

CHAPTER 1

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).

From my first desire to become a counsellor some 30 years ago, I have found myself on a journey, discovering and learning how to work with people in ways that are caring, respectful and effective. This work is about the latter part of my journey where, once again, I was faced with not knowing the best, or most helpful, thing to do.

This gap occurred in my individual therapy work, and was related to clients who were trying 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 unable to control 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 tried 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. Exploring other therapy maps, I 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 childhood – 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 infant aspects within my clients.

I have gone back to that journey in order to investigate what happens when a therapist physically holds a client. My aim was to revisit the therapies of former clients and to find the emerging themes from their various accounts from which to develop an explanation for what occurred. I 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 book.

Positioning the therapy

In the late 1970s the family therapy movement in Sydney offered a new therapeutic map, an alternative discourse to the orthodoxy of the psychodynamic and psychoanalytic psychotherapies. As with 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 approaches, in terms of theory and practice that were well documented at the time,⁴ 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 languaging⁶ and orientation to the assessments and technical interventions was novel in comparison with 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 developed primarily from assessing the therapeutic relationship. External behavioural change was regarded more as a by-product of clients 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. As such, I was introduced to an array of therapeutic modalities in individ-

ual 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 approach to couple work for the Marriage Guidance Council, NSW.⁸ However, my move to private practice in the mid-1980s 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 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 were 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 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 supervision¹¹ 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 cures,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,¹³ was considered to be vital to the success of therapy and was understood to be experienced symbolically. The client was held, metaphorically, 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. By physically holding my clients, I was able to positively facilitate the therapeutic process through actual physical contact. Physical holding helped my clients feel safe enough to experience their unmet and unshared feelings in experiential and expressive ways.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, their therapist, as a maternal figure. Actual and symbolic enactments were possible as clients re-lived past events with their mothers, fathers and significant carers, as well as experiencing me as a significant carer. In such a manner, I found that physical holding helped my clients' healing process.

Cognisant of the theoretical inconsistencies prevalent in my therapy, I continued my journey, working in the landscape and trying 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, which ranged from inappropriate relationships to sexual assault.¹⁵ 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.¹⁶

Situating my research

Revisiting physical holding therapy was a different kind of journey. My first as a therapist meant I had to find my way in a somewhat uncharted landscape, holding professional responsibilities for both the therapy and the welfare of the client.¹⁷ This second journey, where I revisited the therapy, was as a researcher. And, as such, I invited my former clients to describe and discuss their experience of therapy. It was an opportunity for me to ‘re-search’,¹⁸ to look for emerging themes and explanations for what had happened. This time I had responsibilities for the design of the research, and also to the research participants.¹⁹

One factor that wove a connection between the therapy and the research was my dual involvement as both therapist and researcher. This involvement arose out of my desire to research physical holding, which 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 further discuss in Chapter 3 of this book, actual physical contact as a means of creating a facilitating environment had been consistently regarded and widely accepted as perilous, and contrary to the principles inherent in psychotherapy and psychoanalysis. I found, however, that little had been done to investigate these widely accepted assumptions or 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 non-verbal means of communication and can have powerful effects on attitudes and outcomes.

In this research, I attempted to find some explanation for the experiences in which I had been involved, 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 talk 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 opportunities were afforded within the physical holding process and how were these experienced and understood? How did physical holding become positive and therapeutic? Although the clients' experiences of being held were in the foreground of my research, the journey also helped me to reflect on my experiences as the therapist who physically held them. Although 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 allowed me to listen again to what the clients were saying and compare this with my experience and understanding. From this re-search, I set out to elucidate the feelings and processes involved, in order to chart possible landmarks for a therapy map involving physical holding, and to develop some guidelines 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 set out to understand what happened in the sequence of events surrounding physical holding. I have tried to develop an explanation: what happened to them as they were being physically held, and after that experience. James Hillman (1983, p.10) articulated some of the definitional terms in Freudian theory, which was elaborated in his case studies as transference, repression, symptom formation and psychotherapy. In this book I 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. The resultant positive therapeutic effects of physical holding, I believe, require that some of the principles and practices underpinning psychotherapy need to be re-examined.

The similarities between the philosophical and ontological assumptions underpinning phenomenology and Emotionally Focused Therapy, as outlined in Chapter 4 of this book, wove another connection in my research. I was afforded 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 elements from the descriptive, existential and hermeneutic approaches, to discover the essence of the phenomenon of physical holding, and to 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 tried 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. When the interviews were completed and transcribed, I listened to the tapes and reread the transcripts. 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 to the data to attempt to bring together common descriptions for the emergence of patterns and themes.²¹ 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.

Presenting the research

While keeping in mind the academic purpose of this research,²² a number of desires informed me about how I wanted to present this journey. There are many varieties of touch in our society that can form part of our experience: the acceptable and unacceptable touch in families and wider networks, the supportive and erotic between adults, the forbidden and the abusive in relationships, and the diagnostic and empathic in nursing and other helping professions. 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 an adult. 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.

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 want – 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 way similar to 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 my research with this possibility in mind: the reader becoming involved with the text and letting the emerging themes and

patterns envelop them. While many writers have discussed the importance of writing in phenomenological research,²³ 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 and across all the transcripts.

Through its readability, I hope practising clinicians will find this work accessible. In keeping with Peter Willis's (1997, p.3) comments about writing with immediacy and vividness, I set out to develop a writing style that allows for the rigour of academic research in addition to being an interesting reading experience for both the academic and the practising clinician. I have tried to blend a story-telling 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 such manner, I hope readers will be able 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 (Merleau-Ponty, 1973, cited in Van Manen, 1990, p.13).

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 – those of a therapist and a researcher. These voices can be recognised throughout this document, at times linked when each voice has commented on aspects of the research. Although I struggled at times with which voice needed to speak and what each voice wanted to say, I 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 can be seen in Chapters 5 and 6, the therapist's voice sets the context for both 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, I set out 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 give an account of the therapy journey around physical holding, and 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 research, and I try to explain my doubts and reactions so that readers are better able to understand the decisions made along this journey.

Where possible in this research, I wanted the participants to become known by their own voices, through their own words. In addition, I acknowledged the subjectivity of other authors by using their Christian names, where available, when they first appear in the text before using more traditional methods in subsequent referencing. I did this because I 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,²⁴ while reading and considering mine, as the research account unfolds.

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 would identify the writer's own mark, Sally Borbasi's (1996) account of her writing style alerted me to 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 book, my personal signature will have already started to become apparent. I have tried to write in a simple, straightforward style to better enable readers to access and relate to the ideas under discussion, trusting they can draw on the emotional elements in the therapy and research stories to get a better understanding of this investigation.

Using David Abram's example of having two introductory chapters,²⁵ I start Chapter 2 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 provide an account of possibly the first time I physically held a client and what happened to us both. I take the reader along the therapy journey for a few more sessions, and report what happened and how I dealt with various matters. My professional contemplations and my own personal reflections are included to make my journey in dealing with physical holding more accessible. The more technical aspects to beginning a research project, the examination of the literature, and the maps for therapy are set out in Chapter 3. Although I acknowledge that physical contact has been used by therapists working with the physical body, and by therapists of eclectic orientations, I focus more on physical contact – and physical holding in particular – with respect to the main psychodynamic and psychoanalytic therapies. In Chapter 3 I outline the principles and practices of these verbal therapies, starting with Sigmund Freud's legacy of significant work in psychoanalysis and then moving to how the possibilities for the development of therapy incorporating physical contact have been dealt with.

In Chapter 4 I outline my understanding and struggles with the differences between the methodologies of phenomenology that act as part of the backdrop to this research. I describe the method I selected for the research project, outlining the steps and processes to a qualitative inquiry involving interviews and other ancillary sources, such as clinical case-notes, client material in the form of correspondences and drawings, and

audio and video transcriptions. In this chapter, the woven therapy and research comes together again as I consider the issues for the former clients as research participants as well as for myself, the former therapist as researcher.

The results are presented in Chapter 5 and Chapter 6. In Chapter 5, I present the more descriptive and existential phenomenological aspects of the research – the experience of physical holding and what happened in the therapy as a result. Although I make comments both as therapist and researcher, I try to bring the voices of the research participants describing their experience into the foreground. In Chapter 6, I present the second part of the results, reflecting on my conduct as therapist and the meanings attributed to physical holding. Again, the former clients' voices can be heard through their dialogue.

In accordance with Ruth Wajnryb's (2001, pp.310–11) description of an end chapter, I reflect in Chapter 7 on what has emerged from revisiting the therapy journey in light of my desire to investigate the physical holding experience. Although a tidy process of drawing all the threads together and tucking away any unruly ones is recommended, I continue to weave my clinical experience with my clients' experiences into an account of what happens when therapists physically hold their clients in therapy. The landmarks of emotional contact, regression and a mothering experience are described and elaborated. Drawing on theoretical principles, I endeavour to explain 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.