was open to scrutiny by us, and one where I was in the service of helping them develop their emotional well-being. Each therapy relationship was unique. These relationships developed out of my caring and compassion for each client, as well as fitting with their emotional process and way of relating. By working to be in relationship with my clients, by being respectful of their process of relating to themselves and others, and by demonstrating openness by self-disclosure of my reactions to them and their circumstances, trust can begin to develop, which allows them to be more vulnerable in talking about their experiences. The process of relating to a client has been variously called empathy, empathic attunement, and limbic resonance.³ ⁴ Similarly, Thomas Lewis et al (2000, pp.169-170) saw that the first requirement in therapy was for the therapist to know the client, developing resonance at a limbic level by taking up temporary residence in the client's world; to experience it and to get to know the essence of their relatedness.

² Whereas I met Carole's hurting yet defiant inner girl, I met Neil's boy in a directed conversation with his father. Derek and Ruby revealed their fear of others. When Derek put the lonely part of himself in a chair he saw himself at eight years of age saying, I want you to go away. I want to be left alone. You will hurt me. When he sat in that place he started crying and saying that he wanted his dad. Similarly, Ruby saw herself at seven years of age. When she sat in that place she began crying and was unable to tell me what was distressing her.

³ See Bohart and Greenberg, 1997; Bachelor, 1988; Bragan, 1987; Kirschbaum et al, 1990; Lammers, 1986; May, 1939; Miller, 1989; Rogers, 1951; Rogers et al, 1967; Rosenberg, 1987; Webster, 1998a for detailed discussion on empathy; Kohut, 1977, 1982; Rowe et al, 1999 on empathic attunement; and Lewis et al, 2000 on limbic resonance.

⁴ Limbic resonance was described as a symphony of mutual exchange and internal adaptation whereby two mammals become attuned to each others' inner state (Lewis et al, 2000, p.62).
As well as dealing with current difficulties, therapists are also interested in the underlying causes. Based on the accepted assumption in the long-term psychotherapies that patterns of relating develop from early experiences, clients’ childhood histories are investigated. Clients are invited to talk about their family experiences: how they were treated by their parents and other carers, their relationships with their siblings, and other emotional experiences they consciously remember. These discussions provide therapists with the beginning clues as to the origins and development of each client's emotional signature.  

An emotional signature is the expression or display of their emotional template or schema; their patterned way of dealing with emotional experiences, both theirs and others, that developed out of the internalisation of early infant care. From an object-relations perspective, Michael Balint (1989) labelled the problems in the emotional template as the basic fault, due to deficits in the early environment, and Winnicott (1945) understood the emotional signature as representing a template having being coloured by failures in physical communication, where the unintegrated bits of the infant were unable to be held by the mother.

All the participants in this research explored their current and past intimate relationships as well as their childhood histories. Everyone dealt with their unsatisfactory relationships with their mothers, which ranged from experiencing them as absent or uncaring to their being abusive; emotionally, verbally, physically or sexually. Two had to deal with the premature death of their mothers. Six participants had experienced emotional trauma as infants where they had felt unwanted or their mothers had been uncaring or unable to care for them. Although the remaining three remembered many early positive experiences, one uncovered a couple of isolated incidents in early childhood and the remaining two dealt with their mother’s inability to protect them against their father’s verbal abuse. However their unsatisfactory relationships were not confined to their mothers. All participants had to deal with their experiences with their fathers, that ranged from them being absent or unprotective to being abusive; emotionally, verbally, physically or sexually.

In Emotionally Focused psychotherapy, clients are invited to attend and focus on their emotional reactions in the moment. The narrating of their experiences together with a

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5 The first time I heard the term 'emotional signature' was in 2001, when a client used it in reference to his emotional pattern of relating. It was a very appropriate label and similar to a writing signature (Connelly and Clandinin, 1998, p.173); and can refer to rhythm, cadence and expression of how a person reacts and responds to others' emotional responses.

6 'Schema' was the term first used by Bartlett (1932) to describe a general knowledge structure. There has been extensive study of the effects of traumatic experience on childhood schema (see Fine, 1990; Horowitz, 1991; Janet, 1977; McCann & Pearlman, 1990; van der Kolk et al, 1989).

7 Carole, Frank, Neil, Zelda, Robyn and Hilary.

8 Brenda, Ruby and Derek.
therapist's interest in what happened to them, and how they are feeling as they are talking, facilitates their emotional reactions in the session. Their reactions come in the form of bodily sensations or feelings and are the first signs of their emotional signature (Sempe, 1989; Matsakis, 1994; van der Kolk et al, 1996). Understandably, they experience difficulties with these reactions, unable to allow themselves to acknowledge them or experience them. Instead, the feelings are avoided or ignored in ways that clients learnt from childhood. This therapeutic development, where clients are beginning to have some emotional reaction to the content of their narratives, is a very delicate phase of the therapy. Initially, therapists come to know these emotional reactions through their immersion in the therapy relationships as well as by observing the clients. Although therapists offer ways to help them deal with their sentient experiences, many clients are unable to get relief, operating instead from primary maladaptive fear, based on earlier experiences (Greenberg & Paivio, 1997, p.196), responding from their secondary experience (Greenberg & Safran, 1987, p.176) or false self (Winnicott, 1954a, 1960).

In this phase, physical touch provides a means of making contact with the client in a real way. It can be a communication to the clients that the therapist feels for them, or is in touch with what is happening to them. While physical contact may positively increase clients' verbal interaction, self-disclosure and exploration (Alagna et al, 1979; Jourard & Freidman, 1970; Pattison, 1973), touch in a therapy context, in contrast to Pattison's (1973) lack of findings between touch and relationship, is inextricably relationally bound. At some point in the therapy, ranging from one month to two years, I reached out physically and made contact with each participant in this research. These time differences reflected the fact that physical contact was made within a relationship context. Considering physical contact with each client began with my felt inclination to reach out in a more tangible way. In line with Ferenczi's idea that a therapist's task was to find the most appropriate response to clients (Dupont, 1988, p.xix), I made a clinical judgment as to whether offering to make physical contact would be acceptable and appropriate, and whether I felt emotionally ready to do so. In contrast to medical practitioners stating that the patients initiated contact (Kardener et al, 1973) but consistent with patient experiences (Horton et al, 1995) showing clients finding it difficult to initiate touch, physical contact was initiated by me. The types of physical touch and the reasons for making contact were varied. Similar to some of the reasons in the practitioner surveys (Kardener et al, 1973; Leggett, 1994b; Perry, 1976), client surveys (Horton et al, 1995; Horton 1998), client interviews (Geib 1982) and anecdotal therapist reports (Older, 1977; Rabinowitz 1991; Wilson, 1982), I offered my clients...

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physical contact to provide empathy, reassurance and comfort, and to prevent their dissociation or becoming lost in emotional pain.10

Physical contact was processed at the next session. There was considerable discussion about the effect touch had on them, including exploring other interpretations they may have had about my initiating physical contact. In contrast to survey results (Holroyd et al, 1977; Kardener et al, 1973; Leggett, 1994b) where practitioners expressed concern that physical contact would be misconstrued in a sexual light, the clients in this project were clear about my intentions as a therapist. While a number of respondents acknowledged that their own experiences of physical touch were confined to intimate relationships, they commented on the non-erotic nature of my contact. Two participants successfully struggled against sexualising the contact and were able to experience the physical holding for its therapeutic value. Following these discussions, verbal permission was sought for ongoing physical contact as required in the therapy. Physical contact in the form of hugs at the beginning and end of sessions, my reaching out and stroking a client's forearm or shoulder, or putting my arm around their shoulder continued.

7.2 Re-Experiencing in Regression

Regression ... becomes, in Winnicott's hands, a process of healing through a search for missing experiences.
(Goldman, 1993b, p.xxiii)

The physical connection provided a pathway for each client on two levels. It brought them back into relationship with themselves,11 and it enabled them to feel connected to me. In accordance with Imes's conclusion (1998) that touch could be a pathway to unexpressed feelings or actions that were turned back against the body, and consistent with other therapists' accounts that physical contact facilitated deeper feelings (O'Hearne, 1972; Older 1977; Wilson, 1982), physical contact did enable these clients to experience their emotional reactions and to discover their feelings. The synthesis of coming into relationship with themselves as well as with me brought about a deepening of the therapy where clients began opening to their experiences and becoming more obviously distressed. The realness of the physical contact made it impossible for their old emotional signatures to be enacted, and instead everyone spoke of the surfacing of emotional pain. Rather than remembering, they began re-experiencing their emotional

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10 While I offered to hold Carole to help her not to stay removed from herself, I reached out and stroked Frank's arm because my words felt so insufficient. I put my arms around Hillary's and Robyn's shoulders because they were so distressed, and offered to hug Zelda out of compassion, after hearing of her traumatic experiences while hospitalised.

11 Evidenced by Frank coming back into his body and Carole breaking a barrier inside her to herself.
reactions to present and past events. In contrast to remembering, where clients can be partially regressed, they became fully regressed in the re-experiencing, where they lost the duality of the adult-child\textsuperscript{12} to experience only the child perspective (Hammond, 1990, p.509). Initially, accessing these childhood experiences was through my inviting and directing a regression in a therapy session. As therapy progressed, regressions occurred spontaneously when clients quickly moved from their current circumstances to childhood events with similar themes and feelings. Whereas Freud (Stewart, 1996) regarded regression as a defence mechanism, others (Balint, 1985; Little, 1993; Winnicott, 1954) have regarded regression as a psychological experience; a re-living of an earlier emotional time. It was regarded as an opportunity for clients to find the aspects of their experiences that were missing, whether it was their emotional response or the other's less adequate response in the circumstance. It was an opportunity to have all these feelings and to receive a more adequate response from their therapist, who acts as an enlightened witness, providing a corrective emotional response to the situation\textsuperscript{13} (Alexander, 1960, p.286; Miller, 1990, p.171). These regressions heralded the next stage of the therapy. It was here that physical contact progressed to physical holding.

The first point of contact in the physical holding experience is the body. Skin contact, from the body-to-body contact or the active touching, was found to be important, as it provided tangible physical connections, heightening the physical experience and helping to establish the emotional relationship, and helping the clients feel connected to me. I used consistent breathing to soothe them as well as breaking the breathing rhythm to have the painful feelings emerge. Deeper regressions occurred from the effect of the heartbeat, as they experienced this as more organic, with some saying that time stood still, I was gone, and I would fall into some other place. Although they all came into contact with the same aspects, such as skin, heartbeat, breast, smell, noise and eyes, what emerged from the interviews was that various parts of a therapist's body had significance for different clients. Aspects of the bodily contact perturbed the clients' unconscious and they remembered either tender moments between parent and child, or unmet needs and experienced absences. This in turn facilitated further regressions. While Carole experienced her need to reach out and touch me, Derek and Neil remembered the rare times when their mother or father touched their head or forehead, and eye-contact helped Hilary re-experience the lack of her mother's gaze and attention.

\textsuperscript{12} Carole spoke about actually feeling the feelings of being her as a child, being actually back there, while Robyn described the regression as the evaluative part of her stepping away.

\textsuperscript{13} Brenda described how the regression helped as I took her through a painful situation where she had experienced a black mat descend over her as a little girl, and Carole described how her mother's inadequate response to her terror at being left in hospital was soothed by me in the regression.
As the clients gave up the adult-child duality to become their child-selves, they needed me to look after them, making it safe for them to be little and guiding them through the emotional process.

*All the phenomena of regression, as observed in the analytical situation, strike one irresistibly as primitive, reminiscent of early childish behaviour ... and that any psychotherapist must always be aware that he will have to deal - in one way or another - with 'the child in his patient'.*  
(Balint, 1989, p.90)

It was more than looking after them. It was also about relating to them in a responsive and age-appropriate manner. When children are in pain they require real contact and a caring presence. Physical holding, being a more enveloping form of contact, fulfilled this function. Further, consistent with both Ferenczi's comments (1933) and experimental research (Cocker et al, 1994), they related to me in that early emotional state. Child-like language that captured a black-white thinking was evident when clients described what was happening. Whereas Derek, holding my thumb like a baby while being physically held, said, *You can take a piece, it will be okay*, Neil said, *We all need to feel joy but have to cop hurt to get it, okay.* Once they felt safe and began expressing themselves freely, childlike language was also evident in reference to me as their therapist. Carole directly asked me if I liked her, Zelda asked if I would be her Mummy and Hilary referred to a part of her calling me Mummy. Like Ferenczi, I used imaginative and symbolic measures in dealing with the pain to contain fears, to remove clients from distressing experiences, and to soothe and heal. When Zelda described a suitcase that she feared held monsters and snakes, I suggested that she leave it on my verandah until she was ready to deal with it. I removed Frank's child from a sexual abuse scene, ministered to Derek's child with soothing cream and bandages when he experienced his child self as burnt, and began healing Ruby's heart using gauze and avocado cream, wrapping it in cotton wool and placing it under her pillow.

Everyone spoke about how the physical holding allowed them to discover and experience their feelings. Powerful descriptions and images were used, such as, *felt some of my deepest pain, spewed out, not remembering it but actually feeling it, and letting out the part of me that was in pain*. Everyone spoke about how the physical holding enabled them to remember and re-experience childhood events. When their

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14 10 May 1990 and 4 March 1993 respectively.  
17 24 September 1994 and 14 April 1990 respectively.  
18 12 February 1992. The technique for healing the heart came from some earlier work (Webster, 1999b).
difficulties related to experiences with their parents where they felt emotionally neglected by being ignored or harshly treated, they regressed to painful childhood events at all ages. However, when the trauma was centred around a specific event or age, such as Derek losing his mother, Brenda's hospitalisation or Hilary being emotionally abandoned as a baby, most of the regression work became focused around these matters. According to their histories, my clients started to deal with what distressed them or how they had been treated. Whereas Carole and Zelda dealt with feeling damaged, and their need to feel my interest in them or my reassurance, Neil, Brenda and Hilary began with their mother's being distant or absent before talking about their self-experience of unworthiness, self-blame or unlovability. Derek and Ruby, who lost their mothers, started in different places, with Derek having to deal with his inner child's mistrust of him before dealing with the loss, and Ruby remembering the loving experiences with her mother. In contrast to Derek and Ruby having positive maternal experiences, Frank's history had been so abusive that he began by dealing with me; whether I would be committed to the journey, and whether he would be a burden. When everyone felt reassured - by my interest in them, by my direct commitment to their journey, by my reassuring that they were not too much for me, or by my inviting them to relate with me more - they also began to feel the aloneness they experienced in childhood as a result of the loss of relationship with one or both parents, and the gap this caused. Greenberg and Paivio (1997, p.47) described the totality of what they were experiencing as emotional pain, a complex feeling state involving the loss of a relationship and damage to aspects of self.

The goals of regression were directed towards completing past emotional experiences in order to rebuild positive self-regard and foster authentic relating. As with catharsis, a therapist works towards helping a client complete the previously interrupted or blocked emotional expressions (Nichols et al, 1986 p.99). Emotions were encouraged to be felt sentiently, so that the secondary experiences that masked the primary experiences could be felt and the self-experience dealt with, in order to allow the emerging primary experience. In a trajectory similar to those of Winnicott (1945), who conceived regression as an opportunity to heal from unintegrated aspects of experience, and Balint (1985, p.162), who perceived regression as breaking maladaptive patterns of relating, Emotionally Focused psychotherapists regard regression as an opportunity to deal with painful experiences that interrupt the development of a loving sense of self. In contrast to the maladaptive patterns or the conditioned reactions once needed to protect themselves, new inclinations to action, congruent with their needs and actualising tendencies (Greenberg et al, 1987, 1997), become available when clients feel the pain and become themselves again. The 'lived through' quality of regression was taken up more recently by Lewis et al in their description of therapists overthrowing the clients'
emotional templates at a cellular level by consistently relating differently to the clients' conditioned pathways.

But if therapy works, it transforms a patient's limbic brain and his emotional landscape forever.
(Lewis et al, 2000, p.187)

In addition to the clients dealing with their experiences, the importance of a therapist’s actions have been articulated as crucial to the healing process. In contrast to Freud's recommendations (1912b, 1924) for detachment, ranging from therapists putting aside their feelings and being neutral in the analysis to abstaining from any gratification of feelings or physical contact, Winnicott (1954) suggested that one of the problems with regression lay with a therapist's unpreparedness to deal with it. Ferenczi, disagreeing with Freud (Dupont, 1988), adopted a warm, concerned and sympathetic stance. Balint (1985), understanding how interpretations in regression caused distress, also came to believe in some gratification of clients' needs. As the regressions continued, I became familiar with my clients' processes; how they regressed, what they needed in the regression, and how to help them re-emerge from a childlike state. I found verbal and non-verbal ways to be with them, to help them feel the unfelt feelings and find some level of emotional completion, and to comfort them as required. While some clients worked in a primarily verbal medium, others used dreams, hypnosis, cushion work or art as a method of accessing the pathway back to childhood experiences. Further, all the clients experienced their reactions uniquely. Some began to feel twinges and twitches in their body that frightened them, and required reassurance and encouragement for them to proceed to the emotional experience. Others collapsed emotionally and also required reassurance and encouragement to stay with their experiences.

What emerged from the interviews was a common perception that sustained physical holding enabled a space to be created, generally a positively regarded space, that provided safety and warmth, where the clients felt accepted and looked after in the regression process. In this space they relied on me, as the therapist, to be available to them and look after them in their emotional distress. It was a space that each client got to know and seek. A place from which they trusted they could come and go. As the therapist, I worked hard to co-create this space, in which I took responsibility for looking after each client while they were in regression, helping them be little and find their missing experiences. In accordance with object-relations theory, physical holding enabled clients to surrender their false selves and become more themselves.
Michael Balint elegantly described the process.

*It seems that only if patients are allowed to 'regress' - that is, to give up the security gained by relying on the 'caretaker' services of their false ego - which means that only if their analyst can take over the 'caretaking' by 'managing the regression', can an atmosphere be created in which interpretations can reach, and then become intelligible and acceptable to the real ego.*

(Balint, 1989, p.111)

Physical holding enabled this process to occur. In addition to any symbolic sense of being held by the therapy, clients experienced both actual and symbolic holding. Letting themselves go and giving up the security of their past patterns of relating or their false selves occurred as trust developed. Each progression from physical contact to holding was extensively discussed, including my reasons for offering physical holding and the effects on me, as well as their reactions. This allowed them to assess the physical holding experience and to trust both the experience and my intentions. The intentions of the therapist are crucial. In accordance with Anna Freud’s (1954) comments about acknowledging the real encounter that is being experienced in the therapy, the clients stated that they needed to feel that I was authentic in relating to them, holding them for professional reasons and also for altruistic yet personal reasons, because I personally felt for them in their distress. This can be contrasted with Geib’s (1982) account of therapists who suggested physical contact after a few sessions with the rationale that *it would be good for them.* Instead, clients needed to hear about the warmth and compassion that I felt, and they compared this with their pre-reflective experiences of me. Everyone experienced safety in the physical holding, providing descriptions such as *a warm feeling, a safe feeling, made me feel safe, and safety and protection.* Physical holding also provided a tangible way for them to experience acceptance, reassurance and affirmation. There were a variety of descriptions such as, *I got your support, my experience was valid,* and *warmth and deep acceptance,* that supported experimental findings of feeling increased reassurance (Whitcher et al, 1979), and the therapist being seen as trustworthy (Bacorn et al, 1984; Pattison, 1973), warm, friendly and loving (Breed et al, 1973; Fisher et al, 1976, Kleinke et al 1974, Major et al, 1982).

### 7.3 A Mothering Experience

*The aim of all human striving is to establish - or, probably, re-establish - an all-embracing harmony with one’s environment, to be able to love in peace.*

(Balint, 1989, p.65)

Although regression was experienced across the spectrum of adolescent and childhood years, seven participants spoke predominantly about the regression to their baby-selves.
The journeys to their baby-selves were different, each reflecting the difficulties they had experienced in infancy. Carole, who had experienced ongoing emotional abuse and felt she was held as a baby most of the time in the therapy, revelled in the safety and protection before feeling her pain. Hilary, who had felt abandoned as an infant, found that physical holding brought up her distressed baby-self. Frank, who suffered early sexual abuse from his mother, found himself regressing to disturbing baby experiences, and Neil, who felt his mother had been steely-cold and distant, had to deal with symbolic images representing his baby-self before allowing the regression to infancy.

All the clients understood the space that allowed the emergence of the baby-self in therapy as maternal.\(^1\),\(^2\) The experiencing and the understanding of being physically held in a sustained way in a mother-infant type embrace, and the ensuing sensate and emotional reactions, were regarded as an enactment of the maternal paradigm. As the therapist, I was seen as a maternal figure, and the physical encounter with my body was experienced as warm and comforting, making them feel safe and loved. While most emphasised how the heartbeat helped the baby-self to emerge, some had experiences of being a baby at the breast.

Carole spoke of the maternal paradigm in an experiential manner. While she described a mothering experience that healed the gap inside her created by insufficient mothering, Neil felt it allowed him to grieve for what he had not experienced, and ultimately enabled him to come back into relationship with his mother. Balint (1986) did not use the mother-child metaphor but spoke of patients having primitive needs that related to the two-person psychology of the mother-child relations. This was evident in a number of ways; Frank, Zelda and Hilary regarded me as their 'actual' mother because I had provided them with things that had been absent in their infancy, whereas Derek and Ruby spoke about a mothering space that they had lost prematurely but were seeking in order to have their needs met.

Ferenczi (Stanton, 1990, p.135) had recommended a therapist use maternal friendliness and be an affectionate mother towards patients in their distress. He was referring to a therapist conveying warmth, friendliness and spontaneity, and being available to reassure, explain, soothe and comfort. Using his paediatric experience, Winnicott (1945,

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\(^1\) While Carole, Derek, Frank, Hilary, Ruby, Neil and Zelda understood the space as maternal from their experience, Brenda said that it was logical to be maternal. Robyn did not use this description, although she felt that the holding process would redress what had not been experienced in childhood.

\(^2\) Stephen Frosh (1999, p.292) discussed the analogy of mothering and 'management' where a therapist is providing a patient with a setting that allows nurturing to be experienced, and deals with boundaries and consistency of the session. Although he notes Winnicott's comments about patients needing actual contact he also talks of the dangers associated with such an active therapy.
1956) referred to a mothering experience as primary maternal preoccupation, as he believed that patients who had regressed to primary trauma required what mothers provided in infant care: holding, rocking, soothing and intuiting the infant’s needs. As a therapist, I provided a real mothering experience, attending to the children in the clients and providing what was needed to allow them to come back into themselves and deal with painful events and distressing relationships. When my clients regressed to their baby-selves, they re-lived what happened, the traumas of the neglect or abuse, as well as re-experiencing the difficult parental relationships, being uncared for or unloved. As each person openly felt great pain and grief, I encouraged their feelings, soothed and comforted them throughout the experience as a mother would.

In contrast to Freud’s emphasising the mental ability of therapists, verbal psychotherapy that incorporates physical holding emphasises the emotional connectedness of the therapists; their ability to be warm, loving and nurturing at both a symbolic and a real level. Prior to Carl Rogers (1942, 1951), who believed that love, which was communicated through genuineness, empathy and unconditional regard, was the primary force in helping clients change, Ferenczi regarded therapists’ love as being what was needed for patients to be healed and nurtured.

*Furthermore, no analysis can succeed if we do not succeed in really loving the patient. Every patient has the right to be regarded and cared for as an ill-treated, unhappy child.*
(Ferenczi, 12 June 1932, in Dupont, 1988, p.130)

Love was also described by Lewis et al (2000, p.203) as emotional sustenance, and the means to successful therapy and the restoration of the clients’ ability to know themselves and relate differently.

Part of clients’ pain was the damage to their child-selves resulting from feeling uncared for or neglected by their parents. Most of the clients in this project had felt uncared for or unloved, which in turn had created gaps in having a loving sense of themselves. Being loved, looked after and nurtured were the dominant themes relating to the maternal paradigm. While my clients felt loved, and understood this from sources such as warmth, valuing and the unconditional nature of the relationship, they had also been scared that they could not be loved or that there were impossible conditions to be met. While Neil, Frank and Derek felt loved through being physically held and Carole described love as coming from a close-up experience of warmth and protection, Zelda and Hilary felt loved by the consistent holding and valuing without expectation.
However, love was not just one-way. In accordance with Balint's (1996) ideas about primary love, where patients would experience love for their therapists, who became the primary objects to be invested with love, my clients also had love for me. In contrast to the analytic taboo against gratifying clients' needs, they were encouraged to feel their love and discuss the experience. Five clients, Carole, Derek, Frank, Neil and Zelda, felt and discussed their loving feelings towards me during the therapy. They needed reassurance about having these feelings, as they had been fearful of them being overwhelming or misunderstood, and that they would be rejected for having and expressing them. Carole, who had a positive experience of reaching out and touching my face, was also scared of being rejected or becoming too vulnerable to me.

The two remaining elements that can also be described as emotional sustenance were feeling looked after and being nurtured. Ferenczi and Balint both talked about a patient's need to be looked after. Whereas Ferenczi (1932) suggested that patients require the opportunity to have the utmost regression, to be taken care of without expectation or action in order to begin developing themselves again, Balint (1986) recommended that the therapist act as a caretaker to allow the patient absolute surrender. During the physical holding, the clients for this project were taken care of by my actions of actually holding them, encouraging them to feel, soothing them as they felt distressed, and keeping them safe throughout the experiencing process. These actions are akin to the mothering process, where mothers encourage their children to be themselves in the experience, and in so doing support and contain the infants' emotional worlds as required. Being looked after was experienced differently by each person, with Frank connecting it to my calmness and steadiness, Carole feeling she was totally being taken care of, and Derek summarising it as being looked after as a mother does. During the regression to infancy, five clients experienced themselves being nurtured by imaginatively being at my breast. Four of these experienced the desire to be breastfed or suckled; Frank and Zelda experienced this desire while Derek and Hilary were also given my finger to suck in place of providing a bottle. In addition to having the image of being at the breast, Neil felt that it filled the emotional need, to be soothed and healed.

The need to be attached was also experienced in the therapy. The experience of merging was understood as an infant's need for attachment, arising from a common skin and an identification with the mother (Anzieu, 1984a). Five clients experienced themselves as

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21 Derek, Frank, Hilary, Neil and Zelda.
22 I used my finger initially because I had not been able to think about or employ a bottle. After reading Bruce's account (1984) of using a bottle for a regressed client, I employed this successfully with other regressed clients.
23 Carole, Frank, Hilary, Neil and Derek.
becoming merged with me, as the therapist, feeling as if they resided in me for a while, and two said that they wanted to get as close as possible, to have an encompassing experience. Although the experience of being physically held as an infant in-session was described as calming, soothing and loving, it impacted on them in many ways. Some felt pacified, some felt safe enough to begin to try to relate emotionally, and others spoke about their painful awareness of missing this experience in childhood.

During this phase of the therapy where there are ongoing regressions to the child and baby-selves for a number of years, clients become emotionally dependent on their therapists providing the space and maintaining the continuity of care. Given the early nature of the trauma and the therapist becoming the primary object, Winnicott thought dependence was inevitable.

Eventually the false self hands over to the analyst. This is a time of great dependence, and true risk, and the patient is naturally in a deeply regressed state ... This is also a highly painful state because the patient is aware, as the infant in the original situation is not aware, of the risks entailed. (Winnicott, 1992, p.xxix; 1955-6, p.297)

The clients-as-infants are dependent on the therapists becoming the mothers for a variety of things, ranging from feeling acceptable and lovable to being treated gently, being soothed and comforted during the regressive episodes. In this project, all the participants who experienced dependency had been fearful about what it meant about them or their vulnerability to being abused by me. These fears ranged from losing the attention, support and love, to being little and helpless, and to being rejected.24 Some of these fears are real, based on the authority or power a therapist has to determine the continuation of therapy as well as what happens in the therapy. Some are transferenceal, based on their early positive and negative experiences with their parents.

Although traditional analysis (Anzieu, 1984; van Sweden, 1995, p.104) appears to assume satisfactory early mothering experiences so that patients can and should use language to symbolise their difficulties, there were analysts who perceived that their patients had not experienced sufficient early mothering experiences. Early object-relations psychotherapists, Ferenczi, Winnicott and Balint, and analysts such as Lehmann and Anzieu, regarded these clients as being unable to use language to deal with their difficulties, suggesting instead that providing some tactile communication may repair this fault. In Emotionally Focused psychotherapy, when the clients’ emotional templates are damaged by problematic early mothering, interventions are used that match

24 There were only brief comments about dependency in the interviews by Brenda, Carole, Derek, Frank and Hilary, and although I remember it as an issue for everyone, there are many cultural prohibitions against experiencing and discussing dependency and vulnerability with others.
the emotional ages of the clients' traumas. Sustained physical holding, enacting early tactile communication, complements verbal communication, and can heal the original emotional templates. In this project, the healing in the therapy, using physical holding within an essentially verbal psychotherapy, enabled the developmental steps that had been blocked by infant and childhood breaches or traumas, to recommence. Most found the therapy experience successful and realised that although the therapy did not remove the original trauma, it repaired the emotional template. Only two felt unsatisfied and incomplete. They stopped their therapy because they felt that it had not sufficiently met their emotional needs to be healing. However, everyone spoke about discovering their needs, ranging from physical contact, warmth and comfort to feeling cared for and loved. While it was difficult to acknowledge these needs at first, having them met in the therapy process enabled clients to identify them, and realise how these unmet needs were being sought after inappropriately, in their adult relationships. By sorting out what belonged to the past and what belonged to the present, they were able to identify and manage their adult needs, and relate more appropriately and less reactively. They spoke of wholeness, using descriptions such as emotionally growing up and feeling that they had matured. Some spoke of becoming softer and more accepting, while others spoke of becoming internally stronger and less fragmented.

7.4 Possible Landmark Additions for Psychotherapy

*The end of human science research for educators is a critical pedagogical competence: knowing how to act tactfully in pedagogic situations on the basis of a carefully edified thoughtfulness.*

(Van Manen, 1990)

This work that I am now concluding was about my dealing with a gap in my therapeutic work and setting about understanding and correcting it. Both the therapy journeys and the research project have been exciting and ambitious undertakings. They were exciting because each led me into unknown places where I sought understanding from the literature, my clients and my own professional and personal experiences. They were ambitious because they demanded many things from me; commitment, contemplation, remembering and re-experiencing, and these required time, presence and patience.

In this project, I have endeavoured to explore my former clients' experiences of being physically held during their therapy in order to discover the themes that may underlie a verbal psychotherapy that involves sustained physical holding. The reminiscing about their pre-reflective experiences enabled the participants to get back in touch with their sensate experiences of the physical contact and holding, revealing how the contact necessitated their coming back into their physical bodies, and back to themselves. This
move back to themselves led them to start identifying and experiencing feelings that they had been unaware of, or avoiding. Everyone discussed how the physical holding experience enabled them to stay with these emotional reactions and use their current difficulties as the pathways to past childhood and infant traumas.

The process of making physical contact and then progressing to physical holding was contained within an approach that involved warmth, concern and compassion. In addition to acknowledging the symbolic aspects, both the transference and counter-transference aspects of the therapy relationship, the therapy worked with the real aspects involving the warm and personal exchange from the therapist to each client. This authenticity was experienced and understood by the clients and enabled the therapy to move to childhood and infant regression. At this phase of the therapy, with the deepening of experiencing through regression, as the clients experienced dependency as well as safety, trust and love, they were able to find emotional completion around the traumas to their selves and the loss of relationships with their parents. What happened between therapist and client was the essence of the therapy.

Although Ferenczi, Winnicott and Balint studied and made recommendations about effective therapist conduct in relation to primary trauma, it was Michael Kahn (1991, p.1) who succinctly summarised this in his statement that *the relationship is the therapy*. Each therapeutic approach requires certain conduct from a therapist, and in this research my conduct as the therapist was described by my clients as a mothering experience. They described how they trusted me because the warmth, concern and love they felt made them feel safe and looked after. Further, feeling accepted and validated enabled them to progress to infant traumas where they felt that I related to them as a mother to a child, soothing and caring for them while they were little.

This project has identified the landmarks of emotional contact, regression and a mothering experience. Each landmark has been described in terms of what happens and the effects of each element on the ongoing therapy journey. Of crucial importance for using each landmark is understanding what happens for clients and what they require, as well as understanding the conduct of therapists. By using the ideas of adult-child and understanding how the duality of adult-child progresses to only the child in regression, what clients need in this phase of therapy becomes clear. By integrating and working with both the real and the symbolic aspects in the therapy relationship, therapists are able to effectively meet the task of regression and relate therapeutically with clients. By accepting the regression to dependence and by accepting its real and symbolic nature, therapists are able to provide a mothering experience that enables their clients to feel safe enough to surrender themselves to the therapy and the process of healing.
In this conclusion I have endeavoured to synthesise my clients' experiences with mine in order to develop an account of Emotionally Focused psychotherapy, with a plot that involves healing through emotional contact, regression, and a mothering experience, brought about by sustained physical holding during a verbal psychotherapy. These landmarks, as described and identified, were influential in the positive therapeutic outcomes that were described in terms of a sense of personal wholeness, positive self-regard, and authentic relating. While aspects of these landmarks have been described prior to this project, this research can provide the therapy community with a unique opportunity to examine what happens in a verbal psychotherapy that incorporates sustained physical holding, from the perspectives of both the clients and the practitioners. The participants' accounts have enabled themes to emerge, and landmarks to be described and identified, which invite further contemplation and discussion of some of the principles and practices underpinning psychotherapy. This project also leaves a number of pathways for further exploration. This research has explored therapy based on the principles of Emotionally Focused psychotherapy, using only one therapist, who offered physical holding in the service of regression and client care. Further research with other clients as well as therapists, who use similar and different therapeutic modalities and offer ongoing physical holding, would facilitate further investigation and exploration of these and other landmarks in psychotherapy.
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Appendix 1: Client Progress Notes

Progress Notes: No:_________ Rec/quality_________
Date: Name: 
On time: Late: _______ Canc/def/dna: _______ Fee:_________

Significant/recent events - content and process

Observation/Appearance/Affect

Therapist Assessment/Reactions

Therapist stated opinion

Between session work

Treatment Plan
Appendix 2: The Nudist Tree for Experience
Appendix 3: The Nudist Tree for Effects
Appendix 4: The Nudist Tree for Meaning and Process
PHYSICAL HOLDING IN PSYCHOTHERAPY

by

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PLEASE NOTE

The greatest amount of care has been taken while scanning this thesis,

and the best possible result has been obtained.
To you who made this possible

Brenda
Carole
Derek
Frank
Hilary
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Ruby
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And finally, I wish to thank David Springett for his unending support and unconditional acceptance of the time I have spent in the therapy room with my clients as well as the time I committed to bringing this research to fruition.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in whole or in part, for a degree at this or any other institution.

Michelle Webster

Michelle Anne Webster
The Research Endeavour

This research is about physical holding in psychotherapy. Physical holding is an intense form of physical contact that can be initiated by a therapist during the course of therapy. As a therapist, I employed physical holding with a number of clients based on my clinical assessment and relationship with them. The purpose of this research has been to investigate the clients' accounts of what happened in an endeavour to develop a coherent explanation for what occurred in the holding experience.

Former clients who experienced sustained physical holding during their therapy described these experiences, and discussed the effects and meanings they attributed to physical holding. The framework for the research endeavour was the methodology of phenomenology, drawing in particular from the descriptive, existential and hermeneutic phenomenologies. Multiple data sources were employed by using non-standardised interviews in conjunction with clinical notes, client correspondences, and therapy transcripts. Each interview was considered for emerging themes before a process of reflection across interviews.

The results were organised around experience, effects and meaning. The respondents' experiences were recalled in terms of the physicality of the experience, with comments about the therapist's body, ranging from skin contact to heartbeat. The main effects of physical holding were the identifying and experiencing of feelings, and the remembering and re-experiencing of past events. The respondents elaborated a view that physical holding created a space that can be understood in terms of a maternal paradigm. Using this paradigm, my conduct as a therapist, ranging from providing safety, warmth and love to being nurturing, was discussed.

By weaving the therapy material and the research accounts together, the emerging plot in a therapy that incorporates sustained physical holding is emotional healing through emotional contact, regression and a mothering experience. Guided by these elements, an account of Emotionally Focused psychotherapy is elaborated to provide an explanation of how clients heal from past infant and childhood traumas through the process of being loved, cared for and nurtured in a mothering experience that is both real and symbolic in a verbal psychotherapy.
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