The lived body experience of the therapist-practitioner in the South African social service delivery field

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Summary

The majority of the South African population receives counselling/psychotherapeutic services based on the Western medical framework, which has relegated the lived body to a body-as-object, that which is observable, tangible and devoid of any subjectivity, and also has disregarded and minimised lived bodily experiences to epiphenomena. Furthermore, for much of the past 100 years, mainstream Western psychology has been operating from a Cartesian paradigm that encourages dualistic ontological and epistemological thinking and practices, which has resulted in separating the body-from-mind (implicit and embodied knowing from explicit and conceptual knowing), and therapist-from-client amongst others. Dualistic counselling/ psychotherapeutic approaches promote one-person psychology, predominantly focusing on the intrapsychic issues of the client and thus neglecting the interpersonal and intersubjective (reciprocal and mutually influencing) phenomena occurring in the therapeutic field on an embodied and nonverbal level between the therapist and the client. Other consequences that have resulted from dualistic thinking within the therapeutic context are the exclusion, dismissal or suppression of the lived body (body-as-subject) and experiences of bodily phenomena (such as embodied self-awareness and implicit relational knowing amongst others), especially those of the therapist.

The more recent developments into infant research, body memory (such as the adaptive oscillators) and the mirror neuron system have not only provided neurological evidence of embodied mechanisms that enable individuals to share, experience, sense and understand another's actions and emotions on an embodied and nonverbal level, but also highlight the importance of the pre-verbal and implicit domain (embodied knowing) as a valid source of knowing of how to be and relate with others and the environment, which includes the therapist within the therapeutic space. Thus dismissing the lived body experiences of the therapist and conceptualising the therapist as being a neutral, objective and disembodied professional, seem inconceivable. A literature search produced sparse research involving South African therapist-practitioners' experiences of their lived body and the meanings held about these experiences within the therapeutic context.

This qualitative interpretive study sought to explore and describe the South African therapist-practitioner's lived experiences of the body within the therapeutic context and the meanings constructed or held about these experiences. Thirteen registered therapist-practitioners in private practice and government organisations in the Western Cape and Gauteng were selected by means of snowball sampling. Data were collected by means of naïve sketches and/or drawings, experiential body awareness activities, and in-depth one-on-one semi-structured interviews. The findings from the thematic analysis of the data revealed that lived body experiences appear to be a true phenomenon among South African therapist-practitioners. The participants reported that lived body experiences while doing therapy included bodily felt sensations and reactions, implicit knowing about something such as intuitive knowing, sense of warning/danger, implicit relational knowing about the clients and their own spatial and movement needs amongst others.

These findings are reported in three articles. Article One focuses on the participants' experiences of their lived body in terms of embodied self-awareness (ESA). Intuitive or spiritual knowing, a sense of warning/danger and a sense of how to relate and be with the client (the body-schema-in-relation) were the most frequent forms of implicit knowing experienced during the therapeutic process. The participants indicated that the use of their implicit knowing (ESA) enabled them to make quick and deliberate decisions and perform actions that regulated the immediate dynamics of the therapeutic field.

The second article reported on how the participants used their ESA as a form of implicit relational knowing to facilitate the therapeutic relationship, which enabled regulation of the counter-transference relationship through use of body movements and gestures, as well as facilitating their own and their client's spatial and movement needs.

Article Three reflected on how the researcher's use of multiple data collection sources which were grounded in visual and sensory mediums, had evoked participant reflexivity throughout the entire interview. Participant reflexivity elicited different type data, namely the participants' ESA, into the conversational space, which enabled the participants to interpret and create meaning of their own lived body experiences, thereby contributing to the richness of the data and the credibility of the research findings.

The study provides the beginning of a platform (a data base of new knowledge of the South African therapist-practitioner's experiences of the lived body) for future research

and opens the dialogue for changing current practices and training, as well as for further developing current qualitative research methods which are grounded in visual and sensory mediums. Sensory based data collection methods have the potential to generate additional type of data (ESA or implicit knowing), which would not be possible through interviews alone. New insights could be gained through conducting future research that includes larger homogeneous population groups who have specific context-based understandings of ESA and the lived body. Thus insight might provide input to the further development of current counselling/ psychotherapeutic practices and training programmes that encompass the diverse South African context. It is also suggested that future research could benefit from investigating how the therapist's implicit knowing and embodied relational process factors impact the development of the therapeutic relationship and current practice.

Keywords: lived body; embodied self-awareness; conceptual self-awareness; intersubjectivity; implicit knowing; interpretive inquiry

Opsomming

Die meerderheid van die Suid-Afrikaanse bevolking ontvang berading/ psigoterapeutiese dienste gebaseer op die Westerse mediese raamwerk, wat die "geleefde liggaam" gerelegeer het tot 'n liggaam-as-objek, iets wat waargeneem en aangeraak kan word, vry van enige subjektiwiteit, en wat lewende liggaamlike ervarings as minderwaardig geag en geminimaliseer het tot epifenomene.

Verder het hoofstroom Westerse psigologie vir die grootste deel van die laaste 100 jaar gefunksioneer vanuit 'n Kartesiese paradigma wat dualistiese ontologiese en epistemologiese denke en praktyke aanmoedig. Dit het onder andere gelei tot 'n skeiding tussen liggaam en verstand (implisiete en beliggaamde kennis teenoor eksplisiete en konseptuele kennis), asook tussen terapeut en kliënt. Dualistiese beradings-/psigoterapeutiese benaderings bevorder een-persoon-psigologie, wat hoofsaaklik fokus op die intrapsigiese kwessies van die kliënt en sodoende die interpersoonlike en intersubjektiewe (resiprokale en wedersyds beïnvloedende) verskynsels wat in die terapeutiese veld op 'n beliggaamde, nie-verbale vlak tussen die terapeut en die kliënt plaasvind, nalaat.

Ander gevolge wat uit die dualistiese denke binne die terapeutiese konteks voortgespruit het is die uitsluiting, verontagsaming of onderdrukking van die geleefde liggaam (liggaam-as-subjek) en ervarings van liggaamlike verskynsels (waaronder beliggaamde selfbewussyn en implisiete relasionele kennis), veral dié van die terapeut.

Die meer onlangse ontwikkelings op die gebied van babanavorsing, liggaamsgeheue (soos die aanpassingswisselaars) en die spieël-neuron-stelsel, het nie net neurologiese getuienis gelewer van beliggaamde meganismes wat individue in staat stel om te deel, ervaar, sensories te beleef en 'n ander persoon se aksies en emosies op 'n beliggaamde en nie-verbale vlak te verstaan nie. Dit het ook die belangrikheid beklemtoon van die pre-verbale en implisiete domein (beliggaamde kennis) as 'n geldige bron van kennis oor hoe om te wees en met ander en die omgewing in verhouding te staan. Dit sluit die terapeut binne die terapeutiese ruimte in. Om dus die geleefde liggaamservarings van die terapeut te verontagsaam en die terapeut te beskou as 'n neutrale, objektiewe en ontliggaamde professionele persoon, blyk onvoorstelbaar te wees. 'n Literatuursoektog

het bitter min navorsing opgelewer waarby Suid-Afrikaanse terapeut-praktisyns se ervarings van hulle geleefde liggaam en die opinies wat hulle het oor hierdie ervarings binne die terapeutiese konteks betrek is.

Hierdie kwalitatiewe, interpretatiewe studie het gepoog om die Suid-Afrikaanse terapeut-praktisyn se geleefde ervarings van die liggaam binne die terapeutiese konteks sowel as die menings wat oor hierdie ervarings gekonstrueer of gehuldig word, na te vors en te beskryf. Dertien geregistreerde terapeut-praktisyns in privaatpraktyk en in staatsorganisasies in die Wes-Kaap en Gauteng is by wyse van sneeubalmonsterneming uitgesoek. Data is ingesamel deur middel van naïewe beskrywings en/of tekeninge, aktiwiteite waarin liggaamsbewussyn ervaar is en in-diepte een-tot-een semigestruktureerde onderhoude. Die bevindinge van die tematiese analise van die data het aangedui dat geleefde liggaam-ervarings blyk ’n ware verskynsel by Suid-Afrikaanse terapeut-praktisyns te wees. Die deelnemers het verslag gelewer dat geleefde liggaam-ervarings terwyl terapie gedoen word, die volgende insluit: sensasies en reaksies wat in die liggaam gevoel word, implisiete kennis oor iets (soos intuïtiewe kennis), ’n gevoel van waarskuwing/gevaar, implisiete relasionele kennis oor die kliënte en byvoorbeeld hulle eie ruimtelike en bewegingsbehoeftes.

Oor hierdie bevindings word in drie artikels verslag gedoen. Artikel 1 fokus op die deelnemers se ervarings van hulle geleefde liggaam in terme van beliggaamde selfbewussyn (in Engels ESA). Intuïtiewe of geestelike kennis, ’n gevoel van waarskuwing/gevaar en ’n aanvoeling van hoe om teenoor die kliënt op te tree en die gesamentlike ruimte te deel (die liggaam-skema-in-verhouding) was die vorme van implisiete kennis wat die meeste gedurende die terapeutiese proses ondervind is. Die deelnemers het aangedui dat die gebruik van implisiete kennis (ESA) hulle in staat stel om vinnige en besliste besluite te neem en handelinge uit te voer wat die onmiddelike dinamiek van die terapeutiese veld reguleer.

Die tweede artikel rapporteer oor hoe die deelnemers hulle ESA gebruik het as ’n implisiete relasionele kennis om die terapeutiese verhouding te fasiliteer, wat regulering van die teenoordragsverhouding moontlik gemaak het deur liggaams-bewegings en gebare te gebruik, sowel as om hulle eie en hulle kliënte se ruimtelike en bewegingsbehoeftes te fasiliteer.

Artikel 3 reflekteer oor hoe die navorser se gebruik van veelvoudige datainsamelingsbronne wat begrond is in visuele en sensoriese mediums, regdeur die onderhoud refleksiwiteit by die deelnemers ontlok het. Deelnemerrefleksiwiteit het verskillende tipes data na die gespreksruimte gebring, naamlik die deelnemers se ESA. Dit het die deelnemers in staat gestel om hulle eie geleefde liggaam-ervarings te interpreteer en betekenis daaraan te heg, wat weer bygedra het tot die rykdom van die data en die kredietwaardigheid van die navorsingsbevindings.

Die studie verskaf die eerste treë na ’n platform (’n databasis van nuwe kennis oor die Suid-Afrikaanse terapeut-praktisyns se ervarings van die geleefde liggaam) vir verdere navorsing en open die gesprek om huidige praktyke en opleiding te wysig, asook om huidige kwalitatiewe navorsingsmetodes wat in visuele en sensoriese mediums begrond is, verder te ontwikkel. Sensoriesgebaseerde datainsamelings-metodes het die potensiaal om addisionele tipes data (ESA of implisiete kennis) te genereer, wat nie deur onderhoude alleen moontlik sou wees nie. Nuwe insigte kan verkry word deur toekomstige navorsing te doen wat groter homogeniese populasiegroepe insluit wat spesifieke konteksgebaseerde verstaan van ESA en die geleefde liggaam het. Sulke insig kan lei tot die verdere ontwikkeling van huidige beradings- of psigoterapeutiese praktyke en opleidingsprogramme wat die diverse Suid-Afrikaanse konteks omvat. Daar word ook voorgestel dat toekomstige navorsing kan baatvind deur te ondersoek hoe die terapeut se implisiete kennis en faktore van die beliggaamde relasionele proses die ontwikkeling van die terapeutiese verhouding en huidige praktyk kan beïnvloed.

Sleutelwoorde: geleefde liggaam, beliggaamde selfbewussyn, konseptuele selfbewussyn, intersubjektiwiteit, implisiete kennis, interpretatiewe navraag.

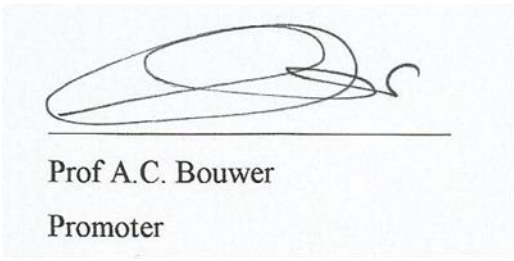
Preface

PhD in Article format

- The thesis is presented in article format as indicated in rule A.3.3.1.2 of the yearbook of the North-West University, Potchefstroom Campus.
- For purposes of examination the articles are presented as part of a single document consisting of four parts that include an introduction, literature section, three articles and the conclusions and recommendations, followed by a consolidated reference list.
- The Harvard method of referencing according to the requirement of North-West University was used for the main body of the thesis. Each article has been formatted according to the specific required guidelines for authors, thus the American Psychological Association (APA) guidelines (6th edition) was used. A copy of the author guidelines precedes each of the three articles.
- Article 1 has been submitted to the *Journal of Psychology in Africa* and has been accepted with amendments for publication in 2017.
- The article format requirements have necessitated the repetition of certain research procedures, tables and figures.
- Consecutive page numbering for the whole thesis has been used.
- A letter of permission from the study promoters authorising the candidate to submit the thesis for examination is attached on page ix.

Letter of permission

We, the promoter and co-promoter, declare that the input and effort of Colleen Angela Potgieter in writing these articles, reflects the research done by her. We hereby grant permission that she may submit these articles for examination purposes in fulfilment of the requirements for the degree *Doctor of Philosophy* in Psychology.



Prof A.C. Bouwer

Promoter

Prof C.H.M. Bloem

Co-promoter

Declaration by language practitioner

Hereby I declare that I have language edited and proofread the thesis *The lived body experience of the therapist-practitioner in the South African social service delivery field* by Colleen A Potgieter for the degree PhD in Psychology.

I am a freelance language practitioner after a career as editor-in-chief at a leading publishing house.

Lambert Daniel Jacobs (BA Hons, MA, BD, MDiv)
November 2017

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INTRODUCTION

CHAPTER 1: Orientation to the research

1.1 Rationale, problem formulation and research question

Human beings have been described as "biological creatures with awareness" (Bloom, 2012:71) or even "creatures of the flesh" (Johnson, 1999:81). For Merleau-Ponty (2005:94) "the body is the vehicle of being in the world", hence the body itself is fundamental to life. The body may be viewed as both a body-object and a body-subject. In the former instance it often implies its biological (organic) nature and in the latter instance it refers to the body as a means of perceiving and experiencing and, as Finlay (2011:29) states, a way of becoming and being-in-the-world. Satina and Hultgren (2001:522) approach the body as a valid source of understanding and creating meaning.

Despite these pronouncements, the body as a subject of human experience and as fundamental to the lived experience has been disregarded, minimised and often reduced to mere object. The body is often uncritically equated with both the metaphor and praxis of the 'man-the-machine' approach in Western mainstream psychology. The metaphorical conception of human beings as machines can be traced back to the influence of René Descartes, widely considered the father of modern scientific medicine, as well as physiological and comparative psychology (Hergenhahn, 1992:99). His famous dictum, *Cogito ergo sum* (I think; therefore I am) is deeply embedded in the Western tradition of medicine, philosophy, psychology and culture, reinforcing the belief that thinking equals self-existence at the expense of the body and lived experiences (Eiden, 2009:15; Hergenhahn, 1992:18; Kepner, 2003a:7; Shaw, 2003:39; Smith, 1998:4). This pervasive perspective is evident from the frequent references to machines or mechanisms in mainstream psychology, cognitive and behavioural sciences and research (Kohler, 2010:40). Descartes believed that "the body's life is modelled upon the workings of inanimate machines", devoid of subjectivity and intention (Leder, 1992:19), and that all animal and human behaviour, internal processes and interactions with the environment could be explained by mechanical principles (Hergenhahn, 1992:96). The mechanical approach set the groundwork for objectifying the

body, allowing it to be broken down into its separate parts and so creating the possibility for 'reshaping'. Mind and body were to be seen as separate entities that interacted with each other, consequently encouraging the development of dualistic ontological thinking (mind-body dualism) (Hergenhahn, 1992:99). The impact of the Cartesian view of the body and of embodiment is widely reflected in current Western medical aetiology, ranging from diagnostics and treatment of disease to bioethical thought. Medical conduct and discourse thus succeeds in often removing the individual's personality during an intervention and so objectifying the body to an "It" (Leder, 1992:23). In this context the body is considered as a physical object and as the "locus" of "medical intervention and biomedical innovation", even viewed as having economic value (Schicktanz, 2007:3). The pervasive view of an objectified body is reflected in activities ranging from "genetic modification and cloning, and through abortion" (Totton, 2009:188), and is evident in the wide usage and sharply rising activity of body consumerism (Lafrance, 2009:18; Sanders, 2006:286).

For much of the past 100 years, mainstream psychology and psychotherapy have been operating mainly from a mind-body and/or therapist-patient dualistic perspective, directly influencing how therapy is perceived in society (Levin & Bar-Yoseph Levine, 2012:5; Soth, 2009:72), how it is practiced (Eiden, 2009:15) and taught (Johnson, 1999:9), promoting science and research to "split mind-body, … and mental processes from the physical world" (Finlay, 2011:21). The result has been failure to address the whole-body phenomenon (Johnson, 1999:9) and encouraging much of Western psychology to be "disembodied" (Cromby, 2007:232; Soth, 2006:54).

Plentiful practical examples of disembodied practices in psychology are evident from published literature:

- Clients are often discouraged from talking about their physicality during therapy in order to alleviate the therapist's anxiety and possibility of their own body becoming visible (Swartz, 2003:95).
- Ethical concerns arise from the prospect of abusing clients through touch or sexual exploitation (Hartley, 2004:6).
- The use of the reductionist medical discourse objectifies body sensation as a symptom (Shaw, 2003:16).

- Embodied subjectivity and feelings, reflecting the phenomenological experienced body-relatedness and body state of individuals and their way of being in the here-and-now, are perceived as irrational and dismissed as nonessential phenomena, or subordinate to cognitive processes and therefore ignored as they cannot be measured objectively within mainstream psychology (Cromby, 2007:233).
- Therapeutic approaches which analyse and interpret neurotic behaviour in terms of child conditioning and family dynamics reinforce a fragmented self (Welwood, 1983:vii).
- Some approaches in psychology view the human characteristic of "introspection or subjective experience" as non-scientific (Kolstad, 2010:60) and therefore often disregard it as a valid source of information.
- Practitioners fear attending to and engaging with the client's and/or their own body (Miller, 2000:437).

Current trends and accompanying academic debate have been focusing on the effect of dualisms caused by the prevailing man-machine paradigm underlying so much of mainstream psychological, cognitive and behavioural sciences, which has given rise to epistemological shortcomings. These shortcomings can potentially lead to "consequences for (mis)understanding of human beings" (Kolstad, 2010:58), when describing and explaining certain aspects of psychological functioning and development, behaviour and activity of 'living beings'. According to Kohler (2010:39), a major epistemological weakness is that the theoretical construct of a 'human being as a machine' is not often defined or researched. His criticism is aimed against the conception of causality and its deterministic assumptions used to model psychological functioning and behaviour, as well as the *a priori* definition of the object of study in research, but not against methodology used in psychology per se (Kohler, 2010:43, 48). Kohler (2010:45) argues that the mechanistic paradigm has given rise to the "disappearance of the experiential dimension … exclusion of introspection as a scientific practice … denial of inner psychological life" by several approaches in psychology, affecting its epistemology. This has further given rise to the (1) exclusion of the role of experience and the subject's point of view or experiential perception, (2) inability to explain agency from a creative point of view, and (3) omission of plasticity (Kohler, 2010:39). Other authors have suggested that the perpetuation of the notion of the body as an object is based on "unquestioned dominant epistemological assumptions" (Johnson, 1999:9), and thereby

ignoring the evidence produced by "contemporary neuroscience and the views of thinkers such as James, Vygotsky and Merleau-Ponty" (Cromby, 2007:232).

Opposition to the mechanistic paradigm, especially its use of inanimate processes and mechanical laws to explain the body and human behaviour, started with early movements such as vitalism (Kono, 2010:330). In vitalism, life cannot be compared to a machine, as a machine does not contain a vital life force referred to as "soul, spirit, or breath of life" (Hergenhahn, 1992:17). Others proposed alternative ways of theorising about the body, and embodiment was introduced by early twentieth-century phenomenological and sociopolitical advocates. Among them, Edmund Husserl, Martin Heidegger, Maurice Merleau-Ponty, Franz Brentano and Ludwig Binswanger introduced concepts of intentionality, natural attitude, "Dasein" (a German term for being-in-the-world) and the notion of "Leib" *(*a German term for "the lived body") (Gallese, 2005:39; Leder, 1992:17; Stern, 2004:95).

Not all approaches in psychology either oppose or completely accept the mainstream Western psychological paradigm of scientific investigation. Some rather proceed from altogether different epistemological bases (Kolstad, 2010:59). Gestalt, phenomenological and other existential humanistic psychotherapies, for instance, approach the individual from a holistic, relational or field theoretical perspective. In doing so, they acknowledge the interdependence and interconnectedness of the physical and the mental, favouring direct experience as an attempt to heal the mind-body split and deal with predominant dualisms (Eiden, 2009:15; Kepner, 2003a:8; Parlett, 2008:4; Totton, 2005:168). These alternative bases support the view that the behaviour of living beings displays plasticity, as the potential for a multitude of possible actions exists, with varying content that the individual is able to choose from (Kono, 2010:333), thereby demonstrating the possibility of free will (Kohler, 2010:49). Other schools of thought advocate new and expanded epistemological frameworks such as an organic paradigm (Kohler, 2010) or an extended mind approach (Kono, 2010). Totton (2011) proposes an eco-systemic therapeutic model called Wild Therapy, which recognises embodiment as being core to all human existence and emphasises relationality and the interdependence of all beings, as well as the connectedness of humans to "the other-than-human and more-than-human" (Totton, 2011:1), including "animals, plants, … dreams, … spirits, … and many other aspects of reality" (Totton, 2011:190). Here, the concept of liminality finds support, a place for potential transformative growth of an emergent self (Denham-Vaughan, 2010:36). Yet others have suggested the inclusion and integration of

complementary and alternative medicine into the practice of psychology (Barnett & Shale, 2012:576-585).

A further form of dualism has emerged, namely epiphenomenalism (Hergenhahn, 1992:14). This is practiced in some non-verbal (body oriented) therapies where the argument is that mental events are by-products caused from the lived experiences of the body. Epiphenomenalism developed as a result of and as an alternative to verbal therapies and other approaches, which perpetuate the subject-object, mind-body dichotomies.

Despite the current movements towards change in the direction of an all-encompassing, extended epistemology and holistic approach within the Western mainstream psychology, there is not much support for the inclusion of the lived body and the embodied subjective experiences as an intrinsic part of the individual's self, self-perception, bodily self-reflection and contact-making (Kepner, 2003a:8; Wakelin, 2003:117). A major reason for the lack of support is the fact that the prevailing social-cultural-psychological field still operates from a techno-rational base of thinking which imposes standardised procedures and frameworks of understanding, producing "information-processing models of aspects of cognition" (Parlett, 2008:7) and thus reinforcing dualism and a disembodied world. Authors such as Yontef (2004:45) and Wakelin (2003:117) are of the opinion that the denial of the body in the social-cultural-psychology field has not so much to do with disembodiment (or not being embodied), but rather that individuals do not have the awareness of being a body whereas they posit that communication occurs simultaneously on an embodied (being in nonverbal body-to-body communication) and a verbal level.

Hartley (2004:221) estimates that every encounter, including therapeutic encounters, consists of more than 90% of implicit knowledge which is "nonverbal, non-symbolic, un-narrated and non-conscious (not repressed or unconscious)". Implicit knowledge involves the individual's "sensory motor procedures, affect patterns, expectations, and even patterns of thinking" (Stern, 2004:242), and thus forms an integral part of making sense and meaning of every encounter (Adler and Towne, cited by Ellingson 2012:528). Even the capacity to interpret the other's tone of voice, range of body movements, gestures and postures, is included in this estimation (Stern, 2004:114). Fuchs (2004:4; 2012:14) refers to this implicit knowledge as a specific type of implicit body memory, namely intercorporeal memory, which is neurologically shaped (Mancia, cited in Kouvelas, 2012:215) by early experiences in the

infant's "primary inter-subjective field" (Stern, 2004:83). Starting from birth, the infant's exposure to the relational parenting style of his or her caregivers, preverbal (proto-linguistic and pre-symbolic) dialogue, and embodied experiences (such as action repertoire, shared affective states, embodied attitudes and associations of touch, pleasure, pain, and mother-infant movement dynamics) all become inscribed experiences, which influence the development of body memory, thereby shaping the individual's "bodily, pre-reflective self-awareness" (Summa, Koch, Fuchs & Müller, 2012:419). The early experiences of the infant are the basis for acquiring dyadic and "inter-subjective patterns of interactions" (Fuchs, 2012:14), forming the individual's embodied history (Frank & La Barre, 2011:80).

In phenomenological and relationally based psychotherapeutic approaches, the notion of an 'inter-subjective pattern of interactions' can be understood as a form of implicit relational knowing, that is "living our body-world interconnection pre-reflectively" (Finlay, 2011:31) and possessing an innate "bodily knowing of how to deal with and be with others" (Stern, 2004:242). According to Husserl, from a phenomenological and relational view the body has been conceptualised as a "lived-body (Leib) constantly there … functioning as an organ of perception" (Husserl, 1999:227 cited in Bloom, 2009:284).

The discovery of the mirror neuron system is one of the modalities of understanding prior to any form of conceptual and linguistic mediation, which gives substance to our experience of others (Rizzolatti & Sinigaglia, 2008:132). The mirror neuron system allows for the immediate understanding of the meaning of "what is seen, felt or imagined (of) what the other is doing" (Rizzolatti & Sinigaglia, 2008:190) and for having an "empathic sense" (Philippson, 2006:60) while observing, without having to mimic or replicate, the other's actions and emotions. Immediate understanding is possible by the act of observing (our perceiving of) actions, intentions and emotions (expressed in the facial and body movements and gestures) of others, because they are emulated (mirrored) in different parts of the premotor cortex of the observer, thereby capturing the intentional dimensions and coding the sensory information respectively into corresponding motor or visceromotor terms (Rizzolatti & Sinigaglia, 2008:130). Understanding is thus embodied within the neural structures and occurs on an implicit level or in terms of nonverbal forms of communication, emerging from the individual's "kinetic text" (La Barre, 2005:252) and "the vocabulary of acts and the motor knowledge" (Rizzolatti & Sinigaglia, 2008:125). Therefore, implicit understanding or knowing can lead to a potentially "shared space of action" (Rizzolatti & Sinigaglia,

2008:131) and "sharing of emotional states" (Rizzolatti & Sinigaglia, 2008:191) thus co-creating an interactive field (in-between space). The shared space is dynamic and allows for the mutual influencing of (non) conscious decision-making processes, sequencing of actions and choice of emotional reactions towards the other, moment-by-moment and so shaping individual relationships and behavioural dispositions (Cromby, 2007:343; Fuchs, 2004:6; Rizzolatti & Sinigaglia, 2008:190). The functioning of the mirror neuron system strongly suggests that the body can no longer be viewed as a machine divorced from subjectivity, but that the body functions at the centre of experience, transforming the object body into the subjective or 'lived body' (Leib), and as a means for perceiving and interpreting the world, as well as being a starting point for acquiring knowledge (Finlay, 2011:21; Shaw, 2003:39).

The shared space created in-between the lived body of the therapist-practitioner[1] and the lived body of the client during social or therapeutic interaction can be viewed as "any psychological field formed by interacting worlds of experience" (Stolorow, Atwood & Orange, cited in Philippson, 2009:46). Experiences arising from the therapeutic space (Lobb, 2008:113) may consist of a series of co-created present moments (Gestalt-figures), being small units of shared subjective experiences and perceptions about the current nature of their relationship, which are "shared and validated between them implicitly and explicitly" (Stern, 2004:243). Recent research conducted into the "nature and structure of subjective experiences" (Stern, 2004:137) and into implicit (procedural) memory (Kouvelas, 2012:215-216) has produced evidence which challenges Western dominant dichotomies of separating mind/body or intellect/feelings (Parlett, 2008:12). Research data of the mirror neuron system and body memory provide a neurological basis for overcoming all linguistic and cultural barriers, as we as members of the human species can "share experience of actions and emotions" (Rizzolatti & Sinigaglia, 2008:191, 131) with others via embodied understanding (Finlay, 2011:21; Stern, 2004:242).

Therefore, the ontology of a phenomenological-relational (two-person) and intersubjective therapeutic field provides strong evidence that *"one-person psychology ought not to exist, or at least must be incomplete"* (Stern & Boston Change Process Study Group, 2003:23), by

[1] The term therapist-practitioner refers to a person registered with a Health Professions Council (such as Health Professions Council of South Africa, South African Council for Social Service Professions or the Allied Health Professions Council of South Africa) that provides professional psychotherapeutic or counselling services (such as clinical, counselling or educational psychology, social work and counselling).

implication changing the focus from exclusively on the client to include the therapist-practitioner, incorporating the experienced body phenomena (such as bodily felt sensations, body reactions, body memory). Both the client's and therapist-practitioner's verbal and non-verbal phenomena constitute a relational embodied therapeutic field (Clemmens, 2012:39). Consequently conceptualising an "I without an us" becomes inconceivable (Rizzolatti & Sinigaglia, 2008:xii).

Regardless of therapeutic orientation, it is generally accepted that the therapeutic relationship is considered pivotal in producing a positive therapeutic outcome and change (Brownell, 2012:61; Flückiger, Del Re, Wampold, Symonds & Horvath, 2012; Gelso, 2014; Horvath, Del Re, Flückiger & Symonds, 2011) and a means of facilitating the client's style of relating to self and others (Gold & Zahm, 2008:34; Totton, 2003:25). Both the therapist-practitioner's and the client's embodied history, including patterns of action and emotions may be elicited from and shaped in the present relational therapeutic interaction, which may either interfere with or facilitate therapeutic work and communication (Frank & La Barre, 2011:79). A relational embodied therapeutic field has clinical implications, requiring the therapist-practitioner to be willing to regulate the relational therapeutic processes, exploring both the explicit (verbal or narrative) content and the nonverbal and implicit material that the client brings (Stern, 2004:119).

Clemmens (2012:39) maintains that a core skill for engaging and supporting a relational embodied therapeutic field is for the therapist-practitioner to be simultaneously aware of her/his own body experiences and in relation to the client's body experiences throughout the therapeutic inquiry. Essential skills needed to support the therapeutic process and the therapist-practitioner in developing a working alliance and for being-with-the-other in a relational embodied space, is the therapist-practitioner's attitude and ability to be reflexive (Finlay & Evans, 2009:41) and to be willing to develop and maintain an embodied energy, presence, empathy and resonance, as well as being able to articulate the language of the body, what Gendlin calls the 'felt sense' (Finlay, 2011:39) arising from the lived experiences of the body (being the lived body) (Clemmens, 2012:46, Geller & Greenberg, 2002:81). Empathy, presence, resonance, attunement, intersubjectivity, as well as experiences such as shame and (counter)transference are all relational processes and consist of bodily based phenomena, which remain largely in the nonverbal and pre-reflective domain and are integral elements of implicit relational knowing (Stern, 2004:78) and other forms of body memory (Fuchs,

2004:12). Thus it becomes of essence for the therapist-practitioner to adopt an openness towards an embodied dialogue, awareness of how the nonverbal and implicit communication contextualises of what is verbalised in the present therapeutic moment and the ability to regulate the nonverbal and (intersubjective) implicit state of therapeutic relationship (dyad) (Frank, 2003:22; Kepner, 2003a:13; Tervo, 2007; 2011).

Even therapist-practitioners who have been trained in or exposed to relational, phenomenological and body-based approaches such as body psychotherapy or Gestalt therapy may find it difficult to work in an embodied way, often having to ignore their own and the client's lived experience of the body (Kepner, 2003a:8; Clemmens, Frank & Smith, 2008:19). The exchange of feelings and sensations, and dealing with the client's nonverbal and somatic expressions may evoke body reactions in terms of somatic counter-transference (Vulcan, 2009:279), as well as shame and even feelings of inadequacy on the part of the therapist-practitioner (Clemmens, 2012:46; Rothschild, 2000:57). Certain research suggests that therapist-practitioners experiencing or having an awareness of their body phenomena may be associated with low perceptions of the professional self (Davidson, 2005:54), as well as partly explaining existing high levels of therapist-practitioner burn-out (Jordaan, Spangenberg, Watson & Fouché, 2007). Thus, the awareness of experiencing one's body phenomena may result in an additional source of stress and embarrassment for the therapist-practitioner (Booth, Trimble & Egan, 2010:285). The prevalent effects of the therapist-practitioners' bodily phenomena were highlighted in a recent study by Booth *et al.* (2010), measuring the somatic reactions (body-centred counter-transference) of 87 Irish psychologists to their clients. Symptoms ranged from muscle tension, sleepiness, headaches, body shifting and nausea to genital pain (Booth *et al.*, 2010:287). The study results suggested that the symptoms experienced by therapist-practitioners in reaction to their clients were not linked to variables such as the age of the therapist-practitioners, the number of working hours, the type of client or theoretical orientation, but rather were influenced by the therapist-practitioners' personal styles of dealing with and managing those body reactions (Booth *et al.*, 2010:287).

The problem, according to Kepner (2003a; 2008:96), is that therapist-practitioners who are disembodied (that is, disconnected from or even disregarding of their body), or have never fully explored their subjective experiences of the embodied self, may lose touch with their own needs, with who they are, their place and connection with the environment, as well as

their ability to adapt or adjust to the environment. Being unaware or disconnected from the lived experiences of the body may result in disturbances in empathy and connection (Athanasiadou & Halewood, 2011:258), showing symptoms of occupational stress and adopting the use of inappropriate coping strategies (Jordaan *et al.*, 2007:176; Van Dyk, 2007:49). Therapist-practitioners who are bodily desensitised or disconnected may not be aware, attuned or open enough to their clients' implicit and body material (Clemmens *et al.*, 2008:19), and may adopt what Martin Buber described as an I-It dialogical relational stance (Mann, 2010:176), approaching the client in a mechanical manner which may result in ignoring or objectifying the client's lived body experiences. Lichtenberg (2006:2) suggests that being disconnected from the body may result in faulty modes of experiencing which are expressed during daily discourse (or in the therapeutic dialogue) and played out as ethnocentrism, racism, homophobia, sexism (as result of flawed projecting or problematic introjection), intolerance of ambiguity or ambivalence, and great fears of dependency, all of which could, according to Hartley (2004; 2009), potentially lead the therapist-practitioner unconsciously to abuse or re-victimise the client.

Disciplines such as body psychotherapy, sociology and psychological anthropology believe that the body and lived body phenomena are socially constructed and informed (Csordas, 2002:59; Totton, 2009:193). Therefore, cross-cultural awareness, sensitivity and openness, not only of the biological nature (object-body) and subjective-body dimensions, but also of the socio-cultural-economical-political ground from which the client's lived body experiences emerge and meaning is derived, are especially important for therapist-practitioners working in the South African environment. Mpofu, Peltzer and Bojuwoye (2011:3-12) have documented that the traditional African approach towards healing can be linked to certain socio-cultural beliefs in being relational (involving the community, family collective in outlook) and may thus be rooted in holistically based approaches wherein a natural connection between the mind and body is assumed. The South African traditional health practitioner [2], for the most part, interacts in a directive manner utilising body oriented modalities, enactment, dream work and ritual amongst other techniques plus group therapy in

[2] A traditional health practitioner is a person who performs "a function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practice and which has as its object – (a) the maintenance or restoration of physical or mental health or function; or (b) the diagnosis, treatment or prevention of a physical or mental illness; or (c) the rehabilitation of a person to enable that person to resume normal functioning within the family or community; or (d) the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth and death" (RSA, 2008:6).

terms of involving family and community members. These therapeutic techniques or methods are all part of common counselling practises (Mpofu, Peltzer and Bojuwoye, 2011:8-12). Despite this traditional antecedent, the majority of the South African population of so-called black African ancestry receives counselling services based on the Western medical framework, reflecting Euro-American values and norms (Mpofu, Bakker & Lopez Levers, 2011:314). Managing all aspects of the therapeutic relationship, (including the nonverbal, implicit knowledge and the lived body experiences of the therapist-practitioner and the client) becomes crucial as these may trigger "moments of meaning" (Kouvelas, 2012:215), thereby shifting the therapeutic relationship and process, potentially impacting the therapeutic outcome (Stern, 2004:119).

Existing literature and research focus mainly on the client's body and body phenomena showing marked ambivalence towards the therapist-practitioner's lived experiences of the body. Kepner (2003a) and Shaw (2003:25) suggest that the absence and/or ambivalence in addressing themes related to the lived body experience and the embodied (or disembodied) self of the therapist-practitioner is evident in training, supervision and literature. Furthermore, research on the effect of nonverbal behaviour on therapy outcome and therapy relationship is "sparse" (Ramseyer & Tschacher, 2011:284; Roos & Werbart, 2013). Others propose that "there is an apparent gap in the academic coverage and clinical utilisation of therapists' somatic states" (Athanasiadou & Halewood, 2011:247), suggesting the need and relevance of conducting further research for "systematic study of the potential therapeutic benefits of the therapist's bodily sensations, movements, and bodily knowledge in the therapeutic process" (Vulcan, 2009:279).

The therapist-practitioner's own embodiment (as a tool) and his or her somatically experienced responses to the client suggest a useful potential starting point for acquiring valuable information about the therapeutic encounter (Bloom, 2006:7; Hartley, 2009:4; Orbach, 2004:143; Shaw, 2003:148). In addition, the therapist-practitioner's lived embodied experiences may function as a "messenger of the unsaid", providing the possibility towards the understanding of certain situations that may be difficult to verbalise or which seem incongruent with the explicit or verbal agenda (Todres, 2007:5). Therapist-practitioners that have an awareness (conceptual and embodied) and the ability to sense and manage bodily data (subjective lived experiences of the body), may be better equipped to create a safe therapeutic relational and embodied holding space, and thus be in a position to facilitate the

client's and their own bodily, pre-reflective and nonverbal phenomena in a beneficial manner (Reynolds, 2009:47).

A literature search of the South African academic databases produced sparse research involving therapist-practitioners' and even the client's lived body phenomena within the therapeutic setting. Therapist-practitioner's lived body and embodied lived experiences may however have significant implications for Western biased "talking cure therapies" (Gallese, 2009:532), especially in an environment such as South Africa which is composed of an amalgamation of cultures and languages, with numerous indigenous (emic) approaches towards health and well-being. According to Ablack (2009:130), developing the therapist-practitioner's ability to perceive through an embodied self allows intervention practices in which cultural sensitivity, competence and proficiency facilitate the dynamics of diversity throughout the therapeutic process. Consequently, this powerfully suggests that the "process of researching embodied lived experiences [of the therapist-practitioner] and the evocative findings that may result have the potential to be transformative" (Finlay, 2011:26).

1.2 Research aim and question

This study aimed to elucidate and thereby gain in-depth insight into the South African social service delivery (SASSD) therapist-practitioner's subjective lived experiences of the body (being the lived body) lived out in the therapeutic context. The direct subjective experiences and intersubjective experiences are considered a valid source of knowledge, which need to be acknowledged and examined (Evans, 2007:194; Haverkamp & Young, 2007:272; Turner & Norwood, 2013:699). Thus, the study focused on exploring and describing therapist-practitioners' experiences of the lived body and the meaning held about those experiences in the SASSD field.

With the capturing and elucidation of the therapist-practitioner's experiences of the lived body it is hoped to stimulate dialogue and debate for the inclusion of the therapist-practitioner's lived body and embodied lived experiences within the psychotherapeutic practice, training and personal development, as well as to consider the implications for knowledge generation that could enrich and inform therapist-practitioners working in the South African field of cross-cultural Social Service Delivery.

The primary research question in this study was formulated as:

What are South African social service therapist-practitioners' experiences of the lived body within the therapeutic context?

To answer the primary research question, the following secondary questions were posed:

- What are South African social service therapist-practitioners' experiences of their own lived body in terms of embodied self-awareness?
- What are South African social service therapist-practitioners' experiences of their client's lived body?
- How does the South African social service therapist's embodied self-awareness facilitate the relationship between the therapist (her/himself) and the client?

1.3 Research methodology

This section presents the research methodology and the research procedure employed. The aim of the study was to identify, describe and analyse SASSD therapist-practitioners' "lived experience of the body" (Frie, 2007:58), that is their "embodied lived experience which is lived out in the world" (Finlay, 2011:23) and the "meaning held about that experience" (Finlay, 2011:16).

Therefore, a qualitative approach aligned with an interpretive naturalistic paradigm was chosen to study the SASSD therapist-practitioners' lived experiences of the body within the therapeutic context. As an orientation and background to this qualitative interpretive study, as well as the researcher's choices and basic worldviews, first an overview is conducted of relevant paradigms and theories within qualitative research and the social sciences.

Subsequently, the philosophical and paradigmatic considerations, including the ontological, epistemological and methodological assumptions underpinning this study are presented. The qualitative research design and its implications, including the sampling process and data collection and data analysis methods that were employed during this interpretive descriptive (ID) study are outlined.

1.3.1 Introduction to paradigms and theories in the social sciences

Evans (2007:193) and Babbie and Mouton (2001:645) refer to the philosopher Thomas Kuhn as having introduced the term 'paradigm' in 1962 as being a set of beliefs and values to guide research. Kuhn's conceptualisation of the term 'paradigm' laid the groundwork for referencing current scientific paradigms or meta-theories of social science and has become an accepted tradition within the scientific field. According to Babbie and Mouton (2001:20), the term 'paradigm/meta-theory' in social science is used interchangeably with terms such as 'philosophy of science', 'meta-science' and 'epistemology of science'.

Paradigms are general frameworks, which provide ways of looking at human social life, and are grounded in sets of assumptions about the nature of social reality (Babbie, 2007:33; Evans, 2007:193; Grix, 2002:177). They are models for observation and understanding, which shape what we see, how we understand and guide the researcher into action (Babbie, 2007:32; Creswell, 2013:13). Factors such as the political climate, economic conditions, spiritual practices, and technological and scientific developments create a Zeitgeist that determines and changes the world philosophies and scientific meta-theories/paradigms of its time as well as over time periods (Hergenhahn, 1992:3). For example, during the classical (or Platonic) period, truth was considered to be universal, grounded in an external creator and reality was based on ideals and forms. Whereas during the time period epitomised by Descartes, knowledge and truth were based on the observation of facts, calculations and development of theories (Evans, 2007:193). The paradigm had shifted from theo-centric to ratio-centric based thinking. In contrast with the rational or reductionist way of thinking, postmodern approaches embrace a more pluralistic and subjective stance, suggesting that there is "no single, universal, privileged, accurate, truthful, and secure way of understanding anything, especially people" (Evans, 2007:194).

Even within the social science meta-theories variations exist, ranging from positivism, realism, post-modernism and interpretivism to critical social science amongst others (Babbie & Mouton, 2001:15; Creswell, 2013:17; Neuman, 2003:62). Each meta-theory, such as interpretive social science, may have a number of variations within its classification. For example, understanding everyday lived experience can be based on hermeneutics, constructionism, ethnomethodology, grounded theory, phenomenological and other

perspectives within the interpretive social science meta-theory (Creswell, 2013:17; Neuman, 2003:68). Theories flesh out paradigms and are "sets of interrelated statements" (Babbie, 2007:43), which are cognitive constructs or concepts that aim at explaining (giving meaning to) and predicting what is empirically observed (Crocker, 2008:124). The function of theories is to assist research by "(1) helping to avoid flukes, (2) making sense of observed patterns, and (3) shaping and directing research efforts" (Babbie, 2007:56), (4) guiding practice and (5) guiding the researcher to achieve the desired goal (Crocker, 2008:125).

In other words, according to Morrow (2007:212), a paradigm is a 'net' consisting of the researcher's philosophical assumptions, feelings about the world and claims about her or his view of the nature and form of reality (ontology), how that reality is known (epistemology) and the relationship between the researcher and participants, the role and inclusion of their values (axiology), and the process of research or acquiring the knowledge (methodology) (Creswell, 2013:21; Creswell, Hanson, Clark & Morales, 2007:238; Denzin & Lincoln, 2011:13), as well as their writing style and structures (rhetoric) (Creswell, 2003:6, McLeod, 2011:38) that frame the research process.

This study has employed a qualitative interpretive approach. The notion of qualitative research is understood to consist of "a set of interpretive activities … which has no theory or paradigm that is distinctly its own … nor has a distinct set of methods or practices" (Denzin & Lincoln, 2011:6). To ensure credibility of the interpretive research, transparency regarding the researcher's choices and basic worldviews needs to be strived for (Díaz Andrade, 2009:43). Therefore, a brief overview of the nature of interpretive qualitative research, the philosophical context and the researcher's paradigmatic considerations influencing this study is presented next.

1.3.2 The philosophical and paradigmatic considerations underpinning this study

The researcher is cognisant that her professional training in Gestalt therapy theory and her experiential work, utilising body oriented modalities such as creative dance, movement, breath work and play, have influenced her paradigmatic stance and attitude. Humanist, existential and relational theories such as Gestalt therapy theory primarily employ an Aristotelian paradigm in its approach to human living and therapeutic tasks (Brownell,

2010:34; Crocker, 2008:127). Crocker (2008:126) describes the Aristotelian paradigm (1) as assuming a verb/adverb or action oriented ontology, as it is mainly concerned with processes of growth (change) and processes of interaction (motion) among events (including physical matter); (2) as growth or change occurring through abstraction and synthetic generalizations; (3) as giving the individual an ontological priority and assuming that the individual is able to comprehend universal truths and patterns of interaction; and (4) as being a field-theoretical approach which considers the context (field) in which an event occurs, with meaning in this context then being linked to a specific dimension. The core of humanistic, existential and relationally oriented approaches such as Gestalt theory is rooted in constructivism which offers a theoretical and pragmatic grounding, as well as practical intervention, for addressing new areas of growth and meaning-making and of facilitating evolving human nature (Wheeler, 2009:15). In this respect, Aristotelian thinking is akin to constructivist and interpretive paradigms.

Constructivist philosophical assumptions are based on a relativistic ontology (multiple realities), a subjectivist epistemology (therapist-practitioner and client co-create meaning), and a naturalistic (in the natural world) set of methodologies (Creswell, 2013:36; Denzin & Lincoln, 2011:13; Evans, 2007:194; Guba & Lincoln, 1994:109). This study has been approached both from a constructivist and an interpretive worldview.

A relativistic ontology therefore also informs this study, which assumes that multiple realities exist, and that reality is personally constructed through lived experiences and interactions with others which must be understood holistically within the person's context and interpersonal dimensions (Creswell, 2013:36; Fouché & Schurink, 2011:310). A relativistic ontology has divergent ways of conceptualising how human beings construct their reality and make sense of their world in which they live, namely an approach through constructionism or an approach through constructivism (Patton, 2002:96). The notion of 'constructionism' is the view that reality or truth is constructed through the process of social mediation, interaction and relationships, emphasising the use of language and conversations (McLeod, 2011:52). Constructionism has been criticised for undermining the individual experience, over-emphasising language, and discarding the physical aspects of human existence and embodiment, often ignoring bodily affective states and emotions (McLeod, 2011:53; Sullivan, 2010:29). On the other hand, the notion of 'constructivism' highlights the unique individual experience and sense-making of a person's reality (Patton, 2002:97; Rubin &

Rubin, 2012:22). These two approaches to a construction of reality can be seen as overlapping since they are both relativistic in stance and view reality as always being subjective, relative to time and space, as well as being embedded within a context (McLeod, 2011:52; Patton, 2002:100). There is no single truth, since multiple realities, which may be contradictory, are able to co-exist (Guba & Lincoln, 1994:113; Rubin & Rubin, 2012:19).

Epistemological assumptions are concerned with how knowledge is gained and what counts as knowledge, as well as what the nature of the relationship between the inquirer (researcher) and the researched may be (Denzin & Lincoln, 2011:12; Grix, 2002:180). In conjunction with constructivism as an ontology which assumes the existence of multiple constructed truths, this study is located within an interpretive epistemology, utilising phenomenology to illuminate the subjective personal experiences of the individual, including the non-linear multi-causality of field theory and holism as the philosophical bases to provide the ground and context for understanding how reality is constructed and meaning is made (Evans, 2007:190). Knowledge is gained and shaped through the subjective (and intersubjective) experiences and meanings that persons seek, as well as what is co-constructed through the actions and interactions between the researcher and the researched (Creswell, 2013:36).

Reality based on a verb or action ontology is considered as a "dynamic and ordered whole of many interpenetrating dimensions, in which events occurring in any dimension are capable … of reciprocally influencing events in any other dimension" (Crocker, 2008:128). Research conducted in neuroscience (Rizzolatti & Sinigaglia, 2008:130) and early developmental intersubjective patterns of interaction (Fuchs, 2012:14; Stern, 2004:242) supports the existence of reciprocal, intersubjective and relationally shared fields or spaces (Lobb, 2008:113). The social and psychological context of individuals, communities and cultures creates, shapes and re-shapes their realities (Guba & Lincoln, 1994:111; Staemmler, 2009:352), due to the influence of change and interactions with others (Denzin & Lincoln, 2011:13). Therefore, the contextual and constructed nature of experienced phenomena by individuals allows for shared realities (Thorne, Kirkham & MacDonald-Emes, 1997:172). Given that some elements of reality may be shared among different individuals and across cultures, the individual experience of a person's reality or truth remains unique to each person (Guba & Lincoln, 1994:110; Patton, 2002:97).

According to Thorne (2008:74), researchers adopting interpretive descriptive research assume that a priori knowledge or theory cannot encompass multiple realities. The life-worlds of participants, however, involve multiple realities that are "complex, contextual, constructed and ultimately subjective" (Thorne, Kirkham & O'Flynn-Magee, 2004:5) and "may well be contradictory" (Thorne, 2008:74). In terms of this study, this means that the subjective reality and life-world of each participant may inform and re-shape the a priori knowledge of the researcher. Given that aspects of reality are socially constructed, and meanings may be shared, then the role and attitudes of a research-practitioner may influence the participant (St. George, 2010:1626). Researchers who are therapist-practitioners, have some theoretical knowledge or previously acquired experience of the phenomenon being researched within a clinical setting or in populations where applied health services are provided in social work, counselling and psychotherapy, and thus do not enter the research field with a neutral stance or with a tabula rasa. These research-practitioners are faced with challenges of how to manage their pre-existing knowledge of clinical practice during interpretation to produce credible information and trustworthy research (Chenail & Maione, 1997:2; Thorne *et al.*, 2004:11). Consequently the researcher's own unique constructions (or sense-making from previous experiences) and clinical knowledge (Thorne *et al.*, 2004:9) cannot be separated or be seen in isolation from those provided by the research participants during researcher-participant encounters, and need to be managed. Authors such as Hunt (2009:1289) and McLeod (2011:48) suggest that the researcher, using reflexivity can manage a priori theoretical and disciplinary knowledge (see Section 1.3.5.2).

To capture the different sets of realities, recognising the phenomenon of the participants' experiences of the lived body within the therapeutic setting, the researcher needs to acknowledge her role as being a vehicle through which reality is revealed. To achieve a coherent and credible account of the lived experiences of the lived body of the participants, the researcher adopted a responsive interviewing style as described by Rubin and Rubin (2012:36). She also applied a phenomenological method of inquiry (Bloom, 2009:277; Brownell, 2010:31), which seeks and views personal subjective experiences as the truth (Clarkson, 2004:15), as a valid source of knowledge (Evans, 2007:194), without an attempt to label, judge, manipulate or prescribe the meaning of an event or the observed phenomenon (Clarkson, 2004:15; Joyce & Sills, 2010:50; Wollants, 2012:96).

The use of a phenomenological method involves following the participants' subjective experiences (how they make sense and meaning of their world) and their nonverbal cues as closely as possible, including describing the what and how while simultaneously maintaining an open mind and genuine curiosity, as well as suspending (bracketing off) own ideas, beliefs, assumptions and explanations (Babbie & Mouton, 2001:31; Brownell, Meara & Polák, 2008:11; Fouché & Schurink, 2011:316; Joyce & Sills 2010:18; Mann, 2010:150; Reynolds, 2009:46). Consequently, the use of the phenomenological method aims to make the observer (researcher) aware of her or his own phenomenal world (by postponing judgement and reactions towards the other; attempting to isolate [bracket] her or himself from all kinds of constructions about the participant/client) and at the same time create an open attitude and stance towards understanding the other (the observed) as clearly or without distortion as she or he can (Bloom, 2009:284).

Methodology is concerned with the logic and process of scientific inquiry and how the researcher goes about acquiring knowledge (Creswell, 2013:21; Grix, 2002:179), all of which is determined by the assumptions mentioned above. The nature of this study called for a qualitative interpretivist and descriptive method of inquiry in line with the phenomenon being researched, as well as with the researcher's own philosophical stance and professional training, being predominantly oriented in humanist, existential, relational and body oriented theories. These theories follow a holistic approach and profound repudiation of Cartesian mind-body dualism (Miller, 2000:441). The body (the lived body) is viewed as the foundation of the human experience and is considered an undeniable part of the whole person. All body expressions and body movements, gestures and postures are considered a primary way of experiencing those individual subjective feelings that reveal meaning, and influence psychological health and organismic self-regulation (Clarkson, 2004:2).

1.3.3 The nature of qualitative research and research design applicable to this study

In this study, a qualitative approach aligned with an interpretive naturalistic paradigm (Hunt, 2009:1285) was chosen to study human experience and societal concerns (Fouché & De Vos, 2011:95; Neuman, 2003:14; Patton, 2002:224). In qualitative research, direct experience is a source of knowledge and is examined (Haverkamp & Young, 2007:272). The principles from a non-categorical research method of interpretive description (ID) could be adopted

effectively (Hunt, 2009:1284; Thorne *et al.,* 1997:173; Thorne *et al.,* 2004:2, 8) for this study in order to address a research question that focuses on the kind of experiences and thoughts people may have, such as, what are the lived experiences of the body within a therapeutic setting? The nature of this study required a framework that contained an exploratory component, facilitating an intensive examination of the phenomenon being studied in combination with a descriptive component, gaining insight into that phenomenon (Barber & Brownell, 2008:38; Berrol & Cruz 2004:37; Fouché & De Vos, 2011:96; Neuman, 2003:14). The phenomenon studied was the therapist-practitioner's lived experiences of the body within the therapeutic context and the meanings constructed or held about these experiences. To this end, the traditional qualitative description in giving account of what is perceived and observed (Thorne *et al.,* 2004:6) and itemising or documenting the phenomenon (Thorne, 2008:47) were not judged sufficiently, therefore an interpretive and descriptive inquiry seemed most suitable.

The aim of ID is to "identify themes and patterns among subjective perspectives, while accounting for variations between individuals" (Hunt, 2009:1285). Data analysis in ID is an inductive and iterative process, studying the phenomenon as it unfolds to transform from base level (bottom-up) the data generated by the study into characteristics, categories, patterns and themes (units of information) or theoretical structures (Creswell, 2013:44; Thorne *et al.,* 2004:6).

The underlying interpretive assumptions and use of interpretive frameworks in qualitative research (Creswell, 2013:23; Denzin & Lincoln, 2011:14) informed the research process and are evident in its paradigmatic/philosophical considerations, the application of an interpretive lens during the process of conceptualisation and sense-making activities, and in the choice of research procedures and design (Creswell, 2013:44). Creswell believes that since the emergence of qualitative research there has been on-going refinements or adaptations in the manner in which qualitative research is conducted, placing more emphasis on the interpretive nature of inquiry and the positioning of the study "within the political, social, and cultural context of the researchers" (Creswell, 2013:45), as well as "the reflexivity or '*presence*' of the researchers in the accounts they present" (Creswell, 2013:45).

Qualitative research takes an interpretive and naturalistic stance towards the world, placing the observer (researcher and research participant) within the natural world (Denzin &

Lincoln, 2011:3). According to Denzin and Lincoln (2011:12), there is no single objective method of observation that can fully explain and understand on-going human experience, actions and intentions, therefore using various interpretive practices such as field notes, interviews and recording of data of the phenomenon of interest within the natural setting is required. Data collection activities such as conducting interviews and observations in a natural setting can be seen as embodied relational researcher-participant encounters, which constitute reciprocal and intersubjective communication (Finlay, 2005:288). The purpose of deploying a set of interpretive practices is to interpret or make sense of the meanings persons or groups have attached to the phenomenon (the social problem or human experience) being studied (Creswell, 2013:44). In this study, the data collection methods consisting of a naïve sketch or drawing, direct observation, an experiential body awareness activity and an in-depth, semi-structured interview, allowed the participant (the therapist-practitioner) to explore, articulate and construct her or his truth or reality and give account of the experienced experiential and implicit sensory knowledge of the lived body, while attributing meaning to those lived body experiences (occurring within the therapeutic setting and encounter). A contextually and subjectively constructed reality and meaning making called for approaching the individuals and the phenomenon of this study in a holistic manner to include those mental, physical, intellectual, emotional and spiritual qualities which are integral to "everything they do" and "all they are" (Barber, 2006:7; 2008:19). The use of multiple data sources and data types contributed towards triangulation (Amankwaa, 2016:122) and trustworthiness of the findings (Hunt, 2009:1285).

Common to interpretive qualitative research is that the researcher is seen as being a key instrument in the activities of data collection and interpretation (Creswell, 2013:45; Turner & Norwood, 2013:696). In quantitative research the researcher-as-instrument is viewed as taking an objective and neutral stance, suggesting a form of disembodied state (Turner & Norwood, 2013:696). In contrast, the researcher-as-instrument in qualitative research is not neutral nor disconnected from the data collection, analysis and interpretation or sense-making process, but is rather seen as participatory (and interactive), and often regarded as connected to an interpretive framework (Seidman, 2006:23; St. George, 2010:1626). Therefore, the researcher (inquirer) and object of inquiry interact and co-construct understandings (Hunt, 2009:1285); that is, the "knower and known are inseparable" (Thorne *et al.*, 2004:5).

The notion of the existence of a shared (in-between space), relational space or field that has been co-constructed and is characterised by reciprocal, interactive and intersubjective dynamics (Crocker, 2008:130; Lobb, 2008:113; Stern, 2004:243) between the researcher and the participant in interpretive research methodology, as well as being the philosophical underpinnings of field theoretical, holistic, relational and phenomenologically based theories which are used in this study, is comparable and instantiated by evidence produced in neuroscience. The existence of mirror neuron systems indicates that implicit understanding or knowing can lead to a potentially "shared space of action" (Rizzolatti & Sinigaglia, 2008:131) and "sharing of emotional states" (Rizzolatti & Sinigaglia, 2008:191).

As stated previously, an interpretive approach does not separate the shared perceptions and experiences (verbal and nonverbal, a priori knowledge and preliminary theoretical/basic assumptions of the researcher and participant) during the data collection and analysis process (Richards, 2009:49; Thorne *et al.*, 2004:9; Turner & Norwood, 2013:696). Even though the researcher's influence and active participation during the research process have been acknowledged in qualitative research literature, the focus has remained predominantly on the utterances or texts produced by the research participants (Finlay, 2006:20), thus largely ignoring or not reflecting on the data (McLeod, 2011:48) produced from the body (the lived body) and the researcher's own embodied self (Sandelowski, 2002:108; Sharma, Reimer-Kirkham & Cochrane, 2009:1642). In this study, keeping the participative perspective as discussed in mind requires an approach that does not view the researcher or participant in isolation nor ignores the contribution of the embodied influence (the lived body) to data generation and understanding. Embracing such a stance suggests a need to modify our understanding of data and its collection. In terms of this study, the researcher supports the perspective of authors such as Sandelowski (2010:80) and Sharma *et al.* (2009:1642), that the interview data (in this study including the data elicited from the practice of reflexivity and the 'felt sense' generated from the lived body), should be recognised as a part of the reality of the lived body (embodiment) of the participant, as well as of the researcher.

The researcher's use of a phenomenological stance and attitude allowed her to approach the investigation with awareness and to be mindful (that is be reflexive) of her preconceptions and previous experiential and theoretical learning. In addition, the researcher was aware of her embodied presence and took cognisance of the potential influences that the embodied interactions (including intersubjective reciprocal interactions) could have between herself and

the participant (therapist-practitioner) during the process of dialogue (both verbally and non-verbally) and co-constructed truth/reality of the participant.

According to Flick (2009:92), in interpretive approaches, the activities of sampling, data collection and data analysis, and interpretation are iterative/cyclical in nature, requiring the researcher to continually engage in a continuous review of the phenomenon. How these methods were employed during this ID study is outlined next.

1.3.4 Research participants

1.3.4.1 Sampling

The population is the theoretical whole (Thorne, 2008:88) and refers to all potential research participants that possess specific characteristics of interest to the researcher (Strydom, 2011b:223; Terre Blanche, Durrheim & Painter, 2006:133). For this study, the defined population was all South African Social Service Delivery (SASSD) therapist-practitioners. Due to considerations of accessibility, the availability of potential therapist-practitioners plus resource constraints of time and cost, the actual population for this study was limited to all SASSD therapist-practitioners practising in Gauteng and the Western Cape area. The study sample was then drawn from this pool (Babbie, 2007:191; Boeije, 2010:35; Strydom, 2011b:223; Terre Blanche *et al.*, 2006:133). The inclusion criteria used for identifying the sample were therapist-practitioners who:

- possessed tertiary degrees in at least one of the registered social sciences health service disciplines (such as clinical, counselling or educational psychology, social work and counselling),
- were practising full-time in psychotherapeutic or counselling services in Gauteng or the Western Cape area and who were registered with at least one of the Health Professional Councils,
- had been in therapeutic practice for at least five years, and
- were able to communicate in English.

The sampling strategy that suited the purpose of this interpretative descriptive inquiry was informed by the research question (Patton, 2002:245; Thorne, 2008:88). The study aimed at "capturing themes and patterns within subjective perceptions" (Thorne *et al.*, 2004:5) of

therapist-practitioners' lived body experiences in the therapeutic setting and therapeutic encounter, with the intention of generating interpretive descriptions to inform others within the psychotherapeutic and counselling discipline. Therefore purposive sampling, also referred to as judgement sampling (Boeije, 2010:35; Patton, 2002:230; Strydom, 2011b:232), and snowball or chain sampling (Creswell, 2013:158) were employed for selecting therapist-practitioners who were considered to be information-rich and divergent cases, and were willing to share their experiences, to produce potential insights and an in-depth understanding of the phenomenon being investigated (Babbie, 2007:184; Creswell, 2013:158; Patton, 2002:237; Strydom, 2011b:233).

At the beginning of the study, purposive sampling provided a way for the researcher to identify those specific persons who were considered key advisors or "key informants" (Thorne, 2008:90). Key advisors consisted of professional therapist-practitioners working in private practice and/or tertiary institutions within the psychotherapeutic and counselling disciplines. The researcher initially contacted through word of mouth, telephone or emails those key advisors who were thought to be willing to engage with her and who had access to other potential individuals or groups of therapist-practitioners. In addition to purposive sampling, snowball sampling thus provided further referrals that were considered information-rich potential participants. Snowball sampling proved to be a useful tool in this study, as it provided a cost and time effective method to reflect multiple realities of a difficult to reach, small group of experienced and professional therapist-practitioners. According to Mason (2007:134), the sample size in qualitative research is of no concern where the data drawn from the participants address the research question adequately. The data generated were aligned with the principles of ID, such as "capitalising on human commonalities as well as experiences of variance within a shared focus" (Thorne, 2008:74).

As stated, in qualitative research there are no fixed rules for what constitutes the right sample size, as it rather depends on the purpose of the inquiry (Patton, 2002:244). Small samples are fitting for research where the intention is to represent a range of in-depth subjective experiences and perceptions (Boeije, 2010:36). Interpretive description is suitable for almost any sample size and often ranges between five and 30, or even anything between one case and up to 200 participants (Thorne, 2008:94). This is in line with what authors such as Creswell (2013:157), Yin (2009:15) and Guest, Bunce and Johnson (2006:61) suggest, namely that the research findings do not constitute a generalisation of the information with

respect to the wider population, but rather to generalise about the theoretical propositions under scrutiny. Thorne (2008:98) states that researching experiences can generate an infinite number of variations, and therefore cautions qualitative researchers against the over-reliance on "theoretical saturation or redundancy" to justify their sample size.

The researcher intended to produce worthwhile reports and analyses derived from the interpretive descriptions that could ultimately inform and provide insights or alternative ways for improved understanding of the clinical phenomenon for therapist-practitioners within the applied health fields. In line with the stated sample approach, the information-rich data produced by the therapist-practitioners proved to be adequate. The process of thematic analysis (Clarke & Braun, 2013) allowed the identification of commonalities, which were developed into thematic patterns while accounting for individual differences (Hunt, 2009:1285; Thorne *et al.*, 2004:7). Thus, the criterion of sufficiency rather than data saturation (Seidman, 2006:55) was supported. The sample in this study (see Table 1 in 1.3.4.2) inevitably reflects a particular perspective, provides the context against which the research findings are presented and shapes the integrity and credibility of the final output.

1.3.4.2 Participant selection process

As explained above, the researcher initiated the sampling process using purposive sampling to identify and contact specific therapist-practitioners thought by the researcher to be key advisors in psychotherapeutic fields in private practice and at tertiary academic institutions. The contact details provided by these key advisors formed the basis of an initial recruitment list and pool of potentially information-rich and divergent research participants. The sampling process was initiated using this list and at first seemed encouraging. It soon became evident that many of those that had initially expressed interest in participating in the research were however now inclined to withdraw. The reasons given were varying, such as having no time available for an interview (*where they had previously been available*) and the nature of the topic was deemed as being too personal and private (*the emotional reactions evoked while conversing with the researcher were evident in the therapist-practitioner's tone of voice, ranging from defensiveness to even antagonism*).

Other potential participants viewed the lived body as a taboo topic or even as not part of the therapeutic context (scope) or their training. Of the 25 therapist-practitioners that were initially contacted, 13 therapist-practitioners were willing to participate in this study on a one-

on-one basis. Recruitment of additional research participants was done through snowball sampling.

All potential participants were initially contacted through an invitation by email. The email contained a brief introduction of the researcher with an explanation of how their contact information had been obtained. In addition, a brief synopsis of the study and requirements from the participants were presented and, if they evinced interest in participating in the research, permission was requested to make further contact. With the emailed permission of the potential participants, the researcher scheduled telephonic appointments. The purpose of the first verbal contact was to explain the nature and details of the study and what involvement was expected from the participant before and during the data collection process, as well as to answer questions and address any concerns (regarding their rights to withdraw, issues of confidentiality, voluntary participation and informed consent, amongst others). Furthermore, the telephonic contact served to establish rapport and build trust between the therapist-practitioner (potential participant) and the researcher. Interested therapist-practitioners that met the inclusion criteria were emailed a consent form and a biographical participant information sheet.

In preparation for the interview each participant was requested to answer the following question: 'What is your relationship with your body?' which was not to take longer than between five to ten minutes to complete. The participants had the option to answer the question expressing themselves in a written narrative (naïve sketch) or in form of a drawing (sketch), or using a combination of both mediums. The prospective participants were requested to email the signed consent form, biographical document and the personal documents (the naïve sketch and/or drawing) to the researcher before the interview or to bring them along on the day of the interview. A cooling-off period of one week was offered to each participant to allow them to reconsider their voluntary participation, and as an opportunity to address additional concerns or questions.

The participants consisted of 13 registered therapist-practitioners (4 psychologists, 7 social workers, 1 counsellor, 1 psychotherapist) who counselled in private practice (n=9) or in government organisations (n=4) within the Western Cape area and Gauteng, South Africa. Their work experience ranged from 5 to 30 years of experience. A summary is provided in Table 1.

Table 1: Participants

Participant*	Gender	Race	Professional registration	Years of experience
1EP	female	white	Educational Psychologist	11-15
2SW	female	white	Social Worker	11-15
3CP	female	white	Clinical Psychologist	21-25
4CP	female	white	Clinical Psychologist	11-15
5SW	female	white	Social Worker	5
6RC	female	white	Registered Counsellor	6-10
7SW	female	white	Social Worker	11-15
8SW	female	white	Social Worker	6-10
9SW	female	black	Social Worker	11-15
10SW	female	black	Social Worker	16-20
11SW	female	black	Social Worker	5
12CP	male	white	Clinical Psychologist	26-30
13RT	female	white	Registered Psychotherapist	11-15

* EP = Educational Psychologist; SW = Social Worker; CP = Clinical Psychologist; RC = -- Registered Counsellor; RT = Registered Psychotherapist

1.3.5 Data collection and analysis

1.3.5.1 Orientation

Interpretive description (ID) is regarded as a "coherent methodological framework" (Thorne, 2008:75) providing the researcher with the flexibility to answer the research question effectively (Thorne, 2008:103) choosing from a wide and diverse range of data collection and analytical methods that have been assimilated through other approaches (Oliver, 2012:410).

Even though ID studies differ in their research design, there are several general principles (or elements) that are shared or are common to all ID designs. For instance, most ID studies espouse and adopt the inherent attitudes and stances underpinning the phenomenological approaches during the data collection and analysis processes (Thorne *et al.,* 2004:6). The inherent iterative or cyclic data collection and analysis process in interpretive studies (Flick, 2009:92; Thorne *et al.,* 2004:11) implies that some aspects of the process inform each other, while others are performed concurrently (Oliver, 2012:410; Thorne, 2008:99). An example of such a principle is that the researcher is encouraged to engage herself in a continual dialectic procedural sequence between data and theory, a process that enables the researcher to manage and interrogate her preconceptions and biases, even to amend preliminary interpretations and conceptualisations made during the data collection phase conceivably based on the a priori analytical framework and disciplinary knowledge approach to the research (Thorne *et al.,* 2004:11; Thorne *et al.,* 1997:174/5). Another central principle is that all qualitative interpretive analysis relies in some way on a "constant comparative analysis approach" (Oliver, 2012:410). These principles are even more relevant for the study, since it assumes that multiple subjective realities exist and are constructed through the lived experiences and interactions with others, but are ultimately uniquely experienced by the individual. Consequently each participant's description of the phenomenon being investigated must be compared and contrasted with the descriptions of others, allowing knowledge to be uncovered.

The choice of data collection methods (the use of personal documents, observation, an experiential body awareness activity and in-depth semi-structured interviews) and the choice of the analysis methods were informed by the research question (Oliver, 2012:410), the epistemological assumptions of this study, and "what is already known about the phenomenon" (Thorne *et al.,* 2004:8), as well as the researcher's phenomenological attitude and values, including her a priori knowledge and disciplinary training. The details of the approach taken are described next.

1.3.5.2 The researcher's use of observation, reflexivity and reflection

The voice of the researcher is required to be reflexive and its "truth value" (Krefting, 1990:215) is enhanced through recording the reflexive knowledge gained, the observations made, and the thoughts considered to be noteworthy during data collection (Creswell,

2013:169; Yin, 2009:109). Field notes (observational notes, methodological notes, theoretical notes and personal notes) contain the written detail of what the researcher has seen, heard, smelt, thought, personally experienced and reflected upon (Patton, 2002:302; Richards, 2009:41). The process of writing up field notes requires the "constant interaction between action and reflection" (Chinn & Kramer, 2011:68), which may trigger personal feelings and reactions (Manson, 2002:99) that can lead to some form of personal knowledge and insight into behaviour and reasoning, often resulting in personal "growth towards wholeness, (and) authenticity" (Chinn & Kramer, 2011:111). The writing up of field notes is commonly found to be the beginning of data analysis, eliciting initial analytical ideas and the classification of information into manageable clusters of concept codes, which could then result in breakthroughs, theoretical concepts and methodological insights (Babbie & Mouton, 2001:293; Corbin & Strauss, 2008:123; Creswell, 2012:162; Patton, 2002:304).

Following interviewing, observation is generally used as a technique for collecting data in a qualitative inquiry (Creswell, 2013:166; Strydom, 2011c:329; Thorne, 2008:80). In ID, observation is viewed as a useful strategy for reflecting upon, and gaining verbal and non-verbal behavioural and contextual understanding (Thorne, 2008:80, 133). Observation always involves some degree of participation and "the act of noting (*observing*) a phenomenon in the field" (Creswell, 2013:166, researcher's italics).

The what, where and how much is observed, the degree of participation involvement (ranging from non-participative to participative) that is required by the researcher (Boeije, 2010:60; Creswell, 2013:159; Strydom, 2011c:330), the extent to which reflexivity is carried out during research (Corbin & Strauss, 2008:31) and how much of the observations and reflections made are documented in field notes (Schurink, Fouché & De Vos, 2011:406), are largely determined by the purpose of the study, the paradigmatic and methodological considerations, as well as the researcher's position within the study.

As previously stated, the paradigmatic assumptions of this study are based on a relativistic ontology, which assumes the existence of multiple realities and the personal construction of reality through the lived experiences and in interactions with others, and utilises an epistemological perspective based on holistic, field theoretical, phenomenological and relational principles, which include Merleau-Ponty's understanding of the lived body as a core concept. It follows that the researcher is both part of "the situation studied and an

instrument of (the) research, active and deeply embedded in the account being produced" (Richards, 2009:21), which includes her embodied presence as an integral part of the field (Turner & Norwood, 2013:696) and the research process. The researcher in the role of research-instrument is purposeful, active and continually engaged (dialoguing and collaborating) with the participant on various levels during those activities of observing and interviewing (listening, eliciting and co-constructing data), while making sense of the participants' descriptions of their lived body experiences (Richards, 2009:36; Seidman, 2006:23; St. George, 2010:1626). The researcher-participant relationship is a reciprocal intertwining encounter mutually communicating (verbally and nonverbally) and influencing each other. Consequently, both persons affect how the data are collected, where the focus is directed and how meaning is attributed to the phenomenon being investigated (Corbin & Strauss, 2008:31).

From the methodological perspective, interviews and participant observation (that are conducted in a natural setting) are seen as embodied relational researcher-participant encounters (Ellingson, 2012:525; Finlay, 2005:288) and therefore always involve a level of observation and participation by the researcher. Observing (or the act of noting) is an activity which may involve the use of one or all the senses (sight, hearing, smell, touch, taste) (Boeije, 2010:60; Flick, 2009:222), as well as the use of body reactions and internal sensations or body states (Fogel, 2009:10), that is, being aware of proprioceptive sensations, including all kinaesthetic and vestibular perceptions and experiences (Kepner, 2008:96). Current trends in qualitative data collection advocate that the researcher's "participation is considered essential in detecting meanings, feelings and experiences" (Boeije, 2010:59). Hence the subjective and intersubjective experiences are considered a valid source of knowledge, which need to be acknowledged and included in the production of knowledge during research (Evans, 2007:194; Turner & Norwood, 2013:699).

The qualitative nature of this study and the phenomenon being investigated (the participants' lived body experiences in the therapeutic setting), necessitated the researcher to have some degree of flexibility to allow for an adaptable mode of observation and participation during the data collection activities (refer to Figure 1 in 1.3.6.1) and data analysis phases. Therefore, the researcher adopted "a middle ground position as observer" (Creswell, 2013:172), as this type of participant observation was in line with the research aim, the epistemological and

methodological assumptions of the study, the researcher's a priori disciplinary knowledge of Gestalt theory and her phenomenological stance and attitude towards the participant.

A middle ground position is one of the various participant involvement options that a qualitative researcher can choose from (Boeije, 2010:60). Placed on a continuum, the degree of participant observation involvement can range from a position of being a complete observer, implying the researcher maintains a distance or is completely separated from the participants, to that of full participation observation, that is being fully engaged with those being observed (Creswell, 2012:166; Patton, 2002:265). A middle ground approach provided the researcher with sufficient flexibility to respond and adjust the degree of observation and participation (Patton, 2002:265) that took place before, during and after the data collection phase, thereby accommodating the existing field conditions at the time (refer to Table 2). In addition, the middle ground observer position enabled the researcher to simultaneously observe her own participation and the participant's actions, interactions, reactions and interpersonal behaviour such as movement patterns, tone of voice and body gestures amongst others (Boeije, 2010:59; Strydom, 2011c:329; Yin, 2009:102). The inclusion of the researcher's philosophical paradigm, values, behaviour and subjective and intersubjective knowing can become crucial (Corbin & Strauss, 2008:31), as this may have direct impact on the integrity and the trustworthiness of the study (Finlay, 2002b:531; 2011:79).

The use of some form of reflexivity (as meta-awareness) during the research process is a useful mechanism for the researcher to understand and examine her potential influence on the research process and the participant (Bulpitt & Martin, 2010:9; Finlay, 2002b:531), while others suggest that the use of reflection, that is thinking about what has been observed or experienced, enhances the truth-value or credibility of the study (Maritz & Visagie, 2009a:11).

Reflexivity is considered an intrinsic part of the process of inquiry (Thorne, 2008:109). Some suggest that reflexivity can be viewed as a "self-critical yet compassionate self-examination as it relates to our research pursuit" (Medved & Turner, 2011:109), while others believe it to be a form of meta-awareness (Scheinberg, Johansson, Stevens & Conway-Hicks, 2008:297), that is, the researcher has "thoughtful, conscious self-awareness" (Finlay, 2002b:532; 2011:23), or is "self-aware" (McLeod, 2011:49) of the "biases, values, and experiences" (Creswell, 2013:216) that the researcher brings to the study. Being a reflexive researcher

implies a willingness to engage in a transparent, "explicit, self-aware meta-analysis" (Finlay, 2002b:532), which can be compared to a form of introspective self-reflection or on-going internal dialogue oscillating between being aware of the experiences and experiencing in the here-and-now moment, which, according to McLeod (2011:48), is "being able to turn back on his or her experience". Reflexivity is about paying attention to the dynamics and experiences in the present moment, and is not to be confused with reflection, which is thinking about something after the event has taken place (Finlay, 2002b:532).

There are different ways to apply the principle of reflexivity effectively during all phases of the qualitative research process. Medved and Turner (2011:109) suggest that reflexivity can be grouped into personal, emotional, embodied and historic reflexivity. Personal reflexivity involves personal introspection and awareness of one's frame of mind, experiences, personal and professional self (which includes a priori knowledge and disciplinary training) (Hunt, 2009:1289), one's biases, preferences, judgements and strengths (Bulpitt & Martin, 2010:10). McLeod (2011:50) suggests that personal reflexivity may also include having an awareness of what is happening in the researcher-participant relationship and how they experience the way they engage and relate (verbally and nonverbally) with the participant. This form of reflexivity is aligned to phenomenological thinking of the notion of the lived body, which includes an inner knowing of how the person lives their body-world interconnections pre-reflectively (Finlay, 2011:31), that is, potentially having some awareness of what is happening dynamically and interactively (intertwining) in the in-between space created by the researcher and the participant. Emotional reflexivity is about being reflexive in the present moment (in the here-and-now), during which the research activities such as interviewing and participant observation take place (Medved & Turner, 2011:109). This skill requires the researcher to manage when to reveal or conceal the impact of her emotional expressions, feelings, judgements, behaviour and reactions (verbal and nonverbal) towards the participant. Embodied reflexivity requires an awareness of how the body (the embodied feelings, sensations, gestures, behaviour, proprioceptive knowing and pre-reflective bodily knowing) shapes communication, relating and the meaning making process (Ellingson, 2012:532; Todres, 2007:1569). Historic reflexivity is about having the awareness of how the researcher's own research and the findings deviate from or are aligned to the context of current academic thinking and dialogue (Medved & Turner, 2011:109).

Although the use of some form of researcher reflexivity has been acknowledged in qualitative research as a valuable tool (Corbin & Strauss, 2008: 31; Finlay, 2011:23), there are those that suggest that the use of reflexivity may be a self-indulgent personal account (McLeod, 2011:50), distracting from the participant (focus of the study) and may be nothing more than a "confessional account of methodology" (Finlay, 2002b:531). Conducting ID research requires the researcher to use some forms of reflexivity during the research process. Examples include the willingness of the researcher to reflect on the potential impact that her a priori knowledge and disciplinary training might have on the participant and setting; to be aware of her choice of type of participatory role and subsequently to reflect on any of the potential ethical dilemmas that may result from that; to have awareness of the nature of the relationship and interactions with the participants; to reflect on methodological aspects such as how much and what aspects of reflexivity are recorded and written up as part of the research findings; and to have the ability to develop a meta-awareness through abstracting and making the initial connections between emerging patterns and themes, thereby formulating an integrated contextual understanding of the whole research field and its field conditions (Creswell, 2013:172, 216; McLeod, 2011:49; Scheinberg *et al.*, 2008:297, Schurink *et al.*, 2011:406).

Consequently, documenting what has been observed and what has been reflected upon in field notes may transform what is viewed by some as a potential methodological "weakness or problem" (Finlay, 2002b:531) into an additional type of data (Yin, 2009:101), data that may be regarded as "raw data" (Mason, 2002:99; Schurink *et al.*, 2011:406) which has the potential of forming part of the research data and the inductive analysis process (Thorne, 2008:109). Furthermore, a researcher reflecting on her reflexivity demonstrates transparency that may provide the reader with some insight into the research process and manner in which the data came into existence (Hertz, cited by McLeod, 2011:48), as well as laying out the theoretical framework that was used for interpreting and co-constructing knowledge (McLeod, 2011:45, 50; Scheinberg *et al.*, 2008:297).

In summary, observation, reflexivity and reflection were integral components of this study research process. Through the use of the activities of reflexivity, reflection, recording of observations and writing up of field notes, the researcher intended to demonstrate a transparent and explicit approach of "what I know and how I know it" (Finlay, 2002b:532), therefore having assisted in the production of trustworthy research findings and aiming to add

towards the credibility of the study (Thorne, 2008:101). According to Schurink *et al.* (2011:407), reflective field notes add a step towards data analysis as the researcher is required to think about and to discover links of what, where, how and when events took place that the actors were involved in and what was experienced, what issues and circumstances impacted the data, thus discovering linkages which will result in establishing evolving ideas, issues and themes.

The researcher adopted a middle ground participant role as this strategy provided the flexibility to adapt and adjust the degree of observation and participation according to the presenting field conditions of each interviewing process (refer to Table 2 for examples). The phenomenological attitude enabled the researcher to adopt a sensitive, reflexive and embodied approach towards the participant and provided some room for researcher reflexivity to be practised (such as emotional and embodied reflexivity) during participation and observation, as well as the ability to observe, describe and reflect on direct observations of other field conditions present in the context of the participant at that time (Brownell, 2010:90; Masquelier, 2006:46; Yontef & Fairfield, 2008:94) rather than explaining and interpreting them (Brownell, 2010:90; Ginger, 2007:105; Joyce & Sills, 2010:21). For instance, during the body awareness activity, the researcher used her own body reflexively and empathetically with the aim of listening to her own 'bodily felt senses' and thereby hoping to shed light or gain some understanding of what was happening with the intersubjective dynamics between the researcher and participant, as well as to how the participants experienced their lived body experiences and the meaning they attributed to those.

The intention was to create conducive space for the participants to immerse themselves in the body awareness activity and to draw upon the sensory information in such a way that these would rise to the foreground, forming part of their frame of reference during the interviewing process, which could potentially guide the understanding, interpretation and meaning attributed to the participants' lived body experiences within the therapeutic setting.

Table 2 summarises the actual physical settings (being an example of a field condition) that framed the context in which the activities of reflexivity, reflection, recording of observations, writing up of field notes and the data collection, took place.

Table 2: Physical setting of data collection

Field condition: physical setting	Number of participants	Professional registration	Number of participants per setting
Private practice consulting room	6	Clinical Psychologist	3
		Social Worker	2
		Registered Counsellor	1
Researcher's consulting room	2	Educational Psychologist	1
		Social Worker	1
NGO private consulting room	3	Social Worker	3
NGO open loft room	1	Social Worker	1
* Researcher-Participant virtual space	1	Registered Psychotherapist	1
Total	13		3

Data collection took place in five different types of settings. The majority, that is 11 of the 13 interviews, were conducted in the natural setting of the participants' working environment. One exception occurred where the setting could be considered a virtually created space (* in Table 2). Both participant and researcher were physically located in their respective consulting rooms, but were able to communicate verbally and visually using the Internet software application Skype. The Webcam lenses of the personal computers created the virtual space which allowed both parties 'to see and hear' each other during their interaction (refer to 1.3.6.4 for additional details).

The physical settings of the private consulting room provided a private and reassuring space for participants and researcher to conduct the body awareness activity, observation, reflexivity and interviews. The field conditions varied from setting to setting, consequently creating unique conditions influencing what needed to be taken into consideration during the data collection phase. For instance, one interview was conducted in a loft room above the lobby of the NGO's reception area, presenting a unique set of field conditions requiring management. Even though the interview took place after hours, which implied relative privacy, the initial part of the data collection phase was interrupted by sounds travelling up from the lobby area with staff members coming up the stairs to interact with the participant. The context in which this particular interview took place was a reflection of the working conditions of that participant, which became evident from her narrated lived experiences.

In addition to the setting in which the data collection took place, other field conditions that were taken into consideration by the researcher included the participants' unique working environment as a whole, the participants' needs and preferences at that time, as well as the researcher's own lived experiences (especially from the lived body) before the interview started, during and after data collection.

1.3.6 Data collection process and methods

1.3.6.1 Overview of the data collection process

The governing principles that guided the data collection process strove towards being (1) a repeatable and documented process and (2) minimising the effect and influence of the researcher's a priori knowledge of Gestalt theory and body based therapeutic work, as well as the potential influence of her embodied presence on what was recalled and how the participant's lived body experiences were (re)constructed during the context of the interview setting. Thus, the use of some forms of researcher reflexivity (such as practising embodied presence and emotional reflexivity) were employed during all phases of the research, as this is, according to Hunt (2009:1289) and McLeod (2011:48), one method of managing the researcher's a priori theoretical and prior body based training in ID.

This study made use of a rigorous data collection strategy which included multiple sources of data and data types, consisting of documents in the form of naïve sketches and drawings (Patton; 2002:4; Tobin & Begley, 2004:392), an experiential body awareness activity (described in Table 3) and an in-depth one-on-one semi-structured individual interview which became the primary source of data (Yin, 2009:107). Together, the spoken word, documents, sensory phenomena and visual images produced a more holistic perspective and understanding of the whole person and how her or his social world is constructed (Babbie & Mouton, 2001:303; Mason, 2007:106). In addition, the researcher made use of observations and noted verbal and non-verbal observational information during all phases of data collection. Some of these free-form notes served as prompts during the interview session. The free-form notes, together with other reflections, insights and observational information were written up (transformed) into various forms of reflective notes (field notes) after the data collection session.

The collection of data was conducted in private consulting rooms of the participants or the researcher, except for one participant (open loft room). To maintain a consistent method of collecting data and thereby adding to the credibility of the study, the researcher used the data collection workflow sequence approach (as depicted in Figure 1 below). The data collection workflow sequence was viewed as a functioning whole (unit) and served as a framework (meta-structure) that guided the process of collecting data.

Figure 1: Data collection workflow process

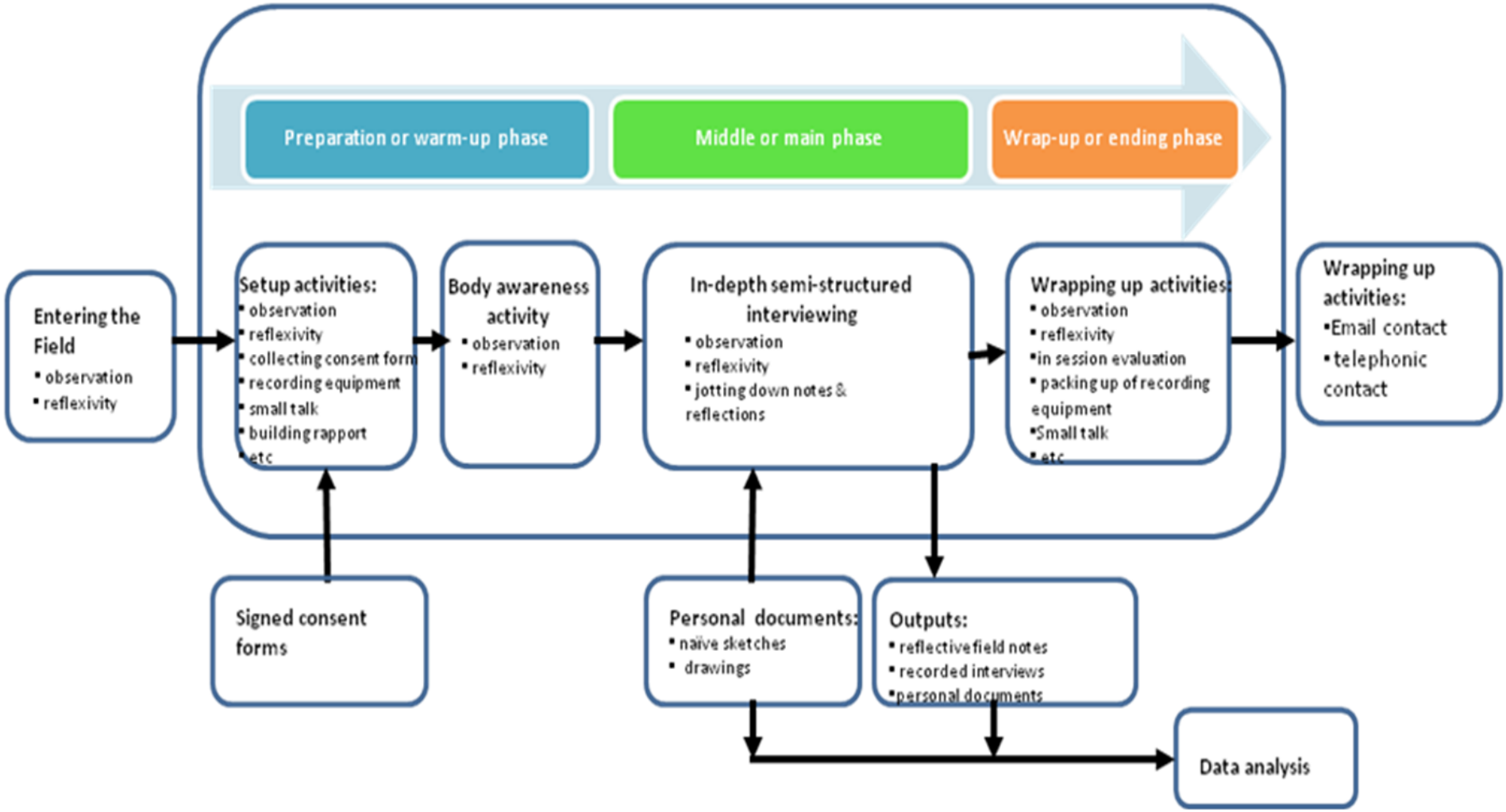

Figure 1 shows that the framework was made up of three main phases, namely (1) the preparation or warm-up phase, (2) the middle and main phase, and (3) the wrapping-up or end phase. Within each of the phases there was enough scope for the researcher to be flexible while being consistent in the approach. The field conditions of each interview setting, and the uniqueness of every participant differed, which necessitated the researcher to make use of a flexible and adjustable approach, such as the use of Rubin and Rubin's (2012:36) responsive interviewing style. This is, according to Elliott and Timulak (2005:152), a necessary ability for the researcher to be able to create alternative "data collection pathways" (Thorne *et al.*, 2004:11), with the purpose of accommodating the prevailing field conditions at that moment that allowed the participant to answer the research question (Thorne, 2008:125), while maintaining a respectful researcher-participant relationship and adhering to the ethical guidelines of research.

The warm-up phase consisted of two sub-phases. The first sub-phase was seen as a 'session setup phase' that involved activities such as becoming familiar with the participant and environment, setting up the recording equipment and obtaining the signed consent forms and biographical sheets, as well as reminding all participants of their voluntary participation, their right to confidentiality and the freedom to withdraw during any point of the research process. It also provided an opportunity as needed for a subsequent debriefing session with an external professional person after the interview session. Further, the informal interaction and dialogue between the researcher and the participant allowed for some familiarisation, establishing rapport and developing an interview relationship. The duration of the session setup phase varied and was influenced by the amount of 'small talk' that took place before the formal interview, the participant's relating style which included the offering of refreshments and even occasionally an invitation to the researcher to go on a walk-through of the participant's working environment. For example, at one of the interview sessions at an NGO, the researcher was introduced to various staff members, ranging from the crisis in-take staff to the support call centre counsellors. The second sub-phase was used to conduct an experiential body awareness activity in preparation for the one-on-one in-depth semi-structured interviews. This activity served as a means for eliciting the participant's unique "personal language" (Panhofer & Payne, 2011:215), that is the nonverbal, felt kinaesthetic perceptions and sensory body experiences, raising these to their awareness (foreground) or consciousness, thus becoming part of the participant's frame of reference during the data collection phase.

The middle or main phase of the data collection workflow process consisted of the one-on-one in-depth semi-structured interview, which was video recorded with the consent of the participant. The single exception of the Skype interview was recorded on audio only due to Internet constraints. As part of the interviewing process, the researcher made use of the personal documentation, and the naïve sketches and/or drawings produced by the participants as requested by the researcher in preparation for the interview sessions.

The wrapping-up or ending phase consisted of two sub-phases. The first part provided the participants with the opportunity to give some feedback and to reflect upon their experience of the full interview and the process itself. In line with the ethical principle of beneficence, each participant was reminded of the standing possibility of a debriefing session with an external professional person to discuss their feelings or any issues immediately after the session in order to address any misconceptions and minimise potential negative effects (non-maleficence) as a direct or indirect consequence of the study (Maritz & Visagie, 2009a:15; Strydom, 2011a: 115, 122). The second sub-phase occurred after the formal data collection session/ process, and involved contacting the participant through a follow-up email and/or telephonic contact, thanking them for their participation, allowing room for requests for feedback or answers to any questions or concerns they may have had.

The use of the data collection workflow framework and the data collection methods allowed the research participants to explore, construct and articulate their truth (reality), as well as attribute meaning to the phenomenon under investigation, which according to Thorne *et al*. (2004:5), is always "complex, contextual, constructed and ultimately subjective". Some of the key aspects of the data collection methods and process used are detailed below.

1.3.6.2 Documents in the form of naïve sketches and drawings

Documents, specifically personal documents, are useful collateral data sources in ID (Thorne, 2008:83). Personal documents may vary in nature, content and scope, ranging from personal diaries, journals, e-mails, web-based posts, graffiti, naïve sketches, photographs and therapist-practitioner case notes to objects such as general artefacts, religious texts, infant items etcetera (Babbie & Mouton, 2001:300; Creswell, 2013:160; Maritz & Visagie, 2009b:42; McLeod, 2011:74).

Personal documents such as naïve sketches (Giorgi, 1985:9; Maritz & Visagie, 2009b:42) and drawings (Lichtman, 2010:164; Mason, 2007:104) provide the research participants with the means of adding nonverbal personal accounts of their "environment and their subjective perception and interpretation of their own lives and the events of the world around them" (Strydom & Delport, 2011:378).

Personal documents reflect the expression and constructed meaning of the participant's subjective experiences free from the influence of the researcher (McLeod, 2011:74; Thorne, 2008:82), whereas the data produced during the interviews through the process of overt self-conscious speech, is influenced and co-constructed with the researcher.

In preparation for the interview (as noted in section 1.3.4.2), each participant was requested to prepare a personal account by answering the pre-interview question: 'What is your relationship with your body?' In line with the ontological and epistemological position of this study, the participants had the option to express themselves using a written narrative (naïve sketch) and/or a drawing (sketch).

A naïve sketch is a written (text-based) self-expressive personal account, a short story, by the participant and pertaining to the phenomenon being studied in response to a research question (Lichtman, 2010:164). The naïve sketch serves as a descriptive method (Giorgi, 1985:10) developed within the phenomenological paradigm that encourages the participant to return to the essence of situations and the lived experiences (Husserl, cited in Oliver, 2012:410).

On the other hand, drawings or sketches are visual methods for eliciting personal stories that offer participants an active, non-text-based, visual/sensory and experiential method (Mason, 2007:104), and may reveal aspects of the participants' emotional, cultural subjective phenomenological experiences and the world they live in (Gitonga & Delport, 2015:989).

The type of personal documents that were chosen by the participants, in answering the pre-interview question: 'What is your relationship with your body?' are detailed in Table 3.

Table 3: Participants' choice of personal documents

Participant*	Drawing	Naïve sketch	Received on day of interview	Received before interview via email
1EP	√	√	√	
2SW		√		√
3CP	√	√	√	
4CP	√		√	
5SW	√	√	√	√
6RC	√	√	√	
7SW	√		√	
8SW	√		√	
9SW	√	√	√	
10SW	√	√	√	
11SW	√		√	
12CP	√		√	
13RT				

* EP = Educational Psychologist; SW = Social Worker; CP = Clinical Psychologist; RC = -- Registered Counsellor; RT = Registered Psychotherapist

Table 3 demonstrates a pronounced predilection for the use of drawings to express their relationship to their body. The drawing served as a second option for those participants who chose not to use the written word as a means for self-expression, or for those who preferred a less invasive or more creative and playful technique to express themselves. Conjecturing on the fact most participants had chosen a visual and sensory method (the drawing) above the use of the written word (the naïve sketch), seems to infer that the characteristics of creating a drawing provided a more spontaneous and less overtly cognitive alternative to answering the pre-interview question. As indicated in Table 3, two of the naïve sketches were emailed beforehand to the researcher, potentially influencing the researcher's a priori knowledge about these participants. The influence can however be considered minimal, as one of the two naïve sketches (participant 2SW) emailed beforehand did not directly answer the question regarding her own relationship towards her body, but rather confirmed her lived body experiences within the therapeutic context.

Personal documents, such as naïve sketches and drawings, can be viewed as objects or independent physical units existing externally from their creators in space and time. Conceptualising personal documents as objects or sources of data imply that in essence they encompass the participants' subjective realities (Mason, 2007:107), including those private, implicit or unspoken attitudes, biases, experiences, beliefs and decisions that are not revealed

nor observable during interviews or interactions with the researcher. Expressive mediums, such as drawings, can stimulate creativity that enables participants to explore the potential implicit or non-verbalised dimensions of their subjective experiences and the meanings held about them (McLeod, 2011:74). The use of personal documents becomes of particular importance for investigating clinical knowledge, attitudes, biases and phenomena experienced in the therapist-practitioner's field of practice, as these are often not shared or revealed through dialogue amongst professionals, including research interviews, for reasons that these might conflict with the professional code of conduct, personal preferences or dislikes (Thorne, 2008:85).

The researcher took an approach that combined the use of personal documents with in-depth interviewing. Such a combined approach served as a "stimulus for paths of inquiry" (Patton, 2002:294) and benefited the whole research process. For instance, the use of the drawings and naïve sketches can provide the researcher with a potential vehicle to probe deeper into a sensitive and personal phenomenon, which may result in additional data or shed light on different dimensions that were previously not obtained, and can verify that which has been revealed during the interview (Mason, 2007:52, 109; McLeod, 2011:75; Thorne, 2008:82), an approach that adds towards credibility of the research (Creswell, 2013:251; Maritz & Visagie, 2009b:42). Other authors suggest that personal documents can be utilised during the interviewing process "to discuss with their creators what they contain and how they were prepared" (Rubin & Rubin, 2012:27).

Utilising personal documents in the manner as described above served the purpose of the study, which sought to provide an information-rich, contextual and holistic perspective, with the data produced from the interviews being the primary data collection strategy. It has been suggested that the use of personal documents in interpretive qualitative studies can be a beneficial method of informing others about the specific details of a research process within that study (Hunt, 2009:1286; Mason 2007:105). As noted above, with the aid of the drawing and naïve sketch, the researcher was able to explore the contents, its creation and the meaning of the personal document *with* the participant (it was not analysed as a projection), unearthing the implicit and nonverbal information as known to the participant, and this included the participant's biases, preferences, sensory information and subjective experiences. Furthermore, it was an approach that provided the researcher with a creative and alternative way for developing trust and rapport, as well as a useful method to probe, verify, draw

insights and generate data (through participant reflexivity). The researcher observed that the use of an object (such as the drawing) had elicited participants' sensory and implicit knowing which contributed to their understanding and meaning making of their lived body experiences. Although personal documents provided a useful data collection strategy in the study, one participant (13RT), who had not prepared any type of personal document, proved not to be an obstacle since she was able to dialogue and produce information-rich data by answering the pre-interview question during the interview. The researcher conjectures that participant 13RT's personal and professional background (being a body psychotherapist) might have been the enabling element.

1.3.6.3 An experiential body awareness activity

An experiential body awareness activity was conducted during the second sub-phase of the warm-up phase. The researcher introduced the participant to the body awareness activity by initially explaining its purpose and the process that would be followed. The purpose of this activity was to create those conditions that encouraged the participant to access (become aware of) their pre-reflective, nonverbal, sensory and implicit knowing (information), thus evoking a form of nonverbal (embodied) self-awareness or bodily knowledge. To achieve this, the activity required the participant to be inwardly directed (focusing on self and what was happening within the person). As part of the body activity, the participant was invited to participate in silence, with closed eyes and listening to the voice of the researcher, who guided him/her to become self-aware of bodily felt sensations, breathing patterns, sensory cues, emotions and thoughts arising from stimuli that originated from outside (including the embodied presence of the researcher) and inside the body. The duration of the body awareness activity varied from participant to participant, ranging from five to eight minutes.

The experiential body awareness activity was in line with the epistemological assumption of the phenomenological notion of lived body, that "the body discloses the world just as the world discloses itself through the body" (Finlay, 2006:19). According to Panhofer and Payne (2011:215), each person has their own "unique personal (*embodied*) language" (researcher's italics), made up of their subjective embodied experiences, memories, thoughts, proprioceptive senses and kinaesthetic perceptions, which are, according to Kepner (2008:94), stored as raw and undifferentiated data in the body. To be able to access,

conceptualise, reflect upon the undifferentiated data in the body, or verbalise their pre-reflective or implicit knowing, including nonverbal, non-symbolic and procedural data (Stern, 2004:113), these data need to be elicited and rise to the person's foreground or consciousness (verbal and conceptual awareness) (Kepner, 2008:94; Leigh & Bailey, 2013:164). Only once the pre-reflective knowledge, felt body sensations and lived body experiences enter a person's awareness, can these then be articulated and assimilated.

Leijssen (2006:126) highlights that the interview and other verbally based therapies are approaches whose epistemologies generally do not address the lived body or make refer to aspects of the body, including body sensations, during intervention. These approaches often have difficulty in operationalising language or lack the adequate technical language as a means and method "of articulating and researching the language of the body" (Vulcan, 2009:280). Furthermore, the predominant use of language can often overshadow or disconnect the person from the kinaesthetic language of their body and other felt body senses and reactions (Kepner, 2008:15). More recently, authors such as McLeod (2011:71) and Vulcan (2009:280) have reaffirmed prior assertions that interviews are not well suited to capture the full range of dynamics and interactions (including verbal inflections, non-verbal communication, gestures and behaviour) of participants, or occurring between the researcher and participant.

Considering that the focus of this study was the therapist-practitioner's lived experience of the body within the therapeutic context, the inclusion of an experiential body awareness activity was relevant (supporting) and beneficial, in that the activity (1) facilitated the participants to become in contact with their embodied selves, and (2) encouraged pre-reflective knowing, felt body sensations and lived body experiences of the participants to enter into their awareness (verbal and conceptual consciousness or foreground). Subsequently, the researcher inferred that the participants' foreground phenomenal data served as a frame of reference (and reservoir of embodied and implicit knowledge) for describing, assimilating and understanding the phenomenon under investigation during the interview. From the researcher's perspective, the body awareness activity served as a useful technique for building non-verbal rapport and for raising awareness of the intersubjective and non-verbal communication occurring between herself and the participant at that time. In addition to noting relevant aspects of the nonverbal communication in the here-and-now moment, the researcher maintained meta-awareness through applied reflexivity, which

allowed her to adapt and adjust her levels of participation and observation, establishing the sought-after research conditions conducive for facilitating an embodied interviewing space.

The process added weight to the proposition that the lived body experiences are sources of understanding and meaning (Satina & Hultgren, 2001:522), which need to be included in the research process.

1.3.6.4 Interviews

In qualitative research, the interview is viewed as a "key naturalistic research method" (Rubin & Rubin, 2012:3) and according to Seidman (2006:10), "interviewing provides access to the context of people's behaviour and thereby provides a way for researchers to understand the meaning of that behaviour". Dialogue that occurs between individuals is seen by some as being "intertwined with the dynamics of human social experience" (Thorne, 2008:128). Thus, in ID studies, interviews are extensively used as a primary in-depth data collection method (Hunt, 2009:1285) for obtaining the verbal accounts and rich descriptions of the lives, experiences, perceptions and thoughts of the participants (Elliott & Timulak, 2005:149; McLeod, 2011:71; Rubin & Rubin, 2012:29) and the meaning made or attributed to the experiences and world they live in (Barber & Brownell, 2008:55). Despite the apparent weaknesses of interviews such as that they are not well suited for capturing the dynamics and interactions (including verbal inflections, non-verbal communication, gestures and behaviour) of the participants, or do not contain the epistemological grounding and technical language to narrate the embodied language of the lived body (McLeod, 2011:71; Leijssen, 2006:126; Vulcan, 2009:280), the use of interviewing as a primary data collection method seemed most suitable, the reason being that this method allowed for the in-depth exploration of multiple perspectives of how therapist-practitioners experience the lived body within the therapeutic context. Other factors that influenced the choice of this method was (1) the nature of participants (practicing therapist-practitioners) that could be viewed as a group of specialised information-rich individuals who had access to specialised knowledge, and (2) the limited accessibility and availability of the participants for scheduled one-on-one data-collection sessions, and (3) the existing constraints of time and costs of this project.

Semi-structured interviews with the use of primarily open-ended questions were employed as a primary source for data collection. Except one interview, 12 of the 13 were conducted face-

to-face (body-to-body) which can be viewed as embodied relational encounters, where both parties were present in the same physical setting. The exception was conducted in a virtual space (refer to Table 2 and section 1.3.5.2 for more details), that is, still face-to-face, albeit using an Internet application, Skype. The reason for utilising Skype was that the participant was at an international location at the scheduled time and so could not physically attend the interview. Thus, to accommodate this participant and not lose a potential information-rich participant, the use of Skype was included.

Collecting data in a virtual space (using Skype) was different to collecting data during the other face-to-face (body-to-body) interviews, considered to be embodied relational encounters. By not being able to engage on an embodied or physical level, the ability to experience nonverbal communication, a felt sense or the exchanges with the other participant's embodied presence was certainly diminished. Thus, the focus and awareness of the researcher was directed towards the verbal and visual dimension of the researcher-participant interactions. Listening to the quality of the participant's voice, assessing the emotions in the tone of voice and observing the facial and body gestures through display on the researcher's computer all became of importance. Despite the slight differences experienced between the virtual space and the other embodied relational encounters with participants, the Skype application yet served as a useful mode for conducting the body awareness activity and the semi-structured in-depth interview, producing in-depth information about the participant's lived experiences of the body. All interviews were recorded on video, with the exception again of the Skype interview, which was preserved using audio only. Due to internet broadband constraints, the video recording facility of the personal computer materially disrupted the natural flow of verbal and visual communication (that is, delayed sound and visual transmission) between the parties, therefore the video recording on the personal computer had to be disabled.

In-depth interviewing immediately began on completion of the body awareness activity, starting with an inquiry about the experience for the participant of preparing the naïve sketch or drawing. Participants were invited to share that experience and the meaning associated with their personal document. Most participants immediately went into an explanatory dialogue. A few stated they were not sure what it meant to them or did not want to talk about it at that particular moment, but would be happy to talk about it at a later stage. Immediately

following this phase, the main research question was presented. Using a pre-set interview schedule, together with follow-up questions, this data set was then collected.

The interview schedule, also referred to as a "conversational guide" (Rubin & Rubin, 2012:125), was developed before the first interview. Seidman (2006:22) suggests that there are no prescribed or standardised structures for conducting in-depth phenomenologically based interviews. A structure or format conducive to conducting in-depth interviews needs to (1) create the interviewing conditions that allow the participant to establish the context (life space) of the lived experience, and (2) contain the type of questions that enable the participant to recall and reconstruct the details of that lived experience, in order to make sense of and construct the meaning held about that experience (Seidman, 2006:17).

The interview schedule made use of primarily open-ended questions based on the main research question and was intended to elicit a depth of information and create opportunities for a set of follow-up questions. Follow-up questions need to meet the inquiry criteria and simultaneously be conversational (Yin, 2009:107), thus providing the depth, richness and credibility of data (Rubin & Rubin, 2012:119), as well as the opportunity to seek information about high level themes or concepts (Patton, 2002:343).

The probes used during the interview were based on the free-form notes made by the researcher, consisting of "questions, comments or gestures" (Rubin & Rubin, 2012:117), and included the use of the participant's naïve sketch and drawing, the information provided on the biographical information sheet, the observations made during discussions, as well as the sensory body data and reflexive information produced by the lived bodies of the researcher and participant. The purpose of the described probes was to manage the flow of dialogue between researcher-participant, to elicit and reveal unspoken or hidden dimensions, to encourage the participants to draw on their sensory or felt sense (knowing) and experiences (evoked during the body awareness activity) and to make sense of those lived body experiences, so that they could be articulated to the researcher.

The first interview served as a pilot interview (Richards, 2009:43) and a way to uncover methodological issues (Yin, 2009:93). It revealed and highlighted the magnitude of personal and sensitive issues of the research topic that could impact on the participants during their descriptions/explanation of how they experienced the lived body from the perspective of a

therapist-practitioner. Based on the observations and reflections resulting from the first interview, as well as the input provided by the study supervisor, the interview schedule was reviewed. As the revisions were minor, the data obtained from the first interview were adjudged to adequately address the research question, making the participant 1 interview data relevant and useable in the study (therefore included in the data analysis). The experience gained during the initial interview, and continuing during data collection and data analysis, made the researcher increasingly aware and sensitive towards the participants as well as her own lived body, leading to subsequently fine tuning the data collection approach again and continually developing (evolving) her own interviewing style.

The 13 semi-structured in-depth interviews were conducted in a flexible open-oriented manner, assuming a conversational style based on Rubin and Rubin's (2012) interviewing approach termed 'responsive interviewing'. This approach is in line with ID, as it encourages an interviewing relationship or conversational partnership (Rubin & Rubin, 2012:92) that is built on trust, understanding and mutuality and where an exchange happens within a meaningful context (Rubin & Rubin, 2012:38). Face-to-face interviews are embodied, dynamic, active and interactional events (Barber & Brownell, 2008:55) and can be viewed as reciprocal encounters between "person-to-person" (Turner & Norwood, 2013:696), bringing together two lived bodies where the inherent nature of the relationship is interactive, intersubjective (verbal and nonverbal) and both affecting each other. The reciprocal and reflexive nature of the interview relationship lent itself to a "give-and-take in the conversation" (Rubin & Rubin, 2012:36), suggesting that the researcher might also "reveal something of herself" (Rubin & Rubin, 2012:36).

The phenomenological attitude and stance (that is, being present, taking on a non-judgemental, horizontal stance towards the participant and using descriptive questioning) embraced by the researcher and a responsive interview style enabled her to be empathetic and reflexive, and to respond to the non-verbal cues, which resulted in a more friendly and supportive type of conversational tone of questioning. Keeping the nature of the research topic in mind, the researcher aimed at placing the participants in an explorative and experiential position with the hope that this would encourage the participants to draw from their pre-reflective and implicit body knowing (that is their sensory awareness and kinaesthetic perceptions) and felt experiences, while describing their lived body experiences. To achieve these interview conditions and in line with a responsive interviewing style, the

use of the naïve sketch, drawing, free-form notes and impromptu adaptation of the prepared interviewing questions were determined by prevailing field conditions (such as the pace and mood of the participant or the interview setting – see Table 2) at that time. As stated by Seidman (2006:10), "interviewing allows us to put behaviour in context and provides access to understanding their action." Within this study, observations and field notes that were made included the contextual, background and temporal dimensions in which the interviews took place with the hope of gaining insights about the context within which the therapist-practitioners' lived body experiences occur, ultimately leading to best practices based on knowledge of the phenomenon being studied. Keeping the context in mind becomes crucial for highlighting and distinguishing between the authentic subjective truths of that participant versus superficial or "popular thinking of the time" (Thorne, 2008:129).

All interviews were recorded on video (with the stated exception of the Skype) and transcribed verbatim. The observations made, reflexive knowledge gained or thoughts (theoretical, conceptual and analytical ideas) considered to be noteworthy by the researcher during the course of data collection (Creswell, 2013:169; Yin, 2009:109), were all written down as informal notes while interacting with the participant during the data collection process (Corbin & Strauss, 2008:123), as the intention was to focus on the participant and be present in the here-and-now, consequently not distracting from the task of data collection. These free-form notes also served as a probe and formed part of the observational data. The researcher made use of personal, emotional and embodied reflexivity which were not recorded in the formally prepared observational protocols (Creswell, 2013:169), but rather written up as reflective notes (containing personal notes, methodological, theoretical and analytical insights) which were used as part of the data collection and verification process, with the aim of providing a mechanism of feedback and reflection on the effect that the researcher had had upon the research field and setting (Thorne, 2008:135).

In addition to the transcribed interview data, reflective notes, according to Schurink, Fouché and De Vos (2011:407), add a step towards data analysis as the researcher is required to think about and to discover links of what, where, how and when events took place that the actors were involved in and what was experienced, what issues and circumstances impacted the data, thus discovering linkages which will result in establishing evolving ideas, issues and themes.

1.3.7 Data analysis

Data analysis in ID research is characterised by inductive reasoning (Hunt, 2009:1286; Thorne *et al.*, 1997:174) that is based on methods which encompass iterative and constant comparative analysis strategies (Thorne *et al.*, 2004:6). Within qualitative data analysis, 'constant comparative analysis' is a universal approach that "involves taking one piece of data … and comparing it with all the others … whose purpose is to generate knowledge about common patterns and themes within human experience" (Thorne, 2000:69) and which forms part of methods such as thematic analysis (Thorne, 2000:69).

Analysis of the data was guided by utilising the six phases of thematic analysis outlined by Clarke and Braun (2013), as it provided a flexible approach "for identifying, analysing and interpreting patterns of meaning (themes)" (Clarke & Braun, 2017:297). After data transcription, the process of data analysis involved initial data familiarisation from reading and repeatedly re-reading the data and simultaneously listening and watching the audio-video recordings, as well as making initial notes on the data (Braun & Clarke, 2012:60), followed by identification of the meaning units (Elliott & Timulak, 2005) or codes which provide initial "meaning about the data content" (Braun & Clarke, 2012:61), categorising/clustering codes and ordering them into coherent themes, generating final themes, and thematic description. The findings are presented in manuscripts (refer to Chapter 3, 4 and 5).

1.4 Establishing trustworthiness

The aim of trustworthiness or rigor in qualitative research is to "establish trust or confidence in the findings" (Thomas & Magilvy, 2011:151). In this study, Lincoln and Guba's (1985) criteria of credibility, transferability, dependability and confirmability and a fifth criterion of authenticity (Guba & Lincoln, 2005:207) were used to enhance the trustworthiness of the research findings.

Credibility demonstrates the confidence in the truthfulness of the data (Maritz & Visagie, 2009a:7). In this study, credibility was achieved through a pilot interview and prolonged engagement (Thomas & Magilvy, 2011:153), which involved the use of naïve sketches and drawings and one-on-one in-depth interviews (90-120 minutes), which resulted in rich data and in-depth descriptions (Thorne, 2008:225) of the participants' experiences of the lived

body within the therapeutic context. Other measures included persistent observation in the field while building rapport and trust during the interviews, the initial and follow-up contact sessions, making use of Rubin and Rubin's (2012:36) responsive (conversational) interviewing style during the data collection activities, which resulted in field notes (observational notes, methodological notes and theoretical notes) and researcher reflective notes (Richards, 2009:41). In addition, the researcher's more than 10 years of experience in the field of Gestalt therapy and body based therapeutic work guided the process of research, thus adding to the credibility of this study.

Transferability refers to the extent in which the research findings can be transferred or applied to other contexts or other respondents (Cope, 2014:89; Thomas & Magilvy, 2011:153), thus the strategy of thick and dense descriptions supported by the direct quotations from the participants was employed. **Dependability** refers to the replication of research findings (Amankwaa, 2016:121) or to the constancy of the data over time in similar conditions (Connelly, 2016:435). Extensive descriptions of the research methods and procedures including the process of participant sampling (Cope, 2014:89), as well as a detailed description of the data collection procedures and analysis (Thomas & Magilvy, 2011:153) were employed as measure of dependability. These aimed to minimise the potential influence that the inductive and reciprocal nature of the research process (Hunt, 2009:1288) could have had on the research outcomes. **Confirmability** is "a degree of neutrality" (Amankwaa, 2016:121) which indicates whether the findings are the product of the inquiry and not the bias or interpretation of the researcher (Connelly, 2016:435). The potential influence of the researcher's bias, preferences and a priori knowledge in understanding the participants' lived experiences of the body were managed through use of self-reflexivity (in reflexive notes). In addition, the use of multiple data sources including field notes, extensive use of verbatim quotes to interpret the data, an audit trail and a literature control (Amankwaa, 2016:122) were employed to enhance confirmability. **Authenticity** is "the extent to which researchers fairly and completely show a range of different realities and realistically convey participants' lives" (Polit & Beck, cited in Connelly, 2016:436). The criterion of authenticity was attained through the researcher rephrasing and clarifying her understanding of the data with the participant during the interview, encouraging participant reflexivity through the researcher's use of reflexive phrases (Oliver, 2012:410), use of verbatim quotes to reflect the participants' voices and researcher follow-up contact.

1.5 Ethical considerations

Ethical approval for this study was obtained (NWU-00060-12-A) from the North-West University's Ethics Committee. The ethical principles outlined in the Helsinki Declaration namely autonomy, benefit, non-harmfulness and justice, as well as the principle of voluntary, informed consent as set out in the Nuremberg Code guided the conduct of the researcher and formed part of ethical practice throughout the study. These are listed next.

- Verbal and written informed consent was obtained from all participants. Participants were informed about the nature and purpose of the study (Hesse-Biber & Leavy, 2011:73), the procedures that were to be followed during the investigation, and of any potential advantages, disadvantages and risks that the participants could be exposed to during the research (Babbie, 2007:64).
- Participants were informed that participation was voluntary and that they could withdraw without prejudice at any time or during any stage of the research (Babbie, 2007:63; Maritz & Visagie, 2009a:15; Strydom, 2011a:117).
- Before the commencement of the research, participants were reminded of any potential harm (physical and psychological distress) that could occur as a direct or indirect consequence of participating in the study (Strydom, 2011a:115), thus providing an additional opportunity for the participant to withdraw from the study.
- The provision of information to the participants ensured that no deliberate forms of deception (Yin, 2009:73) such as the provision of misleading facts or the withholding of information were undertaken, thus prevented misleading participants regarding the nature of the study and provided participants an opportunity to refuse participating in the research.
- Confidentiality and anonymity were ensured through the process of anonymising the data and identities of the participants through use of pseudo codes (King, 2010:101). All data and records, including recorded material, were/are stored in a lockable cabinet and electronically backed-up and on a password protected computer system, which is only accessible to the researcher and authorised entities (Gallagher, M, 2009:20).
- The researcher's personal orientation was influenced by her professional training in Gestalt therapy theory and experiential work which provided sufficient skill and competency to conduct the research. The researcher's phenomenological orientation

provided a stance and attitude based on respect and awareness and to be mindful (that is be reflexive) of the participants' lived experiences of the body and their professional knowledge.

1.6 Layout of the research report

Chapter 1

Introduction: Orientation to the research

Chapter 2

Theoretical foundation to the research

Chapter 3

Article 1: Embodied self-awareness: an unspoken resource for the therapist-practitioner within the South African social service delivery field

Chapter 4

Article 2: Exploring the therapist's use of embodied self-awareness as a means to facilitate the therapeutic relationship

Chapter 5

Article 3: Evoking participants' reflexivity through qualitative inquiry: a means to draw rich data

Chapter 6

Conclusion and recommendations

CHAPTER 2: Theoretical foundation to the research

2.1 Introduction to the human body and embodiment

As a theoretical concept, the human body has always been an integral element of early scientific, medical, philosophical, psychological and anthropological discourse and theoretical debate, resulting in numerous, at times conflicting, approaches to understanding of the living human body, contrasting epistemological perspectives and lacunae (weaknesses) (Schmitz, cited in Ots, 1994:117). Forming part of the literature study and the background of this study, this section presents a brief discussion of the notion of the living human body elicited from two prevailing dominant Western schools of thought, namely the medical mechanistic paradigm stemming from a Cartesian point of view and its contrasting phenomenological philosophical approach. Thereafter the approach to the living body adopted in this study is presented.

As part of the theoretical foundation and the background orientation of this study, relevant phenomenological terms and concepts are explored first. Subsequently the models of the human body are presented, namely the body in terms of an object (body-as-Körper), followed by the phenomenological perspective where the body is viewed as a subject (body-as-Leib), usually referred to as the 'lived body', and the approach to the lived body relevant to this study. All models view the human body as being alive, meaning the living body is not a corpse or cadaver, but the models differ in their theoretical conceptualisations and approaches towards the living human body.

2.2 Background terms related to the understanding of the human body

In this section the German terms 'Leib', 'Körper' and 'Erlebnis' are explored first as an orientation and background to this study. Subsequently, the relevant phenomenological concepts such as intending, intertwining, perception, the world, person's world (the German term 'Lebenswelt' or life-world) and body-world connections that influenced and converged the contemporary understanding of the living body in psychology are briefly presented as part of the orientation and a reminder of how the meanings of these concepts have influenced the

evolution of the manner in which the human body has been conceptualised and adapted into mainstream psychology and research.

2.2.1 The human body in terms of 'Leib' and 'Körper'

In the German language the two terms, 'Leib' and 'Körper', are used to make an important distinction when referring to different conceptual aspects of the living human body. Arising from the early phenomenological movement, philosophers such as Edmund Husserl, Martin Heidegger and Maurice Merleau-Ponty used the term 'Leib' to introduce the notion of an intending, personal and subjectively experiencing body, known as the body-as-subject (Bullington, 2013:36). The body as Leib served to oppose and highlight the difference from the predominant and normative Cartesian understanding of the body, that of being an objectified (inanimate, corpse or dead) body, referred to in German as 'Körper' (Bullington, 2013:25). The word 'Körper' is based on the Latin root, 'corpus', referring to the structural aspects of the body (Schicktanz, 2007:3). The emphasis of a body model based on the notion of Körper is the ontological reality that the physical body can be perceived and observed by oneself and others in an objective or factual manner, hence the living body is conceptualised as a body-as-object (Fuchs & Schlimme, 2009:572).

Viewing the body as Leib refers to aspects of being alive and having intentionality, being dynamic, being personal and subjective (Leder, 1992:25; Reeve, 2011:11; Shaw, 2003:19), as well as being a "body that I pre-reflectively live" (Fuchs & Schlimme, 2009:570). The personal and subjective dimensions of being a Leib encourages a person to achieve an awareness of how they are living in the world, that includes their actions and interactions, perceptions, feelings, emotions, thoughts, wishes and desires. In phenomenology, the *intending body* is considered the only way for living through one's experiences (Finlay, 2011:55). Furthermore, Husserl believed that a person's subjectivity forms the ground of all her/his experiences (Bullington, 2013:20), directly linking subjectivity to affective states. Thus the body viewed as the Leib becomes the means of sensing and expressing emotions (Schmitz, cited in Ots, 1994:117). It follows that emotions are experienced through the body or are types of embodied experiences (Sabar, 2013:18). Research conducted into neuroscience, intersubjectivity and body memory provided evidence that "subjective experiences are not to be found 'in the psyche', nor 'in the brain', but extend over the body, space and world of a person" (Fuchs, 2007:424) and are therefore thought to be a

precondition for understanding, making sense of experiences and a starting point for acquiring knowledge (Bullington, 2013:20).

Contemporary thinkers about the dichotomy Leib/Körper have suggested that much of the original meaning of the phenomenological work of German and French phenomenologists such as Husserl, Heidegger and Merleau-Ponty, in which the terms 'Leib' and 'Körper' were employed to conceptualise different models of the body, was lost in English translation, causing epistemological problems, misinterpretation and loss of the original intended meaning, which has been subsumed in literature. According to Ots (1994:117), the English language does not have an equivalent term for the word 'Leib', therefore both concepts, 'Leib' and 'Körper', seem to have been folded or incorporated into a single English term known as 'the body'.

As an attempt towards retaining the original meaning of 'Leib', indicating qualities of a body that "perceives, experiences and acts in an embodied way" (Gallagher & Payne, 2015:70), the use of a compound term 'lived body' has been put forward as a viable alternative concept and paradigm (Leder, 1992:25). Promoting the latter approach towards the human body, it was the research of early phenomenologists such as Edmund Husserl into the character of universal essences of consciousness in meaning-conferring acts (Bloom, 2009:282) that initially laid the ground for highlighting the dependency of the mind on the 'Leib' or lived body (Kaylo, 2006:9). In considering the same issue, other phenomenological and existential thinkers highlighted the importance of the dynamic quality of the living body and advocated that the German word 'Leib' could be considered a pre-dichotomatic term, reflecting/representing a lived body as a whole, a unifying "mind-body-world system" (Bullington, 2013:25) or alternatively as a "mind/body unity" (Bullington, 2013:51). In alignment with phenomenological thinking, contemporary approaches in psychotherapy that include a field theoretical or systems perspective component, understand the 'lived body' to be an amalgamated whole, consisting of an interacting physiological entity (biological body) with psychological (mind or self) dimensions including all interactions with the others, thus making up (comprising) all the person's lived experiences (Shaw, 2003:19).

2.2.2 The notion of human experience in terms of 'Erlebnis' meaning 'lived experience'

The term 'experience' stems from the Latin root, 'experientia', meaning "trial, proof, experiment, experience" and in its origin, does not contain the meaning lived (Van Manen, 2004:579). Stern (2004:34) states that the more usual ways in which the term 'experience' is depicted in dictionaries are as 'living through or personally undergoing, observing or encountering', an event or something, implying some duration. The notion of experience in terms of meaning 'living through something' is referred to in German as 'Erlebnis', which has been translated into English as 'lived experience'. 'Lived experience' was introduced as a theoretical concept by early phenomenologists and as a method for conducting qualitative research into "pre-reflective dimensions of human existence" (Van Manen, 2004:579). Lived experience implies for some phenomenologists the notion to connect "directly and immediately with the world as we experience it" (Finlay, 2011:15), meaning living through something personally and subjectively, which thus consists of feelings, sensations and actions that occur in a situation or context (implying a spatial component) with others (other people, objects, events, things and the environment) in a given present moment (implying a temporal component) (Stern, 2004:xiii). In phenomenology, the total sum of everyday commonly lived experiences is seen as the person's world, referred to in German as 'Lebenswelt' or "life-world" (Bullington, 2013:22).

Hans-Georg Gadamer (cited in Van Manen, 2004:579) suggests that lived experience contains two dimensions, firstly the immediacy of experience, being aware of and comprehending one's preverbal awareness (pre-reflective knowing), and the other dimension encompassing the content of the lived experience. The immediacy of an experience implies a state of knowing referred to by Daniel Stern (2004:113) as implicit (pre-reflective) knowing, that which is always present in a person's awareness and which may or may not enter the person's consciousness. Only at that instant when pre-reflective or implicit knowing, including nonverbal, non-symbolic and procedural data (Stern, 2004:113), enters into the cognitive realm or into consciousness (verbal awareness), then the subjectively lived experience can be conceptualised, reflected upon, or verbalised as meaningful experience (Stern, 2004:xiv). Examples of everyday common lived subjective experiences that may

emerge into consciousness include the person's perceptions, thoughts, dreams, memories, sensations, wishes and hopes (Stern, 2004:8).

2.2.3 The phenomenological idea of intentionality and perception as a mode of experiencing

From a phenomenological perspective, intentionality and perception are embodied in the human physiology and therefore are inseparable aspects of the lived body (Leder, 1992:33, Merleau-Ponty, 2005:436). According to Husserl, intentionality can be understood as a mode of experiencing, which focuses on *the what* (the content) and *the how* (the context) of the experience. For example, aspects such as the person's enduring interactional patterns, sensory system, reference points and attitudes influence how things are experienced and thus contribute to the context and meaning of an experience (Mann, 2010:148). Phenomenologically oriented thinkers aim to understand the person's "experience of knowing rather than knowing about" (Reeve, 2011:14), emphasising what is immediately felt, directly experienced and the meaning held about that experience (Evans, 2007:194; Reeve, 2011:14).

The concept of intentionality was initially introduced by the phenomenologist Franz Brentano to deal with the "aboutness of experience" (Brownell, 2010:83) or "aboutness of mental phenomena" (Burley & Bloom, 2008:152). Phenomenologists assume that when humans experience, think, feel or take action, it is always about something (aboutness), an *intended object* or has some reference point, which may be tangible, such as a tree, or an impalpable object that is imagined, representational, fictional, or *something* of interest (Brownell, 2010:30; Finlay, 2011: 37, 67). The act of intentionality is an active way of being projected into the world and reaching towards a stimulus or object of attention (the emerging figure of interest) to make meaning of one's perceptual experience (Mann, 2010:148). According to Merleau-Ponty (2005:436), "reaching the thing itself" can be described as the notion of perception. The phenomenon of perception is considered to be the "most pervasive of all human activity" (Kennedy, 2003:85), that which provides access (projects) to something outside oneself (Bullington, 2013:29).

Intentionality and perception are activities that arise from the body's engagement through the operations of the sensory-motor system (such as from the proprioceptive awareness) and its inseparable relationship with the world (Kaylo, 2006:9). Intentionality is considered a form of

being-in-the-world (Gallagher, 2002:2), which is fundamentally dynamic and reciprocally interactive (participatory) in nature (Finlay, 2011:21), continually influencing how the person perceptually experiences the world (Burlington, 2013:29). The activity of "reaching the thing itself" (Merleau-Ponty, 2005:436) can be compared to dialoguing (interacting) or the process of making contact where the emerging figure of interest (the intended object of perception) is seen as a key event of perception and awareness (Kennedy, 2003:78). During the process of engaging and making contact with the intended object, a variety of perceptual experiences may be involved, ranging from "primary perception as a … pre-objective and pre-conscious experience" (Merleau-Ponty, 2005:281) through "inter-subjectivity and motility (considered to be basic intentionality) right up to the cognitive/linguistic level" (Kennedy, 2003:77).

The lifelong activity of the lived body, as an intending and perceiving body, of being in constant dialogue and action (movement) with the world implies the existence of reciprocal interaction which means a folding back towards itself, consequently "reshaping our body" (Leder, 1992:29). The habitual and implicit structures are developed over time, which form the base (as part of body memory and implicit knowledge) and influence how individuals perceive and experience the everyday ordinary life-world (Bullington, 2013:35).

According to Gallagher (2002:2), phenomenologists have recognised the importance of *how* the lived body's embodied intentionality and actions influence and shape perceptions and experiences during dialogue (interaction) or making contact with the object of perception. It was Merleau-Ponty, who in his later and unfinished work, introduced the term 'the flesh' in an attempt to emphasise the existence of reversible interpenetrating relationships between an embodied subject and the world being "within one another and intertwined" (Finlay, 2011:57). The notion of 'the flesh' proposed an evolved ontology representing an intercorporeal body and their reciprocal interactions, resulting in an intersubjective field, suggesting a new kind of subjectivity, a new way of experiencing being-in-the-world or being in relationship with the world (Bullington, 2013:57), a concept that has been adapted into contemporary thinking of the lived body.

2.2.4 The phenomenological idea of the world, the person's world and body-world connections

In phenomenology, the notion of 'the world' is frequently employed in a very general sense or used as a catch-all for describing what is not considered to be part of a whole person (that is the total me) and excluding the person's personal world, also referred to as the phenomenal field or Lebenswelt. Therefore, by implication the term 'the world' describes what is part of "otherness or others-world" (Finlay, 2011:29) that may include other people, objects or things in the world and the surrounding environment.

The notion of 'a person's world' has been conceptualised in different ways and is used interchangeably with terms such as the 'phenomenal field' (O'Shea, 2009:221), 'life-world' or the German term 'Lebenswelt' (Bullington, 2013:22). The person's world is commonly understood to be the field or space that is created in-between the embodied subject (the perceiving and intentional body) and the world (Fuchs, 2007:424) and represents the person's existential ground (Fuchs, 2007:424), that being the total sum of everyday commonly lived experiences (Bullington, 2013:22). According to the early phenomenologist Edmund Husserl, the life-world represents "the embodied life, and the world of human cultures" (Bloom, 2009:285) that is experienced as a meaningful subjective unity and which may appear into human consciousness (Todres, 2007:98). The actual experience of an individual is referred to as being "phenomenal" (Brownell, 2010:89) and the total sum of all instances of immediate experiences is known as the individual's "phenomenal field" (O'Shea, 2009:221), also understood to represent the person's world. In other words, the person's world can be viewed as a structured whole representing the totality of a person's life providing a framework of meaning, that is of how a person is immersed in her/his daily existence and activity of experiencing, doing, thinking, acting and being in relationship with others through space and time (Fuchs, 2007:425).

An important aspect of the person's life-world includes her/his body-world connections and ever-changing relationships with others which can be visualised as an intentional process-related matrix (the space in-between) or flow of happenings that occur between the "meaning-making human subject and the external taken-for-granted, meaning given world" (Finlay, 2011:125). Consequently, the person's lived world is also an interactive field where

the boundary according to Martin Buber between the I and the other (It or Thou) is temporary dissolved, suggesting that the life-world is inherently "an inter-subjective field, not despite my body and historical situation, but on the contrary, by being this body and this situation, and through them, all the rest" (Merleau-Ponty, 2005:525). The life-world as an intersubjective or relational field implies that it can be shared with and experienced by others but each from their own unique and subjective perspective (Finlay, 2011:45).

2.3 Western models in approaching the human body and embodiment

The models of the human body presented in this section are in terms of the body as an object (body-as-Körper), followed by the phenomenological perspective where the body is viewed as a subject (body-as-Leib), usually referred to as the 'lived body'. The models of the human body and embodiment presented in this section, form part of the orientation and serve as a reminder of how the evolution of the living body has been conceptualised and addressed in mainstream psychology. Subsequently, a more contemporary approach to the living body and relevant to this study is offered. Whereas most models view the human body as being alive, meaning the living body neither as corpse nor cadaver, there are significant differences in their theoretical conceptualisations and approach towards the living human body.

2.3.1 Cartesian approach to the living body: body-as-object (Körper)

Stemming from a Cartesian philosophical outlook, as set out by René Descartes, this has led to the notion that the living body can be viewed as a "kind of animated corpse, a functioning mechanism" (Leder, 1992:20), thus forming a model based on the body viewed as inert object. The notion of an inert body is understood as "the sum of its parts with no interior, and the soul as being wholly present to itself without distance" (Merleau-Ponty, 2005:230). Therefore, in Cartesian thought the living body is modelled on mechanistic and replaceable parts, devoid of fundamental subjectivity, aliveness and intentionality. A parts-based mechanical body encourages a value system that allows the body to be seen as a resource (Schicktanz, 2007:3), separated from the person's sense of self. The needs of the mind or soul (Ots, 1994:117) are thus facilitated and housed in a distinct object or vessel, which is a body functioning within its own boundaries independent from the mind. Consequently, the body is relegated to an objective fact, which is treated and controlled as an object in which parts can be altered, fixed and replaced (Lafrance, 2009:18; Sanders, 2006:286; Totton, 2009:188) and

where body experiences are seen as subjective epiphenomenal products of brain states (Gallagher & Payne, 2015:69).

Despite an approach that advocates a dualistic approach towards the body, separating body from the mind, there is some reference within Cartesian thinking that the body and the mind are connected. For example, Cartesian thinking has separated sight (visual perception) from the body's other sensory functions (such as smell, touch, sound, auditory and proprioceptive senses) and linked it to the mind (Reeve, 2011:7). By attaching visual perception to the mind, separation is exacerbated, creating a sense of distance between subject and object. By implication the person is then seen as split while simultaneously creating the conviction that knowledge generated from the visual sense and linked to mind is somehow independent, rational and detached (Reeve, 2011:8). Paradigms that give primacy to the mind and where the mind is seen as a separate entity existing independently from the body encourage alienation, disembodiment and objectification of the body which have informed much of Western daily living, values and norms. The legacy of the objectification of the body is also evident in the mainstream dominant research methods and Western psychology and therapeutic methods that have relegated human variables such as the living experiences of persons, their affective states, emotions, desires, perceptions, subjectivity and intersubjectivity to being largely epiphenomenal (Cromby, 2007:233, Soth, 2006:54), promoting science and research that encourages the separation of mental processes from the subjectively experienced body processes (Finlay, 2011:21; Levine & Bar-Yoseph Levine, 2012:5).

Other predominant authors of Western mainstream psychology during the early 20th century that believed that the body and mind were somehow connected were clinical thinkers such as Sigmund Freud, Wilhelm Reich and Ludwig Binswanger, amongst others. They began the initial groundwork for including the body within the broader context of psychology, suggesting that the person's sense of self is essentially an embodied self. Both Freud and Reich conceptualised the body as being fundamental in the process of embodiment, the development of self and the experience of self. As early as 1923, Freud described "the ego as first and foremost a body ego" (Alvarez, cited in Bloom, 2006:xi; Frie, 2007:56). According to Freud, the body's instinctual drives and somatic processes are primary sources that influence "the development of the ego (personality) and neuroses (*that is suppressed aspects of self*)" (Hartley, 2004:15). Like Freud, Reich viewed the "sexual energy as primary

(*referred to as the experience of orgone energy*)" and "blocking of this energy as the source of all neuroses, social ills, and character traits" (Hartley, 2004:16). In Freud's view, the ego is constantly trying to manage the bodily-based drives, thereby reinforcing the superiority of the mind over bodily functions (Frie, 2007:57). Reich believed that a person's sense of self (character) reflects hers/his total body expression, which is maintained through the body's muscular structure or "armour" (Hartley, 2004:22). Mental (psychic) changes can be evoked through working on or through the body, especially the muscular structure using touch, breath and movement (Totton, 2003:20). However, changes in character (mental or sense of self) functioning could also lead to somatic changes (Hartley, 2004:22). Despite the efforts of thinkers such as Freud, Reich and others to bridge the Cartesian dualism, suggesting that the body is a primary organising principle of self (ego or character), the body and the mind remain as separate parts, interacting with each other (Hartley, 2004:15).

Another well-known psychiatrist and psychoanalyst during that period attempting to bridge the Cartesian mind-body dualism within a clinical setting was Ludwig Binswanger. Binswanger's theory of embodiment moved away from a body-as-Körper (object) model towards a body-as-Leib (subject) model. Heidegger's phenomenological concept of being-in-the-world enabled Binswanger with the means to develop a holistic view of the individual including both mind and body (Frie, 2007:60). For Binswanger the body,

> "provides the experiential context for our interactions with the world … forms the background for on-going experience … *shaping our identity* ... and provides a means of self-expression *augmenting or substituting* verbal language *with the language of the body through expression such as* ... belches, screeches and vomiting … *thus* emphasising the pre-reflective and preverbal experiences of the body that *under* certain circumstances remains the only form of expression left to people" [sic] is the language of the body (Frie, 2007:59, researcher's italics).

Like Freud, Binswanger believed that the ego is primarily body based (Bloom, 2006:xi), but rejected Freud's idea of instinctual drives determining human behaviour (Frie, 2007:56). Expanding on Binswanger's theory of embodiment, the phenomenologist Merleau-Ponty aimed to collapse or transcend the mind-body dualism, elaborated in his infamous life work called *Phenomenology of perception* (Merleau-Ponty, 2005). Merleau-Ponty spent his whole life developing his version of the body-as-Leib which can be understood as a "perceiving body", that is how humans (as embodied subjects) attend to (by focusing on and dialoguing /

interacting with objects) and experience the world through their bodies (Bullington, 2013:22). Merleau-Ponty expressed this as "the perceiving mind is an incarnated body" (Merleau-Ponty, 2005:3), thus arguing that the lived body is not merely an object but is also an embodied person (subject) that exists within the world, that needs to be investigated. Both Merleau-Ponty and Binswanger believed that the mind could only be understood in terms of the body (Frie, 2007:60).

2.3.2 A phenomenological approach to the living body: body-as-subject (Leib)

As suggested earlier, to overcome or even to expunge the Cartesian object-subject, mind-body and interior-exterior dualisms (Finlay, 2011:57), existential and phenomenological proponents such as Husserl, Heidegger and Merleau-Ponty conceptualised the body and embodiment in terms of the body-as-Leib (an intending, personal and subjective body) (Bullington, 2013:36). The lived body (Leib) model differentiates itself from a Cartesian model of the object body (Körper), in that it is an attempt to address the person as a whole entity, including the subjective foundations of the lived body and its embodiment. Thus, the notion of the 'lived body' (Leib) promotes a holistic and non-dualistic approach to life and living (Fuchs & Schlimme, 2009:571; Kennedy, 2003:77; Leder, 1992:25).

The term 'lived body' (Leib) has been conceptualised in different ways and is used interchangeably with terms such as "body-subject (our subjective bodily sense)" (Finlay, 2011:36; Reeve, 2011:15), "subject body (Leib) or pre-reflective embodied self" (Fuchs & Schlimme, 2009:571), or body-as-subject (Gallagher & Payne, 2015:70). Although the phenomenological approach to and the theories of embodiment differ, the term 'lived body' (Leib) can be considered as a meta-term or tag, the reason being that the theories commonly share several key tenets and are founded on a similar ontology, which is discussed next.

The various conceptualisations of the notion of the 'lived body' is based on an ontology which assumes that every human being "not only **has** a body but **is** a body and **expresses** him/herself through the body" (Frie, 2007:59), therefore includes both the physical body (organic or corporality) and the intending, subjective and personal living body, which is the "lived nature of the body" (Finlay, 2011:36). A key phenomenological tenet is that every

human being interacts and exists in the world of things and others through the subject body (which is an intending, personal and subjectively experiencing body) rather than through an object body that is anonymous and mechanistic in processing stimuli from the brain (Bullington, 2013:26). Thus, the lived body (or subject body) is seen as the means and mode for being present in the world, for participating in every (tacit/implicit or explicit) action and interaction, for making contact and relating with others (animate and inanimate) and the world, forming part of every experience (implicitly before reflection or explicitly when the body becomes an object) (Finlay, 2011:31, 55; Fuchs, 2007:424; Hergenhahn, 1992:502). Furthermore, the lived body provides phenomenal data that is produced from the subjectively experienced body processes, also known as the embodied lived experiences (Finlay, 2011:16), originating through the sensory system, body memory and body schema amongst others, functioning as a means and mode for perceiving and interpreting (making meaning), as well as a starting point for acquiring knowledge of one's lived embodied experiences and everyday life situations (Finlay, 2011:21; Joyce & Sills, 2010:34). According to Frie (2007:61), the subject body's meaning making function is reflected in Merleau-Ponty's words that "it is through my body that I understand other people, just as it is through my body that I perceive things" (Merleau-Ponty, 2005:216).

Another important assumption and key tenet shared amongst phenomenological thinkers is the principle of holism. From this perspective the lived body is viewed as a whole entity, system or unified field, composed of the "amalgamation and intertwining aspects of the corporeal body, the self (mind) and the world" (Finlay, 2011:21). The adaptation of the principle of holism is evident in the phenomenological concepts known as the 'intertwining mind-body-presence' or 'mind-body-world system' (Bullington, 2013:26, 51), suggesting that the human body as a lived body is represented as a lived unit or whole system. In holism, a whole as defined by Jan Smuts (1926/1999:114) is a composite consisting of many parts, that has an internal structure, function or character and behaves in a "dynamic, evolutionary, creative" way. A whole can maintain itself "by taking in other parts" (Smuts, 1926/1999:111) and through the process of creative synthesis of separate units (parts) that are in active relation to and interaction with each other, amalgamate into a single entity. A single entity is defined as a "whole, which is more than the sum of its parts" (Smuts, 1926/1999:374,113).

Holism's notion of 'whole' has been adapted into phenomenological existential psychotherapy and psychology and is similarly understood to be a synthesis of parts into a

"whole that is different from the sum of its parts" (Evans, 2007:194; Ginger, 2007:1; Masquelier, 2006:45). Examples of how the principle of holism has been applied by different conceptualisations of the ontology of the body are evident in the systems where the lived body is viewed as a "mind/body unity" (Bullington, 2013:51) and the lived unity of the "mind-body-world system" (Bullington, 2013:26). The ontology of lived body as a mind/body unity represents the embodied subject synthesised by the role of the subject body (the body-as-it-is-lived or subjectively experienced) and the object body (the physical body) that together form a whole (Leder, 1992:27; Reeve, 2011:15). The terms such as 'intertwined mind-body-presence' (Bullington, 2013:27), 'intertwining intending entity' (Leder, 1992:27) and 'person-body' (Finlay, 2011:36) are commonly found and used interchangeably in literature when referring to the lived body in terms of a mind/body unity.

The lived body, understood as the lived unity of the "mind-body-world system" (Bullington, 2013:26) is an ontology constituted by the embodied subject (an intertwining mind/body unity) and the world (Finlay, 2011:36, 56), also known as an intertwining or constituted "body-world" (Finlay, 2011:54), or as a unified field constituted of intertwining spheres made up as a "mind-body-world system" (Bullington, 2013:36). Supporting the latter understanding of the lived body, Martin Heidegger, a former student and colleague of Husserl, introduced the term 'Dasein', meaning being-in-the-world (Finlay, 2011:50). The German term 'Dasein' is composed of two parts 'sein' and 'da'. The word 'sein' literally means 'to be', referring to the dynamic and active processes involving human activities of existence such as experiencing, choosing, evaluating, existing, rejecting and changing and so forth. The word 'da' means 'there', referring to a place in time and space (Hergenhahn, 1992:503). According to Heidegger, the notion of Dasein or being-in-the-world means that the embodied person (mind/body unity) and the world (consisting of other people and things of the world) should be viewed as a dynamic single entity (Finlay, 2011:50) which is in constant flux and in the process of becoming (Reeve, 2011:15).

Expanding on the early phenomenologically based theories of the lived body and embodiment was Merleau-Ponty, commonly referred to as "the philosopher of the body" (Bullington, 2013:26). He conceptualised the notion of 'the lived body' as a system, a unified field or lived unity consisting of the mind, the body and the world, which "are naturally intertwined as human embodiment" (Bullington, 2013:25). Merleau-Ponty's model of the lived body and embodiment can be understood as a "**mind-body** presence always **directed**

towards the world (otherness). Therein **a field arises**, an 'in-between'**,** that is constituted in terms of situations to be mastered and understood" (Bullington, 2013:36).

The application of holism in the Merleau-Ponty model of the lived body is evident in his definition, in that his understanding of the lived body can be compared to a single entity (whole) which is a result of a process of synthesis bringing together self-acting separate parts, such as the intertwining (dialoguing) of the mind, the body and the world, its history including the present, past and future, functioning, exhibiting and exerting in its field (Smuts, 1926/1999:95,125). Phenomenologists that assume an ontological reality which views the lived body acting as a system, whether the system is referred to as a mind-body-world system, unified system or field, draw on the principles of field theory, which is a particular application of Kurt Levin's field theoretical thinking (Fuchs, 2007:426; Kennedy, 2005:109). According to field theory, a unified field is always governed by certain properties, assumptions and principles (precepts) that determine the dynamics, behaviour and organisation of that field, and these need to be understood.

From a phenomenological perspective the governing principles that influence the dynamics of the lived body (conceptualised as a unified field) are that the lived body (1) is always oriented towards the world outside itself, therefore the lived body is understood to be a perceiving and intending body; (2) is in constant dialogue (showing dynamic and reciprocal actions) with the world of things and others; and (3) is always embedded in a situation (context) which is unique to each person, having its own language, culture, past history and everyday commonly lived experiences. In other words, the lived body is a unified system or "an intending entity which gives rise to a world" (Leder, 1992:27). The resulting field (an intersubjective space) is understood to be the personal world or life-world (Bullington, 2013:22), which is in constant flux and in the process of becoming, emerging from the present activity (living in the here-and-now) and simultaneously influenced by the nature of the individual's personal past and embodied history (Reeve, 2011:15).

A person's everyday commonly lived experiences, interactions and relationships with the world (Bullington, 2013:30) emerge from the in-between space (intersubjective space or relational matrix) or field, which can be compared with holistic thought as the parts that emerge out of their interaction and take on their function (or character) from the whole (Phillipson, 2009:132). The total sum of interactions and relationships a person has with the

world represents the person's lived "body-world connections" (Finlay, 2011:30). These body-world relationships and actions are considered to be intentional (always directed towards something), to be fundamentally embodied and are predominantly lived on an implicit and pre-reflective level (Fuchs & Schlimme, 2009:570-571), that is without consciousness or cognitive thought (Finlay, 2011:31, 37). As described previously, experiencing on a pre-reflective level refers to a person's "pre-objective and pre-conscious experiences" (Merleau-Ponty, 2005:281) of others and the world of things as they appear to her/him prior to entering consciousness or at a cognitive/linguistic level (the place where theoretical abstraction and conceptualisation can take place). Some phenomenologists and other contemporary thinkers about the body suggest that one of the effects of daily living in a predominantly objectified and disembodied world is that it encourages alienation and reduced aliveness of one's body, including both the physical and subjectively experienced body.

Consequently, a majority of subjectively experienced body processes and lived body experiences merge with or subside into a person's background or unconscious, operating to a large extent on an unconscious level in daily activities and interactions (Finlay, 2011:21). The non-verbal and sensory phenomenal data are potentially a valuable source of implicit (pre-reflective) knowing and understanding, if they enter the cognitive realm where conceptualisation and meaning is constituted at an explicit and verbal level (Stern, 2004:113). Examples of implicit knowing emerging from the lived experiences of the body may include a person's body schema (Reeve, 2011:14), her/his embodied history including enduring relational patterns and movement repertoire (Frank & La Barre, 2011:80; Kepner, 2008:172), associations and body memory (habitual and procedural) (Summa *et al.*, 2012:419.), and the lived body experiences constituted from the field (the space in-between or the intersubjective relational space) created between the person and their interactions and connections with the world and others (Fuchs, 2007:42; Fuchs, 2012:14; Lobb, 2008:113). Therefore, when attempting to address or understand a person from a holistic perspective, it is important that all lived experiences of the body need to be included.

In summary, authors such as Bullington (2013), Finlay (2011), Frie (2007), Fuchs (2007, 2012), Kennedy (2003, 2005, 2012), Shaw (2003, 2004) amongst others, suggest that the phenomenological notion of the 'lived body' and embodiment that have been conceptualised by philosophers such as Husserl, Heidegger, and more specifically Merleau-Ponty, serves as a useful framework for understanding and conceptualising the living body as a unified whole

(field or system). On the one hand, viewing the body as a lived body system (unified whole or field) discourages dualisms and de-compartmentalises parts-based or disembodied approaches, while on the other hand creating a measure of theoretical ambiguity. As a living system or unified field, the body is understood to be ambiguous since it is constituted of both physiological and psychological dimensions simultaneously (Fuchs & Schlimme, 2009:570; Gallagher & Payne, 2015:70). Merleau-Ponty describes the ambiguity as arising in a body that is "both as lived body, implicit in one's on-going experience, and as an explicit, physical or objective body. An on-going oscillation between these two body modes constitutes a fluid and hardly noticed foundation of all experiences" (Fuchs & Schlimme, 2009:571). Thus, the notion of the 'lived body' as discussed in this section, can be understood to be an amalgamation of the subject body (Leib), as it is subjectively lived and pre-reflectively experienced moment-by-moment, the body as an object (physical) being observable and the body as engaging and interacting with the others and the world (Finlay, 2006:21). The latter understanding of the lived body forms the basis of this study.

2.3.3 The living body and embodiment within this study

The body in this study draws on the philosophical assumptions, assertions and core concepts of the notion of the 'lived body' proposed by phenomenological thinkers as described in the previous section. The governing principles and core concepts of humanistic, field theoretical and relational therapeutic approaches, and the more recent developments into body memory research, developmental psychology and neuroscience, provide a useful framework that guide the understanding of the SASSD therapist-practitioners' lived experiences of the body within the therapeutic context and setting.

This study is based on the core tenet and ontological reality that every human being "not only **has** a body but **is** a body and **expresses** him/herself through the body" (Frie, 2007:59). Thus, the body is viewed as a lived body (as defined by phenomenological thinkers such as Merleau-Ponty) functioning as a unified whole (field or system) drawing on the principles of field theory and core concepts such as intersubjectivity, relational matrices and mirror neuron system amongst others.

Even though the lived body is perceived as a unified whole, phenomenologically based approaches and contemporary perspectives of the body commonly differentiate between the physical body (Körper or body-as-object) and the subject body (Leib or body-as-subject, that is predominantly pre-reflectively lived) (Finlay, 2011:36; Fuchs & Schlimme, 2009:571; Gallagher & Payne, 2015:70).

The physical (corporeal or biological) body is an ontological reality as it is present in the world, thus forming the basis of human existence and living (Kennedy, 2005:109). **Having** a physical body implies an explicit, tangible entity and a biological given, that which is observable by oneself and others, hence it takes on the role of a body-as-object (Fuchs & Schlimme, 2009:571). **Being** a body implies that the body's corporality not only functions in the capacity of an object, but as suggested by Frie (2007:59) behaves, moves and acts in an embodied way (through implicit or pre-reflective knowing, that is having an embodied sense of self), and **expresses** itself through the body, hence according to Gallagher and Payne (2015:70) becomes a body-as-subject. Expressing oneself through the body implies that the body can be viewed as a process or event, which indicates a quality of being dynamic, fluid and ever reconstituting itself (Totton, 2010:23). As a subject body (lived body), the body becomes the means and mode for experiencing, perceiving and participating in all aspects of living through situations, for making contact and relating to others, for doing, being and becoming, as well as for understanding (or making sense of) everyday life situations and experiences (Finlay, 2011:31, 36, 55; Fuchs, 2007:424; Hergenhahn, 1992:502).

The notion of the 'lived body' offers an approach to investigate and understand how a person provides explicit and verbal knowledge (which is observable by oneself or another and using language), as well as phenomenal data that are produced from her/his embodied lived experiences. Phenomenal data can consist of nonverbal and implicit or pre-reflective knowledge expressed through bodily interaction and activity in terms of touch, movement, gesture and body language and arising from the body's sensory background (Joyce & Sills, 2010:34-36). One of the aims of a phenomenological, somatic, relational, Gestalt theoretical or humanistic research-practitioner's perspective is to understand the person's "experience of knowing rather than knowing about" (Reeve, 2011:14), emphasising what is immediately felt, directly experienced and the meaning held about that experience (Evans, 2007:194; Reeve, 2011:14). Consequently, such an approach tends to focus on the dimensions of the bodily 'felt sense' or the subjectively experienced body process also known as the embodied lived

experiences (Finlay, 2011:30), that is the inter-play of the sensory-motor systems as all person experiences are grounded in the bodily sensations which provide moment-to-moment information regarding the person's relation to time and space.

Body sensations can be grouped into those focusing on the internal sense of self such as the proprioceptive system consisting of kinaesthetic and vestibular sense (Frank, 2001:71; Fuchs & Schlimme, 2009:571; Kepner, 2008:96) and those senses such as vision, sound, touch, sight and taste that assist focusing on the external determining the location and relationship with the environment (Kepner, 2008:96). The senses governing implicit operations of the sensory-motor system are referred to in phenomenology as the notion of 'body schema' (Reeve, 2011:14) and unconsciously regulate and communicate the body's distal (social distance) and proximal (intimate distance) boundary space (Kepner, 2008:171), as well as movement repertoire including gesture, postures, voice of tone and facial expressions (Kepner, 2008:172). Thus, the body provides "point of access to, view of, and way of relating to our world" (Finlay, 2011:31).

Within the context of this study the researcher draws from the phenomenological notion of the lived body and its core concepts, as described in this section. The aim and interest of the study was to capture, describe and identify "the lived experience of the body" (Frie, 2007:58), that is the "embodied lived experience which is lived out in the world" (Finlay, 2011:23) and the "meaning held about that experience" (Finlay, 2011:16). The researcher is of the opinion that the notion of the 'lived body' model provided a useful starting point, platform and frame of reference for understanding (interpreting and making sense of) the participants' lived experiences of the body within the therapeutic context, and gaining potential insight into their subjective process of embodiment, the embodied sense of self, experiences of inter-subjectivity, which influence the nonverbal aspect of the therapeutic intersubjective field (relational matrix) and relationship, considered to be the backbone of a therapeutic relationship and agent of change.

CHAPTER 3: Article 1

3.1 Guidelines for authors: *Journal of Psychology in Africa*

The ***Journal of Psychology in Africa*** publishes original empirical research articles, research reviews, conceptual development articles and thematic issues. Manuscripts can be regular research reports, brief reports, and those that address topical professional issues, including case analysis reports. Book reviews are accepted for publication as special announcements. Specifically, manuscripts with the following qualities are encouraged: 1) Combine quantitative and qualitative data, 2) Take a systematic qualitative or ethnographic approach, 3) Use an original and creative methodological approach, 4) Address an important but overlooked topic, 5) Present new theoretical or conceptual ideas; and 6) Present innovative context sensitive applications. Manuscript for publication consideration should show an awareness of the cultural context of the research questions asked, the measures used, the results obtained, and interpretations proposed. Finally the papers should be practical, based on local experience, and applicable to crucial efforts in key areas of psychology for development in African cultural heritage settings.

Instructions to authors

Editorial policy

Submission of a manuscript implies that the material has not previously been published, nor is it being considered for publication elsewhere. Submission of a manuscript will be taken to imply transfer of copyright of the material to the owners, Africa Scholarship Development Enterprize. Contributions are accepted on the understanding that the authors have the authority for publication. Material accepted for publication in this journal may not be reprinted or published without due copyright permissions. The Journal has a policy of anonymous peer review. Papers will be scrutinised and commented on by at least two independent expert referees or consulting editors as well as by an editor. The Editor reserves the right to revise the final draft of the manuscript to conform to editorial requirements.

Publishing ethics

By submitting to the *Journal of Psychology in Africa* for publication review, the author(s) agree to any originality checks during the peer review and production processes. A manuscript is accepted for publication review on the understanding that it contains nothing that is abusive, defamatory, fraudulent, illegal. libellous, or obscene. During manuscript submission, authors should declare any competing and/or relevant financial interest which might be potential sources of bias or constitute conflict of interest. The author who submits the manuscript accepts responsibility for notifying all co-authors and must provide contact information on the co-authors. The Editor-in-Chief will collaborate with Taylor and Francis using the guidelines of the Committee on Publication Ethics [http://publicationethics.org] in

cases of allegations of research errors; authorship complaints; multiple or concurrent (simultaneous) submission; plagiarism complaints; research results misappropriation; reviewer bias; and undisclosed conflicts of interest.

Manuscripts

Manuscripts should be written in English and conform to the publication guidelines of the latest edition of the American Psychological Association (APA) publication manual of instructions for authors.

Submission

Manuscripts should be prepared in MSWord, double spaced with wide margins and submitted via email to the Editor-in-Chief at elias.mpofu@sydney.edu.au. Before submitting a manuscript, authors should peruse and consult a recent issue of the *Journal of Psychology in Africa* for general layout and style.

Manuscript format

All pages must be numbered consecutively, including those containing the references, tables and figures. The typescript of a manuscript should be arranged as follows:

• Title: this should be brief, sufficiently informative for retrieval by automatic searching techniques and should contain important keywords (preferably <13).

• Author(s) and Address(es) of author(s): The corresponding author must be indicated. The author's respective addresses where the work was done must be indicated. An e-mail address, telephone number and fax number for the corresponding author must be provided.

• **Abstract:** Articles and abstracts must be in English. Submission of abstracts translated to French, Portuguese and/ or Spanish is encouraged. For data-based contributions, the abstract should be structured as follows: Objective – the primary purpose of the paper, Method – data source, participants, design, measures, data analysis, Results – key findings, implications, future directions and Conclusions – in relation to the research questions and theory development. For all other contributions (except editorials, book reviews, special announcements) the abstract must be a concise statement of the content of the paper. Abstracts must not exceed

150 words. The statement of the abstract should summarise the information presented in the paper but should not include references.

• **Text:** (1) Per APA guidelines, only one space should follow any punctuation; (2) Do not insert spaces at the beginning or end of paragraphs; (3) Do not use colour in text; and (4) Do not align references using spaces or tabs, use a hanging indent.

• **Tables and figures**: These should contain only information directly relevant to the content of the paper. Each table and figure must include a full, stand-alone caption, and each must be sequentially mentioned in the text. Collect tables and figures together at the end of the manuscript or supply as separate files. Indicate the correct placement in the text in this form <insert Table 1 here>. Figures must conform to the journals style. Pay particular attention to line thickness, font and figure proportions, taking into account the journal's printed page size – plan around one column (82 mm) or two column width (170 mm). For digital photographs or scanned images the resolution should be at least 300 dpi for colour or greyscale artwork and a minimum of 600 dpi for black line drawings. These files can be saved (in order of

preference) in PSD, PDF or JPEG format. Graphs, charts or maps can be saved in AI, PDF or EPS format. MS Office files (Word, Powerpoint, Excel) are also acceptable but DO NOT EMBED Excel graphs or Powerpoint slides in a MS Word document.

Referencing

Referencing style should follow latest edition of the APA manual of instructions for authors.

• **References in text:** References in running text should be quoted as follows: (Louw & Mkize, 2012), or (Louw, 2011), or Louw (2000, 2004a, 2004b). All surnames should be cited the first time the reference occurs, e.g., Louw, Mkize, and Naidoo (2009) or (Louw, Mkize, & Naidoo, 2010). Subsequent citations should use et al., e.g. Louw et al. (2004) or (Louw et al., 2004). 'Unpublished observations' and 'personal communications' may be cited in the text, but not in the reference list. Manuscripts submitted but not yet published can be included as references followed by 'in press'.

• **Reference list:** Full references should be given at the end of the article in alphabetical order, using double spacing. References to journals should include the author's surnames and initials, the full title of the paper, the full name of the journal, the year of publication, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to books should include the authors' surnames and initials, the year of publication, full title of the book, the place of publication, and the publisher's name. References should be cited as per the examples below:

Reference samples

Journal article

Peltzer, K. (2001). Factors at follow-up associated with adherence with adherence with directly observed therapy (DOT) for tuberculosis patients in South Africa. *Journal of Psychology in Africa, 11*, 165–185.

Book

Gore, A. (2006). *An inconvenient truth: The planetary emergency of global warming and what we can do about it.* Emmaus, PA: Rodale.

Edited book

Galley. K. E. (Ed.). (2004). *Global climate change and wildlife in North America.* Bethesda, MD: Wildlife Society.

Chapter in a book

Cook, D. A., & Wiley, C. Y. (2000). Psychotherapy with members of the African American churches and spiritual traditions. In P. S. Richards & A. E. Bergin (Ed.), *Handbook of psychotherapy and religiosity diversity* (pp 369–396). Washington, DC: American Psychological Association.

Magazine article

Begley, S., & Murr, A. (2007, July 2). Which of these is not causing global warming? A. Sport utility vehicles; B. Rice fields; C. Increased solar output. *Newsweek, 150* (2), 48–50.

Newspaper article (unsigned)

College officials agree to cut greenhouse gases. (2007, June 13). *Albany Times Union,* p. A4.

Newspaper article (signed)

Landler, M. (2007, June 2). Bush's Greenhouse Gas Plan Throws Europe Off Guard. *New York Times*, p. A7.

Unpublished thesis

Appoh, L. (1995). The effects of parental attitudes, beliefs and values on the nutritional status of their children in two communities in Ghana (Unpublished master's thesis). University of Trondheim, Norway.

Conference paper

Sternberg, R. J. (2001, June). Cultural approaches to intellectual and social competencies. Paper presented at the Annual Convention of the American Psychological Society, Toronto, Canada.

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3.2 Article 1: Embodied self-awareness: an unspoken resource for the therapist-practitioner within the South African social service delivery field

Article 1 has been submitted to the *Journal of Psychology in Africa* and has been accepted with amendments for publication in 2017.

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Abstract

A qualitative interpretive descriptive design was employed to explore therapist-practitioners' experiences of the lived body in terms of embodied self-awareness within the South African social service delivery field. Thirteen registered therapist-practitioners in private practice and government organisations in the Western Cape and Gauteng were selected by means of snowballing. A naïve sketch and/or drawing, experiential body awareness activities, and in-depth one-on-one semi-structured interviews were conducted. Data were thematically analysed. All participants reported experiences of bodily felt sensations while doing therapy, most frequent being intuitive or spiritual knowing, a sense of warning/danger and a sense of the body-schema-in-relation. Most tended to deny, suppress or control their sensory cues or rationalize them as being non-rational and unprofessional. Embodied self-awareness appears to be a common phenomenon in therapy, thus a potential resource for every therapist-practitioner and moving towards an integrative counselling/psychological framework, allowing for the inclusion of other approaches such as African Psychology.

Keywords: conceptual self-awareness, embodied self-awareness, embodiment, implicit knowing, lived body, self-awareness

Introduction

Western psychology, psychotherapy, philosophy and neuroscience provide a variety of ways to think about the notion of awareness (Clarkson, 2004; Stern, 2004) referring to various kinds or levels of experiencing that may involve mental activities (Fogel, 2009) and the ability to sense and to feel oneself and others. Recent developmental approaches towards human awareness suggest that during the last two prenatal months fetal bodily self-awareness begins to develop (Fogel, 2009), in that the interoceptive and proprioceptive sense-receptors allow the unborn to have some in utero awareness of moving (e.g. hand-to-mouth coordination), sensing and emotions (Fogel, 2009; Frank & La Barre, 2011). The neonate is thus born as a sensory being (Biel, 2014) and has the ability to experience some kind of rudimentary embodied sense of self while interacting with their own body and others (Stone, DeKoeyer-Laros, & Fogel, 2012), suggesting that a level of embodied self-awareness (ESA) is an intrinsic part of the infant's primitive sense of self (Gallese & Sinigaglia, 2010). Daniel Stern was one of the first developmental researchers to recognise that the development of self-awareness begins in the sensory system and continues to influence the developing self during early childhood (Stern, 1985). Recent developmental and neurological research based on "pictorial awareness, mirror self-experience, self-consciousness, interpersonal awareness and sharing in development" (Rochat, 2015, p. 142) provide evidence that supports a model of consciousness that identifies various distinct levels of self-awareness, that develop chronologically during the first five years of life and form part of healthy adult functioning (Rochat, 2010, 2003). With the exception of the non-conscious and unconscious states, Rochat suggests that a healthy individual will as part of everyday lived experiences and

situations oscillate between different kinds of wakeful states of awareness ranging from being "aware (feeling state), co-aware (feeling with others), conscious (objectified thoughts and feelings) to being co-conscious" (Rochat, 2015, p. 123). The last two wakeful states are commonly understood to be a form of "conceptual" self-awareness involving "mental activities such as reasoning, categorising and evaluating aspects about oneself" (Fogel, 2009, p. 11), whereas the first two states of self-awareness are predominantly experienced pre-reflectively and pre-symbolically, on the edge of consciousness before conceptualization and thus are embodied and a form of implicit knowing.

Similar to the notion of awareness, embodiment is understood in a variety of ways. In this study, the notion of embodiment draws from the notion of the lived body proposed by phenomenological and contemporary thinking. The lived body is perceived as a unified whole, comprised of both the physical body (German: Körper or body-as-object) and the intending, personal and predominantly pre-reflectively lived body (German: Leib or body-as-subject) (Finlay, 2011; Fuchs & Schlimme, 2009; Gallagher & Payne, 2015). Thus, embodiment refers to being both a state and a process (Totton, 2015). Embodiment as a state refers to the physical (corporal) body, that which is observable, tangible, devoid of any subjectivity and that may be used as a tool or possession by oneself and others, hence takes on the role of a body-as-object. The body-as-object is commonly understood as "embodiment without self-awareness" (Totton, 2015, p. 57). Embodiment viewed as an event or a process of becoming embodied (Totton, 2015), refers to the manner in which body-as-subject expresses, experiences and interacts in an embodied way (through the sensory system, e.g. interoceptive senses, use of implicit and pre-reflective knowing, embodied relational patterns, intersubjectivity, emotional states and thoughts) with others and the environment (Fuchs & Schlimme, 2009).

I postulate that, having the ability to experience, express and interact through one's body does not automatically imply a state of embodied self-awareness (ESA). ESA is "the ability to pay attention to oneself, to feel … and engage directly in one's senses, emotions and movements on-line, in the present moment, without mediating influence of judgemental thoughts … or naming that phenomenon" (Fogel, 2009, p. 1, 311). ESA involves both body schema and interoceptive senses, which provide moment-by-moment information regarding one's lived experiences of the body in relation to time, space and the situation. The body schema utilises the proprioceptive and vestibular senses which encompass the ability to sense the location of one's body parts in relation to self and others (Fogel, 2009; Frank, 2001), all aspects of movement, spatial awareness, coordination and changes of balance (gravity) (Biel, 2014), one's body size and shape, and an awareness of one's body boundary, thus enabling one to differentiate between self and others (Fogel, 2009).

Interoception is the ability to sense one's own internal body states such as the heart rate, respiration, hunger, fatigue, pulsation of organs such as fullness or emptiness, feeling sensations of pain, pleasure and agitation (Fogel, 2009), and it is "also constituted out of memory and thought" (Sletvold, 2015, p. 84). Evidence from neuroanatomy suggests that interoception forms the basis of embodied processes and self-awareness (Buldeo, 2015; Herbert & Pollatos, 2012). Research suggests that interoceptive senses form an integral part to one's survival, well-being, self-awareness, emotional states, self-regulating behaviours and cognitive functioning such as guiding decision-making (Biel, 2014; Fogel, 2009; Herbert & Pollatos, 2012; Verdejo-Gracia, Clark, & Dunn, 2012). The sensory system provides raw data (sensory information) that are predominantly experienced on an unaware or pre-verbal level moment-by-moment about "what is going on around us … who we are … how we experience our bodies and define our place in the world" (Biel, 2014, p. 21). Experiences of trauma, assault, threat to self and even living and working in disembodied technological society, e.g.

promoting the body-as-object model, may result in a disruption of the perception and appraisal of one's internal bodily sensations and thus negatively impact ESA. Absent or diminished ESA may manifest itself in denial defences, over-intellectualisation, self-soothing activities (Fogel, 2009), self-regulatory challenges, attachment issues, and chronic physical and psychological disorders (Fogel, 2011). Research conducted into the disturbance in interoceptive processes (not translating bodily signals into conscious-awareness) has found it to "primarily affect the pre-reflective embodied sense of self" (Fuchs & Schlimme, 2009, p. 571) and to play a role in psychopathology such as in depression, anxiety (Dunn, Stefanovitch, Evans, Oliver, Hawkins, & Dalgleish, 2010), alexithymia (Herbert et al., 2010 as cited in Herbert & Pollatos, 2012), and somatoform and eating disorders (Fuchs & Schlimme, 2009). Conversely, having access to and awareness of one's bodily felt sensations actualises the ability to modulate avoidance behaviours, maintain emotional and physical well-being (Herbert & Pollatos, 2012) and increase the choice of self-enhancing actions (Fogel, 2009). The practitioner's ability and willingness to empathise with or take on the client's perspective is considered a vital element in facilitating therapeutic change and thus any disruption in the therapist's ESA might negatively impact both the client and the therapist.

South African context

The majority of the South African (SA) population are of black African ancestry, yet receive counselling/psychological services based on the mainstream Western medical model that views the living body as body-as-object and is not inclusive of the numerous indigenous (emic) healing approaches which naturally embrace the embodied experiences of a person as part of the therapeutic context (Mpofu, Bakker, & Lopez Levers, 2011). SA therapist-practitioners must deal with high numbers of clients of whom many have been exposed to

trauma, abuse and sexual assault. The exchange of feelings and bodily sensations, and dealing with their clients' nonverbal and somatic expressions, may evoke body reactions in the therapist-practitioners in terms of somatic countertransference (Vulcan, 2009), even trigger fears and avoidance of their clients' and their own body (Miller, 2000), and thus may cause a disruption in their ESA. Except for studies conducted by Gubb (2010, 2013), research within the SA context of involving the therapist-practitioner's and even the client's lived body experiences within the therapeutic context has been sparse.

It is argued that therapist-practitioners' ESA as well as their willingness to be aware of and to access their bodily sensations and bodily knowledge may emerge as a valuable resource for potential therapeutic change within the SA context. As a first step to this end, the research question that guided this study was: What are South African social service therapist-practitioners' experiences of the lived body in terms of embodied self-awareness?

Method

Research Design

This study employed a qualitative interpretive descriptive design (Thorne, 2008), allowing the capture of multiple realities of the phenomenon being studied. The goal was to explore and describe the SA therapist-practitioner's lived experiences of the body within the therapeutic context and the meanings constructed or held about these experiences, with the aim of identifying "themes and patterns among subjective perspectives, while accounting for variations between individuals" (Hunt, 2009, p. 1285).

Participants and setting

Snowballing (Creswell, 2013) was employed for selecting registered therapist-practitioners in the SASSD field (4 psychologists, 7 social workers, 1 counsellor, 1 psychotherapist, total 13)

who counselled in private practice (n=9) or in government organisations (n=4) within the Western Cape area and Gauteng, South Africa. The participants consisted of 1 male and 12 females of whom 3 were of black African ancestry. Their work experience ranged from 5 to 30 years of experience. A summary is provided in Table 1.

<insert Table 1 here>

Procedure and data collection

Data were collected through multiple sources, comprising a personal document in the form of a naïve sketch and/or drawing (Tobin & Begley, 2004), an experiential body awareness activity and an in-depth one-on-one semi-structured interview as the primary source of data. In preparation for the interview, participants were requested to prepare a nonverbal personal document (text-based and/or sketch-based) answering the question: 'What is your relationship with your body?' Creating a document before entering the interview provided the participants an opportunity to construct a personal account of their subjective experience free from the influence of the researcher (McLeod, 2011). An awareness activity was conducted at the beginning of each interview and served as a means for eliciting each participant's unique personal language (Panhofer & Payne, 2011) about their nonverbal, felt kinaesthetic perceptions and sensory body experiences, with the hope of raising these into his/her consciousness. An interview schedule, known as a conversational guide (Rubin & Rubin, 2012) and consisting of primarily open-ended questions based on the main research question, provided a flexible open-oriented and responsive approach for probing the participants' lived experiences of the body within their therapeutic context. With the consent of the participants, all interviews were video-recorded and transcribed verbatim.

Ethical aspects

The ethical principles of autonomy (respect for persons), beneficence and justice guided the conduct of the researcher and formed part of ethical practice throughout the study. Verbal and written informed consent was obtained from all participants. Confidentiality and anonymity were ensured by encoding all names and undertaking that all data would be kept secure and private. Participants were reminded that participation was voluntary, that the research topic might elicit personal sensitive material and that they could withdraw from the study at any time.

Data analysis

Analysis of the data was guided by utilising the thematic content analysis method outlined by Clarke and Braun (2013). After transcription, the process of data analysis involved initial familiarisation, reading and repeatedly re-reading the data, followed by identification of the meaning units (Elliott & Timulak, 2005) or codes, categorising/clustering codes and ordering them into coherent themes, generation of final themes, and thematic description. Observation and reflexivity were maintained throughout the research. Due to space limitation, only themes relevant to this research question are presented in this paper. Direct quotations extracted from the data provide support for the themes.

Findings

From the data emerged three themes, the second consisting of three subthemes, that are related to the participants' experiences of ESA within the therapeutic context.

Theme 1: All therapist-practitioners experienced ESA during the therapeutic encounter, but in various forms and degrees

All participants reported that during therapeutic encounters they experienced body sensations and/or affective states, or were aware of sensory cues that were directly felt in the moment and seemed to arise within the body or originate from outside the body. These bodily felt sensations were predominantly evaluated as a negative sense of physical, emotional and sensory discomfort/unease. Four participants (1EP, 3CP, 5SW, 13RT) reported experiencing negative body sensations such as disgust when referring to odours emanating from their clients. 13RT interpreted her bodily felt sensation triggered by the client's odour as stemming from the client's issue: *"I get smells sometimes when I'm working in the energy field and we're looking at really old issues. It comes up like a damp, musty smell that I cannot relate to any earthly thing. It is not like it's something that you can open up like an old cupboard and there it is ... it's like something that I can't define but I know it's linked to old stuff. It's happened a few times*". Body sensations experienced by participants seemed to emerge from certain areas (locality) of the body, thus involving their body schema. These included the heart or chest area (2SW, 4CP, 5SW, 12CP), the shoulders and throat area and the stomach area (1EP, 2SW, 10SW), while three participants (1EP, 6RC, 7SW) reported the bodily manifestation of "goose-bumps" in reaction towards their clients. The negative types of bodily and emotional reactions in relation to their clients included headaches, disgust, nausea, anxiety, irritation, anger, fear, disinterest, boredom, yawning and pain. Some participants also had positive experiences. 8SW described her intuitive use of her body schema's implicit knowing of how-to-be-with a blind child client as "*... wonderful, I loved it a lot, he gave me loving energy again"*. Some participants (2SW, 6RC, 7SW, 9SW) described that maintaining some type of non-verbal kinesthetic attunement with the client was experienced as a positive felt body sensation: "*I'm very comfortable ... I actually sit on the floor ... we communicate via activity*" (6RC).

Participants' sensory awareness varied in intensity, ranging from statements such as "*I am disconnected"* (9SW), *"I don't think my body is very present … it's just a tool to facilitate what's going on"* (5SW), to the lived embodied experience of being "*almost like an animalistic or instinctual thing"* (1EP). 12CP, who had over 30 years of professional experience, reported experiencing bodily felt sensations which did not make cognitive sense at the time: *"I experience things but not necessarily may understand them and make the connection until later. So I think it was a bit of a realization that happened afterwards.*" By contrast, 2SW, 4CP, 7SW and 8SW believed that they were more aware of their emotional cues than of their bodily felt sensations during the therapeutic encounter. Comments included *"I have a sense of my own emotional state … I don't have conscious sense of what is happening with my body. I become most aware of my body in a therapeutic situation, if I experience discomfort … [it] is often a kind of a trigger for me"* (4CP). 7SW stated, *"therapy is more about my emotions … I'm not aware of my body … my body doesn't have any meaning … it's like this puppet of my mind and emotions".* Although these examples emphasize their emotional awareness, both participants declared that their emotions originated from their heart area, thus involving the body schema.

The data presented in this theme refer to everyday bodily felt lived experiences, suggesting that ESA is a common human phenomenon of being-in-the-world, including the therapeutic context. Similar findings have been noted in a study conducted by Booth, Trimble, and Egan (2010), who measured the somatic reactions of therapists to their clients. Existing research however focuses mainly on the client's body and body phenomena, virtually ignoring the therapist-practitioner's lived experiences of the body, which are then often relegated to being largely epi-phenomenal (Cromby, 2007; Soth, 2006) or considered unimportant epistemologically.

Theme 2: Therapist-practitioners experienced ESA as a form of implicit knowing during the therapeutic encounter

Experiences of implicit knowing involved the participants' interoceptive, proprioceptive and affective cues, suggesting that they experienced various dimensions of ESA. All participants reported experiencing diverse types of implicit knowing during the therapeutic process, the most frequent being intuitive or spiritual knowing, a sense of warning or danger, and a sense of the body-schema-in-relation. Three subthemes were therefore distinguished:

2.1 ESA was experienced as a sense of intuitive and/or spiritual knowing

Even those participants who stated that they felt disconnected from their body or those who sometimes said they were not aware of their body sensations, experienced some form of intuitive and spiritual knowing about the therapeutic field (client, context and/or themselves) that seemed not to originate from a rational or cognitive source, or to be available from the verbal domain. Phrases such as *intuition, gut feeling, instinct, sense of being in-tune with the other* or *a sensation of discomfort* were used to describe sensations of intuitive or non-logical knowing that emerged spontaneously and unexpectedly. 2SW explained, *"It's more like a feeling you get about this person … it's more like a sense … Literally the gut feeling".* 6RC described her sense of embodied knowing as *"a knowing, it's just that instinct, 'Okay, here is this child, this is how they are'".* 12CP viewed his sensory experiences as a potential resource in the therapeutic encounter: "*Intuition is an expression of possibility in a sense, of what's felt, but felt as possibility and just kind of ideally checked out in terms of reality."*

Another type of intuitive knowing, described by four participants (2SW, 5SW, 6RC, 9SW), seemed to originate from a spiritual domain or higher consciousness. 6RC and 9SW described their intuitive knowing as a form of embodied spirituality. 9SW, of African descent, stated, *"My reality is, I believe that we have ancestors. I believe that sometimes when they communicate it's in my body, I feel it … other people say it's nonsense because I*

don't know how to explain it, but it comes such an intense feeling … it's a big sense of knowing that is persistent and that I'm not able to just ignore." In contrast, 5SW reported that her implicit knowing or higher wisdom originated from her *"spiritual senses"* that seemed not to be connected to her lived body, despite indicating that she felt it in her heart area: "*I leave the body behind. So it's, I would say, almost only voice. It's internally not outwardly, it's … spiritual senses, not physical senses, or it's not hearing, it's internal, it's perceiving … Smell comes into [it] a lot for me on a spiritual level … The Holy Spirit is normally more to do with wisdom or guidance or warning."*

The data presented in this sub-theme suggest that participants' ESA experiences of intuitive and spiritual knowing about something within the therapeutic field form part of the everyday lived therapeutic interactions. Intuition is variously understood as "a mysterious ability to see through clients" (Witteman, Spaanjaars, & Aarts, 2012, p.19), "premonitions" (Pretz, Brookings, Carlson, Keiter Humbert, Roy, Jones, & Memmert, 2014, p. 454), "knowledge from some higher source," (Welling, 2005, p. 23), and even as "an automatic response based on knowledge acquired through significant, explicit learning from textbooks and in clinical practice" (Witteman et al., 2012, p. 19). Siegel (2010, p. 29) suggests a neuro-scientific perspective, viewing intuition as one of nine prefrontal cortex brain functions, that provides "access to the wisdom of the body … which receives information from throughout the interior of the body, including the viscera … and uses this input to give us a 'heartfelt sense' of what to do or a 'gut feeling' about the right choice", thus highlighting its affective and "somatic qualities" (Arnd-Caddigan, 2016, p. 14). Despite the existing theoretical differences, intuition is commonly considered to be a process that is spontaneous, unexpected and an unpredictable lived experience (Lawrence, 2012; Welling, 2005), occurring on the edge of consciousness (non-conscious) (see Arnd-Caddigan, 2016), yielding raw data (pre-verbal information) 'about something', usually the client (Witteman et al., 2012). In my

opinion, it includes intuitive knowing about the context and the therapist-practitioner him/herself, thus the whole therapeutic field.

2.2 ESA was experienced as a sense of warning

Two participants (1EP, 5SW) described experiencing an intuitive sense of warning emanating from the therapeutic field (client and context), which required immediate judgment and action. One situation occurred in a mental hospital, with a patient diagnosed with schizophrenia: *"I had instinctively picked up her sense of being cornered like an animal. There was no rationality there ... the feeling of like an animalistic like when a lion or something like corners you. That's the feeling I had. I was ready to blinking jump out the window! So I could not* [use] *logic, I had to make her feel in control. I didn't know this logically at the time what I was doing. But afterwards I thought what helped me out of this situation ...* [was] *because I allowed myself to be submissive*" (1EP). 5SW explained that her implicit knowing of evilness and danger emanating from certain clients arose from her *"spiritual senses"* [embodied] "*in my chest area … I've dealt with children that I really truly felt, 'Wow, this feels evil',* [with] *boys, especially who have been abused previously ... I think my warning signals are up.*" Further, 5SW stated that she was able to sense danger also while working in community contexts that included traditional health practitioners: "*My spirit is bouncing ... my heart will go a bit faster and my hands might get a bit sweaty."* Despite experiencing ESA suggesting real or imagined danger, she drew from her professional training to manage her embodied sensations: "*Then the professional side has to come in, and then I have to tell myself 'Calm down!'".* 6RC similarly experienced *"... the sensation of creepiness. This was a very disturbed boy and bodily I felt creepy, but cognitively I was watching and fascinated by what he was doing. Uhhh! I'm getting goose-bumps now."*

ESA experienced as a sense of warning can be viewed as one of many types of intuitive experiences (Welling, 2005), which, according to Stern (2004), may yield implicit information (non-conscious data) about something. It can become important in situations that involve a high degree of uncertainty. Trauma and psychopathologies such as schizophrenia affect the person's "basic sense of self, [causing] a disruption of implicit bodily functioning and a disconnection from intercorporality with others" (Fuchs & Schlimme, 2009, p. 571), resulting in a client's inability to modulate behaviour. The therapist-practitioner's use of immediate and spontaneous intuitive knowing of what is happening in the present moment, a term coined by Stern (2004) as a temporal event lasting four or less seconds, is then beneficial for making quick assessments and decisions (Arnd-Caddigan, 2016), and thus may be a useful therapeutic resource in managing the moment-by-moment process of psychotherapy.

2.3 ESA was experienced as a sense of body-schema-in-relation

Self-awareness of one's body schema provides the implicit sense of "movement and coordination between different parts of the body and between the body and environment" (Fogel, 2009, p. 11), a "schema-in-relation, with linkages and boundaries" (Fogel, 2009, p. 72). Some participants reported experiencing an implicit sense of knowing how to be/relate with others through their body schema (involving the body boundary, intuitive movements and gestures).

Awareness of changes in the body boundary (expansion or contraction) during therapeutic interaction was noticed by participants 2SW, 4CP and 5SW. 2SW described ESA of her change in body boundary while empathizing with her client as, "*I lose myself and go up in them … the price … is that I don't shut off in the evening",* suggesting a temporary loss and/or high level of permeability in the body boundary. She also stated, "*I withdraw … I kind*

of give them [clients] *too much space … because I take myself out*", suggesting a contracted boundary. During the interview, 4CP became aware that an object, her chair, had become an extension of her body schema and without it, she was not able to function as a therapist: *"I'm attached to my chair, so I have to sit in my chair … I almost cannot do therapy from sitting in all of the other chairs … If I'm not in the chair, I don't feel like me as a therapist … the chair gives me a certain perspective. It makes me imagine that I can think in a different way and that I can be in a different way. And that I can see in a different way … When I'm not in the chair, then I think, 'Ooo, how do I do that again?'"*

Some participants (1EP, 6RC, 8SW) reported experiencing a sense of implicit knowing about the client's and their own body schema needs, allowing the spontaneous use of movements and gestures, and thus facilitating the process of co-regulation. Co-regulation means to "dynamically coordinate actions … by sensing the boundaries between self and other" (Fogel, 2009, p. 15). 1EP stated, *"My instinct, using the right posture, the right things at the right time … comes from the knowledge of my body and it's not taught …* [I] *draw on my experiences, my early childhood."* 8SW reported, *"I was super-aware of my interaction with him* [a blind child-client] … [it also made me] *aware of my awareness of my body because I use*[d] *my body to help him make contact with the environment and with the play room.*" By contrast, 10SW described how her working environment (an SA NGO) restricted her sense of movement and use of space, impacting the ability to co-regulate with the client: *"It's a setting … you can't change the space … the situation won't allow me to show the client that 'I'm with you'* [referring to her physical presence]."

The data suggest that the therapist-practitioner's body schema is a common phenomenon, part of the therapeutic encounter and relating (often at a non-conscious or pre-reflective level). The implicit knowing of how to be/relate moment-by-moment with others and the environment (Schore, 2011) involves not only the body schema, but also includes

one's interoceptive needs (e.g. sense of personal space), and the embodied awareness of the intersubjective therapeutic field, that is the "shared set of interoceptive sensations and emotions" (Fogel, 2009, p. 75). Together, the sensory system can be viewed as providing intuitive implicit and pre-reflective knowing that affects the body boundary, coordination and movement (kinesics), gestures, postures and use of space. Without ESA of the body schema, embodied social (and therapeutic) interaction and coordination can be challenging, and this may be of clinical interest.

Theme 3: Therapist-practitioners preferred engaging with their conceptual self-awareness

With the exception of one participant (13RT), all preferred to engage with their conceptual self-awareness (CSA) as a means to manage their felt body sensations during the therapeutic encounter. In contrast to ESA, CSA is "the ability to reflect on, interpret, judge and make a decision" (Fogel, 2009, p. 95) about something, which would include felt body sensations. Participants reported the tendency to deny, suppress or control their felt body sensations. 2SW explained, *"I withdraw, because I, like, need time to think about this … I take myself out of* [my bodily awareness]*".* 5SW chose to suppress her feelings: "*I dismiss them … forcing my mind to focus on the work.*", and 7SW claimed, *"I don't get overwhelmed, because I know I can't … it's not allowed … it can't happen … you have to control that* [felt body experiences]."

Some believed that the use of CSA was associated with being a professional therapist-practitioner. For example, even though 1EP viewed herself as being sensory aware, she tended to shift into the cognitive realm: "*For me, my stomach is always my barometer parameter, my second brain … It's a big source of information for me … that churning … then I think to myself, 'Hang on …' then I will use my rational side to try and work out what's going on… I think the professionalism then speaks to the body. The body reacts and*

does its wild thing initially, but the brain then tempers and says, 'Hang on'; ... my instinct was to biff this guy." 5SW said, *"I can feel the tears swelling up inside ... I try and hide it ... then the professional side has to come in, and then I have to tell myself, 'Put that part of you aside' ... it's more my training and just the persona of a social worker that I've taken on."*

A perception was voiced that the practice and influence of mainstream Western psychology in the SA context was a major reason for promoting therapist-practitioners' use of the cognitive domain (CSA) and denigrating the bodily felt experiences. 3CP stated, *"I think psychology is a head thing. Our training, that's how it developed, very intellectual ... as a therapist you are only using your head"*. Similarly, 4CP realized that *"the boundaries of psychotherapy ... that's kind of from a mind space"* had influenced the manner in which she approached the lived body (of the client and herself) within the therapeutic context*: "I do cut off my own sexuality, it's like I split that off. It's not here. It's not in this room, you know. I possibly engage with men in a very de-sexualized way ... very restrained in terms of my movements ... I wouldn't use my hands, like I'm doing now."* 12CP argued that "… *most therapy deals with the mind and the same for me, the mind is a concept, you know, it's got Cartesian dualism. I think most psychology is based on, and therapy is based on, a dualism that doesn't reflect to reality. So, to really deal with the person as a holistic being, you've got to work with spirit and you got to work with body. So if you're not dealing with body you're actually doing half a job, you're actually reinforcing that dualism and therefore people sense alienation. I think sometimes in psychology we're almost like feeding the neurosis by disembodying things."*

The data strongly suggest that even participants that experienced a sense of implicit and pre-reflective knowing about something in the therapeutic field, preferred the use of CSA. Compared to the implicit and intuitive knowing (pre-verbal and non-conceptual information), the information processed through the mind (CSA) was perceived to be rational and accurate,

therefore more professional. Participants indicated that their training and the professional associations they belong to are predominantly based on clinical models, thus tend to exclude/minimize or at the least relegate the subjective experience of the lived body (ESA) to epi-phenomena, thus encouraging the need for participants to suppress, deny and rationalize the experiences of ESA. As indicated by 4CP, "*If you have a sign on your door that says clinical psychologist … I don't say I'm a body therapist or a healer … the boundary of that space is contained … it's like linked to the professional boundaries … it's hugely limiting in many ways to sit in your chair to talk to somebody who is crying*."

Discussion and implications

Counselling/psychological services in SA are predominantly based on the mainstream Western medical aetiology, promoting an approach also in science and research that is based on dualisms separating mind-from-body, therapist-from-client, and cognitive processes from the physical (Finlay, 2011), directly influencing how therapy is perceived in society (Levin & Bar-Yoseph Levine, 2012), how it is practiced (Eiden, 2009) and how it is taught (Johnson, 1999). Consequently, most of SA therapist-practitioners' training, skills and approach towards their clients reflect Euro-American values and norms (Mpofu et al., 2011), a framework that excludes or fails to address therapist-practitioners' corporality and bodily felt sensations (ESA). Within this context, body phenomena are predominantly evaluated as irrational, subordinate to cognitive processes which cannot be measured objectively (Cromby, 2007) and hence non-scientific (Kolstad, 2010), and are therefore disregarded as a valuable resource.

Regardless of therapeutic orientation, the findings in this study however suggest that SA therapist-practitioners' experiences of bodily felt sensations (ESA) are a common phenomenon in therapy. Participants described their bodily felt sensations as experiencing a

sense of intuitive or implicit knowing 'about something', mainly the client, but also about themselves and the environment. The implicit domain consists of a wide range of types of implicit knowing (knowledge) encompassing physical and sensory-motor procedural knowledge (Stern, 2004), also known as regulatory implicit memory (Fuchs, 2012), "affect patterns, expectations, and even patterns of thinking" (Stern, 2004, p. 242), "nonverbal, non-symbolic, un-narrated and non-conscious" knowing (Hartley, 2004, p. 221), and "inter-subjective patterns of interactions" (Fuchs, 2012, p. 14), all forming part of the individual's embodied history (Frank & La Barre, 2011). Implicit knowing is not to be confused with repressed material, but is self-awareness on an embodied pre-reflective level (Stern, 2004). ESA is the ability to sense and access the implicit information (knowing) which is provided moment-by-moment through the sensory neural system in the form of visceral responses and other bodily felt senses, informing us who we are, how we experience our own embodiment (Biel, 2014), and providing tacit-know-how and operative intentionality, as well as experiential understanding of being-in-the-world (Summa, Koch, Fuchs, & Müller, 2012), which includes relational knowing of the intersubjective therapeutic field.

The therapist-practitioner's implicit knowing produced by embodied processes such as intuition and including the embodied history, e.g. relational-patterns, may be elicited during the therapeutic interaction, and may either interfere with or facilitate the therapeutic process. The ability to regulate the implicit and explicit dynamic aspects of the immediate relational (intersubjective) field is an essential skill of every therapist-practitioner in producing positive therapeutic outcome and change (Brownell, 2012). Research data of infant observation (Biel, 2014; Rochat, 2015) and the mirror neuron system provide neurological evidence that the individual's ability to "share experience of actions and emotions" (Rizzolatti & Sinigaglia, 2008, p. 191) provides the basis of immediate embodied (implicit) understanding of the other. Other important aspects of being a psychotherapist that involve the proprioceptive and

interoceptive senses and that largely remain in the nonverbal and implicit domain, are the ability to connect to another through sustaining on-going inter/intra-bodily resonance (Froese & Fuchs, 2012), intersubjectivity, kinesthetic and affective attunement (Stern, 2004), as well as embodied reflective listening (Gendlin, 1996), presence and empathy (Ernst, Northoff, Böker, Seifritz, & Grimm, 2013), that are all integral elements of implicit relational knowing (Fuchs, 2012; Stern, 2004). Thus, having access to and self-awareness of the implicit domain may be of clinical interest, as every encounter, including therapeutic encounter, consists of more than 90% of implicit knowledge (Hartley, 2004).

Jeffrey and Stone Fish (2011) believe that all therapist-practitioners, even if they are not aware of it [and, I would add, those that consciously suppress or deny experiences of ESA], make use of implicit knowing, such as intuition, during some point of the therapeutic process. In this study, some participants reported that the intuitive process of sensing danger generated implicit knowing and thus enabled quick and deliberate decisions and actions to regulate the immediate dynamics in the therapeutic field, thus highlighting that implicit knowing can be beneficial (Arnd-Caddigan, 2016) and crucial for making judgments and decisions in the present therapeutic moment (Glöckner & Witteman, 2010). Similarly, some participants reported utilising the implicit knowing yielded by the body schema, which enabled spontaneous co-regulation (through movements and gestures), change of body boundary (expansion and contraction) in relation to their client's and their own spatial needs, and thus being able to regulate moment-by-moment the intersubjective field without the need for verbal expression and the use of CSA. ESA is linked to "awareness of others" (Fogel, 2009, p. 15), and therefore the ability to distinguish between the lived body experiences of oneself and another becomes of vital importance within a therapeutic context (Sletvold, 2015), especially in the SA context where therapist-practitioners have to deal with high numbers of clients, many of whom have been exposed to traumatic events. Thus, ignoring implicit

knowing generated from the body schema may result in diminished ability to regulate body boundaries between parties (Fogel, 2009) and may evoke bodily reaction such as cross-transferences (Totton, 2015).

The study highlighted that, although all participants reported experiences of bodily felt sensations at some point in the therapeutic process, the majority tended to deny, suppress or control their sensory cues or rationalize them as being non-rational and unprofessional. Even though efforts exist to explain the lived body phenomena in humanistic, phenomenological, relational and body oriented frameworks, research demonstrating the effects of ESA in terms of nonverbal behaviour on the therapeutic relationship and outcome is "sparse" (Ramseyer & Tschacher, 2011, p. 284). Limited or diminished ESA may have clinical implications. For example, discounting implicit knowing yielded from ESA may result in therapist-practitioners implicitly and unknowingly enacting on an embodied level (Welling, 2005) the unspoken dynamics of the therapeutic relationship (Totton, 2015), thus they may attempt to regulate (deny or supress non-verbal co-constructed material between the therapist-practitioner and client), as well as unconsciously determine the verbal therapeutic agenda (Stern, 2004). Discounting implicit knowing may be a marked bias of the therapist-practitioner towards the narrative agenda preferring the verbal therapy (explicit domain) at the expense of the implicit domain (implicit knowing).

CSA (explicit knowing) and ESA (implicit knowing) yield different types of data that affect knowledge construction and meaning-making in different ways (Welling, 2005), also assessments and decisions (Arnd-Caddigan, 2016), and provide different modes of communicating and relating within the therapeutic context. Research suggests that "Conceptual self-awareness informed by embodied self-awareness is the best source for decision making" (Fogel, 2009, p. 97, my emphasis), therefore the ability to extract/mine the rich meaning contained in the implicit domain (Preston, 2008) becomes an important

therapeutic skill. The therapist-practitioner's openness and ability to grasp meaning from the lived body experiences involves the utilization of the implicit domain (Todres, 2007), which may result in words, memory, images or new ideas providing data for understanding (verbal accounts) of one's lived body experiences (Finlay, 2006; Stern, 2004) previously not available. Not utilizing the different types of implicit knowing such as intuition would be a waste and loss of a potentially valuable additional resource for SA therapist-practitioners.

Limitations of the study

Although the study yielded rich descriptive data of therapist-practitioners' experiences of ESA, the sample size was smaller than planned, due to some participants' withdrawal before the interview. The sensitive nature of the research topic seemed to have triggered some resistance to participate. Due to the qualitative nature of the study, findings cannot be generalized. Findings may also have been different if the experiences of those practitioners who had been approached but had been unwilling to engage with the field of study, could have been included.

Conclusion

Although some participants attributed the influence of Western paradigm as a major reason for preferring the use of conceptual self-awareness above embodied self-awareness, other findings in the study suggest that the therapist-practitioners' personal disposition of openness towards and willingness to engage with their own lived body experiences, as well as their professional attitude towards the phenomenon, may be important factors in determining the future use and value of embodied self-awareness as a resource, tool and skill within the SA therapeutic context. Sensitivity towards and inclusion of the SA context become relevant, as different types of ESA, such as *umbilini* (intuition) are common practice and a

psychotherapeutic skill and tool amongst *amagqirha* (Traditional Health Practitioners) (Mlisa & Nel, 2013).

Since birth, embodied self-awareness is part of every person's core sense of self. It can play a critical part in paving the way to move beyond epistemologies and theory-driven activities that favour conceptual self-awareness. Embracing the implicit domain, thus including embodied self-awareness as a resource, allows for the inclusion of other approaches such as African Psychology, thus enabling the re-embodiment of therapist-practitioners and the move towards an integrative and holistic framework affecting the manner in which counselling/psychology is taught and practiced in the South African context.

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Table 1: Participants

Participant*	Gender	Race	Professional registration	Years of experience
1EP	female	white	Educational Psychologist	11-15
2SW	female	white	Social Worker	11-15
3CP	female	white	Clinical Psychologist	21-25
4CP	female	white	Clinical Psychologist	11-15
5SW	female	white	Social Worker	5
6RC	female	white	Registered Counsellor	6-10
7SW	female	white	Social Worker	11-15
8SW	female	white	Social Worker	6-10
9SW	female	black	Social Worker	11-15
10SW	female	black	Social Worker	16-20
11SW	female	black	Social Worker	5
12CP	male	white	Clinical Psychologist	26-30
13RT	female	white	Registered Psychotherapist	11-15

* EP = Educational Psychologist; SW = Social Worker; CP = Clinical Psychologist; RC = -- Registered Counsellor; RT = Registered Psychotherapist

CHAPTER 4: Article 2

4.1 Guidelines for authors: Health SA Gesondheid

GUIDE FOR AUTHORS

.

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be published.

4.2 Article 2: Exploring the therapist's use of embodied self-awareness as a means to facilitate the therapeutic relationship

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A B S T R A C T

A qualitative interpretive descriptive research design was employed to explore how South African therapist-practitioners' experiences of their embodied self-awareness as a form of implicit knowing and as a relational process facilitated the therapeutic relationship and the interactions between themselves and their clients. Thirteen registered therapist-practitioners in private practice and government organisations in the Western Cape and Gauteng were selected by means of snowball sampling. Data were collected by means of naïve sketches and/or drawings, experiential body awareness activities, and in-depth one-on-one semi-structured interviews. Findings from the thematic analysis of the data indicated that the therapists' experiences of embodied self-awareness provided implicit relational knowing to regulate counter-transference interactions, and provided additional implicit knowing that facilitated the clients' and their own spatial and movement needs. Therapists tended to engage in relational moves such as body movements, gestures and touch that served as a regulative function during the interactions. The results suggest that therapists' experiences of embodied self-awareness as a form of implicit knowing and a relational process factor seem to be a relatively common phenomenon during therapeutic interactions. Thus, including implicit relational knowing and an embodied relational process may be a crucial factor in developing good therapeutic relationships and changing current practices.

Keywords: embodied self-awareness; counter-transference; implicit relational knowing; therapeutic relationship; lived body

1. Introduction and rationale

Regardless of therapeutic orientation, it is generally accepted that the therapeutic relationship is considered pivotal in producing a positive therapeutic outcome and change (Brownell, 2012; Flückiger, Del Re, Wampold, Symonds & Horvath, 2012; Gelso, 2014; Horvath, Del Re, Flückiger & Symonds, 2011). Although the meaning of the therapeutic relationship has been conceptualized differently across psychotherapeutic approaches, the relationship is commonly understood to be "the feelings and attitudes that therapist and client have towards another, and the manner in which these are expressed" (Norcross & Lambert, 2011, p. 5). This article draws on this definition, as it acknowledges the relational and reciprocal embodied interaction between the therapist and the client, and the phrase "*the manner in which these are expressed"* opens the discussion for including embodied self-awareness (ESA) as a form of implicit knowing and a relational process factor into the therapeutic relationship.

The relational and humanist approaches have advocated the reciprocal and "intersubjective nature of practice and the therapeutic relationship" (Tosone, 2013, p. 252) which has shifted the focus from intrapsychic phenomena (one-person psychology) towards interpersonal and intersubjective phenomena, thus acknowledging the active interaction between the therapist and client (Stern, 2004:77). The view is held that, in a naturalistic setting such as the therapeutic context, interacting occurs between the therapist and client as lived bodies. This view is based on an ontology that assumes that every individual "not only has a body [body as object] but is a body [body as subject] and expresses him/herself through the body [body as process]" (Frie, 2007, p. 59).

Embodiment refers to "the personal sense of the lived body as a unified whole" (Potgieter & Bloem, forthcoming). The lived body is understood to comprise the physical body (body-as-object), that which is observable, tangible, devoid of any subjectivity and may be used as a tool or possession, as well as the intending, personal and predominantly pre-reflectively lived body (body-as-subject) (Finlay, 2011; Gallagher & Payne, 2015). As a process, embodiment refers to the way the body-as-subject expresses, experiences and interacts through the sensory system (e.g. use of implicit and pre-reflective knowing and affective states) with others and the environment (Fuchs & Schlimme, 2009; Totton, 2015).

Research into body memory (such as the adaptive oscillators) (Fuchs, 2012) and the mirror neuron system (Gallese, 2001; Rizzolatti & Sinigaglia, 2008) has provided neurological evidence of embodied mechanisms that enable individuals to "share experience of actions and

emotions" (Rizzolatti & Sinigaglia, 2008, p. 191), and to "participate in the intentional states of the other" (Boston Change Process Study Group, 2010, p. 148). These neurological systems are embodied and implicit ways of "feeling/sharing with/understanding them" (BCPSG, 2010, p. 171), and thus enable individuals to empathise and establish "intersubjective contact" (Stern, 2004, p. 79) with another, thereby co-creating an intersubjective therapeutic field. Experiences arising from the intersubjective therapeutic field (Lobb, 2008:113) may consist of a series of co-created present-moments, which are small units of implicit relational knowing (BCPSG, 2010) about the current nature of the relationship, which are "shared and validated between [the therapist and the client] implicitly and explicitly" (Stern, 2004:243).

The co-created present-moments are the result of the process of interacting, and are known as relational moves (BCPSG, 2010). Relational moves serve as an interpersonal self-regulative function in that they intend "to alter or adjust the relationship" (Stern, 2004, p. 243), and thus may interfere with or facilitate the therapeutic process. Relational moves are short (thus are viewed as present-moments) and are any intentional non-conscious (implicit) or conscious (explicit) communicative verbal or nonverbal behaviours or actions (also gestures, including silence) directed towards another (BCPSG, 2010). Although both participants' nonverbal and verbal behaviours influence the quality of the therapeutic relationship, Gelso and Silberberg (2016) have found that the therapist's nonverbal and embodied actions may have a greater impact on the relationship and the clients. For instance, therapists who are unaware of their nonverbal actions and expressions or whose nonverbal behaviour is incongruent with their verbal communication, may unknowingly communicate inconsistency to the client and thereby negatively impact the therapeutic relationship and outcome (Gelso, 2014; Gelso & Silberberg, 2016). Being aware of and understanding what happens in the intersubjective field may be of clinical interest.

Accessing implicit relational knowing and drawing these into the explicit and conceptual domain require the therapist to have an awareness of his/her bodily felt sensations, also known as embodied self-awareness (Fogel, 2009). Embodied self-awareness (ESA) is a process aspect of the lived body (Potgieter & Bloem, forthcoming) which is manifested moment-by-moment through the sensory neural system in the form of visceral responses (interoceptive senses) and other bodily felt senses that emanate from the proprioceptive and vestibular senses or body schema (Fogel, 2009). ESA provides tacit know-how and operative intentionality as well as experiential understanding of being-in-the-world (Summa, Koch, Fuchs & Müller, 2012), which includes relational knowing of the intersubjective therapeutic

field (Potgieter & Bloem, forthcoming). Thus, ESA provides an important mechanism to form an embodied relationship which, according to Totton (2015, p. xvii), "is a necessary condition for working as a psychotherapist".

Research evidence in many meta-studies (Del Re, Flückiger, Horvath, Symonds & Wampold, 2012; Flückiger et al., 2012; Horvath et al., 2011; Luedke, Peluso, Diaz, Freund & Baker, 2017) suggests that the therapeutic relationship is unarguably a key factor in contributing to a positive therapeutic outcome and a significant predictor thereof. Despite common findings among these studies, Del Re et al. (2012, p. 642) point out that there is a "significant variability in this overall alliance-outcome relationship". Norcross and Lambert (2014) ascribe the differences to the use of the numerous diverse measurement factors. Factors that have been used to assess and are known to impact the therapeutic relationship and its outcome, include amongst others elements such as goal and task setting, especially when working with men (Bedi & Richards, 2011); duration of the relationship; impact of client characteristics and disorders; rating perspectives (client, therapist); type and context of treatment (Del Re et al., 2012; Horvath et al., 2011); the early development of a good working alliance (Flückiger et al., 2012); degree of mutual engagement and collaboration (Horvath et al., 2011); and therapists' willingness to adapt their relational style according to the client's unique characteristics (such as culture, coping style and religion) (Norcross & Wampold, 2011), as well as positive affective therapist-client exchanges (Luedke et al., 2017).

Recent studies (Del Re et al., 2012; Roos & Werbart, 2013) indicate that therapist's factors (such as actions and characteristics) may have a bigger impact on the effectiveness of the therapeutic relationship and outcome than client's factors. A meta-study conducted by Roos and Werbart (2013) highlights that the "scarcity of studies [that include] therapist, relationship and process factors", need to be further investigated to understand the impact that therapists and relational factors have on the therapeutic relationship and outcome.

Essential skills needed to support the therapeutic interaction and to develop a quality therapeutic relationship include skills of empathy, presence, warmth, resonance, attunement and inter-subjectivity, ESA and management of (counter)transferences (Luedke et al., 2017). These skills are all relational processes and consist of bodily based phenomena which remain largely in the nonverbal domain and are integral elements of implicit relational knowing (Fogel, 2009; Stern, 2004:78). Not being aware of bodily phenomena, especially implicit relational knowing, might hinder the management/regulation of the present-moments emerging from the implicit intersubjective field which may cause increased levels of anxiety

and fear within the therapist (Stern, 2004:224), and consequently negatively affect the client and the therapeutic outcome. We argue that therapists' ESA as well as their willingness to be aware of and to access their bodily (implicit) knowledge about the therapeutic relationship may emerge as a valuable practice in developing and maintaining a quality therapeutic relationship.

2. Purpose of the study

The study sought to explore and describe the South African therapist's lived experiences of the body within the therapeutic context and the meanings constructed or held about these experiences. This article was guided by the following question: How does the therapist's ESA (in terms of implicit relational knowing) facilitate the relationship between the therapist (her/himself) and the client?

3. Research methodology

3.1 *Research design*

The study employed a qualitative interpretive descriptive design (Thorne, 2008), allowing the capture of multiple realities of the phenomenon being studied. The goal was to explore and describe the SA therapist's lived experiences of the body within the therapeutic context and the meanings constructed or held about these experiences, with the aim of identifying "themes and patterns among subjective perspectives, while accounting for variations between individuals" (Hunt, 2009, p. 1285).

3.2 *Participants and setting*

Snowball sampling was employed for selecting 13 registered social service therapists from the Western Cape area and Gauteng Province of South Africa. The participants consisted of four psychologists, seven social workers, one counsellor and one psychotherapist, including one male and three black Africans. Nine were in private practice and four in government service. Their work experience ranged from five to 30 years of experience. A summary is provided in Table 1.

Table 1 – Participants

Participant*	Gender	Race	Professional registration	Years of experience
1EP	female	white	Educational Psychologist	11-15
2SW	female	white	Social Worker	11-15
3CP	female	white	Clinical Psychologist	21-25
4CP	female	white	Clinical Psychologist	11-15
5SW	female	white	Social Worker	5
6RC	female	white	Registered Counsellor	6-10
7SW	female	white	Social Worker	11-15
8SW	female	white	Social Worker	6-10
9SW	female	black	Social Worker	11-15
10SW	female	black	Social Worker	16-20
11SW	female	black	Social Worker	5
12CP	male	white	Clinical Psychologist	26-30
13RT	female	white	Registered Psychotherapist	11-15

* EP = Educational Psychologist; SW = Social Worker; CP = Clinical Psychologist; RC = --Registered Counsellor; RT = Registered Psychotherapist

3.3 *Data collection*

Data were collected through multiple sources: naïve sketches and/or drawings (Tobin & Begley, 2004), an experiential body awareness activity and an in-depth one-on-one semi-structured interview. In the interview, we utilized a conversational guide interview schedule (Rubin & Rubin, 2012) for probing the participants' lived experiences of the body within their therapeutic context. All interviews were video-recorded and transcribed verbatim.

3.4 *Data analysis*

The data consisted of the transcriptions, field notes and the participants' personal documents. Data analysis was guided by using thematic content analysis (Clarke & Braun, 2013) as follows: data transcription, initial data familiarisation from reading and repeatedly re-reading, identification of the meaning units, categorising/clustering codes and ordering them into coherent themes. The findings are reported using direct quotations extracted from the data to provide support for the themes.

3.5 *Trustworthiness*

Lincoln and Guba's (1985) criteria of credibility, transferability, dependability and confirmability and a fifth criterion of authenticity (Guba & Lincoln, 2005) were used to enhance the trustworthiness in this study. Credibility was achieved through a pilot interview and prolonged engagement (90-120 minutes) which resulted in in-depth and rich data. Transferability was attained through providing thick descriptions supported by the direct quotations from the participants.

Dependability was attained through the dense descriptions of the research design and methods, as well as the sample. Confirmability was achieved through use of multiple data sources including field notes, an audit trail, application of reflexivity, as well as a literature control. The criterion of authenticity was attained through the researcher rephrasing and clarifying her understanding of the data with the participants during the interview, participant reflexivity, and researcher follow-up contact.

3.6 *Ethical considerations*

Permission for the study was granted by the North-West University's ethics committee (NWU-00060-12-A). Verbal and written informed consent was obtained from all participants. Participants were reminded that participation was voluntary, that the research topic might elicit personal and sensitive material and that they could withdraw from the study at any time. The ethical principles of autonomy (respect for persons), beneficence and justice guided the conduct of the researcher and formed part of the ethical practice throughout the study. Confidentiality and anonymity were ensured by encoding all names and undertaking that all data would be kept secure and private.

4. Findings

Two main themes were identified. We report on these below.

Theme 1: ESA was experienced as a means for regulating cross-transferences interactions

Most therapists reported experiencing bodily felt sensations and body reactions directed towards those of their clients, which seemed to arise spontaneously during their interactions. The reactions described by the therapists included material of their own unresolved conflicts and vulnerabilities, thus suggesting a form of embodied counter-transference. One therapist

described how she regulated her counter-transference issue (regarding feet) through her embodiment relational moves (or her embodiment) as: "*When I am giving therapy I am aware of where the client's feet are in relation to me in my space … but I don't like the feet being stuck in my face … my rational side says you are being unreasonable now … then I'll simply move back* [creating physical distance]" (1EP). In addition, the same therapist's counter-transference issues of feet were a symbol of her disrespect and power issues: "*especially with male clients … there's a kind of need for me to assert my boundary and my space … I find that* [with] *lady clients I don't really have that problem. But male clients … tend to be dominating in terms of their space and if they extend their legs out towards me and I happen to be close to their foot area, I have the need to move away. I feel that's an intrusion of my space"* (1EP). Similarly, 3CP's awareness of her weight related issues influenced the way she engaged with certain clients: *"I'm very uncomfortable when I notice I pick up weight and I know that people watch their therapist. Most of them don't say anything so then I can act as if it's ok but with this specific guy where I've got transference issues anyway. Ok, I'm just terrified of him coming again … most dysfunctions you can hide in therapy … you can't hide the body, even the therapist's body … then I feel I can't cope*" (3CP).

Four therapists reported regulating experiences of sexual-transferences relationships by intuitively interacting with their clients through body movements, posturing and gesturing, thus utilising the implicit relational knowing of their body schemata. For example, one therapist described her interaction as: "*what I do to the poor men who are in therapy … I do cut off my own sexuality … It's not in this room … I engage with men in a very de-sexualized way … I'm formal … less spontaneous … very restrained in terms of my movements … I wouldn't use my hands, like I'm doing now … things just tighten up"* (4CP), suggesting a form of bodily disconnection. Another therapist described that he consciously engaged in physical exercise to manage cross-transferences. He explained: *"You know that the transfer/counter-transference thing is going to be there. I know I don't have the right actually to express them …* [I am] *physically involved in other things … my body actually handles things [and] it's not a repression"* (12CP). Therapists also reported experiencing feelings of anger, dislike, frustration and pity (ESA) towards their clients. One therapist stated that her self-regulative relational move involved creating physical distance; *"my body moves away"* (11SW) when she experiences pity towards a client.

The data suggests that the therapists' experiences of ESA directed towards their clients are types of counter-transference containing bodily phenomena. Their implicit relational knowing about the current nature of the therapeutic relationship manifested evoked intuitively

relational moves involving the therapists' body schemata which served as a valuable means of regulating cross-transferences.

Theme 2: ESA was experienced as a means for facilitating spatial and movement needs

Many of the therapists reported experiencing an implicit sense of knowing of how to be or relate with their clients through the implicit relational knowledge provided by the body schema, which enabled them to regulate and to alter the current dynamics of the therapeutic relationship and interaction. The body schema provides the implicit sense of "movement and coordination between different parts of the body and between the body and environment" (Fogel, 2009, p. 11). Some of these therapists' level of ESA of their own spatial and boundary needs, together with their implicit knowing of the current nature of the therapeutic relationship, elicited embodied relational moves which altered the course of interaction. For instance, 1EP described how her spontaneous embodied relational move during a difficult present-moment with her client diffused a potentially difficult situation: *"I stood up, I lifted up my chest and I looked at him … then I said: You need to leave now, the session is terminated! … he just looked at me, so I opened the door, I went past him*". In a similar situation, 1EP's implicit relational knowledge enabled her to regulate the interaction: *"I didn't get up … I allowed myself to be submissive … that helped me out of this situation"* (1EP). 8SW's spatial and body boundary requirements involved creating physical distance between herself and the client: *"I would get up … I would steal a minute or two in a session to put it back* [referring to an object] *in my cupboard"*. While 5SW's boundary requirements were met through self-regulative relational moves that included "[having] *somebody with me* [creation of extended physical space] *or I will leave the door open",* consequently altering the current nature of the interacting. Other therapists preferred to restrict their own and their client's spatial and embodied movement requirements: *"My clients work in the verbal modality … I stay in my chair always … everybody stays in their chair … people don't get up in my therapy … there is a sort of an unspoken rule of what we do here is, we sit"* (4CP). Avoidance of implicit relational knowing may indicate an unawareness of or disconnection of their ESA, or even suggest a fear of their own bodily sensations while relating with their clients, which was articulated by 4CP: *"the body is not a safe space … there's life, there's desire, there's all sorts of stuff … I have to keep things safe … movement, and body movement, and touch, and things like that in psychotherapy … would be dangerous"*.

Contrary to those therapists who reported self-awareness of their own spatial and boundary needs, others seemed to implicitly understand their clients' relational needs, which facilitated a process of co-regulation. Co-regulation is the ability to "dynamically coordinate actions … by sensing the boundaries between self and other" (Fogel, 2009, p. 15), consequently enabling the therapist to alter or maintain the therapeutic relationship. 2SW described her empathetic and kinaesthetic understanding of her client as: *"I lose myself in the moment and I feel what they feel"*, which evoked a relational move (ability to co-regulate) to *"work on the floor … or on the cushions … With my teenagers I would sit* [on chairs] *… I have to put the client first".* Similarly, 6RC stated: "*it's just a knowing … if the child is going to be comfortable on the floor".* Contrary to the previous therapists, 1EP denied or suppressed her tendency to interact with her clients on an embodied level, as she emphasised that this would be unprofessional and in conflict with her *"psycho-dynamic training"*. Another form of embodied relational cue in response to clients' needs that was expressed involved body contact, such as a touch or a hug. For example, 5SW stated: *"If I'm very empathetic towards a client, that's when I tend to hold their hands while speaking or just put my hand on their shoulder or give a hug or just reassure them*", whereas other therapists felt even if they would like to make appropriate physical contact the ethical boundaries of therapy prohibit them.

The data suggest that the therapist's ESA as implicit relational knowledge is an innate ability to empathise and kinaesthetically resonate with their clients' spatial and relational needs and is not only a common phenomenon, but also provides an embodied mechanism to maintain and alter the current dynamics of the therapeutic relationship, through engaging in relational moves that involve coordinated movements and even touch.

5. Discussion

Therapeutic interaction between lived bodies consists simultaneously of both verbal and nonverbal communication and actions (Westland, 2009). Interacting in an embodied way in the therapeutic context involves experiencing "my felt sense of the person, and the other's felt sense of me" (Totton, 2015, p. 32), consequently highlighting the reciprocal and implicit intersubjective nature of the therapeutic relationship. The implicit intersubjective field contains both, the therapist's and client's body felt sensations, affective cues, thoughts, behaviours, fantasies and reactions towards another (Stern, 2004). Sensing each other on a pre-verbal and implicit level during interacting may infer that embodied phenomena may form part of cross-transference interactions (Soth, 2013). Findings indicated that experiences

of body phenomena were part of the counter-transference relationship. Even though mainstream psychotherapy considers the enactment of counter-transferences "a danger to be avoided" (Soth, 2013, p. 134), the therapists utilised relational moves such as body movements and gestures, and even disconnection from their own embodiment as means to regulate the counter-transferences. Research suggests that selective enactment of counter-transference can provide therapeutic value for the client, and even act as a "reparative" means of the therapeutic relationship (Tosone, 2013, p. 253), as well as contributing towards maintaining of a good therapeutic relationship.

In addition, therapists reported that their innate ability to intuitively empathise and kinaesthetically connect and resonate with their clients, evoked additional implicit relational knowing (from their body schemata) of how to-be-with and interact with them in an embodied way. The implicit knowing about their clients' and their own spatial and relational needs, was facilitated through relational moves which assisted therapists to regulate difficult and sensitive key moments during the therapeutic interaction through the process of co-regulation which included the use of movement (e.g. being congruent with clients' seating arrangements) and touch. The findings suggest that therapists who are willing to engage in relational processes such as empathy, presence, kinaesthetic and affective attunement (Stern, 2004) and who are willing to connect to another through sustaining on-going inter/intra-bodily resonance (Froese & Fuchs, 2012), can elicit implicit relational knowing (BCPSG, 2010) which provides a different source of information to support the therapeutic relationship in an embodied way. Expressing empathy in an embodied way can communicate understanding and acceptance to the client, which in turn may strengthen the therapeutic relationship (Gelso & Silberberg, 2016). Therapists who are not willing or able to be bodily aware of the implicit relational domain may not only negatively impact the therapeutic relationship and outcome, but also induce therapists to project fear and anxiety (Totton, 2015), and may thus alter the immediate and future course of interaction.

6. Limitations of the study

This was a small interpretive study and findings cannot be generalised. The sensitive nature of the research topic may have influenced therapists' responses in unknown ways, as experiences of body sensations in reactions towards their clients are personal and thus may cause vulnerability or feelings of exposure. Future studies should allow for larger numbers of participants from all ethnic backgrounds and therapeutic disciplines. Including more

homogenous groups with specific context-based understanding of ESA as means for developing and maintaining the therapeutic relationship, could generate valuable new insights for practice within the multiracial South African context.

7. Conclusion

Although "embodied relating … is an open secret, both in therapy and in life" (Totton, 2015, p. xx), the findings in this study have shown that the roles of embodiment and embodied relating are fundamental aspects to developing and maintaining a good therapeutic relationship and outcome. Therapists' experiences of ESA as a form of implicit knowing and a relational process factor seem to be a relatively common phenomenon during therapeutic interactions. Therapists' awareness of their bodily felt sensations and reactions provided implicit ways to feel (emphasise, resonate or attune) and to establish intersubjective reciprocal contact, thus co-creating an intersubjective relational field which allowed for the mutual sharing and understanding of cross-transference phenomena and spatial and movement needs.

The findings indicated that therapists tended to engage in relational moves that included body movements, gestures and touch as regulative functions that intended to alter and change the therapeutic relationship. Others evaluated their sense of implicit knowing as unprofessional, and thus discounted or denied their tendency to engage in embodied relational moves, which could negatively affect the therapeutic outcome.

We conclude that therapists' level of ESA and their willingness to utilise implicit relational knowing may play an important part in strengthening and regulating the therapeutic relationship and provide an embodied way of interacting. Psychotherapy needs not only to pay attention to the client's embodied experience, but also needs to include the therapist's and in particular "how these two experiences impact upon and relate with each other" (Totton, 2015:26) in the intersubjective therapeutic field. Including implicit knowing and embodied relational process factors into the therapeutic relationship may be an important factor in changing current practices (from a one-person to a two-person/relational approach), as well as open the debate to reconceptualise theoretical constructs such as the therapeutic relationship and cross-transference.

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CHAPTER 5: Article 3

5.1 Guidelines for authors: *Journal of Psychology in Africa*

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Manuscripts should be written in English and conform to the publication guidelines of the latest edition of the American Psychological Association (APA) publication manual of instructions for authors.

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Manuscripts should be prepared in MSWord, double spaced with wide margins and submitted via email to the Editor-in-Chief at elias.mpofu@sydney.edu.au. Before submitting a manuscript, authors should peruse and consult a recent issue of the *Journal of Psychology in Africa* for general layout and style.

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All pages must be numbered consecutively, including those containing the references, tables and figures. The typescript of a manuscript should be arranged as follows:

• Title: this should be brief, sufficiently informative for retrieval by automatic searching techniques and should contain important keywords (preferably <13).

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Book

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Magazine article

Begley, S., & Murr, A. (2007, July 2). Which of these is not causing global warming? A. Sport utility vehicles; B. Rice fields; C. Increased solar output. *Newsweek, 150* (2), 48–50.

Newspaper article (unsigned)

College officials agree to cut greenhouse gases. (2007, June 13). *Albany Times Union,* p. A4.

Newspaper article (signed)

Landler, M. (2007, June 2). Bush's Greenhouse Gas Plan Throws Europe Off Guard. *New York Times*, p. A7.

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5.2 Article 3: Evoking participants' reflexivity through qualitative inquiry: a means to draw rich data

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Abstract

We explored how the use of multiple types of data collection methods (those addressing both the participant's implicit and explicit self-knowledge) had evoked participant reflexivity during interpretive inquiry and how this contributed to the richness of data. Thirteen registered therapist-practitioners in private practice and government organisations in the Western Cape and Gauteng were selected by means of snowball sampling. Data were collected and participant reflexivity (embodied and conceptual self-awareness) was evoked by the means of naïve sketches and/or drawings, experiential body awareness activities, in-depth one-on-one semi-structured interviews, and through researcher reflexivity. Findings from an *a priori* coding procedure indicated that both bodily felt sensations and personal and professional insights were evoked by the data methods. The results suggest that participant reflexivity appears to be a valuable means for generating additional in-depth and rich data.

Keywords: reflexivity, participant reflexivity, embodied self-awareness, conceptual self-awareness, interpretive inquiry

Introduction

Current discourse on reflexivity, within qualitative research, is predominantly focused on the role and the potential influence the researcher may have on the research process, outcomes and the participant (Takhar & Chitakunye, 2012; Underwood, Satterthwait, & Bartlett, 2010; Yang, 2015), thus often neglecting to consider "the contribution that participants could make to research through their self-reflections" (Yang, 2015, p. 447).

The term 'reflexive' is used "to denote actions that direct attention back to the self and foster a circular relationship between subject and object" (Probst, 2015, p. 37). Being reflexive is considered an everyday lived ongoing cognitive activity by some (Band-Winterstein, Doron, & Naim, 2014), which entails some sort of recursive "turning [back] one's attention to what one is doing" (McLeod, 2011, p. 49). Reflexivity is viewed as a conscious process of self-awareness (Finlay, 2002) that involves ongoing internal dialogue through introspection or reflecting on and interpreting personal experiences, focusing on the questions "what I know" and "how I know it", while simultaneously living in the present-moment (Hertz cited in McLeod, 2011, p. 28).

The notion of reflexivity remains contested, is fraught with ambiguity and lacks consensus (Darawsheh, 2014; Finlay, 2002). Some suggest that possible reasons include the fact that the terms *reflection* and *reflexivity* are closely related (D'Cruz, Gillingham, & Melendez, 2007; Mann, 2016), have similarities (Dowling, 2006) and "are often confused and wrongly assumed to be interchangeable" (Finlay, 2008, p. 6). The main differentiating factor between the two concepts is that reflexivity is "about being (continuously) self-aware" (McLeod, 2011, p. 49), and on the simplest level reflection can be understood as "thinking about" something (Finlay, 2002, p. 532), such as an object, observation, and recapturing an experience or event (Finlay, 2011), to gain knowledge and insight of self and of practice (Finlay, 2008). Despite existing conceptual variances, Mann (2016) suggests that all

conceptualisations of reflexivity acknowledge "agency (focus on the self) and the actions of the self" (Mann, 2016, p. 12). Reflexivity that engages in cognitive activities can be understood, according to Fogel (2009), as conceptual self-awareness (CSA). However, recent developmental and neurological research has provided empirical evidence for identifying various distinct wakeful states of self-awareness that range from the pre-reflective and implicit (embodied) to the explicit or conceptual domain (Rochat, 2015).

Embodied self-awareness (ESA) is the ability to sense and access the implicit information (embodied knowing or self-knowledge) which is provided moment-by-moment through the sensory neural system in the form of visceral responses (interoceptive senses) and other bodily felt senses that emanate from the proprioceptive and vestibular senses (or body schema) (Fogel, 2009). It informs us "what is going on around us … who we are … how we experience our bodies and define our place in the world" (Biel, 2014, p. 21), which includes relational knowing of the intersubjective field (Stern, 2004), such as the interviewing space. The ability and willingness to focus one's awareness on experiencing one's bodily felt sensations and reactions is known as embodied self-reflexivity (Pagis, 2009), which can result in yielding embodied self-knowledge into the conceptual domain. We therefore argue that reflexivity that predominantly focuses on CSA neglects to consider what other states of self-awareness (e.g. embodied self-awareness) can contribute to generating knowledge and constructing meaning within qualitative research, thereby enriching the data. It is further argued that, if researchers are "self-interpreting beings" and have "the capacity to turn back on his or her experience, and then to use this material to inform the process and outcomes of inquiry" as proposed by McLeod (2011, p. 48), then by implication so can "research participants also employ this capacity" (Doyle, 2013, p. 251). Recent, but limited, research conducted by Pink and Leder Mackley (2014), Takhar and Chitakunye (2012) and Yang (2015) suggests that eliciting participant self-reflexivity during the qualitative research

process can indeed yield rich data, aiding the participants to create meaning about themselves as well as providing the researcher with a better understanding of their reality and context. Although much has been written about the issues and importance pertaining to researcher reflexivity in qualitative research (Berger, 2015; Probst, 2015), seemingly few researchers give reflexive accounts of how reflexivity was or could be operationalised into their research practice (Mauthner & Doucet, 2003; Probst, 2015; Takhar & Chitakunye, 2012; Underwood et al., 2010) and "how their positions and methods have evolved as a result of their interaction with the study participants" (Underwood et al., 2010, p. 1587).

We put forward that evoking participant reflexivity (cognitive as well as embodied self-awareness), may emerge as a valuable method for gaining richer and diverse types of data, as well as being an innovative approach to transform and expand conventional qualitative Western research. This article seeks to explore the means and significance of evoking participant reflexivity within an interpretive research design (Thorne, 2008) and how it contributed to the richness of data in a study that endeavoured to probe deeply and collect thick descriptions of therapist-practitioners' lived body experiences.

Research context

The study sought to explore and describe the South African therapist-practitioners' lived experiences of the body within the therapeutic context and the meanings constructed or held about these experiences. To this end, the research question that guided the qualitative inquiry was: What are therapist-practitioners' experiences of the lived body (in terms of embodied self-awareness [ESA]) in the South African social service delivery field*?* Embodiment in this study drew from the notion of the lived body proposed by phenomenological and contemporary thinking, which is comprised of the physical body (body-as-object), that which is observable, tangible, devoid of any subjectivity and that may be used as a tool or

possession, as well as the intending, personal and predominantly pre-reflectively lived body (body-as-subject) (Finlay, 2011; Gallagher, & Payne, 2015). By implication, the nature of the research topic required some focus on one's level of ESA, which necessitated the participant as well as the researcher to tap into their bodily felt sensations and sensory cues. To this end, multiple data collection methods were utilised (see Table 2) which, together with the researcher's reflexive stance, aimed to evoke the participants' reflexivity with the intention of eliciting the bodily felt sensations (as ESA) from the implicit and pre-conceptual domain into the explicit and reflective verbal domain.

Method

Participants and setting

Snowball sampling was employed for selecting 13 registered social service therapist-practitioners from the Western Cape area and Gauteng Province of South Africa. The participants consisted of four psychologists, seven social workers, one counsellor and one psychotherapist, including one male and three black Africans. Nine were in private practice and four in government service. Their work experience ranged from five to 30 years of experience. A summary is provided in Table 1.

<insert Table 1 here>

Ethical considerations

Permission for the study was granted by the North-West University's ethics committee (NWU-00060-12-A). Verbal and written informed consent was obtained from all participants. Participants were reminded that participation was voluntary, that the research topic might elicit personal and sensitive material and that they could withdraw from the study at any time.

The ethical principles of autonomy (respect for persons), beneficence and justice guided the conduct of the researcher and formed part of ethical practice throughout the study. Confidentiality and anonymity were ensured by encoding all names and undertaking that all data would be kept secure and private.

Data collection

The naïve sketch and/or drawing, experiential body awareness activity and in-depth one-on-one semi-structured interview were applied in the sequence indicated in the workflow framework in Table 2.

<insert Table 2 here>

Preceding the interview, data collection started with requesting participants to prepare a personal document (text-based and/or sketch-based) by answering the question: 'What is your relationship with your body?' Creating a document before entering the interview provided the participants the opportunity to be self-reflexive and to construct a personal account (their reality), free from the influence of the researcher (McLeod, 2011). As an introduction to the interview (in the preparation phase), an experiential body awareness activity was conducted, which served as a means for eliciting each participant's unique personal language (Panhofer & Payne, 2011) about their nonverbal, felt kinaesthetic perceptions and sensory body experiences in the present-moment. As part of the body activity, the participant was invited to participate in silence, with closed eyes and listening to the voice of the researcher, who guided him/her to become self-aware of bodily felt sensations and sensory cues arising from stimuli that originated from outside (including the embodied presence of the researcher) and inside the body. The verbally guided body activity ended in silence, allowing both parties the

space and time to engage and attend reflexively to their own bodily felt sensations and sensory cues. Whilst the body activity aimed to create ESA within the participant, it simultaneously enabled the researcher to become reflexively aware of her own bodily felt sensations, emotions and thoughts as well as the nonverbal dynamics occurring in the intersubjective field (between the participant and herself). The middle or main phase of the interview began through inviting the participants to discuss their experience of having created their naïve sketch and/or drawing.

With the aid of an interview schedule, the main interview progressed. An interview schedule, known as a conversational guide (Rubin & Rubin, 2012) and consisting of primarily open-ended questions based on the main research question, together with the personal document, provided a flexible open-oriented and responsive approach for probing the participants' lived experiences of the body within their therapeutic context. During the ending phase of the interview, the interview provided an opportunity for the participants to reflect (conceptual self-awareness [CSA]) upon their experience of the interview process and topic. On completion of the formal data collection, that is during the after-interview-phase, participants were contacted through follow-up email and/or a telephonic call, allowing an opportunity for feedback. Field notes were made during and after the interview highlighting general gestures, body language and rhythm, voice tone and the researcher's bodily felt sensations and reactions in response to the participant. All interviews were video-recorded and transcribed verbatim.

Data analysis

The data consisted of the transcriptions, field notes and the participants' personal documents. After initial data familiarisation by reading and repeatedly re-reading (Clarke & Braun, 2013), data analysis for this article was based on the *a priori* coding procedure. This involved

identifying instances of data where there were indications of participant reflexivity, followed by an analysis of the nature and content thereof, with the aim of understanding how reflexivity had been evoked and how this had contributed to enriching the data. The findings are reported using direct quotations extracted from the data as support.

Findings

The four phases from the data collection process (see Table 2), that appear to have evoked most reflexivity have been selected to present our findings. Indications of reflexivity are underlined.

Finding 1: Reflexivity evoked by means of the experiential body activity indicated ESA and contributed to rich data

In all the participants but one, participation in the body activity evoked nonverbal responses to the researcher's instructions in the form of body movements and gestures such as shifts from tense and rigid arm, leg and head positions to more relaxed ones, movements of agitation and fidgeting, and changes in facial expressions and breathing patterns. Participants' unsolicited remarks such as *"I feel more relaxed"* (6RC) and *"it was quite good awareness"* (11SW) seemed mostly to confirm experiences of positive bodily responses. However, four participants stated their awareness of physical and sensory discomfort/unease, such as experiencing sensations of numbness, heaviness, tightness, pain or tensions localised in the shoulder, chest and neck area. 2SW explained, *"I feel a bit more relaxed … my body feels quite tired … I noticed the strain on my shoulder blades* [using her hands to demonstrate the strain] … *I think it's stress … when we did the exercise it made me aware of that … I try to disconnect from it".*

The data presented suggest that the participation in the body activity evoked participant reflexivity that resulted in an awareness of bodily sensations and sensory cues (ESA) which seemed to emerge from the implicit into the conceptual domain. ESA is a form of embodied self-knowledge (Pagis, 2009), thus being able to experience and access one's bodily felt sensations, can provide rich data (in the form of sensory information) for further exploration, thereby achieving deeper meaning and understanding (Mann, Gordon, & MacLeod, 2009) of the phenomenon being researched.

Finding 2: Reflexivity evoked by means of a naïve sketch and/or drawing indicated ESA and CSA and contributed to rich data

Statements made during the discussion of the naïve sketch/drawing indicate that participants' engagement in reflexive processes differed and fluctuated. For instance, some form of resistance and a lack of reflexivity were implied by 3CP: *"I knew I had a picture somewhere which I did for something else so I just got it out of the file".* This contrasted sharply with her later statement, "*I was very reluctant, I only did it yesterday evening … I felt I don't want to write this again … I have become so aware how messed up my relationship is with my body … as if it will never change".* On the other hand, two participants' initial unwillingness to discuss their drawings was contradicted by indications of reflexivity in their explanations: "*I don't know what to say about my picture … I really drew from a feeling or from a sensation or from an impulse"* (4CP), and [I don't want to discuss my drawing now] "*because my body is very personal for me …* [but] *maybe later"* (7SW).

Some participants' process of evoked reflexivity involved engaging reflexively on a rational and conceptual level over a period of time: *"thinking what I wanna draw took about a week"* (8SW), and 9SW stated *"it made me aware … but during the week I really had to think about what I knew what's the relationship I have with my body … then I realized this is*

an IT (an object), *then I drew the sad face* (ESA) *... there is no connection, there is no relationship ... this made me realize that's the relationship I have ... this drawing is a body, but my body is in a square, but it's a sound proof square which means my body communicates but then the sound cannot get out ... I realized it when I was doing the drawing"*. Similarly, 2SW's process of creating the naïve sketch/drawing also evoked reflexivity that yielded cognitive understanding (CSA) about her relationship with her body: *"I have to try to ... keep an open and relaxed posture ... I also need to be aware of my breathing ... I need to be emotionally present ... it was nice actually to think about what it feels like to be in therapy with someone in embodiment with your body, in relationship with your body"*. Other participants' level of CSA that resulted from being reflexive – and represents rich data – is indicated in phrases such as, "*One circle is my body and soul which are interrelated. If one of them is not okay it affects the other. It's my interpretation."* (10SW, suggesting wholeness); and *"what I tried to show ... my weight ... I think the inside is more the perfection ... the outside is more realistic, and the dance position is kind of wanting to break free ..."* (5SW). Finally, a level of ESA is suggested in "*Look, I guess it represents ... chakras ... vibration ... around the stomach area ... it became very clear that ... something happens in my tummy area"* (12CP).

The examples presented in this finding suggest that reflexivity was evoked through the use of a naïve sketch/drawing which yielded rich data, namely the participants' awareness of bodily sensations, affective states (ESA) of pain, resistance, embarrassment, feelings of sadness and being "cut off emotionally"(12CP), as well as conceptual insights (CSA) about their relationship with their body, thus contributing progressively, adding different/additional content and context about the participants' reality.

Finding 3: Reflexivity evoked during the middle interview-phase indicated ESA and CSA and contributed to rich data

The data show that the researcher's intentional use of reflexive phrases during the main interview phase was an important contributor in facilitating participants to attend reflexively to their lived body experiences in the present-moment. The researcher's reflexive phrases were drawn from the observations of the participants' lived body which included body reactions that manifested as goose-bumps, facial, breath and postural changes (similar to those in Finding1), and the researcher's own embodied reflexive process (ESA). The following are illustrative examples: "*Are there tears in your eyes?"*; *"I see even your face changes!"*; *"Your whole body reaction changed now, do you feel it?"*; and *"Is that* [responding to something the participant said] *affecting you now?"*; *"Do you have a sense of what is happening right now?"; "How do you sense your body now?";* and *"How is your body communicating to me now?"*. The data generated from such dialogue allowed for further exploration of the participants' bodily felt sensations and reactions, and the meaning attached to them (thus moving on to CSA). For instance, 2SW's reflexive remarks revealed different forms of ESA, starting with an initial awareness of anxiety: *"I'm now a bit stressed because I don't know what to answer you ... I feel my stomach is a bit tight ... it's an unfamiliar topic*", then progressing into the awareness of discomfort of feeling exposed: *"I got quite uncomfortable telling someone ...*", and ending with a sense of relief and self-understanding of her bodily needs (CSA): "*I realize now ... I would love to talk."*

In addition, other types of bodily felt sensations such as feelings of anxiety, fear, mistrust, anger, embarrassment and relief emerged, suggesting that use of reflexive statements evoked seemingly previously repressed (see Finding 2) and/or implicit material, as well as the present-moment relational dimensions into the conversational space, which led to stages of increasing insight. 7SW's reflexive interaction with the researcher progressively revealed a

range of bodily sensations (ESA) that provided the content and context to understand her previous seemingly resistant attitude and unwillingness to discuss her drawing (see Finding 2): *"I feel a bit stiff and stressed ... I don't know ... maybe I can sit on the floor ...* [7SW moved to the floor and the researcher responded reflexively by mirroring 7SW's position on the floor] … *it's better* [sense of relief]*"*; the interview then evoked experiences of stress/anxiety and sensations in her hands and feet (ESA), whereupon 7SW spontaneously reverted to her drawing (Finding 2), explaining: "*I realize today ... it's difficult* [and a] *private part of me and I have to put it on paper ... Who do YOU* [researcher] *think YOU are ... like YOU have the audacity, to expect that from ME! YOU don't know ME ..."* [7SW stopped breathing and grabbed her throat and the researcher reflexively responded, "Is there a knot in your throat?"] *"... Yah, an angry one!"* [laughing loudly, causing the researcher to respond reflexively, "You're laughing now"] *"I was angry that I agreed for this ... I don't know you and I don't trust you ... I said to myself, why did I get myself into ... I was angry with myself ... I'm more at ease now ... I'm more relaxed ... I feel that I'm not enough aware of my body* [signs of embarrassment] … [the way] *YOU are engaging with me now ... makes me feel more at ease,* [you are] *listening and not judging"* [expressing sense of trust and relief]. By contrast, 12CP's reflexive remarks enabled him to achieve stages of increasing insight (CSA): *"The way I'm talking things through* [now] *are making more sense ... I think there's a level of physical awareness happening* [referring to his bodily sensations] *... it becomes an insight ... it is happening up here* [his throat] *... I'm* [not] *thinking now ... It's* [his intuitive ESA] *actually coming more from here* [indicating his stomach area] *... and then I am processing it"* [CSA]. In this way, 12CP spontaneously gained new awareness and insight (CSA) of how he unknowingly utilises his ESA during the therapeutic encounter: *"I think I am creating an environment ... in which I actually experience it* [the client's bodily

felt sensations] *in my own body ... I am opening people up to more embodiment ... so actually that's interesting, I think that's what I'm doing."* [CSA]

The data presented in this phase suggest that the readiness of the researcher to focus on "the embodied felt sense and the gestural duet of nonverbal communication that occurs between the interviewer and the interviewee" (Finlay, 2012, p. 325) contributed to evoking participant reflexivity that aided in eliciting implicit information into the conversational domain, thus adding additional context and content to the verbal data and thereby achieving CSA. The data suggest that embedding reflexive practise (e.g. reflexive phrases and reflexive body gestures) into the interviewing style may evoke relational dimensions of reflexivity, as well as spontaneous insights for the participant. Viewing reflexivity as a "process of co-construction of multifaceted and many-layered perspectives together with the participants" (Niemi, Heikkinen, & Kannas, 2010, p. 138), thus shifts the focus solely from self-awareness to self-other-awareness.

Finding 4: Reflexivity evoked during the ending and after-interview-phase indicated CSA and contributed to rich data

The data show that the intentional invitation to participants to be reflexive about (that is reflect on) their personal experience of the qualitative inquiry, resulted in participants gaining new/additional understanding and insight (CSA). Increased awareness of their personal and professional weaknesses and strengths is observable in: *"I have learnt ... that my engagement ... self-development I must work on ... I think I was underestimating the role of the body"* (P6); *"It* [the interview] *has heightened my awareness again ... I'll give it some thought about how ..."* (8SW); and *"I've learned ... makes me realize I just haven't got a clue and I need to be conscious of ... I don't pay enough attention to it"* (9SW).

4CP's understanding and insight of her reflexive engagement during the previous interview-phases were summarised as follows: "*I think what stands out for me from this conversation ... to be a better therapist, you need to be more present ... you have to be in your body ... is what I realize* (CSA) *... it's given me lots of food for thought ... in this conversation ... I went through lots of bodily experiences ... the tightness to the animation to the flustered-ness and the frustration, to the sadness* (ESA) *... it's given me a lot to think about in terms of my work ... I feel quite tense ... I feel a bit tired ... it's been a great conversation, but it's really kind of challenged me to think and to reflect and that has made me tired and it's also left me feeling slightly ... I don't know? Agitated, a bit stressed, anxious?* (ESA) *... I think it's more the nature of the conversation which is both excitement ... it's pleasant ..."*; And then 4CP spontaneously referred back to her drawing, giving meaning (CSA) to her drawing which previously had no meaning (see Finding 2), "*You see, that thing around the heart is exactly what I'm feeling now ... I don't know what it is ... it's both an excitement and anxiety and a feeling of the awareness of the heart, you know"* [takes a deep breath in and sighs out]. 4CP's reflexive processes ultimately resulted in rich data, in that the pre-reflective and non-verbal (implicit) knowing about her drawing (see Finding 2) and the bodily sensations experienced during previous phases, had emerged during the ending interview-phase into the conceptual and conversational space, thus not only aiding her to create meaning and clarity of her bodily experiences, but also providing professional insights (CSA).

Similarly, 7SW's explanatory statements provide meaning about her reflexive stance (referring to her resistance in Finding 2 and 3): "*To answer things* [referring to interview questions] *that I don't really know about* [triggered unworthiness] *so I feel a bit not good enough ... because I am a therapist I'm supposed to know more about this topic* (CSA) *... then the picture was intrusive for me* (reflexive stance, ESA, gives context for 7SW's

resistance) *... something I already know and I'm trying to deal with it for years ...* [I have a] *weight issue ... it's a big thing for me for years now*." [The researcher responded reflexively: *"How do you feel about me and the topic? You said you didn't trust me ..."*] *"I feel more open now after the conversation ... I need time to trust ... I want to teach the clients ... but I can't do it myself ... I still realize* [referring to her drawing] *... the way I see my body it's like this puppet of my mind and emotions ... I don't really treasure my body ... it's not nice to realize that again ... I think because I had this interview ... it triggers so much ..."* Thus 7SW's reflexive participation also enabled her to create meaning of her bodily experiences, such as feelings of unworthiness, anxiety, resistance, fears etc., contributing towards new/additional personal understanding and professional insights (CSA).

The data presented during the ending interview-phase and in the after-interview-phase (grouped together into a logical unit for analysis) suggest that participants' reflexive processes (reflection-on their experiences) encouraged critical self-evaluation, contributing to generating more in-depth descriptive data.

Discussion

The use of the data collection methods selected (see Table 2) had encouraged participants to engage in reflexive processes, successfully evoking participant reflexivity, which served as an unexpected additional data source, yielding both bodily felt sensations (ESA) and conceptual insights (CSA), from which meaningful findings emerged. The nature of the content and context of the data (ESA and CSA) and the way the data were enriched appear to be directly influenced by the type of data method, as well as their position within the data collection process. As the study aimed to deeply explore and understand the lived body experiences of the participants, it called for an approach that included data methods which would enable participants to generate data in the form of elicited pre-verbal and implicit self-

knowledge during the initial stages of the inquiry into the conceptual and verbal domain. ESA (implicit knowing) and CSA (explicit knowing) are diverse types of data that affect knowledge construction and meaning-making in different ways (Welling, 2005). Therefore, failing to attempt to generate implicit information from the beginning of the interview phases, could result in a potential loss of rich and meaningful data, ultimately impacting the quality and the contents of the research findings.

Therefore, implementing a data collection strategy that predominantly relies on an interview, considered the most frequently used method for collecting in-depth data in qualitative inquiry (Mann, 2016), seems inadequate. Interviewing is a data method grounded in linguistic, symbolic and evaluative forms of expression (Fogel, 2009), which evokes conscious self-awareness (Finlay, 2002) involving mental activities such as critical self-reflection, evaluation and analysis (Finlay, 2012; Fogel, 2009). Thus, using a data method that interacts with participants primarily on a conceptual level, that is thinking (reflecting-on) about something (Finlay, 2002), by implication neglects to include or focus on the participant's embodied knowledge. The embodied knowledge consists of a wide range of types of implicit knowing (knowledge) encompassing physical and sensory-motor procedural knowledge, affect patterns and "even patterns of thinking" (Stern, 2004, p. 242), and implicit relational patterns of knowing to be with another (Summa, Koch, Fuchs, & Müller, 2012), all forming part of the individual's embodied history. Authors such as Fogel (2009) and Glöckner and Witteman (2010) suggest that, being aware of and having access to one's embodied knowledge (ESA) play a crucial role in cognitive activities such as judgements and decisions, and we further put forward self-reflection and meaning-making processes (CSA). Therefore, including data methods that encourage participants to mine the rich meaning contained in the implicit domain (Preston, 2008), formed an integral part of this study and may be of considerable methodological interest to interpretive research.

The implications of having embedded data methods (as described in Table 2) which were grounded in expressive and visual/sensory mediums (Mason, 2007) are evident in the findings. For instance, the participation in the experiential body activity elicited body sensations such as numbness, heaviness, tightness, pain or tensions localised in the stomach, shoulder, chest and neck area. Although all participants were able to identify and describe their bodily felt sensations (ESA) during this phase, for some their bodily felt sensations did not make sense or have much meaning at that time, and they only got clarity (CSA) during the subsequent phases (see 4CP in Finding 2 and 4). Similar to the body activity, the discussion of the drawing elicited ESA. The nature of ESA during this phase had shifted from physical sensations to predominantly visceral cues to responses such as embarrassment, anxiety and fear amongst others. These types of data methods demonstrated how participants were enabled to focus their awareness reflexively on their bodily felt sensations, which helped to yield implicit data for further exploration in the verbal and conceptual domain. The explicated ESA provided continuous input for the researcher and the participants, enabling them to continuously reflect on their feelings and thoughts which materialised into instant moments of insight (CSA) and formed part of progressively increasing the participants' awareness and understanding of their bodily felt experiences, and eventually resulted in personal and professional insights (CSA) specifically during the ending interview-phase.

Another important contributor that evoked participant reflexivity was the influence of the researcher's reflexive processes which were characterised by the intentional use of reflexive phrases and gestures, based on the influence of the researcher's phenomenological stance and attitude towards the participant and the research topic. Recent research by Pezalla, Pettigrew and Miller-Day (2012) indeed suggests that the unique personal characteristics of researchers and their perceived sensitivity towards the research topic may play an important part in influencing the nature of the conversational spaces and the quality of material elicited from

the participant, and this includes evoking participant reflexivity. Within this study, the researcher kept the personal and sensitive nature of the research topic in mind, and positioned herself as part of the conversational-interviewing space and chose an adaptable mode of participation, making use of Rubin and Rubin's (2012) responsive (conversational) interviewing style during the data collection activities. Taking on a middle ground participant involvement strategy, according to Patton (2002), provides researchers with sufficient flexibility to respond to the needs of participants and adjust the degree of interaction with them. The consequences of the researcher's reflexive stance are evident in the findings, where some participants felt safe and empowered enough to reveal and 'give voice' to their unspoken or hidden dimensions of their bodily experiences such as fear, anxiety and unspoken negative and positive dynamics inter-subjectively occurring between the participant and researcher, that encouraged us to further explore their reality and self-knowledge. These findings are in line with Riach (2009, p. 361), in that the emergence of contentious or controversial moments during qualitative inquiry suggest "participant-induced reflexivity … often triggered by the research theme itself or the embodied nature of the research interaction … that affect the structure and subsequent production of data".

Evoking participant reflexivity using multiple data sources may challenge existing research methods as expressed in the following words: "If the research interview is to continue being a widely used research tool, we must acknowledge the value of the participant as a reflexive subject" (Riach, 2009, p. 358). Viewing the participant as a reflexive subject has implications for the current practice of reflexivity in terms of its focus and its application. For example, it may require researchers to change their philosophical position, as to how they position and engage with the participants within the research context (Corbin & Strauss, 2008; Thorne, 2008). In line with previous authors and the findings in this study, Takhar and Chitakunye (2012) propose that the use of participant reflexivity and multiple data methods

may advance methodological knowledge in that the participant is viewed as being more active and participatory (reciprocal and mutually influencing), which could be beneficial in understanding participants' lived experiences and practices, including the implicit and unspoken experiences of the body, and thus contributing to the depth of the phenomena being studied. Employing a participatory approach implies a more horizontal research-participant relationship, thus less influenced by the researcher's biases or preferences (Rubin & Rubin, 2012) and may actually change the role of the participant to that of a co-researcher (Takhar & Chitakunye, 2012). Adopting multiple types of data sources (those that address both the participant's implicit and explicit self-knowledge – my emphasis) and positing them throughout the research process, encourages participants to continually reflect-in-action on their body sensations and thoughts, with may lead to the re-framing of prior knowledge and thus the developing of new insights (generating and enriching data) through self-interpretation and analysis, which not only add to richer in-depth data but also contribute towards the credibility of the research findings (Mann, 2016; Onwuegbuzie, Leech, & Collins, 2012; Riach, 2009; Takhar & Chitakunye, 2012). Furthermore, including participant reflexivity as an integral part of interpretive inquiry suggests a holistic approach and attitude towards the participant, by implication addressing all aspects of the lived body and, according to Riach (2009, p. 367), "is not only reflexive consideration but a key dimension of being an ethical, socially responsible researcher".

Limitations of the study

This was a small interpretive study and findings cannot be generalised. Responses might have been different if participants had not been exposed to or were unfamiliar with reflexivity as a therapeutic practice. Future studies could explore different data collection methods that evoke participant reflexivity focusing on elements such as embodiment or self-other awareness with

larger numbers of participants from all ethnic backgrounds. Including more homogenous groups with specific context-based understanding of ESA and the lived body, could generate valuable new insights within the multiracial South African context.

Summary and conclusion

This study has shown that adopting multiple types of data sources (those that address both the participant's implicit and explicit self-knowledge) not only evoked participant reflexivity, but also encouraged participants to be active members during the interpretive inquiry, which generated several types of data (ESA and CSA) throughout the inquiry. The participants' reflexive engagement during the inquiry not only contributed to the richness of data, but also enabled them to interpret and create meaning about themselves, thus contributing towards the credibility of the research findings.

The use of participant reflexivity, as described in this article, departs from the traditional practice of reflexivity as merely being a tool for improving the quality and validity (Darawsheh, 2014) of the researcher's role in generating and interpreting data, to a useful tool for encouraging participants themselves to actively and deliberately generate knowledge (Band-Winterstein et al., 2014) and construct meaning (D'Cruz, et al., 2007) about their lived body experiences and practices. Supporting the call of authors advocating that conventional qualitative research practices "of how and what sort of knowledge is generated by researchers" (Edwards & Brannelly, 2017, p. 271) are being challenged to democratise and transform Western research methods to include "alternative ways of knowing … in terms of what counts as knowledge and who produces, owns, uses and benefits from it" (Edwards & Brannelly, 2017, p. 271), we conclude that embracing participant reflexivity may emerge as a valuable and innovative method for including 'all South African voices', thus gaining richer data in qualitative research and contributing to methodological debates.

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Table 1: Participants

Participant*	Gender	Race	Professional registration	Years of experience
1EP	female	white	Educational Psychologist	11-15
2SW	female	white	Social Worker	11-15
3CP	female	white	Clinical Psychologist	21-25
4CP	female	white	Clinical Psychologist	11-15
5SW	female	white	Social Worker	5
6RC	female	white	Registered Counsellor	6-10
7SW	female	white	Social Worker	11-15
8SW	female	white	Social Worker	6-10
9SW	female	black	Social Worker	11-15
10SW	female	black	Social Worker	16-20
11SW	female	black	Social Worker	5
12CP	male	white	Clinical Psychologist	26-30
13RT	female	white	Registered Psychotherapist	11-15

* EP = Educational Psychologist; SW = Social Worker; CP = Clinical Psychologist; RC = --Registered Counsellor; RT = Registered Psychotherapist

Table 2: Data collection workflow framework

Data collection phases	Data sources	Objectives
Pre-interview-phase	personal document (drawing and/or naïve sketch)	• To create awareness of embodiment (ESA) • To encourage self-reflexivity without the influence of the researcher (create own reality and source of insight)
One-on-one interview:		
• sub-phase: preparation	experiential body activity	• To create awareness of embodiment (in-action reflexivity) • To elicit ESA into participants' verbal domain • To build trust and rapport
• sub-phase: middle or main	drawing and/or naïve sketch; interview	• To encourage participants to share experience and meaning of their personal document • To encourage participants to be active in attending reflexively to their lived body experiences during the interview process • To elicit implicit and pre-verbal knowing into verbal domain
• sub-phase: ending	interview	• To encourage reflective self-evaluation of participants' experience of the interview (understanding themselves through thinking about)
After-interview-phase	follow-up email &/or telephonic contact	• To capture any self-reflective insights gained on their ESA

CHAPTER 6: Conclusions and recommendations

6.1 Conclusion

This qualitative interpretive study sought to explore and elucidate the South African therapist-practitioner's experiences of the lived body and the meanings held about these experiences within the therapeutic context. It is hoped that better understanding of the nature and the degree of how the therapist-practitioner's experiences of the lived body influence the therapeutic space and the interactions with the client will open the discussion for the inclusion of the therapist-practitioner's embodiment and experiences of body phenomena (such as embodied self-awareness and implicit relational knowing amongst others) within current practice and thus direct future theoretical, methodological and research efforts. The research findings revealed that lived body experiences (such as bodily felt sensations and reactions, implicit knowing about something amongst others) appear to be a true phenomenon among South African therapist-practitioners.

The phenomenological notion of the 'lived body' provided a useful framework for the capturing, describing and understanding of the therapist-practitioner's lived experiences of the body. The lived body was viewed as "a unified whole" (Potgieter & Bloem, 2017), comprising the physical body (body-as-object) – that which is observable, tangible and devoid of any subjectivity – and the intending, personal and predominantly pre-reflectively lived body (body-as-subject) (Finlay, 2011; Gallagher & Payne, 2015). In addition the conceptual framework for understanding the lived body experiences drew from the more recent developments into infant research (Fogel, 2009; Rochat, 2015; Stern, 2012), body memory (such as the adaptive oscillators) (Fuchs, 2012) and the mirror neuron system (Gallese, 2001; Rizzolatti & Sinigaglia, 2008), as these **not only** provide neurological evidence of embodied mechanisms that enable individuals to share, experience, sense and understand another's actions and emotions on an embodied and nonverbal level (Boston Change Process Study Group, 2010:148; Rizzolatti, & Sinigaglia, 2008:191), **but also** highlight the importance of the pre-verbal and implicit domain (embodied knowing) as a valid source of knowing of how to be and relate with others and the environment, including

the therapeutic space. Conceptualising the therapist-practitioner in the role of being a neutral, objective and disembodied professional therefore seemed inconceivable.

The aims of the study have been addressed in separate chapters, each article focusing on various aspects of the therapist-practitioner's lived body experiences within the therapeutic context. These are summarised below.

The first article (see Chapter 3) focused on the participants' experiences of their lived body in terms of embodied self-awareness (ESA). ESA is the ability to sense and access pre-reflective and implicit information (embodied self-knowledge) which is provided moment-by-moment through the neural system in the form of visceral responses and other bodily felt sensations that inform the individual on an embodied and tacit level of who they are and how to interact with others (Biel, 2014; Fogel, 2009; Summa, Koch, Fuchs & Müller, 2012). The findings revealed that all participants reported experiences of bodily felt sensations while doing therapy. Similar findings have been noted in a study conducted by Booth, Trimble and Egan (2010), who measured the somatic reactions of therapists to their clients. Intuitive or spiritual knowing, a sense of warning/danger and a sense of how to relate and be with the client (the body-schema-in-relation) were the most frequent forms of implicit knowing experienced during the therapeutic process. Comparable with the findings of Jeffery and Stone Fish (2011), participants reported that the use of their implicit knowing enabled them to make quick and deliberate decisions and perform actions that regulated the immediate dynamics of the therapeutic field. Even though the participants reported being aware of their bodily felt phenomena, the majority tended to deny, suppress or control their sensory cues or rationalise them as being non-rational and unprofessional. Discounted or suppressed ESA may trigger fear and anxiety within the therapist (Stern, 2004:224; Totton, 2015), may unknowingly result in embodied actions such as counter-transferences (Vulcan, 2009), and show bias towards verbal narrative at the expense of the implicit domain (Potgieter & Bloem, 2017), and thus may be of clinical interest.

The second article (see Chapter 4) focused on the findings showing how the participants used their embodied self-awareness as form of implicit relational knowing to facilitate the therapeutic relationship. Most participants reported that experiences of ESA were evoked during the counter-transference interactions. The counter-transference relationship was regulated by some participants through the enactment of relational moves involving body

movements and gestures, while others seemed to disconnect or suppress their knowing about the nonverbal and implicit aspects of the therapeutic relationship. Furthermore, participants reported that their ability to empathise and kinaesthetically connect with clients evoked implicit knowing (ESA) about their client's and their own embodied spatial and relational needs. Comparable to the regulation of the counter-transference relationship, the embodied relational needs were enacted using body movements and gestures, which regulated difficult present-moment situations and also met the client's embodied needs such as seating arrangements and touch. The study contributed to the understanding of how the use of ESA is utilised as a general method to manage and regulate the therapeutic relationship and interactions. Comparable with recent studies that indicate therapist factors such as their actions (movements and gestures) may have a bigger impact on the effectiveness of the therapeutic relationship and outcome than client factors (Del Re et al., 2012; Roos & Werbart, 2013), the use of ESA in this study may be a crucial factor in strengthening the therapeutic relationship and changing current practices.

Article 3 (see Chapter 5) reflected on how the researcher's methodological decisions such as use of multiple data collection sources had contributed to the richness of the data and the credibility of the research findings. The nature of the research topic (the therapist-practitioner's lived experiences of the body) required some focus on one's level of ESA, which necessitated the participants as well as the researcher to tap into their bodily felt sensations and sensory cues. To this end, the use of multiple data methods which were grounded in visual and sensory mediums (Mason, 2007) were used during the beginning, middle and end phases of the data collection process. The data collection process served as a useful repeatable and flexible approach for probing and evoking participant reflexivity throughout the entire interview.

Participant reflexivity resulted in eliciting a different type of data, namely participants' implicit knowing and ESA into the conversational space, which created the opportunity for them to reflect upon their lived body experiences within the therapeutic context, and consequently enabled them to interpret and create meaning (conceptual self-awareness [CSA]) about themselves. The study contributed to the understanding of how adopting multiple types of data sources (those that address both the participant's implicit and explicit self-knowledge) had generated different types of data (ESA and CSA) which contributed to

the richness of data and provided a useful method for collecting qualitative in-depth data about the lived experiences of participants.

6.2 Limitations of the study

The findings of this study are based on a relatively small group of South African therapist-practitioners that gave an in-depth personal and subjective account of their lived experiences of the body within the therapeutic context, and thus the findings cannot be generalised to other groups of therapist-practitioners with different characteristics and those practising in other contexts.

Findings may also have been different if the experiences of those additional 12 therapist-practitioners who had been approached but then were unwilling to engage with the field of study, could have been obtained. The sensitive nature of the research topic may further have influenced participant responses in unknown ways, as experiences of body sensations are subjective and thus personal, and context bound. The findings may also have been influenced by the participants' professional a priori professional knowledge and therapeutic skills such as use of reflection. Findings were purely based on in-depth descriptive data (due to the qualitative design), which could be viewed as a limiting factor, in that interpretation and meaning making is not a quantifiable activity, but is rather influenced by the participants' and researcher's characteristics and preferences.

6.3 Recommendations for future studies

Based on the qualitative findings and the experience gained during the research, the following recommendations for future research, theoretical reconceptualisation, methodological efforts and psychotherapeutic practice are suggested.

Future studies should allow for larger numbers of participants from all ethnic backgrounds and various therapeutic disciplines. The inclusion of a wider population group which could have specific context-based understandings of ESA and the lived body, as well as emic knowledge of counselling practices, could generate valuable new insights. These insights could provide input towards the development of alternative and more integrative and holistic

counselling/psychological frameworks, training programmes and open debate for changing current practice within the multiracial South African context.

Future studies could benefit from investigating how the therapist's implicit knowing and embodied relational process factors impact the development of the therapeutic relationship and current practice. These insights might contribute to the development of new assessment tools, and open the debate for reconceptualisation of theoretical constructs such as the lived body, therapeutic relationship, co-regulation and empathy amongst others.

The results suggested that the use of participant reflexivity appeared to be a valuable means for generating additional in-depth and rich data. Research predominantly relying on interviewing as a data collection method, may fail to include the participant's pre-verbal and implicit knowing. Thus, future studies should explore and evaluate different data collection methods that evoke participant reflexivity focusing on elements such as embodiment or self-other awareness, thereby adding to the richness and understanding of participant's subjective reality. It is also recommended that the use of participant reflexivity as an alternative data source should be incorporated in methodological debate for gaining different and richer qualitative data that would not have been collected through conventional data collection methods such as the interview.

Lastly, the research findings have highlighted that the therapist-practitioner's experiences of the lived body influence the therapeutic space and the interactions with the client, which have clinical and theoretical implications. Inclusion of the therapist-practitioner's embodiment and experiences of body phenomena in current practice and future theoretical, methodological and research efforts may be beneficial for innovative and new developments within the health sciences.

6.4 Contributions of the study

Except for studies conducted by Gubb (2010; 2013), no studies were identified that examined South African therapist-practitioners' experiences of their lived body and the meanings held about these experiences within the therapeutic context. This study has contributed to the body of counselling/psychotherapeutic research findings and literature (see Potgieter & Bloem,

2017) in that the findings provide better understanding and insight about the nature and degree of the therapist-practitioner's bodily felt sensations and body reactions, implicit knowing (ESA) about the therapeutic context (the client and the dynamics of the therapeutic relationship), and how these are acted on or dismissed in everyday therapeutic interactions. For example, even though many research participants reported interacting with their clients in an embodied way, they tended to dismiss or suppress their bodily felt sensations and reactions, as these were viewed as being in contradiction with their professional counselling/psychotherapeutic practice or modality. Thus the study provides the beginning of a platform (a data base of new knowledge of the South African therapist-practitioner's experiences of the lived body) for future research and opens the dialogue for changing current practices and training.

6.5 In closing

I am grateful to the participants for partaking in this very personal and sensitive study. They have reaffirmed my own *Weltanschauung* and highlighted that the therapists' lived body and their body phenomena experienced form an integral part of the relational (intersubjective) therapeutic space, and thus cannot be ignored within current therapeutic practice and training programmes. I hope that this study will contribute to further research in readdressing conventional Cartesian Western oriented psychotherapeutic approaches.

"Psychotherapy has in a sense been about the mystery of the mind/body relationship – not the supposed mystery of how they come together, but the mystery of how they appear to be split!" (Totton, 2011:24)

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