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Our Bodies Relating: How do Child and Adolescent Psychoanalytic Psychotherapists working with the body in specialist settings understand their bodies in relation to their patients?

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A thesis submitted for the Professional Doctorate in
Child and Adolescent Psychoanalytic Psychotherapy

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Abstract

This study explores how Child and Adolescent Psychotherapists (CAPs) understand their bodies in relation to their patients. Using semi-structured interviews and an Interpretative Phenomenological Analysis (IPA) method, it delves into the lived experiences of each participant.

The study first situates the body within a psychoanalytic framework through the literature review, drawing on various psychoanalytic theories to examine the meaning of the body and its position in therapeutic interactions.

Participant interviews explore participant's personal, lived experiences in specialist therapeutic environments where the body plays an explicit role in daily practice. The CAPs interviewed for this study work with cases involving sexual perversion and violence, in hospital settings, with learning and physical disabilities, anorexia, and other eating disorders.

The findings reveal that discussing and reflecting on the body can feel unsafe, often triggering defence mechanisms. The experience of being interviewed on this topic stirred anxieties in both participants and the interviewer, bringing up themes of consent, intrusion, and boundaries. This, in turn, raised fundamental questions about the nature of therapeutic work and what therapists are consenting to in their relationships with patients.

The interviews also uncovered latent messages regarding the sexuality of bodies, which evoked considerable discomfort. A working hypothesis suggests that CAPs in the NHS may find it particularly challenging to engage with this topic freely. Additionally, participants spoke sparingly about play-a fundamental aspect of child

and adolescent psychotherapy. This absence felt significant, given the inherent bodily nature of play.

All participants worked in highly intense settings, which naturally influenced both the interviews and the experiences they shared. It is possible that highly embodied play becomes more difficult in environments with high levels of disturbance, where the therapist's body may be more vulnerable to intense states of projection.

Declaration

I declare that this work is my own, and that I have accurately referenced the ideas of others. I have taken all necessary and reasonable measures to anonymise patient material and personal information about the participants that might make them identifiable.

This project has received full ethical approval from the Tavistock Research Ethics Committee (TREC).

Acknowledgements

I wasn't sure if I would be able to adequately birth this project onto the page and into reality. I would like to thank those that have supported me along the way. Laura Balfour; your steady support and insightful contributions have helped me to keep going and keep thinking. Alex- sistering with you on this training journey has massively contributed to me being able to submit this piece of work, you have always encouraged and inspired me, thank you.

I'd like to thank my parents in law for their belief in me and for their support. You have stood behind me on this 7-year training journey.

And Ray- my partner. Thank you. This project and my training has been such an enormous part of our lives. Thank you for making space for it in your life the way you have.

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Introduction

"It is through my body that I understand people, just as it is through my body that I perceive"

(Merleau-Ponty, 1962, p. 186)

'….a mind….that which defines a person, requires a body, and that a body, a human body….naturally generates one mind, a mind is so closely shaped by the body and destined to serve it that only one mind could possibly arise in it"

(Damasio, 2000, p142)

Background to the Project

This project was conceived in my time as a trainee, but this project has roots in my time working in a Youth Offending Service (YOS). My role involved regular visits to young men in prison, often in locked visiting rooms for hours at a stretch, as well as lone home visits in environments I now recognise as physically and psychologically unsafe. I was in my early-mid 20s, and it was one of my first roles in the field. Colleagues and I adopted a hardy exterior to manage the intense anxieties the work provoked. Looking back, I see how I dissociated from my bodily experience to cope- a sentiment echoed by two participants in this study.

While on the M7 pre-qualifying course, I wrote a 'Work Discussion' paper about my YOS role, which first connected me with the danger and anxiety I had blocked out. I realised how unsafe I felt: my feminine body felt at risk, objectified as I walked past young men starved of contact and intimacy. I managed this by shutting down my awareness of it.

Whilst in this role, I developed some unexplained physical 'reactions'-beginning with a small neck rash which escalated over five months into swollen eyes and widespread blotches. I'll never be completely sure of the cause, but I've reflected on the array of physical symptoms I experienced, a time when I was particularly detached from my body, at a time when I felt somewhat 'under threat.'

As I progressed through my clinical journey (and this project), a thoughtfulness about bodily experiences remained. This project emerged from a question I asked myself during my time as a trainee CAP[1]: *Do we have a responsibility to our patients to better understand what is happening in, for, and to our own bodies in the context of our work with them?* This question initiated my interest in developing a psychoanalytic understanding of the body and it led me to explore a complexity I experienced in the consulting room, both as a therapist and as a patient. I observed how a deep understanding of the body felt both present and removed, a paradox also recognized by others (Goldberg, 2022; Harding, 2001; Lombardi, 2017).

[1] Child and Adolescent Psychotherapist

Through following this curiosity, I hope to contribute to the psychoanalytic field-offering insights into the relationship between body and mind. Harrang (2022) posed crucial questions: *How do therapists reach the body in a way the body can understand? How do therapists learn to speak to the body?* These questions, I believe, are of importance.

Reflecting on infantile experiences and how infants come to understand their bodies served as an essential starting point. I wondered through what mechanisms they recognize their bodies as their own-distinct yet dependent on others. Extending this thinking to the therapist-child relationship, I considered how a child might learn about their body through their interactions with a therapist and, conversely, what a therapist might learn about their own body through working with a patient.

Developing the Project: Research Question and Aims

This project is ontological in its design and spirit, meaning it is concerned with the experience of *being* rather than knowing (Ogden, 2023).

Shaw (2003) discusses the *lived body paradigm*, which shifts away from historical Western views of the body as primal and tainted, and away from modern notions that reduce the body to organs and functions. Instead, this paradigm acknowledges that our relationship with our bodies forms the foundation for experiencing and understanding.

I was also influenced by Thanopulos's (2022) concept of the *psychoanalytic body*, which is a body distinct from those studied in biology, medicine, or sociocultural disciplines. Rather, the psychoanalytic body is one that *speaks* (Thanopulos, 2022). This notion lies at the heart of my research, keeping the project rooted in a

psychoanalytic ontology. This ontological perspective ensures that the project remains an *embodied inquiry* rather than a *disembodied encounter* (Shaw, 2003); in this kind of encounter, the body might be acknowledged but treated as separate from the self.

With these principles in mind, I crafted a research question incorporating key terms such as *understanding*, *related*, and *relating* to guide the reader toward the relational experience of bodies and minds in a lived and embodied experience.

Project Aims

This project aims to:

1. Investigate the question: *Where is the body in psychoanalysis?* and explore why it can be difficult to discuss and perceive, despite its central presence in psychoanalytic thought.
2. To understand therapists' embodied experiences and the meaning they derive from them.
3. Enhance the psychoanalytic community's ability to engage with the body in a way that can be effectively communicated to potential patients, the NHS, and laypeople.
4. Deepen the therapeutic relationship by encouraging therapists to develop awareness of their own bodies and their capacity to understand both their own and their patients' bodily experiences.

Psychoanalysis undeniably considers and engages with the body, particularly in its visceral conceptualizations from its earliest writing (Freud,1985). However, it is noted that psychoanalysis has a tendancy to move *"away from thinking about the body and*

toward the analysis of thought" (Bloom, 2006 p.45), creating a disconnection from bodily experience. This phenomenon intrigues me and has driven this project.

While psychoanalysis addresses the body, it may not always do so as explicitly as other therapeutic modalities that actively incorporate bodily expression. Some psychoanalytic professional groups, such as the Institute of Psychosomatics in Paris and clinical teams specializing in medically unexplained symptoms, have developed expertise in this area. However, this level of skill does not appear widespread across the profession, despite the body being a universal aspect of human experience. CAPs work with the body through play, which carries unconscious symbolic meaning. Joyce McDougall captures this idea: *"The body speaks no known language, yet it serves, time and time again, as a framework for communicating the psychic scenes of the internal theatre"* (1986, p. 141).

Given contemporary understandings of trauma and its somatic manifestations, there is a growing emphasis on body-oriented therapies, such as movement-based interventions and mindfulness practices. A psychoanalytic approach that listens to both the body and the mind may be better equipped to offer diverse and effective treatments. I do not propose a dilution of psychoanalysis but rather an open dialogue that allows psychoanalysis to sit alongside other therapies in considering the best approach for a given patient.

Stating Hypotheses and Assumptions

As this project stems from my deep interest, I have been mindful of my own biases, assumptions, and hypotheses to ensure ethical and rigorous research.

I have taken a reflexive stance, continuously considering my position within the research and striving to maintain neutrality while acknowledging my hope that this project will be valuable. I also recognize my inclination to honour the body's wisdom- a perspective I struggle to set aside as the researcher.

Assuming the role of researcher has required some adjustment but over time I have developed a respect for this position. Through self-observation, reflection, supervision, and my own psychoanalysis, I have worked on *letting go* of desired outcomes, allowing myself to remain open to participants' lived experiences. Interpretative Phenomenological Analysis Method- known as IPA (Smith, Flowers, & Larkin, 2022) method of data analysis has been instrumental in this process. I will speak about this more in the 'Research Design' section.

A key underlying assumption I have identified is that the body is often *split off* in psychoanalysis. It seems essential to acknowledge this assumption, particularly since this notion is the basis for one of the Group Experiential Themes.

Another working hypothesis is that bodies relate to one another beyond what we can clearly see. This idea aligns with the psychoanalytic ontology of this research, where unconscious processes are central to understanding human experience, and cannot be avoided.

Throughout this project, I have actively tracked these assumptions to minimize their hidden influence on the study's validity while recognizing that, as the researcher, my perspectives will inevitably shape the work.

Research Question Design

Formulating the research question was an important process, involving extensive discussions with my supervisor.

'Our Bodies Relating' signals the core assumption of this project-that therapists' and patients' bodies are in constant relation. Although framed as a question, I realise that I don't actually doubt this.

I specified '*Child and Adolescent Psychotherapists'* to explore how *this* discipline engages with the body. I am also bringing myself into this research by speaking to participants who share the same profession as me.

By inviting participants who '*work with the body in specialist settings'*, I sought therapists with relevant expertise and rich clinical experiences. This purposive sampling method allowed me to recruit professionals from diverse fields, such as hospitals, learning disability services, sexuality work, and eating disorder treatment. My goal was to engage with therapists who had encountered impactful, visceral, and complex bodily phenomena in their work.

Body and Mind or Bodymind?

I have deliberated over the use of the words 'body' and 'mind' in my research question. We refer to body and mind separately in everyday language without thinking much about it. But separating the words might be furthering the split between them. Use of the term 'bodymind' might refer to a more integrated and interconnected system, which is more correct in terms of neuroscience (Damasio,

2012). Winnicott (1954) used the term '*Psyche-Soma*' which is arguably along the same lines as the 'bodymind.'

I considered using the term 'bodymind' in the research question, to remind us that a body is never separated from the mind (Dychtwald, 1950). However, after much thought and discussion with my research supervisor, I decided against this- I noticed that I was trying to impose an agenda. Using 'bodymind' might suggest a 'correct' way of understanding the body mind relationship, and potentially influence participants' perspectives and their answering of the questions.

Literature Review

Aim

This literature review aims to orient the reader to the project, and offer a deeper understanding of the 'body' from a psychoanalytic perspective. It presents rich ideas and perspectives that explore the body-mind paradigm, rather than attempting to answer the research question.

Methodology

This review incorporates literature gathered through two methods.

Narrative Sampling: This method involved selecting literature based on perceived relevance and importance as determined by me, the researcher. These works are not typically discovered through search engines but are instead drawn from recommendations, literature I was already familiar with, literature I saw listed in bibliographies or significant historical psychoanalytic texts that might not typically appear in a systematic review (Creswell and Creswell, 2018).

Key psychoanalytic texts included under this approach provide foundational ideas that help contextualize this project within a psychoanalytic framework. Some of these texts would not populate in a systematic search because a reference to the body is not explicit, but it is there in the subtext.

Systematic Sampling: This method involved imputing search terms in databases to explore a broader range of literature. While this approach allows for greater

objectivity and helps uncover new resources, ultimately I select sources as I deem relevant to the project (Creswell and Creswell, 2018).

Search Terms and Exclusions/ Inclusions

I was already aware from my interest in this topic that the literature is vast, but that I might nonetheless be challenged to find nuanced and specific pieces of writing about the body. Therefore, I used the Tavistock library 'discovery' feature which searches across all data bases.

The task was to select search criteria that would sufficiently capture different elements of the project, rather than attempting to answer the overall research question. I decided to use three different search terms to capture different elements of the topic. The first was:

1) Psychotherap* AND body in psychoanal*

I decided to use one search that was broader, to pull in interesting sources that might not appear in a more specific search.

I decided upon this search term to gather literature that was generally about the body in psychoanalysis. This produced 23,104 hits. Despite this large number of results, it was a quick task to rule out literature that was not relevant, by eliminating sources in languages other than English, and many sources that were not easily accessible to me and not relevant enough to try to obtain.

I found that involving the word ‘body’ in the search pulled in vast amount of literature from all realms of body psychology. Although these search terms pulled the largest number of results, the vast majority were off topic.

I then used two more search terms that might offer more focused material on what is occurring between the body of the therapist and patient. When I conducted the search, my thinking on the project orientated largely around embodied countertransference (countertransference being experienced in the body of the therapist). I was interested to see what was available on this topic, and I hypothesized that it would provide me with some clinical examples.

2)Somatic AND countertransference

This yielded 27 results

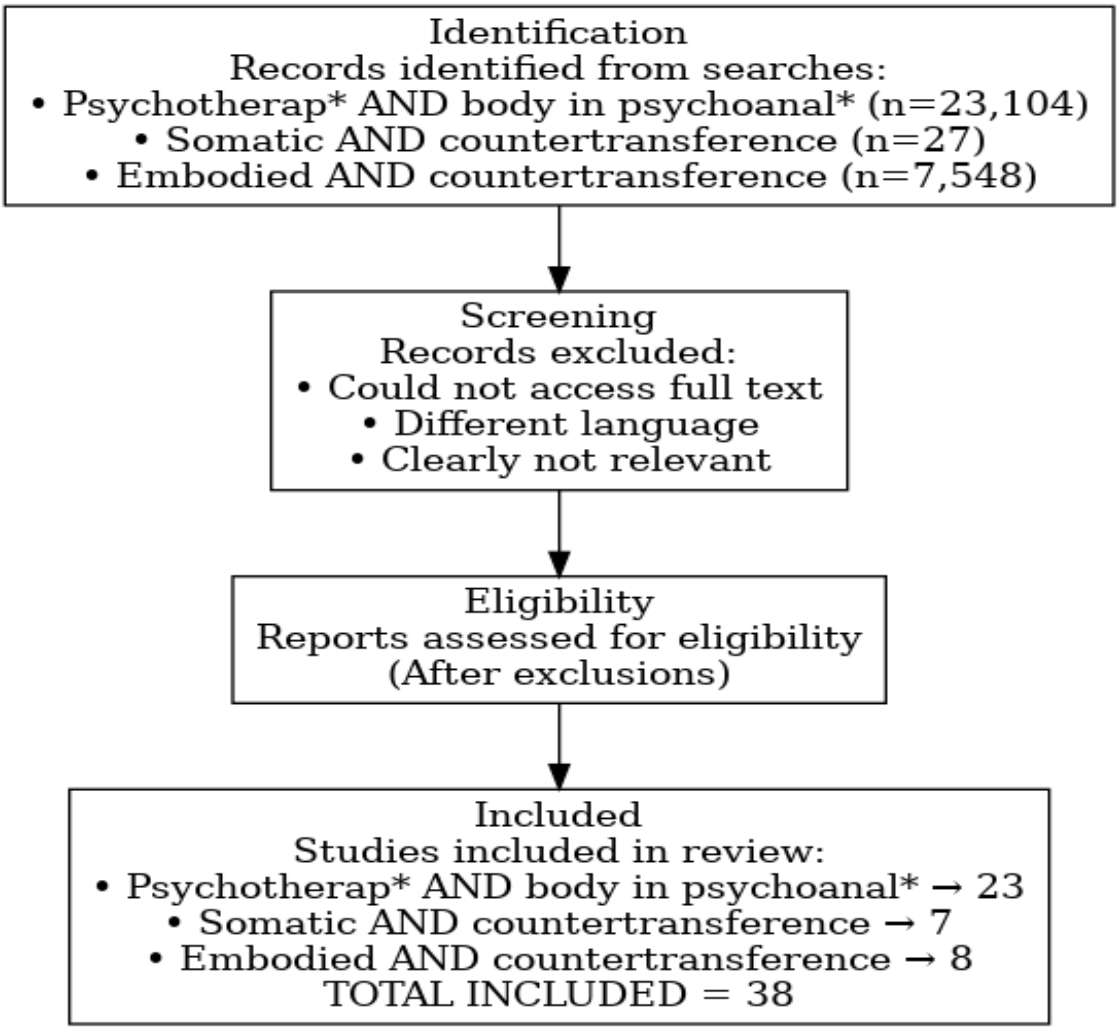
I decided to use the term countertransference (see footnote for definition)[2], not because this is the term I will be focusing on in the main body of the research but because it is a term that locates a somatic experience in the body of the psychotherapist as opposed to the patient. This is an important distinction for this research.

[2] I have chosen Pine’s (1993) definition of countertransference, as *“the analyst’s monitoring and acknowledgement of her own unconscious affective reaction to her patient and her communications” p. 25*

3) Embodied AND countertransference

This yielded 7,548 results

This was easily narrowed down by eliminating texts in different languages and those in books that I could not access. I was then able to swiftly decide which articles might be relevant. See prisma diagram below:



Arranging my findings

I have chosen not to separate the findings into narrative and systematic results, as I think this would disrupt the thematic flow of the material.

To honour the systematic search, I made an effort to use the relevant and accessible literature identified through this method. However, I did not feel it was appropriate to rely exclusively on this literature because it did not populate historical psychoanalytic works, which felt important to include. As a result, this literature review is more subjective and personalized, as I have hand-selected materials for discussion. I have been mindful of this approach and have tried to avoid excessive reliance on these narrative sampling choices.

Note on the scope of the literature review

The literature available on the topic of the ‘body’ is vast, yet finding nuanced and focused material on the body from a psychoanalytic perspective was challenging. This may, in fact, be beneficial for this project, as it allows more room to rely on participant material to answer the research question. The literature review, in turn, serves its intended purpose of providing context and background.

Throughout this literature review, I have reflected on the fact that the body is understood in various ways by different people, in different cultures and disciplines of thought. The literature mirrors this diversity. There is no singular way to conceptualize the body.

To maintain focus and establish boundaries for this research, I have chosen to remain within the realm of psychoanalytic thinking. While I am aware of other perspectives on the body, such as those related to trauma or neuroscience, exploring these areas would shift the focus of the research away from a psychoanalytic foundation, additionally there is not the scope to do so.

Within psychoanalytic literature, there are numerous directions to explore, including themes such as the body and drives, gender, the sexual body, and the maternal body. I have aimed to provide a snapshot of literature that offers diverse reference points, encouraging thoughtful engagement with the concept of the body.

Findings

Introducing the Body from a Psychoanalytic Perspective: Freud's Contribution and Developments

Various literature sources (Bloom, 2006; Carignani, 2012; Lemma, 2016; Saketopoulou, 2023) cite Freud as a starting point for a consideration of the body, and this seemed like an appropriate place for this literature review to begin. Freud's understanding of the body-mind paradigm was of critical importance to the conception of psychoanalysis, and it posed significant challenges to Freud (Carignani, 2012). As Carignani (2012) observed, the 'problem' of untangling how mental functioning roots itself in the body permeates Freud's work. He likens this to *"a huge whale which only occasionally resurfaces before plunging down"* (Carignani, 2012, p.291). The body's presence is felt in Freud's theories, even when not explicitly referenced.

Discussions of Freud's work in this context often begins with the quote: "*The ego is first and foremost a body ego…the ego is ultimately derived from bodily sensations*" (Freud, 1923 p.25-26). According to Lemma (2014), Freud saw the ego as a mental representation "*of the individual's perceived libidinized relationship to his body"* (2014, p.4). Bloom (2006) suggests that Freud is describing the 'self' as a bodily based being, emphasizing how humans use their bodies to explore themselves and the world. This aligns with Harrang (2022), who asserts that psychoanalysis considers mental life as inherently rooted in bodily experience.

Freud identified sexuality as the fuel for many preoccupations and anxieties impacting the body (Freud, 1916-1917). He studied 'hysterical' bodies (Alvarez, in

Bloom, 2006) and explored how anxieties, often centred around sexuality, might manifest in physical symptoms (Bloom, 2006; Freud, 1905). There was use of the term *'conversion'* to say that psychological pain, often with a sexual nature, might be converted into bodily symptoms such as fainting, or numbness (Breuer and Freud, 1895).

Freud was committed to understanding the mind body link, and to him sexuality was an obvious and indisputable way to link up somatic and psychic events (Carignani, 2012; Jones,1953,). Sexuality has "*so obviously both physical and mental components. Is libido a mental or physical concept in its origin?*" (Jones,1953, p.272). This question runs through Freud's work, and in the conceptualizing of psychoanalysis as a way of understanding the human experience.

Freud's analysis of hysteria, as evident in the case of Dora (1905), provides foundational insights into his understanding of the body's role in mental life. Initially, Freud posited the 'seduction theory' (1896) hypothesizing that hysterical symptoms resulted from actual sexual abuse that had been repressed (Scarfone, 2023). However, further clinical exploration led him to revise this view. In his *'Three Essays'* (1905) Freud introduced the concept of infantile sexuality, suggesting that sexuality arises organically within the infant, stimulated by erogenous zones on the body (Scarfone, 2023).

Freud's shift from seduction theory to infantile sexuality reflects his attempt to pinpoint the origins of sexuality. While he settled on the latter, other psychoanalytic thinkers such as Laplanche (1970) and more modern thinkers (Ashtor, 2022; Saketopoulou, 2023; Scarfone & Saketopoulou, 2023) argue that the abandonment of seduction theory resulted in loss of nuanced thinking regarding the activating of

sexuality that occurs ordinarily between infant and caregivers. Laplanche (1970) revisited the seduction theory, suggesting that Freud erred in discarding it. For Laplanche (1970) and subsequent thinkers (Ashtor, 2022; Scarfone & Saketopoulou) there is an ordinary relational development of sexuality that takes place when an infant is exposed to the adult sexual unconscious, through the everyday acts of daily caregiving that are sensual and bodily (Saketopoulou, 2023; Scarfone & Saketopoulou, 2023).

Holding the theory of infantile sexuality alongside the seduction theory is useful. It reminds us that we are talking about an excitable infantile body, with erogenous zones that are activated through ordinary exchanges between parent and child, in the developing of the individual and their unconscious (Scarfone & Saketopoulou, 2023).

Drives and the erotic body

Freud's drive theory offers a pivotal connection between the body and the mind. He referred to drives as the frontier between the mental and the somatic, as energetic forces emerging from bodily needs which impact upon mental life (Freud, 1915a, pp. 121–122). Harding (2001) describes drives as a force requiring bodily satisfaction to achieve a homeostasis, with psychic consequences arising from how these demands are managed, and if they are satisfied or not.

Some psychoanalytic thinkers, such as Harding (2001) and Lombardi (2008), express concern that drive theory has lost prominence within psychoanalysis. This is considered a loss because drive theory connects Freud's original insights to contemporary scientific thought about the body and mind. There is a community of

thinkers, well-versed in neuroscience and psychoanalysis, who have explored the links between intense bodily sensations, self-awareness, and the development of consciousness (Damasio, 1999, 2018; Solms, 2021). Damasio (2012) highlights the importance of homeostasis for the human organism and explains how emotions, bodily drives, and motivations work to maintain it. These processes can be studied using neuroscience technologies.

Alongside an acknowledgement of the 'loss' of the drive theory, is a 'de-eroticization' of the body in psychoanalytic literature according to some, such as (Harding, 2001; Laplanche, 1970). De-eroticization refers to the diminished acknowledgment of the body's sensual and erotic aspects. Elise (2019) suggests that this discomfort around eroticism may trickle into the therapeutic environment, creating a space where erotic dynamics between therapist and patient are avoided. She thinks that acknowledging the erotic-not as overt sexuality but as a quality of aliveness and connection-is vital for therapeutic relationships. [3]

The literature (Elise, 2019; Harding, 2001, Pine 1993,) highlights some trends around societal discomfort in equating early mother-infant relationships with eroticism. Ashtor (2022) emphasized the dual role of the breast as both a feeding and sexual organ. This point reminds us of the depth of meaning of the breast in an object relations context. [4] It can be both nurturing and incredibly erotic.

[3] Elise (2019, p. 1) reminds us that "the erotic" is the adjective form of *Eros* and can refer to embodied, affective energies that originate in sexual impulse, encompassing libidinal vitality, tempestuous passions, unruly urges, vigor, ardor, and a stimulating, vibrant state of mind.
[4] 'Object relations Theory' considers the development of the self through relationship to others (early caregivers). Object relations theory emphasises how the mind is formed through internalised relationships and experiences, and these are taken into the psyche as 'objects' (Gomez, 1997).

Associations to the term "erotic" [5] may help explain why acknowledging these dynamics can feel challenging. The term may evoke ideas of overt sexuality, which could feel inappropriate or even abusive in contexts like the parent-child or therapist-patient relationship, particularly within a public health setting. However, the language of eros requires some decoding, and it is valuable to think about it, because it represents a sense of aliveness and a connection to the body-concepts rooted in psychoanalytic theory-that we don't want to lose. Elise (2019) questions therapeutic relationships that lack eroticism. She wonders if, when a patient does not bring an erotic dimension into therapy, something may have gone "very wrong" in their early life, as sensuality and intimacy are vital components of the infant experience.

Psychoanalytic perspectives on phantasy often centre on the body, particularly the mother's body, as explored by Klein (1946), Isaacs (1952) and Meltzer (1992). This emphasizes the fundamental role bodily relationships have in the shaping of self-perception, erotic life and the development of boundaries that differentiate ourselves from others.

A Sensorial Perspective on the body

Goldberg (2022) identifies 'types' of body: the biological body, the social-symbolic body and the sensory somatic body. The biological body becomes the source of drives in psychical life. This links with Freud's (1905, 1915a,) thinking of the body as an individual organism full of wishes and impulses, which directly impacts upon the development of the individual's psyche. This body has a concrete reality; it is

[5] Freud (1920) referred to the 'erotic' as impulses of connection and aliveness

understood through science and medicine, and it can be measured and quantified (Goldberg, 2022).

The social-symbolic construction of a body can be viewed through a societal lens. This iteration of the body is subjective, and it holds a different meaning to each individual. This definition might refer to the kind of body represented in unconscious phantasy, and gathered through relating together, as considered by Klein (1946) and later, Isaacs (1952). This body, constructed through systems of representation (Goldberg, 2022) cannot be measured and pinned down. As I understand it - an experience in the body is subjective, and we view our body and the body of others subjectively; the perspective of the body can change, and morph under the pressures of identifications and projections.

The sensory-somatic body exists in the realm of sensations, constantly interacting with its surroundings. This is a corporeal body, in constant relationship with its surroundings, through the '*shared pattern language of sensoriality…. the movement of the body in relation to its objects'* (Goldberg, 2022 p.120).

The sensory-somatic body holds particular relevance to this research project, as it identifies a field of experience between bodies in the consulting room. In a session, this could manifest as a profound sense of attunement, a deep countertransference experience, a sense of intuitive 'knowing,' or a connection beyond words. This occurs on psychic and somatic planes, where sensitivity and receptivity between bodies and minds becomes the primary means of connection and communication. In this realm, bodies do the speaking (Thanopulos, 2022).

This type of ‘speaking’ is not as easily articulated through words and may be less understood. This could contribute to the reputation psychoanalysis might have of favouring thought over intuitive bodily feelings (Bloom, 2006; Goldberg, 2022). The mind is often perceived as superior because it possesses language, applies logic, and symbolizes, whereas the body may be seen by some as mute or primitive (Goldberg, 2022). However, Goldberg argues against this perspective, emphasizing the body’s role in creating life experiences through the senses—through “*immediate sensation, through what is heard, seen, and felt as it happens”* (p. 121).

The sensory body and Bion

Bion (1962a) linked sensory experience and emotion to the development of the personality, and this perspective has been a foundational piece in psychoanalysis. Bion’s focus on somatic experience and its interaction with the forming personality is deeply embedded in his work, though it may not be immediately obvious on first reading (Carignani, 2012). Notably, Bion was the “*first to bind thought to the presence of emotion-so that…if there is no emotion, there is no thought either”* (Lombardi, 2017, page 35).

Bion theorises (1962, 1962a) that the capacity to think originates from sensory experience. An infant experiences sensation, and they require thoughts to allow for an understanding of them. Bion describes the frustration of ‘no breast’ as provoking intense sensory states, including hunger, waiting, and a sense of not being held (1962a). Over time, this ordinary stress on the infant develops the capacity to form thoughts that enable them to tolerate difficulty.

For example, an infant might summon an imagined breast and be able to reassure themselves on a preverbal level that they will be fed again, as they have been before. This phenomenon can also be understood through Bion's writings on alpha function[6]. One way in which this happens is through the process of containment. The theory of 'container and contained' (Bion,1962) is important in psychoanalysis, and refers to the capacity of the caregiver to contain the infant's intense emotional and sensory data, which they cannot process on their own. The caregiver, typically is able to mentally digest this data for the infant and transmute it back to them in a way that they can better integrate. This process is a bodily one; and it might involve an infant's experience of sensory experiences, that they find excruciating (Carignani, 2012). The raw data (beta elements) is offered up to the caregiver to contain in an unconscious process. The caregiver will likely use their own body to contain, in the way they rock, feed or touch the baby, alongside thinking about their experience and wondering what might be happening for them. Over time the infant can integrate these experiences of being contained, which in turn supports them to develop their own capacity to manage their intense emotional states (Bion,1962).

Here, we can see that Bion's concepts of alpha and beta elements alongside containment further elucidate how sensory data is transformed into mental phenomena for growth and understanding (Carignani, 2012).

Ferrari and the Concrete Original Object

Ferrari (2004), a student of Bion examined the original prototype of the body and its interaction with the mind. In his model, the body-referred to as the 'Concrete Original

[6] According to Bion (1962), alpha function is the capacity to transform beta elements which are raw sensory and emotional data, into alpha elements, which are mental phenomena that enable digestion, assimilation, understanding, and growth (Carignani, 2012).

Object' (COO) is concrete and non-symbolic. To understand this, one might consider an infant's experience of their body to be entirely corporeal and sensorial. The infant fully inhabits their body and is deeply attuned to their embodied experience, though they lack the capacity to assign meaning or interpret these experiences. This concept resonates with Ester Bick's (1968) writings on the 'second skin.' [7]

Ferrari's notion of the COO should not be confused with the Kleinian use of the term 'object' (Carignani, 2012) which is symbolic. Ferrari explains:

> '*It is an object because it is there; it isn't made, nor is it the result of a developmental process (such as introjection or projection). Rather, it is the child itself… The object is concrete because its primary quality is its physicality'* (Ferrari, 2004, p. 48).

Ferrari theorized that individuals transition from a deeply sensual, concrete, and physical experience grounded in material reality, to a symbolic awareness of the world (Lemma, 2016). This developmental trajectory can be understood as a movement from the vertical axis, representing the original relationship between the infant's body and mind, to the horizontal axis, which connects the infant with their caregiver (Lombardi, 2017). The horizontal relationship serves as a channel for containment and reverie-a process facilitating the development of thoughts and the mind itself (Ferrari, 2004; Lombardi, 2017).

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[7] Bick (1968) describes how an infant might respond to environmental stresses using their body as a form of defence. Observations of infants reveal their acute sensitivity to their surroundings, which they experience primarily through their senses.

Although this is a sensorial and 'concrete' experience rooted in bodily sensations, Lemma (2016) says that Ferrari's (2004) theory of the COO *is* rooted in object relations theory. This is because the relationship the infant has to their body is via the caregiving experience they receive, which informs how they will come to experience themselves as they develop. This also links to the work of Saketopoulou (2023), mentioned earlier in this literature review; where she talks about the impact very ordinary sensual handling of the infant's body has on their unconscious development.

From Ferrari's perspective, the mind emerges in response to the need to contain and alleviate the intense '*red-hot sensory elements'* of the body (Lombardi, 2017, pp. 94). As the mind develops its capacity to manage these elements*, "the eclipse of the body and the dawn of mental phenomena"* begins (Lombardi, 2017, pp. 95).

The work of Pollak (2009) is relevant here. There is an acknowledgement of a concrete body in his descriptions; the body with its three-dimensional structure and boundaries, distinguishes between inside and outside. Its orifices, openings, and points of access create a *"psycho-physical space with innate potential for insertion, extraction, and holding"* (Pollak, 2009, p. 488). This concept bridges the body's concrete containment functions with Bion's (1962) psychic process of containment, a fundamentally relational process.

Body in Phantasy

Phantasy is a concept integral to psychoanalysis and it refers to a constant mental activity of impulses, needs and instincts which shape mental life and relationships because of how they influence how one relates to self and others (Isaacs, 1948). Phantasies contribute to the forming of a rich internal world, a place of symbolic representations constructed from introjections from the external world (Carignani, 2012).

Rather than focusing on the actual, corporeal body (Carignani, 2012), the literature around phantasy considers how bodily experiences lead to symbolic representations in the infant's mind, shaping the developing person throughout life. Infantile phantasies about their own body and the bodies of those who feed, handle, and sustain them are fundamental to development and the unconscious. The shift toward the body as a symbol rather than a primary reality links to Ferrari's theory of the Concrete Original Object (2004), where the infant's corporeal experience is *'eclipsed'* by acts of thinking and symbolizing.

Klein, the Mother's Body in Phantasy and Corporeality

Melanie Klein's writings on phantasy emphasize the centrality of the body, particularly the mother's body in developing the mind and personality (Klein,1923).

Klein (1946) described these preoccupations as all-consuming, characterized by phantasies of wanting to *"suck dry, bite up, scoop out, and rob the mother's body of its good contents"* (p.107).

Isaacs (1952) said that the infant's earliest phantasies are woven from bodily sensations and experiences. This ties to the concept of the *'sensory-somatic body'* (Goldberg, 2022) repositioning sensations as the foundation for developing a symbolic understanding of the body. Klein (1946) says that through projections of 'good' and 'bad' onto the mother's body, particularly the breast, infants build and develop their emotional landscape. Carignani (2012) highlights that an infant's body is 'unthinkable' without a reference point to the mother's body.

Klein proposed that infants phantasize actions being done to them by others, which forms the foundation of object relations theory (Bloom, 2006; Segal, 1970). For instance, a baby in pain might phantasize being hated (Segal, 1970). Physical experiences are thus interpreted as phantasy object relationships (Segal, 1991).

Lemma (2014) expands this idea with the term '*body imaginings'*, referring to the mental images of the body shaped by early bodily experiences. In this theoretical stance, these imaginings are relational, as infants perceive bodily experiences as originating from external sources. Carignani (2012) however critiques what he considers to be the over psychologization of the body, arguing that the focus on symbolic processes risks neglecting the corporeal nature of bodies. This view is echoed in other sources (Caldwell, 2022 ; Harding, 2001). However, by staying close to the literature in terms of Klein (1946) and Isaacs (1952), we see that they are communicating just how integral bodily senses are to the development of the personality.

The infant's earliest experiences of life are deeply corporeal, with *"phantasies springing from bodily impulses interwoven with sensations and affects"* (Isaacs,

1952, p. 93). Isaacs (1952) vividly describes how sensations, such as light, sound, warmth, or rhythmic sucking form the mechanism for unconscious phantasy.

Winnicott and the Psyche-Soma

The work of Winnicott considers the sensory, phantasy and somatic. In his 1954 paper 'Mind and Its Relation to the Psyche-Soma,' Winnicott approaches this enquiry from the starting point of the mind. He asks, *does the mind exist as an entity in itself?* In this paper, he begins to lay out his theory of the mind, beginning at the start of an infant's life, charting their psycho-somatic journey.

Winnicott asserts that the mind does not exist as a separate entity; rather, a healthy mind is an expression of the psyche-soma. He uses the *'mind'* as a verb-an active and alive functioning of the psyche-soma (Ogden, 2023), as opposed to viewing it as a named entity.

He conceptualizes the psyche as the experience of being imaginatively alive, involving "*the imaginative elaboration of somatic parts, feelings, and functions, that is, of physical aliveness"* (1954, p. 202).

Winnicott's message is quite simple: a healthy, alive mind and body are mutually necessary and inseparable (Ogden, 2023). In understanding the location of the psyche-soma, Ogden (2023) suggests they 'exist' nowhere; they are felt experiences. "*Soma is the experience of physical aliveness; psyche is the experience of imaginative aliveness"* (Ogden, 2023, p. 9).

Winnicott returns to the infant, first in the womb and then with the mother post-birth. He considers there to be no split between the mind/body or psyche/soma of an

infant. Their mind-psyche-bodily-somatic experiences are intrinsic to homeostatic development, contributing to a sense of aliveness and survival. As the infant grows, their sense of an *'alived'* body-fundamental to their core self-develops (Caldwell and Joyce, 2011). This body forms limits, boundaries, and a sense of inside and outside (Pollak, 2009). Caregivers must adapt to these developments, and the infant symbolizes their mind-body-psyche-soma experiences with the scaffolding provided by the mother/caregiver. This includes adaptation to bodily needs (*'handling'*) and the caregiver's imaginative elaboration of the infant's states (*'holding'*) (Caldwell and Joyce, 2011). Lombardi (2017) refers to Winnicott's concept of '*holding'* as revolutionary in how primitive states of mind intersect with bodily boundaries.

In his 1970 paper 'Basis for Self in Body,' Winnicott states that integrating psyche and soma involves deeply anchoring the self into the body (Carignani, 2012). He describes an environment where the mother *"constantly introduces and reintroduces the baby's body and psyche to each other"* (Winnicott, 1970a, p. 271).

Bodies in the Consulting Room: Some Theoretical Concepts

This next section of the literature review considers bodies in the consulting room, engaging with recent writing that is more closely aligned to the research question. These studies reflect therapists' explorations of the physical and psychological phenomena emerging during treatment with their patients.

Lemma (2014; 2016) explored the embodied setting, focusing on how the therapist's body contributes to the therapeutic environment. Some patients may perceive the therapist's body as a static, unchanging fixture within the consulting room that should remain unchanged. The reality that bodies are always in flux-and that patients do not

have a ‘right’ over their therapist-can be painful. However, there is also an argument for patients expecting stability in aspects of their setting (Bleager,1967). This expectation might reflect a psychotic part of the patient struggling to differentiate self from object (Bleager, 1967). If the therapist is considered part of the setting, changes in the therapist’s body may mobilize phantasies and anxieties in the patient (Lemma, 2014).

Lemma (2014) uses the term ‘*symbiotic fusion’* to describe patients who struggle to differentiate from their objects and wish to fuse with them to maintain psychic equilibrium. When working with such patients, therapists may receive intense projections into their body as the patient attempts to merge with and control their body and mind. Therapists may feel intruded upon, particularly when the patient imposes commands on their body: to not move, not be alive, be a receptacle, or remain inseparable (Lemma, 2014). Stone (2006) noted how embodied countertransference often bypasses language, while Lemma (2014) highlights how somatic responses can similarly bypass language, depositing directly into the therapist’s body. For Lemma, this communication evoked somatic responses such as effortful speech, murmuring, flattened sensations, strained breathing, and a low-volume voice. These somatic responses are notably flattened, and anti-life, reflecting Lemma’s stance that separateness might feel ’catastrophic’ for the patient and so a deadening in the therapist is necessary.

Lemma (2014) explores the idea of whether further consideration should be given to the therapist's body being an integral part of the therapeutic setting. The therapist’s body, appearance, and presence may provide an embodied form of containment for the patient. Lemma notes that some patients may require *‘depositories’* to feel safe.

This concept is intriguing as it bridges the body in phantasy to corporeal existence; the patient might imagine, in phantasy, depositing something into the therapist's actual body based on something of their physical appearance. The patient may draw on the therapist's physical presence to inform this act of depositing.

I refer back to Pollak (2009) and his discussions about the body as a container, not only as a metaphorical or symbolic entity but as a three-dimensional body with space inside. This idea connects to Meltzer's concept of the 'Claustrum' (1992), a claustrophobic mental state in which the patient aggressively identifies with and seeks to operate from within the mother's body. In this state, the individual seeks refuge within the maternal body (Meltzer, 1992) in a phantasized unity aimed at controlling the mother to mitigate a fear of being engulfed or overtaken. Meltzer identifies the breast, head, rectum, and/or vagina as areas particularly vulnerable to these intrusive attacks.

Counter Transference and Projective Identification

Ogden (1997a, 1997b) expanded on Bion's (1962) concept of *reverie* to think about counter transference responses. In this context, a therapist's response emerges from the combined psyche-somas of both therapist and patient, rather than being exclusively attributable to one (Gubb, 2014). Gubb (2014) explored instances where therapists lack control over somatic communications with patients, recounting the implications of his own rumbling stomach during a session with a patient who severely restricted her eating.

Gubb defines counter transference as *"emotionally...and somatically based responses which particular qualities of the patient arouse in the analyst" (*p. 70). He

proposes that somatic counter transference, akin to somatization, reflects a failure in mentalizing, leading the unconscious to communicate through the body. He says that therapists must actively interpret their physical responses with curiosity and willingness.

Gubb (2014) acknowledges that somatic experiences are challenging for therapists as they require mentalizing into language. Such experiences may evoke shame or other painful feelings, leading therapists to disavow them. Lemma (2014) characterizes somatic counter transference as encompassing motoric and sensory shifts such as changes in breathing, discomfort, and nausea, often triggered by projective processes bypassing verbal articulation when the patient struggles to symbolise.

Owens (2005) describes working with a 13-year-old quadriplegic patient, a survivor of a hit-and-run accident. She linked her somatic responses-headaches and nausea-to the patient's intense use of projective identification[8]. Owens hypothesizes that projective identification helped the patient meet his physical needs and express feelings physically, otherwise inaccessible due to his disability. She recalls being moved to tears by the patient's story, feeling as though her body had been commandeered like a puppet and that her tears were not her own.

This paper examines somatic counter transference and projective identification, emphasizing the discomfort and potential usefulness of allowing patients to influence therapists' bodies. For Owens' patient, embodying his therapist offered a means to experience his own emotions and see them manifest in front of him. Owens believes

[8] Defined by Hanna Segal (1973) as a process whereby parts of the self and internal objects are split off and projected into an external object

that this empowered her patient, by moving her body in a way he could not move his own.

Jaffe (2002) explored projective identification in mother-child and therapist-patient dynamics, highlighting the transmission of sensory and bodily fragments. Jaffe speaks of the therapist's role in deciphering these primitive, preverbal states which are transmitted and imbued into the other (the other being the mother, the parent, the therapist). It is up to the 'other' to feel, to experience and then to decipher these bodily emotional states (Jaffe, 2002). This work links projective identification, containment, and counter transference, demonstrating the complexity of receiving and processing somatic experiences.

Stone (2006) speaks of *embodied counter transference* to describe the bodily receptivity and reactivity between therapists and patients. He argued that preverbal communication often occurs somatically, particularly with psychotic, borderline, or trauma-affected patients prone to projecting unprocessed material and being more unable to be with excruciating or split off pain. Stone's metaphor of the therapist as a *'tuning fork'* illustrates the unconscious resonance between patient and therapist. He also emphasized the influence of therapists' histories and defences on their capacity for embodied resonance.

Samuels (1985a) conceptualized an '*imaginal space'* where therapists and patients co-create a shared experience, drawing on the mystical concept of the '*mundus imaginalis*.' Samuels proposed two forms of counter transference: reflective- involving immediate empathic responses, and embodied- where therapists *'become'* figures from patients' inner worlds. This embodied process situates therapists in a liminal space where their bodies resonate with unconscious communications, and

something might be put inside the therapist for understanding to occur. In this shared space, the body of the therapist is *"is not entirely his own and what it says to him is not a message for him alone…..bodily visions" (p60).*

Samuels' exploration of embodied counter transference illuminates the mystical and transformative nature of this phenomenon, highlighting its potential to deepen therapeutic understanding while raising questions about its mechanisms and implications.

The Embodied Psychotherapist

Shaw's book (2003) is a comprehensive exploration of the therapist's body in psychotherapy settings. He argues that the role of the therapist's body and its interaction with the patient has been overlooked, leaving a significant gap in the field.

Shaw sets the stage with a historical overview, tracing Western perspectives on the body to contextualize the enduring dualism between mind and body. He references: Plato**,** who viewed the body as a tomb imprisoning the soul; Christian theology**,** which framed the body as sinful, advocating for the denial of physical pleasures; The Renaissance which celebrated the beauty of the human body in art while rejecting primal bodily expressions; Modernity and science, which emphasized the mechanical nature of the body, likening it to a machine made of organs and parts.

Shaw critiques Freud's work on hysteria (the physical manifestation of psychological phenomena), arguing that it became subsumed into medical discourse which in turn promoted mind-body dualism. As already mentioned, other theorists celebrate the drives for linking together the body and mind (Damasio 2012; Harrang 2022).

Embodiment and the Lived Body Paradigm

In this book chapter, Shaw introduces a theoretical framework that moves away from traditional psychotherapeutic ideas about the body. Instead, he advocates for viewing therapists' embodied experiences as integral to the therapeutic narrative.

Shaw's perspective is grounded in phenomenology, particularly the work of Merleau-Ponty. In his work runs the sentiment;

> *"The body is never simply a physical object but always an embodiment of consciousness"* (Turner, 1996, as cited in Shaw, 2003, p.32).

This approach fosters a curiosity about the therapist's body and its role in therapy. Shaw notes that understanding in this area remain sparse and insufficiently integrated into practice. He cites Field's (1989) concept of *'embodied counter transference'*, which suggests a preverbal or archaic form of communication, as well as Samuels' (1985) study on the connection between bodily counter transference and the '*mundus imaginalis'* (the imagined world). These ideas frame the body as an overlapping space between patient and therapist-an environment where shared psychic experiences occur.

The lived body paradigm posits that our bodily perception and interpretation of the world form the foundation for acquiring knowledge. This notion, rooted in phenomenological philosophy is highly relevant to this project.

In contrast to Cartesian dualism, which reduces the body to a mechanical entity subordinate to the mind, the lived body paradigm recognizes the body as a dynamic, receptive entity (Shaw, 2003).

The Disembodied Encounter

Shaw (2003) introduces the concept of the *'disembodied encounter,* arguing that neglecting the body in therapy perpetuates Cartesian dualism and creates a disjointed therapeutic experience. He questions whether this disconnection is characteristic of much of the Western medical system.

Shaw reminds us that:

> *"We are neither just mind nor body-it is a fundamental part of being human that we are physical beings, receiving information in a bodily form"* (*Shaw,* 2003 p. 42).

This perspective is particularly significant in therapy, where two living, embodied beings-the patient and therapist-engage in a shared encounter.

Conclusion

Grouping my literature sources under different headings proved challenging due to the fluidity and overlap between ideas. For example, Klein's work is deeply sensorial and bodily while also being rooted in phantasy. Freud, on the other hand, is seen by some as having psychologized the body, while others argue that he provided invaluable insights into its primal, instinctual nature.

There are discussions (Budd, 2001; Harding, 2001) about object relations theory distancing psychoanalysis from the reality of the body as inherently alive and sexual. While this may hold some truth (since the realms of phantasy can drift away from the

raw, physical body) there is also a strong undercurrent of eroticism in writings about the mother's body and the infant's unconscious desires toward her body. The mother's body carries symbolic meaning, existing in phantasy (Klein, 1946). At the same time, there is the tangible act of physical holding (Winnicott, 1964) and the sensual, often erotic, interactions between infant and caregiver (Saketopoulou, 2023).

I spent considerable time deliberating on how to categorize the literature, before ultimately accepting that these ideas do not fit neatly into fixed boxes. If they are to remain alive and reflective of human nature and the human body, the organising of the literature review should reflect the cross-pollination of ideas. While I can attempt to organize them, it is just as important to acknowledge their interconnectedness- many of these concepts have influenced one another in ways beyond my awareness.

What is clear, however, is the complex challenge of understanding a multi-layered experience of inhabiting a physical, three-dimensional body while simultaneously navigating a psychological reality and the symbolic representations of what the body is.

One point of consensus across historical texts and contemporary neuroscience is the fundamental role of the senses in creating an experience in the body, which connects the body and the mind, essential to the fostering of a rich psychological and emotional life.

Research Project

Introduction

The research has been designed to meet the aims of this project[9], along with the literature review which offers a foundation of information.
I submitted for ethical approval in October 2022 and received approval in March 2023, as evidenced in appendix A.

Rationale for Research Design

This is a qualitative research project, and I chose Interpretative Phenomenological Analysis (IPA) as my method for analysing the participants' material because of its emphasis on the *"nuanced, lived experience of participants"* (McLeod, p.147). This focus aligned closely with my research objective: to understand therapists' embodied experiences and the meaning they derive from them.

Each participant brought their own unique lived experience and their individual capacity to be embodied in sessions, all within the context of their specific working environment. The IPA model prioritized attention to the individual, coupled with a

[9] Aims of the project are also detailed in the 'Introduction' section of this project. The aims are to: 1) Investigate the question: where is the body in psychoanalysis? And explore why it can be difficult to discuss and perceive, despite its central presence in psychoanalytic thought 2) To understand therapist's embodied experiences and the meaning they derive from them 3) To enhance the psychoanalytic community's ability to engage with the body in a way that can be effectively communicated to potential patients, the NHS and laypeople 4) To deepen the therapeutic relationship by encouraging therapist's to develop awareness of their own bodies and their capacity to understand both their own and their patients' bodily experiences

high level of analysis, making it particularly suitable for my study (Pietkiewicz & Smith, 2014).

A key feature of IPA is the *'double hermeneutic',* wherein the researcher gathers and interprets participants' interpretations of their own experiences before analysing the material to explore their understanding of the data.[10]

This two-person interaction has the potential to create confusion and ambiguity, much like the therapeutic encounter itself. As the researcher, I had to continually reflect on whether particular responses belonged to me, the participant, or both-or whether they were inseparable. Working through this complexity is intrinsic to psychoanalytic psychotherapy and to this project.

My choice of IPA was also influenced by my personal engagement with the topic. I was curious about my own embodied experience during the research process and how I would receive and interpret the material. I wanted space to feel and be curious about my own process.

Sampling

I structured my research question to attract the specific sample I aimed to engage- CAPs working in settings where the body played a central role. My goal was to capture a diverse range of experiences from CAPs who could articulate their

[10] This relational aspect was essential to my project, which explored the impact of psychoanalytic bodies on one another (Pietkiewicz & Smith, 2014)

embodied experiences in rich detail, and I was prepared for the sample size being small, as per IPA method (Smith, Flowers, & Larkin, 2022). [11]

I hypothesised that the system in which we work can be somewhat 'disembodied'- and mental awareness might not equate to a bodily awareness. I hypothesised that those working in specialist environments, such as hospitals, might have engaged with embodied work more actively, thus making their insights particularly valuable, and more available for discussion in an interview.

I approached participant recruitment with the assumption that some CAPs would have a well-developed ability to reflect on their bodily experiences, while others might not. Importantly, my research did not study the services themselves but rather the individual therapists, in line with IPA's emphasis on personal experience. This approach also streamlined recruitment, as it eliminated the need for service-level approvals that could have delayed the project.

Introducing the participants

I have ordered my findings in the order of the interviews. I have decided to give a brief introduction of the participants, since their work context holds a significance and is referred to in the research question.

Libby: Libby is a qualified CAP, who works predominantly with patients who present with violent and/or sexualized behaviours.

[11] The sample size was four

Elenor: Elenor is a trainee CAP who works with patients with physical disabilities and learning disabilities.

Nadia: Nadia is a trainee CAP who works in a hospital setting.

David: David is a qualified CAP who works in a hospital setting, and he also has private patients and works with adults.

Recruiting

Purposive sampling allowed me to maintain control over participant selection, ensuring I engaged individuals with experience working with the body in specialist services. To achieve this, I began by approaching potential participants directly. While this method was somewhat effective, it also impacted generalizability, as two of my participants were personally selected by me. However, two additional participants responded to advertisements, which introduced an element of diversity to the sample.

I recruited participants through personal emails, and I placed advertisements via the Association of Child Psychotherapists (ACP) and the Tavistock & Portman NHS Foundation Trust. The phrasing of my research question was important in attracting participants outside my personal network. These individuals shared an interest in the topic and worked in settings where the body was central to their practice.

Challenges in Recruitment

I initially approached individuals through word-of-mouth and professional connections, prioritizing those I believed could contribute meaningfully. However, I encountered unexpected challenges:

- Many potential participants did not respond, leading me to wonder if I had overestimated my ability to engage experienced members of the psychoanalytic community.
- A peer I approached hesitated, expressing concerns that the project felt highly personal and that they might not "know enough" or "feel enough." Their feedback was invaluable in refining my approach, though they ultimately did not participate.
- At times, I worried that my project might not be appealing enough. Advertising through the ACP and Tavistock's news bulletin helped address this concern by attracting two additional participants.

Not receiving responses from some individuals led me to reflect on the nature of my inquiry. At times, I questioned whether it was appropriate to ask senior therapists about their bodily experiences. This introspection highlighted the sensitivity of the topic and reinforced the importance of ethical considerations

My final sample included four people, each working in different services.

- Two participants who responded to advertisements, both trainees
- Two qualified CAPs I approached directly.

A possible limitation of purposive sampling through direct recruitment was the potential for participants to feel pressured or uncertain about why they were selected. To mitigate this, I ensured clear communication about consent, revisited consent forms before interviews, and discussed confidentiality thoroughly. Additionally, I reassured participants that services would not be named, reinforcing my commitment to ethical research practices.

Characteristics and Size of the Sample: Demographics

The sample consisted of participants ranging in age from approximately 25 to 60, three women and one man. It was intriguing to see how participants reflected on the experience of being in gendered bodies. Given the small sample size, and in alignment with the intentions of an IPA study, no generalizations were made across age, gender, or professional experience for example, however, the diversity that does exist in the sample enriched the material significantly. Each participant works in a different specialist environment to the next, and each person is uniquely different. The interviews have different flavours, and I believe the personalities and approach of each person is distinct.

This sample was not racially diverse, as all participants were white. While the small sample size limited generalizability, the absence of racial diversity highlighted the missed opportunity to explore how skin colour, race, and cultural identity intersects with the body in clinical work.

Ethical Considerations

A small sample size inherently increased the risk of confidentiality breaches. This was clearly outlined in the consent form [12]and participant information provided[13]. During interviews, it became evident that confidentiality was a significant concern for some participants, while others were more comfortable with disclosure. Given the personal nature of this project, I took particular care to protect participants' anonymity.[14]

Research Setting and Conducting Interviews

I conducted one interview in an NHS clinic in the participant's consulting room, one interview was conducted in the Tavistock, one interview was held online (and we were both in our homes) and one interview was held in the participant's private consulting room. Conducting interviews in different settings offered different experiences that have impacted upon the material. The settings invite reflections regarding power dynamics, roles and a consideration of how our bodies respond in different environments. In some cases, the participant was in their familiar environment while I was the guest, unsure of where to sit or place my belongings- perhaps even occupying the patient's chair. In other interviews, I controlled the space, welcomed the participant, and offered them a seat.

[12] See appendix B
[13] See appendix C

[14] To further confidentiality, I omitted personal details such as hair colour and age from the report even thought it might have been interesting and relevant to retain it. Most importantly, I refrained from specifying the participants' workplaces. This measure, which I discussed with participants, felt like a reasonable step in safeguarding their identities.

Data Collection

Ahead of the interviews, I asked participants to reflect on clinical cases where embodiment played a significant role. During interviews, I provided only a brief introduction to the project to allow for organic discussion.

In my TREC application, I specified a semi-structured interview approach, allowing for prepared questions while providing flexibility for participants to guide the conversation. This approach aligned with an IPA method, which focuses on individual experiences. It also provided an interesting point of comparison during analysis, as I noted when participants took the conversation in new directions or we remained close to the questions.

For the first three interviews, participants largely followed the structured questions, whereas the fourth participant (the most experienced clinician) took more leadership in the discussion. By this point I was more comfortable in interviewing, allowing the interview to unfold more organically. This interview, conducted in the participant's personal clinic, provided insightful feedback on my question design, highlighting inherent conceptual splits. This participant, highly knowledgeable on the topic, pointed out that some of my questions unintentionally reinforced mind-body dualism. They challenged my framing, which led to a more fluid, free-associative discussion- an invaluable learning experience. However, this has also had an impact on the research, and I noticed a process of 'uncovering' where and how this final interview might have influenced the analysis of the interviews that came before it. I had to make effort to scrutinise this, and perhaps also 'undo' some of this influence to remain more open to all of the experiences gathered.

Transcribing

I followed the transcription method recommended in the IPA manual (Smith, Flowers, & Larkin, 2022) but I adapted their method and chose to transcribe all the interviews first before commencing analysis.

Transcribing was a lengthy process, requiring me to meticulously review and correct errors from the automated transcription program. This deep listening experience offered a different perspective, revealing how much meaning we assume during everyday conversation. Occasionally, sentences were unclear upon playback, though they had seemed comprehensible during the interview. Sometimes a sentence was unclear initially, but by the fourth or fifth play back I could hear and understand what the participant was telling me. This highlighted the complexity of spoken communication and how listening is a subjective experience. My capacity to listen and hear changed day-by-day.

Transcribing interviews in parallel with conducting interviews also helped maintain motivation. Listening to the recordings again reinforced my appreciation for participants' willingness to share their stories.

Ethical Considerations When Collecting Data

To protect data, I uploaded the audio recording from my phone onto a password protected transcription app immediately after the interview and I deleted the original recording. Once uploaded, I deleted the app from my phone and accessed the recordings and transcripts through my laptop since that did not leave my home.

Data Analysis Method

I followed the data analysis method in (Smith, Flowers, & Larkin, 2022). Following transcription, I analysed each interview one by one to maintain focus on individual narratives. This required discipline, as I often noticed connections and links between interviews, but I refrained from documenting them prematurely.

I began making notes on the transcript, paying particular attention to what the participant was saying and how they were saying it. I focused on their tone of voice, pauses, hesitations, and the speed at which they responded to questions. I spent a considerable amount of time on this, repeatedly reviewing the transcript to uncover hidden details.

Next, I started jotting down notes in my notebook that could form the basis of experiential statements (Smith, Flowers, & Larkin, 2022). However, I aimed to maintain a broad perspective on the interview to avoid being drawn in any direction too soon. This proved to be a challenge, as each interview was fascinating, filled with key sentences and sound bites that made me reflect on the project at a larger scale.

I found myself wrestling with my new identity as a researcher - a part of me wanted to rush ahead, and I had to work hard to stay focused on the individual rather than getting caught up in the bigger picture and what I wanted the project to be.

I became more proficient, efficient and objective in data analysis as I continued the process for all interviews. Over time, I became better at identifying my biases, premature assumptions and ensuring participant-centred analysis.

Personal Experiential Statements

I arranged my transcript into a table to allow space for notes and to start forming personal experiential statements for each participant. Personal experiential statements concisely capture the experience of the participant (Smith, Flowers, & Larkin, 2022). Initially, I found it challenging to be concise in the wording of the statements, and they were often quite long and required much rephrasing. It was also important to revisit them, as their meaning seemed to change over time. A statement I had initially phrased to capture what the participant was saying no longer felt accurate. While I don't have a clear explanation for this, I suspect that I was unconsciously processing the information, even when I wasn't directly focused on the task. Over time, my understanding became more refined.

Personal Experiential Themes (PET)

I gathered all the personal experiential statements, printed them out, and cut them into strips. [15] I arranged them on the floor to get a clear view and began categorizing them into personal experiential themes, which capture patterns in what the participant has shared (Smith, Flowers, & Larkin, 2022). I worked with the strips on the floor for several days until I had everything categorized. At that point, I created a table to clearly record the PETs, including the reference and quote.

As I progressed through the process of analysing material for each participant, I noticed my role as a 'researcher' becoming more refined and objective.

[15] See appendix G

Once I completed the analysis for all four interviews, I reviewed the tables ahead of a meeting with my supervisor. This prompted a final edit of my PETs as part of a quality control process[16], ensuring they were as participant-centred as possible-a skill I was developing.

Group Experiential Themes (GET)

GETs[17] are themes that exist across the whole data set. I found it intriguing that some aspects of the analysis changed entirely when creating GETs. For example, a PET 'projections into the body' and its related quotes shifted into a broader category of 'boundaries' as a group theme. This process felt strange but important. I observed how a personal experiential statement could be valid on its own but, when placed in the group context, take on a different meaning. I had to be prepared to 'let go' of themes I had decided upon that did not quite fit with the entire group in the same way.

In this process I became more aware of my unconscious biases, noticing what I felt attached to and what I could let go of more easily. I paid attention to attributing more meaning to some voices over others; a bias I noticed was considering the voices of qualified staff differently. I also made a conscious effort to avoid placing a white male voice above others because he was the most experienced member of staff. These biases are deeply ingrained and require ongoing reflection and awareness to address.

[16] See appendix I for example of a complete table of PETs for a participant
[17] See appendix J for complete table of GETs across the entire sample

Reliability and Limitations

As intended in an IPA study, each participant influenced the research. However, this also posed challenges to reliability, as each individual left their mark on the results. Some voices were more dominant than others, while some required more interpretation. For example, I found that analysing data from the two trainee participants took more time due to some reticence in communication.

I noticed that the final interview influenced my thinking, and I managed this complexity through reflection, journaling, and supervisory discussions. These strategies helped me disentangle the intensity of this influence while ensuring the participant's voice retained its strength.

As the researcher, I also impacted reliability. I had to remain mindful of any tendency to prioritize information I agreed with or found important, as this risked overlooking other valuable insights. The early stages of data analysis were particularly crucial in mitigating this risk. By repeatedly listening to audio recordings and reviewing transcripts, I was able to interpret meaning at different levels and identify information I had initially disregarded or misunderstood.

The study's limitations included its small sample size and lack of diversity. In hindsight, greater racial and disability diversity could have provided richer perspectives. However, recruitment proved more challenging than anticipated, and seeking different participants would have delayed the project. Additionally, targeting participants based on specific diversity markers could have introduced ethical complexities.

Findings

In this section, I present the findings of my research in an order that I believe facilitates a fluid immersion into the project based on my understanding of the data, rather than indicating their relative importance.. Through data analysis, I found five GETs[18]. Each GET has underlying subthemes (as shown in the table on the following page). [19]

In this section, I will introduce the Group Experiential Themes, which will be further explored in the 'Discussions' section.

It also feels relevant to add a comment regarding my own reflections from conducting the interviews.

Each was unique, and my bodily experience differed depending on dynamics between us and the setting. For instance, in my interview with David I sat in his patient's chair, which heightened a power dynamic shaped by his experience in the field, and perhaps by gender, evoking paternal overtones and unconscious bias around men holding authority. I also sat in the patient's chair with Libby, though the quality differed. The night before this interview (the first in the sequence) I felt agitated and tense, with a knotted stomach and concern the process might feel intrusive for us both. The interview with Nadia, held online, created a sense of body–mind split: we discussed embodied states while seeing only partial views of each other. At times I felt disconnected from my body, and beforehand I noticed a striking

[18] The GETS are: 1) Boundaries 2) The Public Body/The Private Body, 3) Embodiment or Enactment, 4) Sexuality: The Sexual Nature of Bodies, 5) Body-Mind Split
[19] Each GET and the subtheme is common to each of the four participants, but are illustrated with different angles of experience and understandings.[19]

sense of bodily blankness. In contrast, during my interview with Elenor my body felt immersed in her story, as if it belonged to the exchange. That conversation carried a weight and seriousness I registered in my own body.

Table of Findings

Boundaries	Subtheme A: Intrusion
	Subtheme B: The Body is Projected Into-Made to Do Something
The 'Public Body' / The 'Personal Body'	Subtheme A: The Threat of Exposing the Therapist's 'Personal Body
	Subtheme B: Threat of exposing the Patient's 'Personal' Body
Embodiment or Enactment	Subtheme A: The Threat of Enactment
	Subtheme B Moving With: Embodiment
Sexuality: The Sexual Nature of Bodies	Subtheme A: The Sexual Subtext – Naming Sexuality Explicitly Is Difficult
	Subtheme B: Sexuality in This Context Can Feel Unsafe
	Subtheme C: Sexuality and the Complexity of a Gendered Body
	Subtheme D: Adults and Children
Body-Mind Split	Subtheme A: The Therapist's Body Communicates Something Important and/or a Truth
	Subtheme B: Defences Against Mind and Body Integration

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[20] A table of Group Experiential Statements and subthemes

Boundaries

The theme of boundaries holds a different meaning for each participant, shaped by their personal and professional experiences. While the sample size precludes generalizations, intriguing differences and similarities in the consideration of boundaries emerged across the interviews. From these, I have generated some ideas about their meanings. The topic of boundaries tended to carry an uncomfortable undercurrent across the interviews

Subtheme A: Intrusion

Libby

Libby frequently works with patients who have committed violent and/or sexual harm against others. Her reflections on boundaries were influenced by the nature of her work and the pathology of her patient group, people who have *'written their trauma on another's body.'* For Libby, the work is undeniably bodily, as the patients' issues often revolve around the body, both in terms of harm done to them and harm inflicted on others.

For Libby, intrusion takes on a particularly primitive and unsettling quality, as if it is physically affecting her:

> *"It really felt like they were getting inside and messing with me." (p10)*

She is also acutely aware of her own capacity to intrude, a risk inherent in all therapeutic relationships. However, with this patient group, characterized by sexual violence and histories of intrusion-this risk takes on a unique dimension. Libby

described a sense of ‘double intrusion’, where she feels invaded and is simultaneously drawn into intruding herself:

> *“(They) might be inviting me to be more intrusive towards them and bigger.” (p7)*

This connects to the later GET of ‘Embodiment or Enactment.’ Being drawn into enacting a patient’s trauma (such as a sexual assault) can intrude on the therapist’s boundaries. Libby’s language- ‘*towards them’* and ‘*bigger*’- suggests something very bodily, involving physical, real-life as well as symbolic movements and changes in the body. In her interview, Libby conveyed the disturbing nature of how her body might unconsciously respond to intrusive ‘invitations’ from patients.

While the ‘invitation’ may be to intrude upon the patient, it also represents a crossing of Libby’s own boundaries, drawing her into something she might not be consenting to, and using her body in a way she does not wish.

Elenor

Elenor demonstrated a natural attunement to her body and her patients’ bodies, fostered by her background in more ‘hands-on’ therapeutic work. This sensitivity added depth to our conversation, as she brought a nuanced vocabulary and willingness to engage with these experiences.

Elenor works with children and young people with learning disabilities, severe physical disabilities, and limited verbal communication. The demographic of her patients, combined with her sensitivity, highlighted particular qualities of the intrusions she experiences.

For instance, intrusion into Elenor's body could feel intense and envious:

> *"I had one child this week who wanted to do a body swap." (p8)*

Elenor also described a process of using her body to manage feelings of intrusion and boundary-crossing:

> *"… I sort of feel a bit like "heuhh" (she makes a sound and shudders)… I often need to defuse something. And if I don't do that, it's not great." (p10)*

The 'heuhh' sound vividly conveys the intrusive sensation, which she intuitively feels the need to diffuse through physical movement, such as walking. This practice suggests a general response to moments when the patient's material 'gets inside' her, leaving her unsettled.

Her shuddering further emphasizes the severity of these intrusions.

Nadia

Nadia did not explicitly name intrusion as Libby and Elenor did, but her experiences conveyed a similar theme. For example:

> *"…but then I get this feeling of literally, like I'm poisoned, or I could be sick." (p15)*

In this instance, Nadia described a physical reaction after being with a patient she initially felt 'neutral' about, as she put it. The feeling of sickness and nausea suggested an intrusion or contamination. Nadia also noted the patient's initial 'charming' and 'phallic' demeanour, the latter implying an intruding and penetrative quality.

On another occasion, Nadia described a delayed reaction to a session:

> *"When I was going to bed that night, it was like… I'd had 10 cups of coffee. My mind was racing, which I think was about the session." (p36)*

Here, the intrusion bypassed her conscious awareness, impacting her body directly. Nadia also acknowledged a 'split' in her bodymind, which she is actively working to understand. This split may have contributed to the intrusive physical experiences that bypassed the mind in some way.

David

David, the most clinically experienced participant, spoke with confidence and less anxiety compared to the others. His reflections on boundaries were less personal and more general, though they carried significant weight. Interestingly this was the only interview conducted in the participant's personal consulting room, which was not in an NHS clinic environment. This flavoured the interview in some way, perhaps adding to the idea I might have of David as an authority.

David referenced the sexual aspect of intrusion:

> *"There can be an anxiety that one body will penetrate the other." (p18)*

This statement was made in the context of discussing how and whether to speak to patients about their bodily experiences. David noted the immediacy with which discussions about the body can become over-sexualized:

> *"Because it can get over-sexualized like that (snaps his fingers). You've gone into their bodies." (p18)*

This moment in the interview was particularly powerful, as the finger snap resonated intrusively through the space. The immediacy of the intrusion is captured in his words, and the phrase *"you have"* suggests a sense of direct involvement by the therapist, implying they have entered the patient's body, perhaps unintentionally. Something seemingly innocuous suddenly becomes sexualized and intrusive.

This sentiment echoes Libby's experience:

> *"…it's exciting to hear about what goes on inside of people's bodies. I mean, that's what we're in the business of…they want to know and get right inside" (p.26)*

Here, Libby also speaks more generally about intrusion, though the intruder in her example is the (male) patient wanting to know and get inside.

Subtheme B: The Body is Projected Into-Made to Do Something

The title of this subtheme captures the live, evocative quality of this type of boundary crossing. In these cases, an unseen boundary is broken, impacting the therapist's physical body, and moving them in some way.

This subtheme relates closely to the concept of projective identification, which will be explored further in the discussion section. Within this subtheme, therapists describe experiences where their bodies are affected in ways that feel physical, uncomfortable, and beyond their control.

Often, participants are not speaking about their conscious boundaries but rather unconscious ones that are crossed, prompting a physical and/or emotional reaction.

Libby

Libby shared an experience where she fell down the stairs shortly after learning that her intensive patient had cancelled their final session together:

> *"I was really shaken up by it-how powerful it was-and how humiliated I felt. And I did feel humiliated" (p13)*

While Libby acknowledged it was impossible to definitively know what caused the fall, connecting it to the cancelled session helped her make sense of the event. She understood it as projective identification-a powerful projection that entered her and took over her body, resulting in the fall. This experience allowed her to feel a necessary humiliation, perhaps mirroring her patient's feelings of rejection.

Libby also recalled other moments when she 'lost function' with certain patients, describing a *'zombie'* state. For example, she struggled to complete a simple task:

> *''……being out of my control. It's been unpleasant….it felt bodily. I felt freaked out….I…forgot my mind…" (p14)*

This disorienting experience left her visibly uncomfortable during the interview. Her use of the term *"zombie"* is evocative, implying an intrusive takeover. The imagery of being 'turned' and losing autonomy aligns with her feeling that the projection invaded her. This experience underscores the integrated nature of the body and mind-an attack on one is an attack on the other.

Elenor

Elenor's contributions to this theme mirror Libby's, as she also expressed discomfort and a sense of being overtaken. During the interview, she seemed strained, as though recalling these experiences required significant energy.

Reflecting on her bodily experiences in sessions, she stated:

> *"I feel like I'm sort of under siege sometimes." (p9)*

With one particularly dominant patient, she recalled:

> *"I felt shrunk back into my chair…like it really felt difficult to move." (p9)*

The patient's overwhelming presence left Elenor feeling physically restrained. Her body was forced, aligning with the subtheme's focus on projection-induced bodily responses.

Nadia

Nadia shared an incident where her stomach rumbled with hunger during a session with an anorexic patient:

> *"…And I felt completely humiliated by it." (p25)*
>
> *"…like **I** had to be the person with all the hunger and all the need-the aggressive hunger." (p26)*

Although this event could fit under the later theme 'Bodies Talk', it is placed here due to Nadia's understanding of the experience. She perceived it not as her body

speaking to her but as her body embodying the patient's projection. Intense hunger was displaced onto Nadia, leaving her to carry this overwhelming sensation.

Nadia also discussed numbness as a bodily response:

> *"I'm in a state where I'm cut off…but it doesn't feel as simple as that. And it definitely feels more in relation to what they're projecting into your body as well." (p22)*

Here, Nadia reflects on how projections from the patient seem to disconnect her, numbing her body and mind.

Another occasion involved a rigid, tense bodily state:

> *"…every time I had a thought, my body was tense-as if I wasn't allowed, as if it was dangerous to have that thought." (p15)*

Nadia related this to a male adolescent patient described as *"charming"* and *"phallic,"* similar to Elenor's patient with problematic views on women who also forced her body into a submissive state. These parallels suggest a distinct quality of boundary crossing, inducing a still and tense bodily response in the therapist.

David

David shared an account of being "seen" by a young child as an abuser due to her past sexual trauma.

> *"To have to be seen like that is deeply, deeply disturbing." (p11)*

He described the look in her eyes that conveyed this perception, a memory that continues to haunt him.

The word *"seen"* is significant, as it encapsulates both physical appearance and the projection of personality. David felt his body mind distorted in the patient's perception. His physical form morphed into something and someone else.

His use of *"to have to"* suggests this experience was necessary yet profoundly uncomfortable-a difficult but unavoidable aspect of psychotherapy.

Across participants, a common theme emerged of discomfort and loss of control when boundaries were crossed. While these experiences may hold therapeutic value-such as facilitating projective identification that serves as a communication-they often felt intrusive, disorienting, or distressing.

In David's case, he lost control of how his body was perceived, becoming something he did not recognize as himself. This reflects a broader phenomenon shared by all participants: the unsettling impact of boundary crossings, even when they serve a therapeutic purpose.

The 'Public Body' / The 'Personal Body'

I have positioned this theme after 'boundaries' due to the strong relationship between the two.

This theme explores the concept of personal bodily identity and the aspects of ourselves as therapists that we wish to keep private. These may include personal health matters, pregnancy, menstrual cycles, or elements of appearance that reveal something about who we are as individuals, beyond our professional roles.

The idea of a ‘public body’ suggests that the body does not entirely belong to the individual but is instead publicly accessible. This concept is particularly relevant in the NHS context of ‘public health.’ Lemma (2014) addresses this notion, describing how the therapist’s body can be seen as part of the therapeutic space, room, and setting.

This concept is equally relevant to patients. Do they offer their bodies freely when entering the public health system for therapy? There may be parts of their ‘private’ body that patients have not granted the therapist access to, potentially leading to feelings of intrusion or persecution when their bodies are observed and analysed.

Conversely, some patients may openly discuss somatic issues, sharing intimate details about their ‘private’ bodily experiences. These patients may seek the therapist’s help in understanding their body and how it functions. This raises questions about which aspects of the body are ‘public’ and which are ‘private.’

The subthemes below incorporate the term ‘threat’ to express the anxiety experienced by therapists and patients, and the instinct to protect something personal. This underscores an inherent ‘split’ in the idea: is it possible to separate the personal from the public?

Subtheme A: The Threat of Exposing the Therapist’s ‘Personal Body’

Libby

This topic felt particularly significant for Libby, given her professional context of working with children and adolescents who might exhibit intrusive behaviours due to their own histories of being intruded upon during early life.

Libby reflected on her experiences during the Covid 19 pandemic;

> *"The experience in lockdown… for the first six months, we had to take phone calls or Zoom calls at home. It was really—**I** found anyway—it was shocking." (p19)*

Elenor

Elenor expressed discomfort that;

> *"My body's being noticed more."* (p6)

> *"It's been interesting, going into summer clothes, because I sort of had almost a little uniform that I wore in the winter. It was very predictable and boring. But it somehow got me off the hook with wandering too much because it was quite repeatable." (p7)*

Elenor's unease when describing this might suggest a discomfort when her body is more visible and available for observation during the summer months.

Nadia

During her interview, Nadia discussed somatic responses to her patients. When asked whether she felt comfortable discussing this with colleagues or at her training school, she said:

> *"To talk, like really intensely about your body… err feels too personal and it feels a bit like oversharing." (p28)*

Reflecting on the interview setting-a Zoom video call-Nadia noted:

"I would have been worried about crying, or I would have been worried about my body." (p38)

Here, Nadia conveys her concern about what I might have observed about her body in person, and how conducting the interview online allowed her to maintain some distance from that perceived threat.

David

When asked about a potential 'therapeutic body'-a concept suggesting that a therapist might intentionally engage a 'public body' to attune to somatic countertransference-David responded:

"No such thing (as a therapeutic body)… I just think of resonance… you resonate with whoever is sitting there or lying there…" (p2)

David rejected the idea of a division between personal and professional in the way I had been conceptualizing it. His response, offered early in the interview during the 'icebreaking' phase, encouraged me to reconsider some of my assumptions about this topic. David's interview was the final one, and his expertise and alternative theoretical perspectives had an influence on my thinking and process.

Later in the interview, David shared a more personal perspective when describing a patient analysing his body:

*"It can make you… make **me** really self-conscious…" (p14)*

By using himself as the subject of this statement, David suggests the deeply personal nature of a patient scrutinizing his body in a way he might not have

permitted or wanted. Something of his 'private' body is exposed when a patient observes and evaluates him.

Subtheme B: Threat of exposing the Patient's 'Personal' Body

Libby

Libby reflected on her awareness that the patient's body, and what they have used it for, cannot always remain confidential. Professional requirements around disclosure, safeguarding, and information sharing often limit confidentiality. Highly intimate and personal details may need to be shared with others. Alongside the necessity of such information sharing, she observed:

> *"There needs to be a sort of almost putting the clothes back on element to it as well… to nurture their development." (p22)*

Here, Libby highlights the importance of fostering the patient's development in a way that respects their privacy and encourages a healthy sense of boundaries.

Nadia

When asked whether she might discuss a patient's bodily experiences, Nadia expressed hesitation:

> *"… it's like a bit culturally ummmm… rude as well or like too personal or disrespectful." (p30)*

She elaborated that it felt easier to address bodily issues in specific contexts:

> *"When appearance or body is related to like a defined area of difference, like disability or sexuality or gender or race, then it feels easier to talk about than speaking about their body in the room." (p31)*

This response conveys Nadia's discomfort and awkwardness in speaking directly about a patient's body. Interestingly, she noted that it feels easier to address matters of equality, difference, and inclusion-topics many people find difficult to discuss-rather than to engage with a patient's bodily experiences. This contrast demonstrates how challenging it can be to address the body in therapy.

David

When asked whether it is possible to discuss a patient's bodily experiences, David commented:

> *"It can feel persecutory for patients if we speak about their body too directly." (p14)*

He further reflected on the nature of these interactions, remarking:

> *"… it might feel like some of the things I'm saying are a bit illegal." (p19)*

David seems to be speaking about the appropriate temperature, distance and intimacy with patients which can feel *persecutory* or *illegal* when the patient's body is felt to be/experienced as over exposed.

Embodiment or Enactment

This theme emerged from participants discussing how embodiment and enactment are intertwined yet distinct. In the material, enactment carried a threatening quality,

while embodiment (as I understood it from the material) implied creativity, movement, and fluidity in sessions-something coming to life.

Subtheme A: The Threat of Enactment

Libby

In Libby's working context, the threat of enactment felt particularly unsettling due to the kinds of 'acts' her patients might enact.

Libby highlights how an enactment of trauma might involve harming another person. This implies that such enactments occur because the patient has been unable to process their trauma, giving the enactment a dangerous and unconscious quality. This has significant implications for therapeutic work, as enactments-whether physical or psychic-may arise when something traumatic remains unprocessed.

Libby also spoke about how enactments can happen quickly and unexpectedly:

> *"… and you can find yourself in….it's an enactment (she says quickly), you quickly find yourself in a scenario." (p4)*

At this point in the interview, Libby was describing an occasion where she had used her body creatively with a patient, but the impending enactment abruptly shut that process down.

Elenor

Elenor shared a session where an enactment deeply impacted her:

"I was being put in this position where I felt like he was the dominant one, and I felt that in my body as well, like it felt difficult to move." (p9)

This enactment had a particularly threatening quality, compounded by the fact that the patient had a history of committing sexual assaults against women.

David

David expressed a clear sense of caution around enactments, stating:

"You can quickly get into a replicating traumatic situation." (p16)

Both David and Libby used the word *"quickly"* to describe how enactments take place. Their observations suggest that therapists might *"get into"* (David) or *"find yourself in"* (Libby) an enactment without full awareness, reflecting how these situations can arise almost instantaneously.

David also discussed his gender in relation to the threat of enactment, noting that he is:

"… very aware…if I'm doing my adult work, particulalrly male/female issues, in terms of any abuse history or sense of not trusting that boundaries will be respected and kept." (p13)

Here, David acknowledges some additional complexities he might need to consider as a male therapist working with women who have experienced abuse by men.

He provided an example of working with a young child who enacted trauma in the therapy room:

"… she would enact it, and she would want me to (he trails off)… and she would be lying on the couch and pretending to be asleep, and I would have to come into her room…she enacted it in the room (p.9)

In this case, the enactments didn't have the unaware quality he had referred to earlier. However, they were repetitive, and David was repeatedly drawn into something deeply unsettling.

"… I would have to come into her room…" (p.9)

This phrase suggests that the patient wanted to reenact the scenario multiple times, engaging in repetitive behaviours.

David's account of this work was particularly unsettling because he was cast in the role of the perpetrator.

When asked whether he felt his body still belonged to him during these enactments, David replied:

"… absolutely not." (p10)

Subtheme B Moving With: Embodiment

I have chosen the term *'embodiment'* to describe the differentiation participants made between enactments perceived as threatening and those with a more creative quality. In contrast to feelings of *'threat'*, this section captures the essence of *'moving with'* something in an embodied way. The examples in subthemes A and B may both describe *'enactments'*, but their essence and quality differ. For the purposes of this research, precisely defining different kinds of enactments is unnecessary, as it was

not a focus for the participants. Instead, our task is to convey how these enactments felt for the participants.

The distinction may also relate to the level of consciousness involved. Participants described unconscious enactments as threatening, whereas more conscious ones, which allowed space for thought and awareness, felt embodied and creative. By 'embodied', I mean an experience of attunement to the body-mind connection in the moment.

Libby

Libby provided an example of *'marching'* around a room with a young patient who is fascinated by gang culture:

> *"I give over very much to what he needs, what's on his mind, what he needs to explore. And it helps to regulate something that otherwise… he can be bouncing off the wall a bit." (p5)*

In this example, Libby conveys a sense of choice in her decision to embody this dynamic.

Elenor

Elenor spoke more generally about an embodied experience of being with patients and the inherent potential for connection, creativity, and change:

> *"But then we are always there in our bodies, obviously, there's always an experience of moving and being together." (p12)*

David

In the previous subtheme, David spoke about his work with a young girl and the sexualized enactments that arose in their sessions. In our discussion, David transitioned from speaking about the threat of these enactments and the discomfort of being perceived as a perpetrator, to exploring the potential for empowerment for the young patient:

> *"I suppose the interesting part of that scenario is then the enactment that empowers her to complete the freeze, I suppose, you know, that she was able to complete the action to get someone away." (p13)*

In this vignette, David refers to how something unprocessed and unarticulated can become conscious and intentional within the therapy space.

There was a noticeable difference in tone and energy when comparing the material above, to David's comment under subtheme A of this GET. In subtheme A, David expressed concern and wariness when discussing the threat of enactment. In the extract above, he communicated with a more animated and engaged tone. This shift aligns with Libby's earlier comment: *"I give both over very much to what [the patient] needs."* A lively *'giving over'* suggests less anxiety and more freedom and creativity to move with the flow of the session.

David also described how this young patient wanted to *"propel"* him across the room in their play. They would act this out in an appropriate manner, with the child pretending to hurl David across the room, repelling him. He found ways to embody the child's wishes, enabling her to *"complete the* action" (Levine, 1997). Here, David

is referring to the therapeutic process of allowing the patient to act rather than remain trapped in a frozen trauma response. [21]

Sexuality: The sexual nature of bodies

Subtheme A: The Sexual Subtext – Naming Sexuality Explicitly Is Difficult

This subtheme encompasses extracts from interviews where sexuality was communicated more unconsciously or uncomfortably, making it hard to name explicitly. It felt important to categorize this material under its own subtheme because of a particular quality of sexuality when left unnamed.

Participants often spoke in coded ways, requiring me to rely on my countertransference and attunement to pick up on this content. I will explore this further in the discussion section. An ethical complexity arises from the need to analyse participants deeply, while respecting their boundaries.

Libby

When discussing confidentiality, Libby expressed reassurance that her service would not be named in case patients found the research. This suggests a dynamic in her work where boundaries might be intruded upon.

[21] Peter Levine (1997) has extensively documented 'completing the action' as a therapeutic tool for working with trauma, offering a useful framework for understanding David's approach

"…. it's exciting (for patient's) to hear about what goes on inside of people's bodies. I mean, that's what we're in the business of. Yeah, they want to know and get right inside." (p26)

The sexual subtext reoccurred in Libby's interview, likely influenced by her work environment, where patients have committed sexual and/or violent crimes. Her references to sexuality often carried a perverse or insidious tone. In this instance, her phrase *"getting right inside"* did not convey a healthy curiosity about others.

Elenor

Elenor spoke about her own body and her patients' bodies, omitting explicit references to sexuality:

"The body is used as a symbol… a way of expressing something… questions over gender… lack of sleep, or hours of gaming… it's still all in the body." (p14)

Regarding her own body, she said:

"I move in my body, eat in it, sleep in it, experience relationships and friendships and life in my body. So, it's something that I experience pleasure in and sadness in…it's the being, the being in relationship in my body." (p3)

These reflections on the body avoid explicit mention of sex or sexuality, possibly indicating difficulty in addressing the topic more directly. While pleasure is acknowledged, it is quickly tempered with sadness. This reserve might be contextual, influenced by the interview's location on a work site and Elenor's position

as a trainee during an interview. These factors may have unconsciously imposed a restraint on openly discussing sexuality.

Nadia

Nadia addressed how her body might be perceived by her patients. Initially, she answered this question quickly, stating that she didn't feel the significance of this difference. However, unprompted, she later revisited the question:

> *"I keep going back to the question that you asked about – how your body is perceived by the patient or how an adult body is – and…. I just… I'm finding that really hard to think about." (p26)*

This vignette could also fit under Subtheme D of this GET, but it is included here because of how potent the difficulty of thinking about this topic felt. Nadia seemed to touch on something significant: the challenge of considering how her body might be perceived by patients and the potency of having a sexual adult body in a therapeutic dynamic.

David

David remarked:

> *"…the things I'm saying are a bit illegal… and not quite psychoanalytically kosher." (p19)*

The literature (Ashtor, 2022; Elise, 2019; Harding 2001; Saketopoulou, 2023) suggests that the British Object Relations school might be less well-versed in addressing sexuality. David *may* be referencing this as a dilemma, reflecting how

psychoanalytic schools in the UK/NHS context are less comfortable discussing sexuality. He does not state this explicitly, and I am relying on my counter transference and drawing upon the interview in general to inform what I am saying.

He added:

> *"It just seems mad to be sort of phobic about it, but it's this society, it's cultural. It's really cultural." (p19)*

When asked to share an experience he had in his own body, David initially referred to a supervisee's recent experience rather than his own.

This occurred at the beginning of the interview, before the ice had broken. Later, David spoke in detail about his work with a young girl (as discussed in previous sections).

David's initial hesitation to discuss his personal experiences may reflect an unconscious resistance, shaped by the societal and psychoanalytic norms around what can be spoken about. Although he stated that this topic was not *"illegal"* for him, he may still be influenced by cultural and professional discomforts regarding sexuality.

Subtheme B: Sexuality in This Context Can Feel Unsafe

When sexuality was directly addressed in interviews, the topic felt unsafe.

Libby

When asked about how safe she felt in her working environment, Libby initially responded confidently but then reconsidered:

“Yeah, it feels safe. Alright…. is that true?” (p17)

She recalled an incident where she did not feel safe:

> *“And there was one case that I'd seen for the first time and me and a female colleague got really anxious that he hadn't left the building, and we ended up rushing into the toilet (to check if he was there).” (p17)*

The anxiety from this event was palpable in her retelling. By mentioning her *“female colleague,”* Libby oriented us to themes of gender, sexuality, and the precariousness of women feeling alone in a clinic with a male patient who had a disturbing sexual history. The bracketed clarification makes clear that Libby and her colleague entered the toilet not to hide but to check if the patient was concealing himself in there. This context contributes to the intensity of the situation: two colleagues storming the male toilets together to find a patient.

Safety was also a consideration for Libby when arranging the interview at her workplace:

> *“I suppose there is sort of that awareness, or I'm aware that there are mainly men in the building who have done terrible things to other people's bodies.” (p17)*

To ensure safety, Libby arranged for me to enter the building in a way that avoided sitting in the waiting room with any patients-something she also reflected on during the interview.

Elenor

Elenor described working with a male patient who had a history of sexually assaulting women:

> *“He's certainly spoken a lot about what he sees me as, his sort of his ideas about me, which are actually-quite wrong. But it's quite interesting what's projected onto me.” (p9)*

Elenor’s slow, laboured speech while discussing this topic conveyed a sense of unease. It seemed that the subject felt unsafe, and she was carefully editing her words to avoid saying something overly arresting.

She explicitly named the feeling of unsafety, which was also reflected in her restraint and vagueness:

> *“That feels incredibly there, but also very, very unsafe to be around for all sorts of reasons. It just feels too much sometimes, and that feels really not okay.” (p10)*

Elenor wondered aloud:

> *“And how safe is it to bring attention to that as well, where you don't always know what you're in touch with?” (p11)*

Here, Elenor touches on something fundamental: How safe is it to notice that which feel unsafe? How do we bring awareness to something that feels difficult to access?

David

As the interview progressed and rapport was established, David spoke candidly about the anxiety stirred by the presence of sexuality in sessions.

This was evocatively conveyed through his snapping fingers, a sound and movement that left a lasting impression on me.

In discussing a therapeutic relationship with a young child who viewed him as a perpetrator in the transference, David remarked:

> *"It's very disturbing to be seen in that way." (p17)*

David's slow speech and unsettling tone when making this comment communicated an intensity and discomfort.

Subtheme C: Sexuality and the Complexity of a Gendered Body

This subtheme explores the material regarding gender and its complexities in terms of relationships with patients. The participants identified as women and a man, and the patients they spoke about were also cisgendered. Therefore, this section does not include considerations about other ways of identifying.

Each participant reflects on their experiences of gender in relation to their stage of life, work environment, and personal history.

Libby

Libby works predominantly with male patients. Reflecting on their perspective, she notes:

"It can be quite frightening to be with a female body." (p8)

She adds:

"When aspects of my real body come into things, it's quite alarming at times for patients…. And other times, I think all of that is negated as if I'm a sort of sexless nothing. And that makes me much safer as well, but not real." (p8)

Libby's choice of language reveals several layers of meaning. Her use of *"a female body"* instead of "my body" or "my female body" suggests a deliberate attempt to emphasize the gendered nature of her body. At the same time, this phrasing could serve as a protective mechanism, by creating distance from the projections she may encounter as a woman. As Elenor says in her interview, these projections can sometimes be *"quite wrong."*

The terms *"frightening*" and "*alarming"* are particularly striking in this context of sexualized dynamics. Libby explains that patients may manage their discomfort with her *"alarming"* body by perceiving it as *"sexless."* While this might create a fragile sense of safety, it leaves Libby feeling "*not real."*

Elenor

In reference to working with a female patient with physical disabilities, Elenor shared:

"I had one child this week who wanted to do a body swap." (p8)

This statement has been placed under two different GETS (boundaries and sexuality), to preserve the different qualities in Elenor's communication. It highlights

a trend of participants expressing themselves in coded ways that require layered analysis.

Elenor's experience could be viewed through several intersecting lenses-gender, disability, and adult-to-child power dynamics. However, it is included under this theme because of the implication that Elenor's female body is both envied and denigrated by her patient, who fantasizes about taking it over. In the context of the patient's disability, Elenor's femininity might hold particular significance. The patient may perceive Elenor's body as potent and capable of fulfilling a fuller range of functioning and sexuality.

The complexity of gender and sexuality was also evident in Elenor's interview when she discussed her male patient with a history of assaults on women.

> *"When I did move more or speak more, he would typically fall asleep" (p27)*

Nadia

Nadia reflects:

> *"…about femaleness and the femininity of my body. And [I] feel like it's… provocative or, is the area that gets denigrated and attacked." (p18)*

Nadia went on to describe specific cases where her body was directly targeted. For instance, she recounted how an adolescent girl began to dress like her. In another case, while working with a patient with a severe eating disorder, Nadia experienced attacks on her body through intense projective identification of ravenous hunger.

David

David approached the topic from a different perspective, discussing the complexities he experiences as a male therapist.

He emphasized the need to be:

> *"…particularly [aware of] male-female issues, in terms of any abuse history or sense of not trusting that boundaries will be respected and kept." (p16)*

Although this remark may primarily reflect his work with adolescents and adults, it is also relevant to his interactions with children and young people.

In discussing being seen as a perpetrator in the transference, David remarked:

> *"It's very disturbing to be seen in that way." (p16)*

However, he also acknowledged:

> *"I think if in an abuse situation…that's common for us in transference work, you're seen as a particular person." (p17)*

While being viewed as a perpetrator is unsettling, David recognizes that such projections are a fundamental part of transferential work. He highlights how his gender adds complexity to these dynamics: when working with patients who have been abused by men, male therapists may be perceived as perpetrators but of course, the transference is not gender specific although there may be potential for gender valence.

Subtheme D: Adults and Children

This subtheme explores how participants understand their position as adults working with children and young people. While the power dynamics of such relationships are considered within the profession, the implications in terms of sexuality may be more challenging to address and acknowledge. The physical differences between the bodies of adults, children, and young people, along with psychological differences, influence fantasies about what might happen when these bodies come together.

Not all extracts in this section are overtly “sexual.” Defining what constitutes ‘sexual’ is complex, and overly rigid definitions risk excluding important material that do not fit neatly into a category. In this section, the approach to sexuality is broad, recognising that, as human beings, we all have an unconscious whirring in the background, composed of complex ideas about sexuality (Saketopoulou, 2023). Adults and children both use their unconscious to process sexual material, but their psychological “operating systems” differ (Scarfone and Saketopoulou, 2023). These differences are explored here, often revealing ordinary features of adult-child dynamics that might still be overlooked.

Libby

Libby works with children and young people who may have been abused, may commit crimes against others, or may express desires to harm others. She describes a potent sense of sexuality in this work, which she characterizes as particularly charged and sometimes disturbing, deviating from a normative developmental trajectory. There is a disturbing quality in the instances where a child’s developing sense of sexuality was imprinted upon by an adult.

Libby observed how some children might enact specific behaviours, saying:

> *"[They] might be inviting me to be more intrusive towards them and bigger." (p6)*

This enactment made her acutely aware of her adult body and size relative to the child, who may be attempting to recreate an abuse scenario.

Elenor

Elenor discussed the differences between herself and her patients, many of whom have physical and learning disabilities:

> *"Particularly the children I'm working with who have physical disabilities are very, very aware of my body, and that does come into conversation sometimes. You know—how do they perceive me?" (p7)*

Later, she reflected on her heightened awareness of her body:

> *"I feel like my body's being noticed more." (p20)*

Elenor may be acknowledging the multiple levels of difference between herself and her patients-she is both an adult and able-bodied.

When asked about the implications of being an able-bodied adult working with children with disabilities, Elenor reflected on her previous experience in a hands-on the body therapy role:

> *"…there was much more of a clear transactional goal that you were aiming to improve function and improve quality of life. You had a child who was*

struggling to walk, and you might make their knee feel a bit easier that day. At the moment, I'm being encouraged to just really bear with that pain." (p21)

Elenor contrasts the nature of her previous work (focused on measurable outcomes, such as easing a child's physical discomfort) with her current psychoanalytic work. She emphasizes the emotional weight of bearing with a patient's pain that cannot be immediately alleviated. Her reference to the knee evokes the image of a mother soothing a baby's physical discomfort, and in contrast, her current work involves enduring a broader, less tangible kind of suffering that cannot be easily soothed.

Nadia

When asked about the nuanced dynamics of adults working with children, Nadia initially spoke about envy directed toward her adult body. She noted her child patient's envious feelings about her adult capacity to think. Nadia then linked this to a broader form of adult power-specifically, power over a child.

"…adult bodies and adults being allowed to do whatever they want. And children having no power and powerlessness in the kind of child's body." (p19)

Nadia's emphasis on the "child's body" communicates the way children may feel smaller, weaker, and more vulnerable to being overpowered. Everyday parenting interactions, such as grabbing a child to prevent them from running into the road or enforcing boundaries like staying seated in class-demonstrate how adult power routinely overrides a child's autonomy. However, in work with abused children, these dynamics carry an additional charge. Adhering to adult-imposed boundaries, like staying inside the consulting room, may feel like a power struggle for the child.

Nadia added another dimension when she described a child expecting a reaction from her, as an adult:

> *"I think there was something about my adult body that became a bit like, well-why aren't you doing anything?! Why aren't I activating you? Why aren't you putting in boundaries as adults do more rigidly, or getting worked up like an adult should?"*

This theme elicited a strong emotional response from Nadia. She spoke passionately but then distanced herself, saying:

> *"For me, anyway, it feels harder to differentiate between adult and child bodies. It just feels like you've been experienced as an adult, and you've been seen as an adult, and that your body's been seen as an adult." (p21)*

This reflection was somewhat fragmented and difficult to process, as it seemed to carry a scrambling quality during the interview and subsequent analysis.

At the end of the interview, I asked Nadia how she felt in her body:

> *"I'm definitely a bit wriggly… I can't feel anything very viscerally in my body at the moment, but I'm a bit fidgety. And I think I keep going back to the questions you asked about-how your body is perceived by the patient, or how [the] adult body is, and thinking-I just-I'm finding that really hard to think about. Ummm yeah-I don't know if that's because I've not thought about it before or because it's difficult, difficult to think about." (p26)*

Nadia's description of feeling *"wriggly"* and *"fidgety"* suggests a sense of bodily discomfort linked to the conversation, which she struggled to connect to a specific idea.

David

David acknowledged the inherent power imbalance in therapeutic work with children. He highlighted instances where a therapist's insistence might inadvertently replicate a traumatic dynamic:

> *"A therapist might think-I'm not going to let them control me; I'm going to continue talking- then you can quickly get into a replicating traumatic situation where an adult is going to do something despite what the child feels. You get into a constellation where the child's views are overwritten and ignored, and the adult's wishes are asserted, which gets you rapidly, potentially into an absolute abuse situation." (p16)*

Body-Mind Split

This final GET examines the various aspects and qualities of body-mind splitting. It is positioned at the end of the sequence because it underpins much of the material gathered in the interviews concerning participants' relationships between body and mind.

As human beings, splitting our body-mind experiences is central to how we navigate life. Some experiences are typically associated with the 'mind,' such as thoughts and thinking, while others are attributed to the body, like headaches or rashes. This separation of mind and body might reflect a Western cultural tendency to conceptualize the two as separate (Shaw, 2003).

This section highlights the phenomenon of body-mind splitting. I identify instances where participants appeared to default to body-mind splitting during interviews. Sometimes, participants spoke about this dynamic with awareness; other times, it seemed more unconscious.

Subtheme A: The Therapist's Body Communicates Something Important and/or a Truth

In this subtheme, participants describe how their bodies may communicate independently of their minds, often conveying what they perceive to be the truth of a situation.

Some of these responses align with concepts of counter transference. In the literature review, I referred to somatic, bodily, and embodied counter transference. In this section, I may use the term 'bodily counter transference', though I aim to leave these accounts largely in the realm of felt experiences rather than theory, as they were communicated to me by participants, without the use of theoretical concepts.

Libby

Libby described how her body often alerted her to critical dynamics in her work with patients. For instance:

> *"And it just suddenly comes to you-to your gut and to your head, like this is not okay." (p.6)*

Here, Libby reflected on her body-mind, particularly her gut, signalling discomfort during an enactment scenario.

She also described an instance where her body communicated aggression:

> *“And literally, my stomach went braaah.” (p.12)*

Libby speculated that her aggressive bodily response might have been triggered by the patient’s attempts to unconsciously provoke her.

Additionally, Libby noted how observing her body provided insights into her work:

> *“It really helps me to tune in to something-something's different today, or, you know, I found myself sat very still, like with my legs crossed.” (p.7)*

This statement reflects her curiosity about how an awareness of her own body-mind can enhance her understanding of her patient.

Elenor

For Elenor, the body played a particularly significant role in her practice. She expressed a conviction that her body’s responses often provided a greater truth and accuracy than her thoughts:

> *“I'm very aware that what I think and what I conjecture isn't actually always accurate. And I really need to listen to my body.” (p.13)*

The use of the word *"conjecture"* here is noteworthy. Conjecture, defined as-an opinion or conclusion formed based on incomplete information (Merriam-Webster), suggests a kind of overthinking that may not accurately reflect reality. Elenor contrasted this with a psychoanalytic thinking which integrates emotive and sensory experiences, aligning body and mind.

Drawing on her prior hands-on therapeutic work, Elenor shared how listening with her body informed her understanding:

> *"Bodies don't lie-I could have a thought in my mind, and then touch a body and feel something different. And then I'd be like, 'Ah, I've got it wrong."* (p.15)

Elenor's belief that a patient's body offers nuanced, truthful information carried into her current practice. For example:

> *"A younger adult might be saying they're fine, but my body is really feeling something quite distant, you know, quite different." (p.12)*

She also recounted moments when sensations in her own body revealed dynamics with a patient:

> *"I was noticing in the room, a feeling in me of being incredibly watchful, vigilant-my body was tense." (p.9)*

This occurred with a patient who had a history of perpetrating sexual violence against women. Elenor suggested that her body registered these dynamics first, with her mind later interpreting the bodily response.

In her extracts, Elenor consistently conveyed a pronounced awareness of body-mind splits, recognizing how her body and mind often operated in distinct ways. She expressed a deep trust in her body's insights, describing it with a sense of allyship and affection:

“My body is what I wake up, and feel, and see-it’s part of my identity and also something that is constantly changing. And it feels like something that’s very much a part of me.” (p.7)

Nadia

In contrast, Nadia expressed a lack of awareness about her state, often realizing the truth of her feelings only through her body’s responses. For instance:

“I was a bit taken in by this kid, thinking like, fine, like they’re lovely, they’re great, they’re not disturbed. (Body says something different).” (p.37)

“I must be really disturbed by what's going on…but I feel absolutely fine.” (p.15)

These examples illustrate how Nadia’s body often signalled discomfort or disturbance before her mind recognized these feelings.

Nadia shared that she has always been *“somatic,”* linking this to childhood experiences of bereavement and illness. This suggests that, for her, painful emotions may be more readily expressed through the body than processed cognitively. This tendency might amplify her somatic responses, when her mind perceives a lack of emotional activity.

In her interview, Nadia described intense somatic reactions during moments when her mind registered little or nothing significant. This split between body and mind awareness was a recurring theme in her reflections.

Subtheme B: Defences Against Mind and Body Integration

Libby

Libby identified ways in which she and her colleagues used splitting mechanisms as a defence against the challenges of their work:

> *"I don't know if maybe our own bodies and private selves are sort of split off a bit here." (p.18)*

She also mentioned the use of *"gallows humour"* as a coping mechanism:

> *"I think we are used to being a bit… we can be quite crass here (use of humour)." (p.18)*

> Libby acknowledged that these defences are, at times, necessary:

> *"But what are we to do? We really have to put a boundary up-I've always worked in these environments. I might be a little bit cut off from that. In a helpful way."* (p.17/18)

At the beginning of her interview, Libby made a compelling comment about her perspective on the body:

> *"Friend or foe?" (p.3)*

Reflecting on Libby's interview as a whole, this subtheme conveyed a suspicion toward the body and its responses. This stance may stem from the nature of her work, where patients have often caused harm to others. Defences against the disturbance of this reality may be necessary in a challenging environment.

Elenor

Elenor's reflections conveyed a sense of separation between her body and mind, often describing experiences where her body seemed to operate 'above' her mind.

This sense of a "split" emerged in her response to the warm-up question, *"What is your body?"* While this question was intended to open the conversation, it inadvertently implied a division, which may have shaped her response:

> *"My body is what I wake up in-and feel-and see." (p.7)*

This statement suggests a separation between her body and her sense of self. However, Elenor went on to express a more integrated view of her body and identity:

> *"And my body seems to… be part of my identity and also something that is constantly changing-with my identity, I guess. And it feels like something that… is very much part of me, it is me. But I'm very aware of how it is constantly changing, and I am constantly changing. I experience relationships and friendships and life in my body." (p.7)*

This section of the interview captures a spectrum of experiences, from division to integration. However, the sense of a split re-emerged later:

> *"I put my clothes on and do my teeth and, you know… but I'm not so thinking about my body." (p.8)*

This fluctuation-from split to integration and back again-illustrates the nuanced and dynamic experiences of body-mind connection and separation.

Nadia

Nadia contributed the most material to this subtheme, explicitly identifying her tendency to defensively split her body and mind. She described how her past experiences necessitated this strategy:

> *"It involved a lot of physical restraint, and to survive, you had to cut off-you just had to cut off your body and you had to make your body like a machine." (p.36)*

Her use of the simile *"like a machine"* powerfully conveys an emotional detachment, suggesting a mechanical, dehumanized state.

Regarding her current training placement, Nadia observed:

> *"Often the body becomes the area of treatment rather than it feeling like the whole person." (p.30)*

She elaborated on this idea, noting a tendency to *"medicalize"* the body:

> *"As soon as it comes to the body, I think, well, it's not real unless I have science to back it up. It becomes medicalized somehow." (p.32)*

Nadia also expressed mistrust toward the body:

> *"Too much of the body stuff is polluting-polluting something, maybe." (p.29)*

She spoke to a sense of mystery and uncertainty regarding the body:

> *"God, there's loads that I don't know. And that is hidden and unprocessed within the body as well." (p.10)*

These reflections illustrate Nadia's ambivalence about the body. Her mistrust may stem from her intense, unclear somatic responses, which she described as occurring even when she felt *"blank"* or *"fine."* This mistrust might both result from and contribute to her reliance on splitting mechanisms to separate her mind and body experiences.

David

David's consideration of body-mind splitting was less personal compared to other participants. Instead, he provided a strong and theoretical perspective on the topic.

In response to the question, *"What is your body?"*, David replied:

> *"I don't distinguish body and mind… it's a completely Descartes era, as Damasio would call it. Mind and body are the same or interconnected. I don't even like the language (of body and mind as separate)." (p.4)*

David's response was passionate and somewhat educational, rejecting the idea of a body-mind split on a physiological level. However, he did not engage with the psychological aspect of this division, which is often central to human experience. His denial of the split's reality might itself reflect a form of splitting, perhaps as a defence against acknowledging its complexities.

David's comments were framed by his professional identity. As an experienced clinician, he might feel a responsibility to promote body-mind integration as a guiding principle for practice:

> *“People are so alienated-divorced from their bodies a lot of the time, which means that they're divorced from their minds.” (p.12)*

It is important to consider David’s material in the context of his role within the project and the profession. As an authoritative figure, his contributions may reflect a conscious effort to model and advocate for body-mind integration. This stance has brought valuable insight and perspective to the project. However, it may have also limited the vulnerability or personal reflections he could share, which might have added another layer of understanding to how bodies relate together.

As the researcher, I recognize my role viewing David’s contributions in a more elevated way. His position, experience, and other socio-economic or cultural factors likely influenced the dynamics of the interview. It is worth questioning whether there was ever sufficient space for David to be vulnerable in this setting.

Discussion

Boundaries

In considering this theme, I have thought about the body as the first thing we witness and experience of person-it is an initial insight into who they are. Assumptions and projections quickly follow. Our bodies are observed and analysed without our explicit consent, which may feel like a breach of personal boundaries, yet it is a fact of life: bodies are inspected, judged, desired and dismissed moment by moment. In therapeutic work, interactions with another's body can have a particular quality to it, as I will discuss below in relation to the two subthemes.

'Boundaries' emerged as an important theme for the participants, and varying by their work environment, type of work, and personal views on their own boundaries and what might constitute an invasion of them. For some, the work with patients seemed very capable of 'getting inside' the therapist, with patients potentially feeling this as well (that they can get inside the therapist, or the therapist can get inside them).

When spoken about in the interviews, boundaries often referred to emotional and psychic breaches, rather than physical boundaries. This includes "unseen" bodily boundaries, where working with the body by speaking about it, or thinking about it might constitute a boundary breach. For therapists, boundaries were felt to be crossed when a patient impacted the therapist's body, creating a physical response. Here, the breach is psychic, but the impact can be physical.

The term "boundaries" is not confined to the psychoanalytic field, yet it is ubiquitous in our culture and crucial in distinguishing between self and other, (Freud, 1923) defining where we end, and another begins. In modern culture, boundaries are important; school children are now taught to communicate touch preferences and understand boundary violations. The language of boundaries is particularly associated with sexuality and sexual abuse, and current discourse stresses explicit consent to avoid crossing boundaries.

In this research, boundaries are a charged topic, which might suggest how aspects of consent within the therapeutic relationship have not been thoroughly considered. What has the therapist agreed to? What are their boundaries? Are therapists empowered to protect their boundaries from being crossed?

Saketopoulou and Russell (2024) discuss how psychoanalytic spaces might involve an implied consent to push or cross boundaries, for both parties. Both therapist and patient consent in some form to experiences that are unforeseen, which are unprepared for, or even unwanted. They (Saketopoulou and Russell, 2024) say that for therapists, there's little room to stop a journey once started, even if it feels like their psychic boundaries are being crossed, and they aren't consenting to the process anymore. [22]

There are physical boundaries to consider when working with children and young people (e.g., spitting, kicking, scrutinizing appearance), as well as psychological violations that feel insidious and intrusive. Elenor's evocative *"heuhhh"* and shudder

[22] I regard this as an opinion, as in reality there will be situations where a therapist can terminate a treatment.

when discussing a patient wanting a *"body swap"* suggests an intuitive attempt to shake off an intrusion that she might not have consented to.

When boundaries are crossed, the line between therapist and patient becomes blurred; one can "get inside" the other. The examples in this section convey an unsettling feeling, suggesting that boundary breaches don't feel comfortable, pleasurable, or creative-though they may indeed be creative acts, they often don't feel that way.

Subtheme A: Intrusion

Libby spoke of a patient getting inside and messing with her. Elenor discussed a body swap phantasy, while Nadia described feeling *"poisoned"* after being with a patient. The female participants shared a sense of intrusion that was particularly disturbing. These conversations made me feel uncomfortable, and prompted me to think about experiences in sessions where I felt that patients wanted to 'fill up' my own creative womb space[23] with something bad.

David expressed an awareness of being intrusive. He warned against handing projections back too quickly, acknowledging the risk of one body penetrating another, and the awareness that speaking about the body or acknowledging the body could lead to entering the patient's body.

David's comments suggest a double breach for the therapist; one where their boundaries are intruded upon, and another where the therapist is pushed into the role of the intruder which constitutes another breach for the therapist. This raises

[23] This is my understanding, of how it felt for me rather than a comment about how it felt for the participants.

questions about whether therapists fully consent to being perceived as intruders or abusers in the transference. CAPs may be familiar with this dynamic (where intrusion feels inevitable) because that dynamic is what the patient needs to bring to their therapy to be worked on. And it can evoke a deep sense of violation for the therapist.

As a male therapist, David seemed more attuned and mindful of ways that patients could perceive him to be intrusive, rather than think about intrusion into his own body. In the literature, I identified texts that referred to the storing capacities of the mother's body, as a vessel that might hold projections (Klein,1946; Meltzer, 1992; Pollak, 2009). The literature did not explicitly give reference to a man's body, I don't think because psychoanalysis wishes to exclude the father, but because we tend to think about the mother, the breast and the mother's body as the prototype for phantasy to form. A body that stretches and morphs to hold a baby. The male body also exists in phantasy and be projected into. Meltzer's, 'Claustrum' (1992) could equally be applied to the body of the father. However, the anatomical differences between male and female bodies arguably do evoke different symbolic qualities. In phantasy, a man's body might be perceived to be more penetrating, which I believe David is referring to.

In the literature review, I noted how phantasies about 'getting inside' the body of another has an erotic subtext. David linked intrusion to an experience becoming *"sexualised" and* Libby also noted the sexualized undertones of intrusion, observing how patients are fascinated by what goes on inside the body.

Subtheme B: The Body Is Projected Into – Made to Do Something

The phrase ‘the body is…. made to do something’ refers to the concept of projective identification. In the context of the interviews, it refers to the therapist’s experience of their body being taken over by the patient’s projections. This is discussed under the theme of boundaries, since projective identification, in these examples involved a lack of will and choice.

Projective identification has been thought about in various ways and it has different qualities. It has been widely thought about as the earliest form of communication, from infant to caregiver (Bion,1962), where it is almost as though the caregiver *feels for* the infant. The literature review refers to the clinical example of the therapist being *“moved to tears”* by her patient who is quadriplegic (2005), leaving the therapist with work to do in terms of understanding what her patient is wanting her to feel. Jaffe (2002) speaks of the therapist feeling for the patient and then needing to decipher the emotional states. Libby, Elenor and Nadia, experienced powerful bodily states that had an all-consuming quality, causing their body to move in a way they did not wish. Each participant used this experience to take them deeper into their work with their patient, learning more about them and what the mechanism of projective identification might be revealing to them.

Segal (1973) defined projective identification as a process whereby internal objects and parts of the self are split off and projected into another. This results in the other (in this case, the therapist) being controlled by the projections and also identifying with them-by profoundly feeling and experiencing them as if they were their own. Meltzer (1967) wrote about instances where patients might use projective identification as the mechanism for offering up projected parts of themselves to

another, because they don't have the psychic integrity to hold themselves together. It might also be used to control another by taking hold of their body and minds. Furthermore, projective identification involving the evacuation of distress into another, might offer a form of psychic relief (Meltzer, 1967), and I wonder if these qualities considered by Meltzer (1967) reflect the experiences of the participants.

All four participants described experiences where their bodies were taken over; Libby fell down the stairs, Elenor felt *"under siege,"* Nadia's stomach growled, and she felt poisoned. David, in contrast, described being made to *"be"* someone else, a perpetrator of sexual abuse in this example.

Lemma (2014) wrote about symbiotic fusion; a term used to describe the therapist's body being taken over by the patient. The participants' examples from the interviews, conveyed a loss of control over the own bodies. Libby referred to a *"giving over"* of oneself, that may be necessary for this work.

Nadia shared visceral examples of her body feeling overtaken-feeling poisoned or jittery-and yet at times, she felt cut off from these sensations. This tension between physical responses and emotional detachment seems important, and it was a reoccurring theme for Nadia who referred to feeling numb, cut off, or unaware of the intensity of an experience until she felt an intense bodily response after the session had ended. Perhaps feeling cut off was a defensive response to very intense projections, particularly intrusive ones.

Nadia's material has prompted me to think about the roots of these bodily manifestations and consider whether they might serve as a defensive strategy or alarm bell for the therapist. For example, could Nadia's nausea indicate psychic

poisoning-something she needed to expel? Similarly, Elenor's "freeze" response might represent an instinctive defence against a perceived threat from a patient who was threatening. Alternatively, it could be a projection from the patient, intended to exert control over her body. There is a complexity present here when interpreting such experiences for the purpose of the research. [24]

The 'Public Body', The 'Personal Body'

The 'Boundaries' GET conveys intrusion and quality of 'getting right inside'. Whereas the 'Public' and 'Personal' body GET touches on personal and professional identity and what therapists and patients choose to reveal about themselves through their bodies.

The wording of the two subthemes suggests that the personal body requires protection and is at risk of being overexposed in therapeutic work.

This experiential theme questions whether it is even possible for a therapist to have a 'private' body in the same way they might try to maintain a private life. This theme connects with boundaries and consent, exploring what a therapist might permit in therapeutic work with patients.

The theme also highlights the 'public' nature of working in the National Health Service. [25] Working in a public system may evoke a sense of being 'public property' and this theme might not have emerged in the same way had I spoken only with participants from private practice. The NHS is a shared context among participants

[24] There is an ethical complexity here, as this approaches the limits of what participants consented to within the project.
[25] All participants are NHS employees.

and myself. Personal motivations for working in the NHS vary, as do assumptions about why we choose this work and how we understand it internally. I did not ask participants directly why they work in the NHS or whether they feel like 'public property,' so I can only infer through my own subjective lens.

Training through a funded NHS programme, or teaching on it, may create a sense of 'owing' something to the NHS, with unconscious implications that we should continue working within it. I have held this belief myself at points in training, and I may be projecting it onto participants. As a CAP, I share various reference points with participants, which aids understanding but also limits objectivity.

The wording of the subthemes [26] reflects the unease that comes with fully bringing oneself into the therapeutic encounter. The 'threat' exists along multiple axes: the threat to the therapist when they expose something personal, the threat to the patient when they expose something personal and there is potential threat to both if the other is personally exposed. When Libby speaks about working from home during the pandemic, I believe she is considering the threat to herself and to the patient in this over exposure of her personal life.

Throughout this project is evidence of deep 'splits' between the body and mind. In this GET it is represented in the separating of public and private bodies, which is both an illusion and a felt reality. It is illusory because it is impossible to physically 'split' the personal and public body. This psychic splitting becomes a defensive strategy, well-articulated in psychoanalytic theory (Klein,1946) where splitting mechanism are used to protect oneself from the reality that the 'good and 'bad' are

[26] 'Threat of exposing the therapist's body' and 'Threat of exposing the patient's body'

the same object. In the context of public/personal, the use of this defence mechanism, protects the body (Ferrari, 2004). Ferrari refers to the 'original body' as the body a child is born into, their home and vessel (2004). I believe it is this body that is being preserved. As a psychotherapist myself, I might struggle with pure impartiality as the researcher because I, too, will unconsciously protect parts of myself to avoid being constantly projected onto in my work. On some days, I may feel ready for this kind of exposure and open availability, while on others, I may utilise more boundaries. This kind of boundary may be consciously utilised by a therapist, if they are wanting an early pregnancy to remain private for example, or an injury. Or it might be more unconscious; a therapist might create a subtle boundary around themselves to protect a part of them that feels sensitive, vulnerable and core to their identity.

The perspectives of the participants vary with regards to this topic. Some express a more distinct split than others, influenced by the nature of their work (e.g., the perceived riskiness or intrusiveness of the work), their experience level, and their personal demographics. These factors impact how each participant engages with others and what they choose to share publicly versus privately. The public/personal split is also reflected somewhat in the interview setting. Nadia's was online for reasons of distance, but she told me how that also protected her body. My interview with Libby was in her place of work, but she was mindful of how I entered into the building so that I did not have to sit in the waiting room. My interview with David was in his private and personal consulting room. There was an ease in having the interview here. I felt comfortable in this location[27], and in a familiar power dynamic as

[27] At the time of the interview, I was still an analysand myself. This 'set up' felt familiar in some ways.

a student deferring to being taught about the topic. I am not making sweeping generalisations about gender and power, but naming how they exist in phantasy and may be projected onto participants.

My interview with David, the most experienced participant, prompted me to reflect on the relationship between age and the body. Does the outward expression of age through the body imply that one must assume certain roles and meet specific expectations?

Across all of the interviews, age and experience were inscribed on participants' bodies. Our bodies reveal something of who we are, generating expectations to behave in ways deemed appropriate for our age. Age carries associations of experience, knowledge, authority, and, paradoxically, the loss of power.

Turning to the question of how one might protect the body from exposure, I considered how the psychoanalytic stance is a kind of professional persona or identity-one that delineates what is publicly accessible about the therapist from what remains private. Although the field has long moved beyond the white coat tradition, the coat may once have performed a similar function: marking a boundary between public and private, while simultaneously inviting phantasies about what lay beneath.

Eleanor's comments about transitioning from winter *"uniforms"* to summer clothes might imply that revealing more of her physical body also exposes more psychological vulnerability. Nadia said *"I am worried about my body"*, explaining that if we had met in person rather than over Zoom, she would have felt more vulnerable.

This split language ties to the Concrete Original Object theoretical position (Ferrari, 2004), where the body is seen as an object requiring preservation.

David, however, offered a different perspective, rejecting the split between public and private bodies. He questioned the notion of a "therapeutic body," suggesting instead that therapists simply resonate with whoever is present-one human being to another. This echoes Stone's (2006) description of the therapist resonating with the patient like a tuning fork, and aligns with scientific views of body and mind as an interconnected network rather than separate entities (Damasio, 2012; Lombardi, 2017). Familiar with Damasio's work, David has cultivated this approach, offering patients a different therapeutic experience and advocating for greater body and mind integration within the psychoanalytic community. David's contribution provided a valuable theoretical perspective for this research, though I must also acknowledge the influence of his experience and intellect on the project (perhaps disproportionately to other participants.

At several points, David used the words *"illegal"* or *"illegality."* On one occasion, this referred directly to aspects of therapeutic work that could become sexualized. More subtly, *"illegality"* suggested that when the private bodies of therapist and patient come into focus, it can feel transgressive. Similarly, Nadia's reference to *"appropriateness"* implied that discussing the body may seem too personal or even disrespectful.

Embodiment or Enactment

GETs in this project interlink and build upon one another. From boundaries to anxieties about the public/private body, a threat arises when something is enacted.

Participants shared how some enactments posed a ‘threat,’ with therapists feeling gripped by them, leaving no room to think. However, Subtheme B presents a different experience, one with more ‘movement,’ creativity, and a sense of embodiment.

Some literature on enactment, particularly on the theme of ‘erotic transference’ suggests that an enactment offers vital information to the therapy, and the context is important to consider (Levy, 2008; Stefano,1994). All participants spoke of enactments that were either indirectly sexual (but heavily implied), or directly sexual. The link between enactment and sexuality will be explored further in the next GET on ‘Sexuality.’

Enactments can be thought about as instances where a patient repeats situations and dynamics from their past, in their current relationship with their therapist (Freud, 1912). Participants described enactments with a threatening quality which implied being pulled into a scenario without their conscious awareness. If the enactment involves sexual, violent, or highly charged elements, this will heighten the sense of threat. As Libby pointed out, patients may *“write their trauma on another’s body”* emphasizing the bodily nature of enactment. Participants describe how enactments involve the body ‘acting’-there is a physicality to it.

Libby and David both described being ‘cast’ as abusers in enactments with young people who had been sexually abused. Both therapists mentioned feeling active in these enactments (as perpetrators) but also passive, as their bodies were involuntarily guided by the transference dynamics.

Elenor and Nadia both described experiences of feeling passive. Elenor's patient appeared dominant, leaving her struggling to move, while Nadia felt physically tense and *"on eggshells"* with a 'charismatic' patient. She also described him as *"phallic"*, which I interpreted as conveying a penetrating quality, though she did not clarify the term.

All enactments in Subtheme A had sexualized elements, either explicit (related to sexual abuse) or implicit (involving power dynamics, force, and passive or receptive qualities).

Levy (2008) discusses how patients use repetition compulsion to re-enact sexual trauma. In her work with a male patient, Levy (2008) reflected on how her patient's persistent sexualised provocations towards her were bound up in a perverse therapeutic striving to mother his biological mother. Contorted through the trauma and perversion, *the "patient's illness is expressive of their unconscious attempt to cure the doctor"* (Levy, 2008. p.8 referencing Searles, 1979). The patient Levy is referring to seemed to crave actual physical contact with her, in her transferential position as the mother. Levy's work was to bring the two of them together in a more integrated, healthy and mature relationship.

Pines (1993) writes about the therapist's role as a potential parent in the transference, but without the physical contact. This is important when considering the physicality of enactments and how a craving for physical contact, might intensify the enactments. [28]

[28] This also makes me think about work with younger children who might try to illicit physical contact in sessions by climbing on furniture/ running out of the room etc.

The participants conveyed a sense of ‘threat’, and I wonder if the fear of allegations is an example of a particular ‘threat.’ Working with children and young people who exhibit sexualized behaviours might heighten this fear, due to the complexity of the material they are bringing and the confusion around sexuality and their own sexual feelings.

Subtheme B[29] conveyed a more vitalizing energy, where participants discussed how they used their bodies intentionally in service of the work needed by their patients.

Trauma-informed literature suggests that working through trauma involves integrating bodily movement and feeling (Levine, 1997). Libby and Elenor described working with patients in a physical, embodied way, while Nadia spoke of grounding techniques to regulate the nervous system. David spoke of a situation where a perceived threat and past trauma was transformed into an empowering moment for the patient. He allowed a child to pretend to throw him across the room, facilitating her transition from a freeze response to action, completing the movement as described by Levine (1997). David consciously and willingly moved his body in this dynamic.

In this example, the enactment shifted from one that felt unprocessed to one with intention, where both parties consciously embodied roles to create a change. This speaks to the potential of the therapeutic alliance, where a shift in the transferential relationship can lead to significant therapeutic change.

[29] Entitled ‘Moving with-Embodiment’

I hypothesise that psychotherapists in NHS settings may feel wary of embodied enactments like the one David described. Therapists may lack support in developing the capacity to move through enactments.

Saketopoulou (2023) discusses the compulsion to touch wounds, referencing Freud's (1914) theory that repetition is a remembering through action, which can lead to freedom. Freud later revised this, suggesting that repetition is doomed to fail (Saketopoulou, 2023), however this project might also demonstrate how repetition, when engaged with creatively, can have a powerful healing capacity.

In my analysis of the material, I noticed the project's seriousness. Although Subtheme B is more lively than other sections, it still feels dense. Play and playfulness are central to child psychotherapy, yet in this project they seem compromised, with participants struggling to be less inhibited with their patients.

I also reflected on how my interviewing and analysis may have shaped this. My choice to speak with specialists managing intense caseloads, along with my wish to pursue 'serious' information that would be 'taken seriously,' likely contributed to the project's tone.

Sexuality: The sexual nature of bodies

'Not everything human is sexual, but the Sexual is in everything human' p84

Scarfone (2023) quoting Laplanche

This quote reflects the size and scope of this GET, comprised of four subthemes.

In work with adults, the erotic transference [30] is widely acknowledged, though it remains a difficult dynamic for therapists to engage with, sometimes even avoided (Elise, 2019). Based on my research and personal experience working with children and adolescents therapeutically, the sexual nature of transference is more challenging to discuss and less widely recognized.

The literature reviewed (Ashtor, 2022; Elise, 2019; Saketopoulou, 2023; Scarfone & Saketopoulou, 2023) has helped me consider complex dynamics that can arise between adults and children. These writers describe mechanisms through which an adult's fully developed sexuality may impact a child's or adolescent's developing sexuality (Scarfone & Saketopoulou, 2023). They also remind us that the mother-child relationship is inherently sensual, making it impossible to overlook the potential for transference to take on sensual, sexual, or erotic qualities. I wonder if this makes it particularly difficult for a CAP to acknowledge, think about, and speak about such dynamics when they emerge in work with children and young people.

All four participants alluded to sexuality indirectly, with a significant sense of subtext. Libby spoke of an excitement in knowing what's going on inside people's bodies, Elenor described experiencing life in her body whilst avoiding naming sex, Nadia felt uneasy about how her patients perceive her body, and David noted that this topic might be considered *"illegal."*

To gather nuanced and subtle information, I paid close attention to my countertransference. When participants did not speak explicitly but conveyed

[30] "The term 'erotic transference is defined … as any transference in which the patient's fantasies contain elements that are primarily reverential, romantic, intimate, sensual or sexual." (Book, 1995, p. 504)

meaning through tone, feeling, or omission, my countertransference became a tool for interpreting these subtle cues, alongside careful analysis of the audio recordings and transcripts. Using countertransference as a research tool has limitations, as it's highly subjective and personalised to me. It is challenging to separate my own experiences, perceptions, and beliefs from my analysis, though I have been reflective about this and have questioned my own ideas and analysis throughout the process. From an ontological perspective (Ogden, 2022), the research evolves with me as the researcher, and my bias is woven into the project. This position has freed up space to use my countertransference as an aid, which I have bolstered through a very close attention to the audio recordings.

Nadia spoke about a difficulty when considering how her patients perceive her body; and the meaning and material she conveyed extended beyond her actual words. The interview atmosphere communicated a discomfort, a charged feeling, and an uncomfortable confusion that felt somewhat sexualised. Listening to the audio recordings multiple times over, and on different days helped me to identify the material, distil it and analyse it.

Purcell (2006) notes that content may seem non-sexual on the surface but still generate erotic tension. This aligns with subtheme A, in that sexuality does not have to be overt to be sexual. Purcell referenced a patient sleeping in session as an example of *"non-sexual"* content evoking excitement for the therapist. Elenor also spoke about a patient who fell asleep in sessions, which carried a sexual subtext to it.

The literature brought attention to the British Object Relations School's approach to sexuality (Ashtor, 2022; Harding, 2001). Elenor's difficulty in naming sexuality and

David's reference to *"illegality"* may reflect their training and work within a tradition that does not emphasise sexuality. This is further compounded by broader societal taboos surrounding open discussion of sexuality, particularly in professional settings.

Considering Subtheme B[31] and themes of unsafety; David's reflections regarding what happens when sexuality enters a session held echoes the discussion of Saketopoulou and Russell (2024). They describe how therapeutic work lacks 'safety' and 'consent' in the ways mainstream culture understands these terms. They argue that analytic spaces are inherently unpredictable, requiring therapists to give much of themselves over to the work.

One must question whether CAP are prepared for sexual material to surface in treatment. Elise (2019) noted that therapists often unconsciously avoid sexual material if they feel unequipped to handle it, especially when it involves a theme a therapist has not yet traversed within themselves, such as homosexuality.

In NHS settings, particularly with vulnerable patient groups, naming sexuality can feel even more challenging. Elenor captured this when she asked, "*How safe is it to bring attention to something when you don't always know what you're in touch with?"* Sometimes, it feels safer to leave things unexplored rather than address what feels precarious. Subetheme C[32] considered sexuality and gender. The participants identified as cis women, but their perspectives on what it means to be a woman in this context varied. Libby recognized that her female body, particularly her breasts, might be alarming to patients because they reveal a maternal quality, and the female

[31] Entitled 'Sexuality in the Therapeutic Context Can Feel Unsafe'
[32] Entitled 'Sexuality and the Complexity of a Gendered Body'

body might challenge the perception that she is a static object belonging to the consulting room (Lemma, 2014).

Libby speaks from her particular professional perspective, acknowledging that for her patients, where there has been a prevalence of child abuse, a ‘mother’ might have a disturbing quality. The work of Glasser (1978) is relevant to Libby’s work and the type of mother she might embody in the transference; perhaps becoming an engulfing or smothering mother to the patient.

Melanie Klein’s (1946) notion of the breast- as something the infant may experience as intrusive and persecutory is useful here. Defences against contact with an intrusive maternal body may lead patients to negate the presence of the practitioner. In Libby’s case, this took the form of being perceived as a *“sexless nothing,”* as she described it. Such perceptions can function as a defence mechanism, allowing patients to render the therapist as impotent and sexless in order to feel safer. This dynamic can be understood within the context of patients who have experienced sexual abuse by adults, as was the case for many of Libby’s patients.

Libby and I also discussed topics specific to women; bleeding cycles, menopause, and pregnancy- all deeply personal body states that may not always be visible but are emotionally intense and can be intuited by others. These states are ubiquitous for women and often linked to notions of motherhood. For some patients, these cyclical bodily states may pose a ‘threat’, particularly if they wish for their therapists’ bodies to remain unchanged or under control.

Elenor implied a gendered dynamic in describing a patient who exerted dominance over her body; when she asserted autonomy, he fell into a deep sleep. This illustrates the intensity of the female therapist's body, which may be experienced as maternal. A patient may struggle to perceive the therapist's body as separate, echoing Lemma's (2014) concept of *"symbiotic fusion."* In Elenor's example, the patient appeared unable to tolerate her female body as separate and autonomous, and his sleep could be understood as a denial of this separateness. This resonates with Libby's observation of her female body as *"alarming."* For Elenor's patient, simply being in the presence of a female body may have been intolerable.

Nadia used the term *"provocative"* to describe the sense of *"femaleness and femininity"* of her body, a term tied perhaps to wider societal discourse about a woman's body being provocative to men. Nadia's language may reflect societal judgments that a woman must control her provocativeness, avoiding appearing 'too feminine' or 'too sexual' lest she attract male attention. In the context of NHS work with children and adolescents, this paradigm is precarious.

In my reflection, I have wondered whether female CAPs are expected to be less erotic-but what does that even mean? Lorde (1984) writes about the erotic in the context of being a woman, describing it as existing on a *"deeply female and spiritual plane, firmly rooted in the power of our unexpressed or unrecognised feelings"* (p. 53). She frames the erotic as a transformative force-an energy of courage and change.

To be erotic is to be alive. But how much can a CAP within the NHS embody eroticism in their work? This question also highlights the deeply personal nature of this research, particularly within an IPA framework. I am both a CAP and a woman,

and I want to bring my full self into this work-to be an alive, embodied, erotic woman-because that is when I feel most whole. Yet in NHS/CAMHS (amongst professionals), I'm not sure I do feel comfortable to speak about these experiences safely. I fear being perceived as "too much" or as crossing professional boundaries. As Nadia noted, something about this feels like oversharing.

When it comes to men as erotic beings, and erotically alive in their work as CAP, this feels like an incredibly complex and perhaps precarious topic. But it is important. It would have been valuable to speak with more men for the project, particularly those with less professional experience than David, who are still finding their way in the field.[33]

I wonder if psychotherapists are adequately supported to consider and work with these erotic and relational dynamics. Elise (Elise and Morgan, 2024) raises the point that if therapy isn't erotic, then we should wonder, why not? Since early relationships are inherently erotic, bodily, and sensual. I wonder if this idea is considered at all in current NHS practice.

Concerns about female provocativeness also emerge in Elenor's reference to feeling more noticed when she started wearing summer clothes. Alvarez (2010) discusses how warmer weather can affect patients, stating how female therapists wearing sandals for the first time provoke strong sexualized and aggressive phantasies.

David's interview touched on gender in terms of his awareness of male perpetration, saying that he is mindful and aware of female patients with abuse histories at the

[33] I have not reflected deeply on psychotherapists with diverse gender identities, as this was not represented in the participant sample or in the patients they discussed. This is a valuable area for further thought and future research.

hands of a man. David did not refer to any of his work with men or boys and so I cannot make gender comparisons there. Libby also referred to herself as the 'perpetrator', explaining that a patient might enact an abuse situation and cast her in this role in phantasy.

Subtheme D[34] is important to the developmental arc of this project, and it highlights a unique quality at the core of CAP's work.

The literature (Ashtor, 2022; Elise, 2019; Scarfone and Saketopoulou, 2023) says that children/young people and adults have different bodies with varying capacities, potentials, and 'systems' for sexual functioning (Scarfone and Saketopoulou, 2023). Scarfone (Scarfone, et al. 2024) uses the term *"tongues"* to describe the differing unconscious languages spoken (tongues) of children and adults regarding sexuality, which require translation. This need for translation, and the process of attempting to translate, is central to the development of the unconscious, according to Scarfone and Saketopoulou (2023).

When comparing work with children to work with adults, there are clear differences in terms of sexuality and eroticism. Adults generally have a better understanding of sexuality; they likely know how children are conceived, they may have had sexual experiences, they might be married, and possibly have children of their own. However, when working with children and adolescents, sexuality and eroticism are understood and experienced from a child/adolescent's mind and body, not that of an adult. Moreover, the patients of these participants may have been exposed to abusive or inappropriate sexual experiences, making this area feel even more

[34] Entitled 'Sexuality: Adults and Children'

precarious for therapists who could be cast as an abusive adult or sexualized parental figure. I use ‘sexualized’ to refer to a perverse quality in sexuality, as discussed in Levy’s (2008) article, where a relationship is made to be hypersexual, to fend off and manage other intense feelings. Harding (2001) echoes this, saying that a sexualised therapeutic relationship might be a way to maintain distance and control the relationship.

The idea of inappropriate adult sexuality being placed onto a child is such a disturbing thing, that it might limit our ability to have conversations about ordinary aspects of adult and childhood eroticism. Freud (1905) speaks of ordinary bodily care awakening sexual drives (Scarfone and Saketopoulou, 2023). Scarfone and Saketopoulou (2023) use the term *"asymmetry"* to describe the differing psychological apparatus required by children to translate these experiences.

In terms of adult therapeutic work, Scarfone (Scarfone and Saketopoulou, 2023) argues that the patient and therapist are *"endowed with a sexual unconscious"* (p. 65) and that there is still asymmetry due to the analytic stance, which fosters the *“infantile sexual”* at the core of psychic reality.

Working with children and adolescents, especially in CAMHS can feel unsettling for therapists, due to the vulnerability and need of the patient. Elenor’s example of a patient falling asleep when she asserted autonomy over her body, vividly illustrates the confusion and disturbance that may arise in these encounters. Whilst David reflected on how a therapist’s attempts to maintain control over a session could veer unconsciously into abusiveness.

Budd (2021) discusses the de-eroticized nature of British Object Relations, which shifted analytic focus from sexual drive to infantile relations. According to Budd, this led therapists to view patients as *“de-eroticized infants”* and themselves as *“de-eroticized mother figures”.* When sexuality is too difficult to handle, therapists may de-sexualize both their own and their patient’s bodies, exacerbating body-mind splits and increasing the danger of erotic desires being acted out, according to Harding (2001).

Subtheme D is bodily[35], and considers the body and mind’s inherent capacity for sexuality and how this is integral to relating and aliveness. In the case of these patients, something likely went awry in early relationships (Elise, 2019), and this may later manifest in the therapeutic relationship, presenting in complex sexualized ways that are challenging to manage.

In this reflective research process, I have tried to understand my position as the researcher as thoroughly as possible, aware that the work evolves through my interpretation, and how I conduct the interviews. I am motivated by this area of research because it feels like a potential blind spot in the profession- as David put it, *"a bit illegal."* I feel strongly about encouraging the profession to delve deeper into these uncomfortable areas, whilst also being curious about ways that I might have found meaning in certain areas of conversation because I find them to be of importance and interest.

Despite the challenges to maintaining objectivity inherent in IPA analysis, it is reasonable to suggest that acknowledging the impact we have on patients-simply

[35] Libby discusses her body appearing larger during an enactment, Elenor speaks about patients with disabilities noticing her body more, Nadia describes *"adult bodies"* asserting themselves, and David addresses how his body may be seen as that of an abuser.

through our presence and the resonance between our bodies and minds-can be uncomfortable. Nadia articulated this discomfort poignantly when she reflected*, "I'm just finding that really hard to think about,"* in relation to considering her adult body in proximity to a child's.

Body-Mind Split

In this final GET, participants reflect on and/or demonstrate their experiences of the body and mind split. Our individual experience of this split and relationship to it, I think has significant implications for therapeutic practice and patient interactions. How could it not? Since a therapist's attentiveness to their own body-mind split may influence their ability to guide patients in exploring their body-mind connection. Lombardi (2008) describes the therapist's role as facilitating the patient's dialogue between body and mind. This position becomes even more pronounced when considering the transference-how, similarly to a child learning about their body through the caregiver, the patient may learn about their body through the body of the transferential mother and father (Lombardi, 2017, referencing Freud, 1929).

To better understand body and mind splitting, we can turn to Klein's writing on early primitive splitting (1946) which she describes as a defence mechanism which protects an infant from overwhelm by preserving the 'good' and separating it from the 'bad.' Much has been written on the paranoid-schizoid position and the depressive position (Klein, 1946), which we move in and out of throughout life. If we apply this concept to this topic of the mind and body split, then splitting may protect us from an intensity that might be overwhelming. How would a person manage if they were always fully attuned to their body and mind simultaneously- with an emotional-

sensorial-mental connection running at all times? For example, imagine having such an acute sense of awareness, that a change in heart rate, a headache, stomach cramp, or illness-whether minor or chronic-was deeply *felt* in the mind and body as an integrated system. Not just as a physical symptom, but perhaps as an emotional one too, with a psychic origin. While this connection could enhance health and well-being, if it were constant without an 'off' switch, the ordinary person might struggle to manage daily tasks such as work or childcare if they lived without a sense of body and mind split, and a compartmentalisation of physical and mental.

As discussed, splitting often involves a division into 'good' and 'bad,' 'us' and 'them,' raising the question: when the body and mind are split, which is considered 'good,' and which 'bad'?[36] Some participants viewed the body as polluting, confusing, or untrustworthy, while others saw it as ultimately truthful-perhaps more so than the mind.

Referring to the literature review, Shaw (2003) highlights the longstanding cultural and societal division between body and mind, tracing its roots back to Plato's dissociation of the two, in which the body was regarded as impure and contaminated (Lombardi, 2017). This dualism was further reinforced by the influence of the Church and later by Descartes, solidifying the notion of the body as separate from the mind. As Nadia expressed in her interview, the body continues to be associated with *"the area of treatment."* Dychtwald (1950) outlines various forms of body-mind splits embedded in our understanding of the "bodymind," such as divisions between right

[36] I use the language of good and bad not to imply a value, but in reference to the language used by Klein to indicate a split is occurring between one thing and another

and left, top and bottom, head and body, and front and back. I found this particularly striking, as these fundamental separations are rarely considered consciously.

The persistence of the body-mind divide is evident in the participants' language. As discussed in the introduction, I considered using the term *bodymind* in the project title, as a way to conceptually integrate the two. I also experimented with incorporating it into my writing. However, this ultimately felt disingenuous, as it did not reflect the language used by the participants themselves. Instead, I believe the project is better served by revealing and exposing these deep-seated splits, rather than obscuring them through imposed corrective terminology.

The first subtheme of this GET explores phenomena that may be considered 'countertransference.' The therapist's bodily communications wove a common thread between the participants, although the communications varied in intensity. Some communications demanded immediate attention, some were intense but delayed, and others were more subtle.

Participants sensed that their bodily responses revealed what was truly happening in the room. These examples often carried discomfort, signalling that something *"is not okay"* (Libby). Elenor emphasized that *"bodies don't lie"* and described how her *"conjectures"* needed to be verified by her body. Nadia initially believed she wasn't impacted by a patient, thinking, *"they're great, they're not disturbed,"* but her body's response told her otherwise. These examples indicate some incongruence between body and mind. Stone's (2006) work on embodied countertransference suggests that this kind of countertransference may signal a level of dissociation, where the experience bypasses the mind due to its intensity.

David did not share explicit examples of his own somatic responses to his work. However, he did express wanting to avoid furthering the body-mind split, although this might have led to him denying that his body and mind does split his experience.[37]

Participants spoke about the necessity of splitting, particularly in challenging work environments[38]. In my interview with Libby, we reflected on shared experiences of working in settings where splitting felt essential for self-preservation. While analysing the material related to body–mind splitting, I noticed that I had forgotten parts of certain interviews while vividly retaining others, leading to moments of confusion when revisiting transcripts I had previously understood. This selective splitting-where disturbing details were dissociated while resonant elements were held onto-emerged as a pattern I needed to remain attentive to.

During the writing of the findings, I observed how some experiences seemed to have been split off or dislodged from memory, particularly in Nadia's interview, where conversations about splitting were most pronounced. Some of her descriptions were visceral and bodily, making them difficult to process. Additionally, hers was the only interview conducted online. Nadia occasionally expressed a wish for *"science"* to explain these phenomena, a response that feels significant given cultural norms surrounding the body-mind divide. It suggests a tendency to defer to scientific frameworks to make sense of our bodies, rather than cultivating the capacity to listen deeply to ourselves.

[37] In this context, I am referring to an experience of the body and mind having separate experiences that are difficult to integrate and bring together

[38] such as Libby's work with young people who commit sexual acts or Nadia's hospital experiences involving restraint

David's contribution revealed a paradox: while we may perceive and psychologically create a body-mind split, in physical reality, no such division exists. The body-mind is an interconnected whole. As Damasio (2000) states:

> *"For every brain, there is a body... One person, one body; one mind, one body."* *(p. 142)*

> *" A mind is so closely shaped by the body and destined to serve it that only one mind could possibly arise in it" (p. 142)*

Conclusion

Concluding Comments

For this project, I interviewed four participants about their experiences of their bodies in relation to their patients. All had worked in services where the patient's body was central, making the therapist's body more likely to be activated, involved, and thought about. I recruited with this in mind, aiming to engage individuals able to speak with depth.

The participants provided rich material, each offering a distinct perspective on what their own body means to them personally and professionally, as well as what might be happening to their body in the work. Their differing professional environments influenced their experiences and their personal beliefs. One participant felt her body held a truth more reliable than the mind, while another wondered if her body was a *"friend or foe."*

A striking feature of the interviews was the unease present. At times, there was a

heavy atmosphere. Participants spoke about attacks on their bodies, concerns about enactments, boundary crossings, and the unwelcome intrusion of sexuality. There were few enthusiastic stories of embodiment, and none spoke about the capacity to play—a key tenet of child psychotherapy. Just as we notice when a child struggles to play, the interviews revealed how therapists might also struggle. Play involves risk-taking, self-exposure, and bodily expression, which may feel unsafe when sexuality threatens to intrude.

Clinical examples of the therapist's body being used creatively emerged only twice—both bordering on enactments. One involved an empowered repetition of an abuse scenario where the patient could "complete the action" (Levine, 1997). Throughout the interviews, communications recurred about the threat of something unwanted, impeding free and embodied play.

I have reflected on how my position as researcher created a serious tone and lack of playfulness. If I were to develop this work, I might enquire into this further.

Implications for Clinical Practice

Now that the research is complete, I reflect on the project's original aims, assessing whether I met them and what I learned. I believe the project successfully addressed its four aims, though the third was most challenging.[39]

I cannot be certain this work will reach the wider community, but I hope it stimulates thought. The research touched a nerve, unearthing something unspoken, vulnerable,

[39] Third aim: To enhance the psychoanalytic community's ability to engage with the body in a way that can be effectively communicated to potential patients, the NHS, and laypeople

and exposing. This is perhaps why ‘boundaries’ emerged as the first major theme. Discussing this topic felt like crossing personal and professional boundaries. I recall feeling anxious and physically unwell the night before my first interview, distressed at the thought of asking a qualified professional about what happens in their body. Despite the difficulty of these conversations, I believe they need to be normalized. Radical, open discussions about how this work affects us could be liberating. Such dialogue might loosen something stuck and unacknowledged, fostering greater awareness of relational dynamics between children and adults, including sexuality. Levy (2008) wrote boldly about her work with an adult patient where erotic transference was present. Reading about this in such a frank way, particularly in an NHS setting, felt liberating. This research gives voice to challenging aspects of the work: engaging fully while protecting oneself from intrusions that cross boundaries.

Limitations of the Study

When designing the project and applying for TREC approval, I discussed recruitment extensively with my supervisor and group. I chose participants with experience of the body in their work.[40]

I stand by this, although it introduced extremes. None came from a generic service or worked with more moderate patient presentations. This influenced the intensity of the interviews. Interviewing staff from less specialist environments might have yielded different insights-perhaps more about play and creative use of the body.
A significant limitation is generalizability, inherent to IPA due to the small sample size. All participants were white and able-bodied. Including individuals from other

[40] I was determined to speak to individuals with rich experience on this topic, with an ability to discuss their bodies in relation to their patients at length. We discussed this preoccupation of mine in great detail

racial backgrounds would have shown how race and colour interplay in therapy. Interviewing therapists with disabilities might have deepened understanding of bodily dynamics.

All participants were cisgender, as were the patients they discussed (to my knowledge). Exploring gender diversity would have addressed some of these limitations, especially regarding transference roles. Female participants were experienced as such, while the male participant described being perceived as a perpetrator. Further research could explore these dynamics with individuals who identify differently.

Another limitation is my analysis of what was unsaid or indirectly referenced. IPA allows nuanced meaning to emerge over time, and immersion in transcripts and recordings enabled me to analyse implicit themes and atmospheres. This required reliance on my own 'sense.' While I do not feel I over-relied, it remains both a limitation and a strength. If I had focused exclusively on spoken words, much of the deeper meaning would have been lost.

Future Research

The topics above (race, disability, gender) are significant areas for further exploration. One research direction could investigate the therapist's ability to play and remain embodied when working with risk. This project also shed light on sexuality in therapeutic work with children and young people. Future studies could ask more direct questions to gain deeper insights.

Last reflections

Because of my deep interest in this project, it felt personal. It has been intriguing, and sad, to reflect on the absence of joy in what participants shared. This is not to say the work itself cannot be joyful, but this topic, with these participants, evoked distressing, confusing, and difficult emotions. They described intrusions on their bodies, leading to discomfort.

Acknowledging this has been crucial for me as a researcher. It required letting go of some idealized notions about embodied therapy as always liberating.
In the introduction I asked:

'Do we have a responsibility to our patients to better understand what is happening in, for, and to our own bodies?'

I remain uncertain. But I now better understand why therapists might resist exploring bodily experiences and why being embodied with patients can feel confronting. A therapist's presence can evoke envy, provoke attacks, and mobilize wishes to control the therapist's body.

This research has also deepened my appreciation for the wonders of the body and mind, particularly in psychoanalysis, where the body holds many meanings. I encourage therapists to reflect on their bodily experiences and explore them deeply. Doing so may help patients to do the same. This awareness, I believe, creates a

foundation for harmony between body and mind—a body and mind that are alive (Winnicott, 1954).

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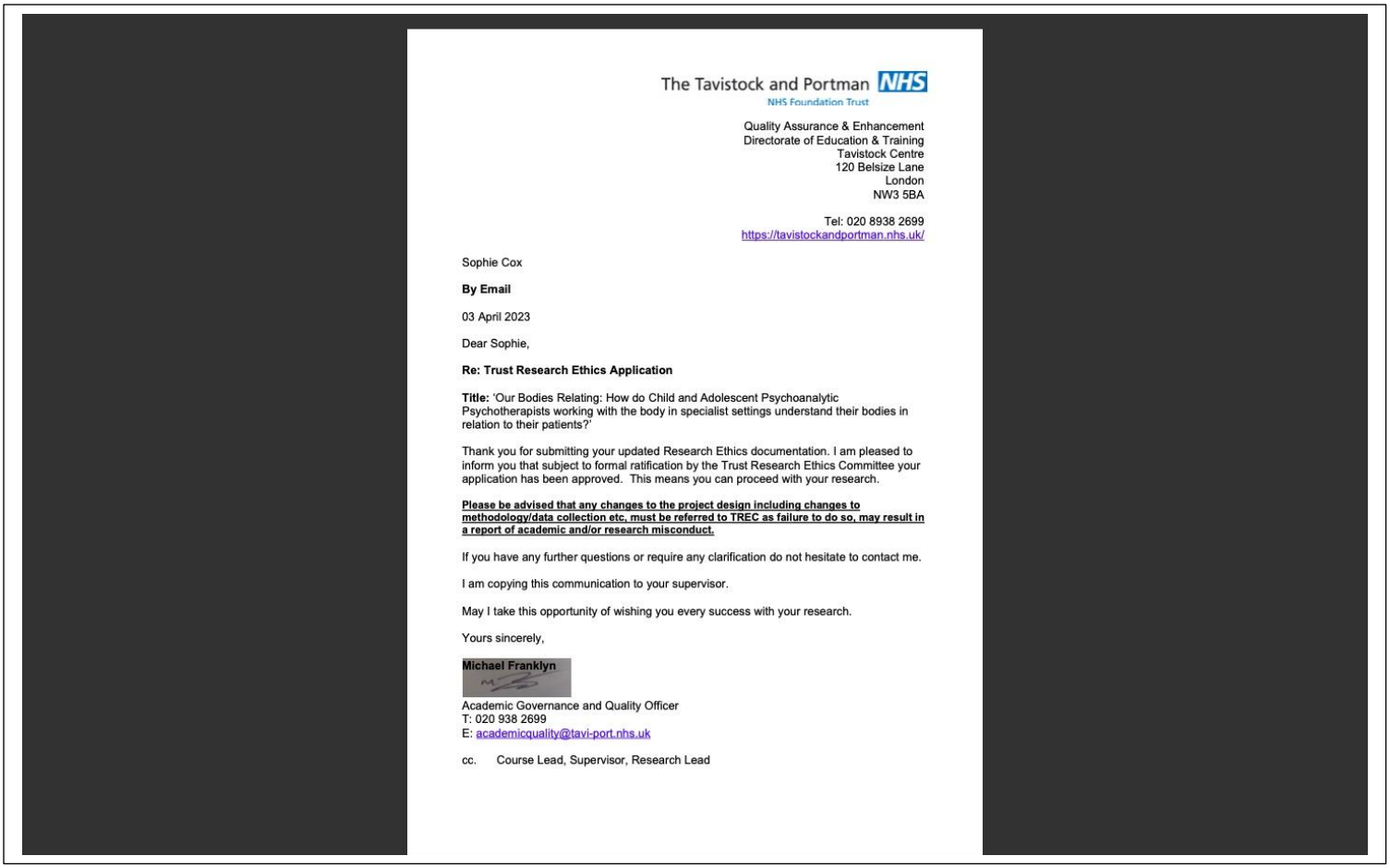
Ethical Approval Confirmation



The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699
https://tavistockandportman.nhs.uk/

Sophie Cox

By Email

03 April 2023

Dear Sophie,

Re: Trust Research Ethics Application

Title: 'Our Bodies Relating: How do Child and Adolescent Psychoanalytic Psychotherapists working with the body in specialist settings understand their bodies in relation to their patients?'

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

Michael Franklyn

Academic Governance and Quality Officer
T: 020 938 2699
E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor, Research Lead

Appendix B: Consent Form

The Tavistock and Portman NHS
NHS Foundation Trust

Consent Form

Our Bodies Relating: How do Child and Adolescent Psychoanalytic Psychotherapists working with the body in specialist settings understand their bodies in relation to their patients?

Name of researcher: Sophie Cox

- I_____ voluntarily agree to participate in this research project. This research project is part of a professional doctorate in child and adolescent psychotherapy ☐
- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to one week after the completion of the interview. ☐
- I understand that the interview will be digitally recorded and transcribed as described in the participant information sheet. ☐
- I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk. ☐
- I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher. ☐

☐

- I understand that it is my responsibility to anonymise any examples referring to cases I chose to discuss during the interview.

- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications. ☐

- I understand that because the sample is small, it may be possible for someone to recognise me from the material provided.

Contact details:

Researcher: Sophie Cox Email: sophie.cox@spft.nhs.uk

Supervisor: Dr Laura Balfour Email: laura.balfour@nhs.net

Participant's Name (Printed):

Participant's signature:

Date:

Thank you for agreeing to take part in this study.

Your contribution is very much appreciated.

Appendix C: Participant Information Sheet

The Tavistock and Portman NHS
NHS Foundation Trust

Our Bodies Relating: How do Child and Adolescent Psychoanalytic Psychotherapists working with the body in specialist settings understand their bodies in relation to their patients?

Researcher: Sophie Cox

This information sheet is inviting you to take part in a research project. In this document I will describe the research project and explain what will be involved if you decide to take part.

Who am I?

I am a third-year trainee, studying on the Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy (M80 course).

This research project has been born out of my interests and observations over a 10-year period, working with children and young people in different professional settings. My psychoanalytic learning has provided a framework for me to begin to understand the role of the body in a psychoanalytic psychotherapy setting and develop these ideas into this research project.

This project is being sponsored and supported by The Tavistock and Portman Centre and has been through all relevant ethics approval (TREC). This course is overseen and certified by The University of Essex.

What is the purpose of this study?

I want to speak to Child and Adolescent Psychoanalytic Psychotherapists and/or child psychoanalysts about the experiences they have in their bodies.

The purpose is to better understand the role of the therapist's body in a psychoanalytic psychotherapy setting and to develop an understanding of the relationship between the therapist's body and the patient/the patient's body.

Background

The human experience of being in a body is ubiquitous. This has been thought about extensively in psychoanalytic literature, but somehow the body can still feel difficult to

speak about and acknowledge in a psychoanalytic setting. This phenomenon is important to notice and think about, particularly when the experience of being with patients is a bodily one, and patients tell us about bodies; how their bodies feel and what they do to them and with them.

This research project wishes to understand 'where is the body?' in psychoanalytic psychotherapy, and 'what is it doing?'

To answer these questions, I am turning to therapists who have experience working with the body; to ask them about their understanding of their own bodies in relation to their patients.

This project will not be comparing service delivery, performance, or approach. Services will not be named in this project.

The wider reach of this project

I expect this project will have an impact on the field of psychoanalytic psychotherapy in the following ways.

- · By encouraging a deepening of the experience between therapist and patient. The project will develop a therapist's capacity for understanding and working with their patient, through an increased awareness of their own body.
- · By developing the psychoanalytic community's capacity for understanding and working with the body, in a way that can be more readily communicated to potential patients, the NHS and lay people.

What is required of participants?

Participants are required to engage in an interview lasting 1-1.5 hours. It is preferable for this to take place in person at your place of work or at the Tavistock building. If it is not possible to meet in person, the meeting can be conducted over zoom in a confidential and private setting.

In this interview I am interested to hear about detailed and personal experiences relating to your body, how you feel in your body in sessions with your patients, what you think your body may be doing, and how you think the two bodies in the room (yours and your patient's) are communicating with one another. You may also have examples from outside the therapy room if your patient has an impact on your body before and after sessions aswell.

The interview is semi- structured. This means that I will ask some questions during the interview to guide you, but that there will be space and flexibility within the interview to explore new ideas and thoughts that emerge organically. I will be conducting this interview within a psychoanalytic frame, which means that I will be using observational skills to notice detail and gather the richness of the encounter.

I will seek your permission to audio record our interview conversation and I may request to video record if we meet on zoom.

I will analyse interview material using the Interpretative Phenomenological Analysis method.

Do I have to take part, and could I withdraw if I change my mind?

You do not have to take part; it is completely your choice if you want to take part in this study or not.

If you agree to take part but then change your mind you can withdraw without giving any reason, at any time up to one week after the interview. After one week it is expected that your data will have been processed and analysed and therefore you cannot withdraw after that.

Any unprocessed data that you wish to withdraw will be immediately destroyed.

What will happen to the information I give?

Your interview will be audio recorded and I will use the recording to transcribe the interview before analysing it. The audio recording will be destroyed after I have finished transcribing.

I will not state your name, the service where you may work, or your patients' details in my transcript or at any other point in my report. I will be the only person with sight of your

personal contact details. Your details will not be shared at any point in this project, and I will anonymize you and the patients you may discuss in all my notes and writing.

Your name and personal details will be stored separately from the transcript in accordance with the University of Essex Data Protection Policy and the General Data Protection Regulations 2018 (GDPR, see below). This means that all electronic data will be digitally encrypted and stored on a password protected computer which only I will have access to. All data will be destroyed no later than two years after the study has been written up for academic submission.

The sample for this project is small and therefore you may be concerned about the potential for your identity being disclosed through the information you give about yourself in the interview. If you are willing to participate, we can discuss this further and I will ask you if there are any additional measures I can take to ensure you feel comfortable, beyond the measures I will already be taking to ensure confidentiality.

Where participants are in a dependent relationship with any of the researchers, participation in the research will have no impact on assessment / treatment / service-use or support. However, it is unlikely that this would be relevant because of my status as a trainee.

If you would like more information on the Tavistock and Portman and GHC privacy policies please follow these links:

https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/
https://www.ghc.nhs.uk/privacy-notice/

You can find out more about the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

There will be limitations to the confidentiality of information provided if it is deemed that yourself or someone else is at risk. I would discuss this with you if this situation arises.

This project will be supervised by: Dr Laura Balfour

laura.balfour@nhs.net

If participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Lisa Harris, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in the research please complete the consent form provided

Appendix D: Recruitment Email

The Tavistock and Portman NHS
NHS Foundation Trust

Dear

I am about to embark on my Doctoral Research Project as part of my Child and Adolescent Psychotherapy training. I am contacting you to see if you would be interested in taking part.

The project title is:

Our Bodies Relating: How do Child and Adolescent Psychoanalytic Psychotherapists working with the body in specialist settings understand their bodies in relation to their patients?

In this study I want to speak to Child and Adolescent Psychoanalytic Psychotherapists about the experiences they have in their body, and in relation to their patients.

The purpose is to better understand the role of the therapist's body in a psychoanalytic psychotherapy setting and to develop an understanding of the relationship between the therapist's body and the patient/the patient's body.

I am hoping this research will be an interesting experience which encourages different ways of thinking about therapeutic encounters.

I would like to invite any Child and Adolescent Psychotherapist in a setting where the body of their patient features in the day-to-day work, to take part in an interview with me to discuss these experiences. This interview will last between 1-1.5 hours.

If you are interested and willing to take part, please find attached a participant information sheet for your information.

Best wishes
Sophie

Appendix E: Interview Schedule

Semi-structured interview schedule for psychotherapists

Our Bodies Relating: How do Child and Adolescent Psychoanalytic Psychotherapists working with the body in specialist settings understand their bodies in relation to their patients?

Welcome
This is a semi-structured interview lasting between 60 and 90 minutes.

Orientating towards the body

*What is your body?
*How do you tune into your bodily feelings and sensations on a day to day basis?

The body in the consulting room

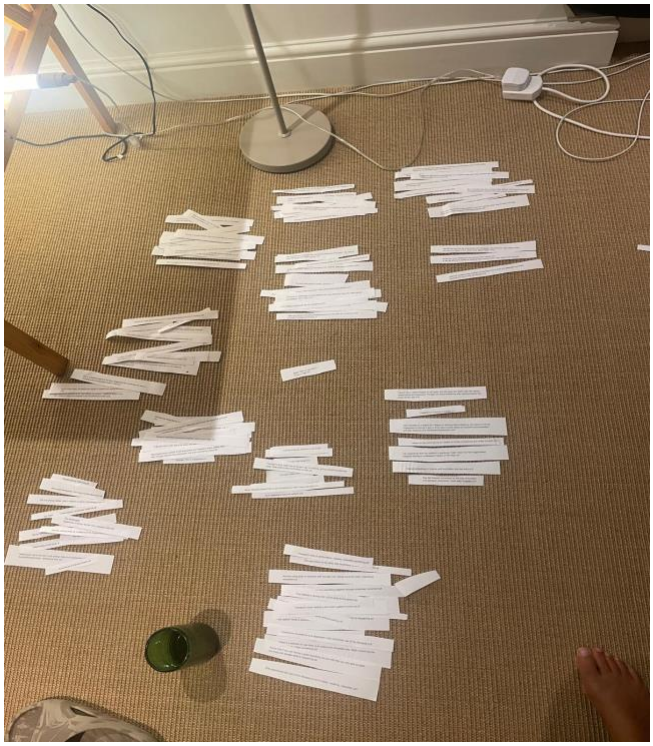
*What is the role of your body in your therapeutic work?
*How are your patient's perceiving your body?
*Do you have any thoughts about the meaning of having an adult body in relation to working with children and young people?
*What do you think is happening to your body when you are with patients?
*Can you describe an instance where your patient has communicated with you via your body?
*Can you describe an instance where your body and your patient's body has communicated with eachother?
*How do your patient communicate with you via your body and how do you feel this?

---
*At this point in the conversation, is there anything that you would like to add?

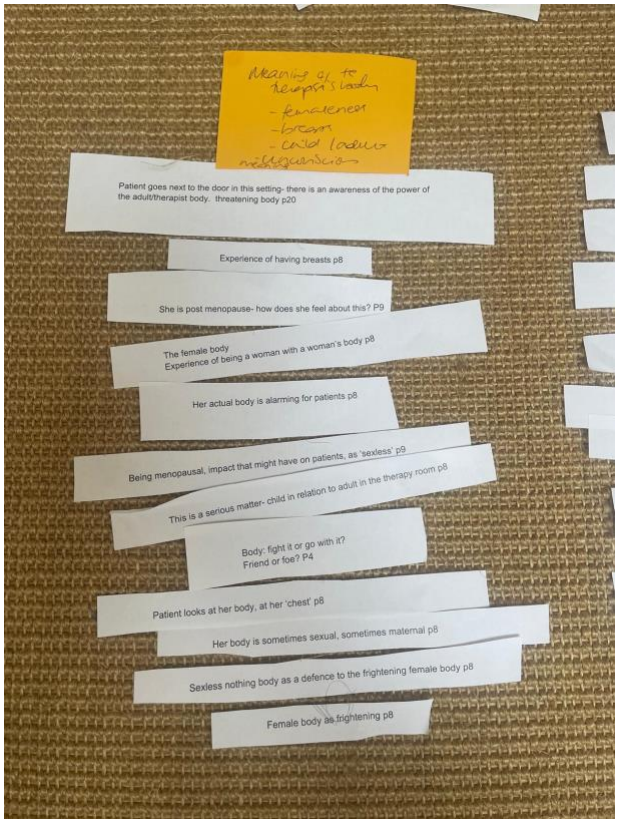
The psychoanalytic body

*How do you think bodies relate to one another in the psychoanalytic setting?
*Are there any psychoanalytic theories that help you understand this topic?
*How do you understand your body from a psychoanalytic perspective?
*how does your body experience the work you do?
*I am interested to know what you think about psychoanalysis' understanding of the body- this is not a technical question, but I am trying to think about how much psychoanalysis considers the body?
*Can you rate on a scale of 1-10 how easy or difficult it is to acknowledge and talk about the body in a psychoanalytic psychotherapy setting? With 1 being difficult and 10 being easy.
*Can you then say a bit more about the figure you've given and why you think this?
*Where is the body in a psychoanalytic psychotherapy setting?

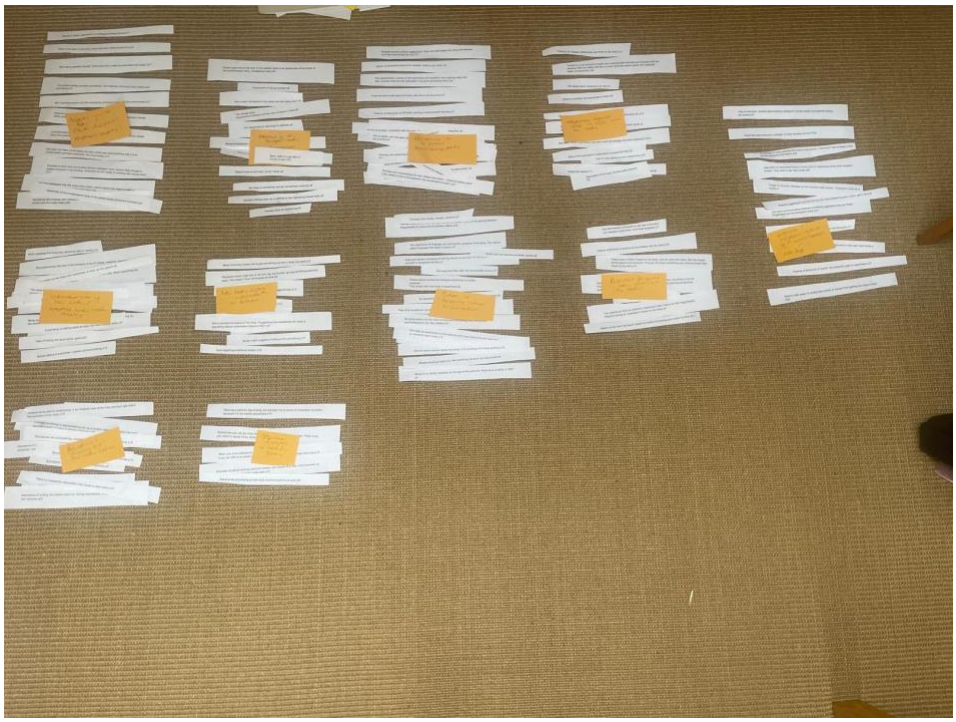
Appendix F: Arranging personal experiential statements



Appendix G: Generating Personal Experiential Theme



Appendix H: Generating Personal Experiential themes for a participant



Appendix I: Example of complete table of Personal Experiential Themes for a participant

Table of Personal Experiential Themes from Participant 1 Analysis

	Page	Quotes
The body is private, the work crosses boundaries		
Speaking about the body is very private	13	*But at the same time, it is very private. So it's a weird one*
Clothes (boundaries) need to be put back on p22	22	*there needs to be a sort of almost putting the clothes back on element to it as well to nurture their development in every realm*
Working at home in lock down crossed boundaries p19	19	*the experience in lockdown where we, for the first six months, we had to take phone calls or Zoom calls at home, was really-**I found** anyway…… was shocking.*
Putting up a boundary to keep the work out is empowering	18	*We really have to put a boundary up. And actually, it's incredibly empowering to do that, as well*
The team have a way to reclaim their bodies	25	*I really noticed the sort of fog of trauma in me by Friday evening sort of thing after a week, working in both here and cams, and I just became completely addicted to the reset that it gave my body on a Saturday morning. Just- it just does something. You know, maybe it's individual, or maybe it's just like, psychological, but I genuinely felt like it was like, a sort of wipe of the whole system.* *Yes, lots of us go swimming in the ponds in in hampstead. These that have established a kind of after work, that's where we need to go.*
Embodiment in sessions can have implications for boundaries		*And I use my body to do that. To show him different aspects that I'm prepared to go into with him……(voice tone changes as this fine line is recongised). And then I have to think about boundaries with that very very closely and carefully.*

Breach of boundaries	P21	*And, and this can also be a problem, you know, network meetings, I find, we talk sometimes about noticing how much the person's body has become everyone's business is so intrusive p21* *become everyone's business is so intrusive p21*
The work gets into you		
Her body can be perceived as a bigger body, an intrusive threat	P7	*And my physical response to that, and how sort of is it measured I might want to be in response might be inviting me to be more intrusive towards them and bigger*
Patients can be very nosy	P26	*That would be good i think because we have very nosy patients p26*
Patients can have an insidious way of getting inside	P18	*I think a patient can smell (giggle) when you have that sense of your body as an outline that can't be penetrated*
Intrusion can be arousing	P26	*Just it's exciting to hear to hear about what goes on inside of people's bodies. I mean, that's what we're in the business of Yeah, they want to know and get right inside. So that's something maybe to think about*
Intrusion can evoke fear, it is horrible	P19, p11	*But, you know, suddenly sort of seeing something much more private about my colleagues, and also the thought of my patients sort of in any way in my home. was shocking p19* … sort of out of nowhere and it's horrible p11
The body knows how to get something out that it does not want	P12	*But I suddenly noticed, I just did a burp and open in any way and kind of, like I needed to, and it will be at a point where I realise I've been kind of holding on to something maybe for a bit, and then something (speaks slowly) gets worked through*
Intense projections of shame and humiliation into the body	P10	*And I was really shaken up by it, how powerful it was, and how humiliated I felt. And I did feel humiliated*
Patient had a violent impact on her body	P10	*I fell down the stairs here. I did, I completely missed the last three stairs after I'd got the message. And it was so humiliating*
Feeling like a zombie	P11, p4	Just sort of zombie, *So I've had the experience where I'm like, write, like trying to do a calendar with a patient. And I can't draw lines and remember numbers*
Projections got into her body	P10	*And I communicated back to them, and what's going on between us because I'd never had it before. It really felt like they were inside and messing with me.*
Feeling out of control	P13, p11	*is that it's at being out of my control. It's been unpleasant,* I know that's less body but it felt bodily. I liked *I felt freaked out.* Yeah, I can't I forgot my mind
Theories can help make sense of this	P20	*Core complex. I was bound to say that here, but I find it incredibly helpful-some sort of sense of being too close and too far, and what distance you use here*
Defences against connection		
Talking used defensively	P11, 3	*you can do all the talking. But if you're not sort of screening, what else is going on. You can miss something p11* *Well, being really literal, and then just drawing, like the body sitting opposite my patient, but sort of with the bits of me that are kind of involved…. I think. (there are some more final scribbles). P3*
Locating pathology in the patients	P18	*don't know if maybe our own bodies and private selves are sort of split off a bit here*
Use of humour	P18	*I think we are used to being a bit sort of, we can be quite crass here*
Necessary dissociation	P18, 17	*But what are we to do? really have to put a boundary up* *I've sort of always worked in these environments. I might be a little bit cut off from that. In an unhelpful way*
A wish to shut it down	P6	*is often something where I want to stop it, I want to close it down I want to be the grown up that's saying no, don't do that*

Physical appearance as a defence	P9	*I'm helped by my white hair. In that regard, you know, I can look sort of older, and perhaps that's sort of safer in some way p9*
Threat of enactment		
Patients need to show something with bodies	P16	*I'm aware that there are mainly men in the building who have done terrible things to other people's bodies, you know, that's why they're here, they've sort of call it- that they've kind of written their trauma on another body because they couldn't process it themselves or speak speak to it*
Enactment is uncontained	P16	*S: And the enactment seems even more worrying here. Bodies enacting things? E: Yeah. That's why they got referred basically*
Bodies can turn perverse, quickly Also embodiment/enactment	P6,p6, p4	*and you can find yourself- it's an enactment, quickly to find yourself in a scenario* *you suddenly you're much bigger than the child or they're in a corner and you're sort of and they're sort of sticking a part of their body out* *there are some point kind of shocking moments with the body that come in, in terms of sort of them being very revealing or performative with their bodies p7* *my immediate thought was sort of do I fight it or go with it sort of- something to be kind of ignored or brought into and very present p4*
Creative use of the body in sessions		
Body speaking the thing that cannot be said or stated	P13	*And it's, there's a question that's just not been spoken about? Or acted out. And my body's sort of done it for me*
Her body can enliven the patient or downregulate them	P4	*They need a bit of livening up and they need me to do sometimes*
Embodied movement with younger patients	P5	*because I see some patients that I get very bodily with, so I do. With the younger kids, I'll be doing quite a lot of marching around or hide and seek or play and I get quite… I use my body to hold something in me to be thought about in the kind of body way*
Giving over of your body is sometimes what the patient needs	P6	And so physically, I give both over very much to what he needs, what's on his mind what he needs to explore. And it sort of helps to regulate something that otherwise he can be bouncing off the wall a bit
Her body state helps her to think about her patient	P7	*it really helps me to tune in to something-about something's different today, or, you know, I found myself sat very still, as I say, like, with my legs crossed*
Bodies talk to eachother	P10	*but I did sort of start to tune in a bit on digestion, and how the patient communicates something like that. And I communicated back to them, and what's going on between us*
Her body speaking		
stomach that talks and shouts	P10, p12	*stomach can sometimes start talking in a really embarrassing way* *And literally, my stomach went braaah p12*
Gut/head tell you that this is not ok	P6	*And it just suddenly comes to you to your gut and to head really like this is not okay*
The body rebels	P13	*And my body's sort of done it for me*
Concern that her body might communicate uncomfortableness	P9	*oh, God, I got really hot when the patient was really like this…*
What does her body mean?		
Power of an adult body Also meaning of the body	P20	*that the patient is by the door, there's an escape route, and that that goes against a lot of other places where you put yourself next to the door as a professional so that you can get escape*
Complexity of a woman's body Also meaning of the body	P8, p9	*So I think when aspects of my real body come into things, it's quite alarming at times for patients p8* *And other times, I think I am all of that is negated as if I'm a sort of sexless nothing. And that makes me much safer as well, but not real p8*

		Impacting of being post menopause p9 *but he is a patient who,he looks at my chest, not and my, and sometimes that's sexualized, and sometimes it feels maternal p8* *And felt to be in that it can be quite frightening to be with a female body p8* *Well.. I have a female body, i'm a woman. Aaaandd I think there's something about that, that comes and goes for patients of any age p8* *but he is a patient who,he looks at my chest, not and my, and sometimes that's sexualized, and sometimes it feels maternal* *But I could talk about the fact that I'm more sexless in that way, you know that I'm not a fertile possibility. And maybe that renders something….*
Power, safety, anxiety		
Safety coming from the team and the setting	P19, 14, 21	*We need to be together in our professional identities, not our home identities (during lockdown) p19* *Well, I have good colleagues here and a team that I trustp14* *I just go back to the real basics. You know, I have the setting. And my training is just that core kind of psychoanalytic Kleinian thinking as well. Really, settles something in me, it's sort of grounds me and helps me sort of think about in a sort of thinking platform p21*
She's not certain of her safety Also anxiety/safety	P17	Yeah, it feels. Alright, is that true? (doubting) *I suppose is sort of that there is an awareness, or I'm aware that there are mainly men in the building who have done terrible things to other people's bodies that they've kind of written their trauma on another body because they couldn't process it themselves or speak speak to it. So it was written on someone else's body kind of thing. (my vulnerability in this. E perceiving something about my body's sexuality, or by body being an object of desire potentially.)* *And there was one case that I'd seen for the first time and me and a female colleague got really anxious that he hadn't left the building and ended up rushing into the toilet thinking p17*

Appendix J: Complete table of Group Experiential Themes

Table of Group Experiential Themes

Group Experiential Theme 1: Boundaries

a. Intrusion

#1	*It really felt like they were inside and messing with me.*	P10
	might be inviting me to be more intrusive towards them and bigger	P7
	Just it's exciting to hear to hear about what goes on inside of people's bodies. I mean, that's what we're in the business of Yeah, they want to know and get right inside. So that's something maybe to think about	P26
	Core complex. I was bound to say that here, but I find it incredibly helpful-some sort of sense of being too close and too far, and what distance you use here	P20
	there needs to be a sort of almost putting the clothes back on element to it as well to nurture their development in every realm	P22
#2	*then usually… um with him, there's usually a period of time before I sort of feel a bit like 'heuhh' (sound and chuckle) something happened (says this quietly, hard to make out) at first it sounds weird* (she says this whilst speaking about experiences with patients getting inside of her) *I can often need to feel like I need to defuse something. And….that if I don't do that, it's not great (she is getting something out)*	P10

#3	*But then when I get this feeling of literally like, I'm poisoned, or I could be sick, or this real nausea*	P15
#4	*There can be an anxiety that one body will penetrate the other p18*	P18
	it would be very persecutory for them I think (if we speak about a patient's body)	P14
	But I would always explain why I'm doing it so that they could have some cognitive understanding (speaking about the body is intrusive)	P22
	Talking to a patient about what they have projected into you might be handing it back too quickly p10	P10
	The power balance inherent in this work can be frightening for patients p16	P16
	because it….can get over sexualized like that (snaps his fingers). You've gone into their bodies	P15

b. The body is projected into-made to do something

#1	*And I was really shaken up by it, how powerful it was, and how humiliated I felt. And I did feel humiliated (falling down the stairs)*	P10
	Just sort of zombie	P4 p11
	So I've had the experience where I'm like, write, like trying to do a calendar with a patient. And I can't draw lines and remember numbers	
	is that it's at being out of my control. It's been unpleasant, I know that's less body but it felt bodily. I liked *I felt freaked out.* Yeah, I can't I forgot my mind (loosing ability to use a pen and draw a calendar)	
#2	*I still feel like, I'm sort of under siege sometimes p9*	P3, p9
	I felt really, like I was sort of shrunk back into my chair feeling	
	but also that I was being put in this position where I felt like he was the dominant one, and I felt that in my body as well, like I really felt difficult to move	
	I felt that in my body as well, like I really felt difficult to move p9	
#3	*about femaleness and the female femininity of my body. And feel like it's errr provocative or, or is the area that gets kind of denigrated and attacked*	P18,20
	I think there's been something a bit about, of envy about a well body, but also a bit of disgust at my body about being a healthy body or a healthy, healthy weight p20	P20
	And I felt completely humiliated by it. P25 (her body responding to an envious attack)	P26
	like I had to be the person with all the hunger and all the need and all the kind of aggressive, aggressive hunger p26	
	I'm in a state where I'm cut off it doesn't it doesn't kind of feel as simple as that. And, and it is definitely feels more in relation to what they're projecting into ya body as well p22 (patient induces cut off feeling)	P22
	….. But I've noticed that I was on eggshells in term like, physically, I was physically very rigid and tense. And every time I had a thought (quick chuckle) that I even thought came into my head errr my body was tense as if I wasn't allowed it was if it was dangerous to have that thought	
#4	*To have to be seen like that is deeply, deeply disturbing*	P18

Group Experiential Theme 2: The 'public' body, the 'personal' body

a. The threat of exposing the therapist's 'personal' body

#1	*the experience in lockdown where we, for the first six months, we had to take phone calls or Zoom calls at home, was really-**I found** anyway…. was shocking.*	P19
	And I use my body to do that. To show him different aspects that I'm prepared to go into with him……(voice tone changes as this fine line is recongised). And then I have to think about boundaries with that very very closely and carefully.	P18
	We really have to put a boundary up. And actually, it's incredibly empowering to do that, as well	
#2	*it's been interesting, going into summer clothes, because I sort of had almost like a little uniform that I wore in the winter*	P7
	It was very predictable and boring. But it somehow got me off the hook with wandering too much because it was quite repeatable	
	my body's being noticed more	P7
#3	*To talk like really intensely about your body err feels too personal and it feels a bit like oversharing*	P28
	I would have been worried about crying, or I would have been worried about my body p38	P38
#4	*But whaddo you mean?' (he says quickly in response to my question).*	P2
	No such thing as a therapeutic body	
	can make you… make me really self conscious. (patient analysing his body)	P14
	*it's not an **illegal s**ubject for me it really, really isn't. I encourage it with people I supervise, I encourage it with people I teach*	P19

b Exposing the patient's 'personal' body

#1	*there needs to be a sort of almost putting the clothes back on element to it as well to nurture their development in every realm*	P22
#3	*is like a bit culturally ummmm….. rude as well or like too personal or disrespectful p30*	P30

	when appearance or body is related to like a defined area of difference, like disability or sexuality or gender or race, then it feels easier to talk about than speaking about their body in the room p31	P31
#4	*It can feel persecutory for patients if we speak about their body too directly p14*	P14

Group Experiential Theme 3: Embodiment or enactment

.a The threat of enactment

#1	*that they've kind of written their trauma on another body because they couldn't process it themselves or speak to it*	P16
	and you can find yourself- it's an enactment, quickly to find yourself in a scenario	P4
#2	*that I was being put in this position where I felt like he was the dominant one, and I felt that in my body as well, like I really felt difficult to move*	P9
#4	*You can quickly get into a replicating traumatic situation*	P16
	So very aware about particularly male/female, if I'm doing my adult work, male/ female issues, in terms of any abuse history or sense of not trusting that boundaries will be respected and kept	
	S: your body did not belong to you really? 4: absolutely not	P18
	And, you know, she would enact it, and she would want me to… and she would be lying on the couch and pretending to be asleep, and I would have to come into her room	P17
	a girl who had been sexually abused by her mother's partner. And she enacted it in the room	P17

b Moving with: embodiment

#1	*I give both over very much to what he needs, what's on his mind what he needs to explore. And it sort of helps to regulate something that otherwise he can be bouncing off the wall a bit*	P6
#2	*But then we are always there in our bodies, obviously, there's always, always an experience of moving.., you know, being…being together p12*	P12
#3	*grounding was something that I always thought was really important*	P11
	I think something physical does need to come to ground you out of a kind of dissociated or vigilant state and, and be able to work in the transference a bit better	P12
#4	*I suppose the interesting part of that scenario is then the enactment that empowers her to complete the freeze, I suppose, you know, that she was able to complete the action to get someone away*	P18

Group Experiential Theme 4: Sexuality: The sexual nature of bodies

a The sexual subtext: it is hard to name sexuality in an explicit way

#1	*Just it's exciting to hear to hear about what goes on inside of people's bodies. I mean, that's what we're in the business of Yeah, they want to know and get right inside. So that's something maybe to think about*	P26
	- it's an enactment, quickly to find yourself in a scenario	P6
	you suddenly you're much bigger than the child or they're in a corner and you're sort of and they're sort of sticking a part of their body out	
#2	*how the body is used to symbol….a way of expressing something…..questions over gender…lack of sleep, or hours of gaming….it's still all in, it's still in the body*	P14
	*I move in my body, eat in, sleep in my body experience relationships and friendships and life **in** my body. So it's something that I experience pleasure in and sadness and yeah, it's it's the being the being in relationship experiences as well in my body*	P3
#3	*And I think I keep going back to the questions that you asked about- how your body is perceived by the patient or how adult body is and thinking I just- I'm finding that really hard to think about. P26*	P26
#4	*things I'm saying are a bit illegal,*	P19
	i'm supervising….in supervision today actually (he speaks about supervisee rather than himself)	P9

b Sexuality in this context can feel unsafe

#1	*Yeah, it feels safe. Alright, is that true? (doubting)*	P17
	Well, I have good colleagues here and a team that I trust	P14
	I suppose is sort of that there is an awareness, or I'm aware that there are mainly men in the building who have done terrible things to other people's bodies hat they've kind of written their trauma on another body because they couldn't process it themselves or speak to it. So it was written on someone else's body	P17
	And there was one case that I'd seen for the first time and me and a female colleague got really anxious that he hadn't left the building and we ended up rushing into the toilet p17	P17
	I suppose is sort of that there is an awareness, or I'm aware that there are mainly men in the building who have done terrible things to other people's bodies	P17
#2	*And how safe is it to bring attention to that as well, where you don't always know what you're in touch with?*	P11
	*that feels **incredibly, incredibly** there, but also very, very unsafe to be around for all sorts of reasons*	P10
	it just feels too much sometimes	
	and that feels really not okay	

		he's certainly spoken a lot about what he sees me as, his sort of his ideas about me, which are actually quite wrong. But it's quite interesting that what's projected onto me	P9
		If something is felt so strongly in the body…..you know, how, how does one then speak, or think of that also in a way that can be tolerated	P6
	#4	*because it….can get over sexualized like that (snaps his fingers). You've gone into their bodies. That's another kind of thing. I think that's part of the illegality about bodies is sexuality.*	P15
		it's very disturbing to be to be seen in that way	P17
		it heralds potential catastrophic change, like changes of technique, which are completely essential for working with the kind of patients that come into CAMHS	
		reference to someone who has been ostracised	
		It can make you… make me really self conscious.	
c	Complexity of a gendered body and sexuality		
	#1	*So I think when aspects of my real body come into things, it's quite alarming at times for patients p8*	P8
		And other times, I think I am all of that is negated as if I'm a sort of sexless nothing. And that makes me much safer as well, but not real p8	
		but he is a patient who-he looks at my chest…. and sometimes that's sexualized, and sometimes it feels maternal p8	
		it can be quite frightening to be with a female body p8	
		Well.. I have a female body, i'm a woman. Aaaandd I think there's something about that, that comes and goes for patients of any age p8	
		But I could talk about the fact that I'm more sexless in that way, you know that I'm not a fertile possibility. And maybe that renders something….	
	#2	*it's been interesting, going into summer clothes, because I sort of had almost like a little uniform that I wore in the winter*	P7
	#3	*…about femaleness and the female femininity of my body. And feel like it's errr provocative or, or is the area that gets kind of denigrated and attacked p18*	P18
	#4	*So very aware about particularly male female, if I'm doing my adult work, male female issues, in terms of any abuse history or sense of not trusting that boundaries will be respected and kept*	P16
		it's very disturbing to be to be seen in that way	P16
		I think if in an abuse situation, when people attribute you…but that's common for us in transference work, you're seen as a particular person	P17
d	Adults and children		
	#1	*(they) might be inviting me to be more intrusive towards them and bigger*	P7
		that the patient is by the door, there's an escape route, and that that goes against a lot of other places where you put yourself next to the door as a professional so that you can get escape	P20
	#2	*But that sort of painful wait for a child to give it a go. And possibly fail, but to give it a go, and to be there and to be in my experience with them*	P8
		But I think particularly the children I'm working with with physical disabilities and very very aware of my body and that does come into conversation sometimes, you know- how do they, how do they perceive me?	P7
		*I'm very aware… **I** am constantly changing- in my body as well I guess*	P3
		And then, yeah, that's bodies are also a reminder somehow ,have something to do with where one is positioned in life maybe	P4
		I had one child this week who wanted to do a body swap. So that was very obviously in relation to my…. body	P8
		he's certainly spoken a lot about what he sees me as, his sort of his ideas about me, which are actually quite wrong. But it's quite interesting that what's projected onto me	P9
	#3	*adult bodies and adults have been allowed to do whatever they want. And children having no power and powerlessness in the kind of child's body*	P19
		something that does carry history in the same way	P9
		well, why aren't you doing anything? Why aren't I activating you? P20 (patient expecting use of adult body)	P19
		Paticipant was quite disturbed by this question (about adult body in relation to a child's)	
	#4	*I think if in an abuse situation…. people attribute you…but that's common for us in transference work, you're seen as a particular person*	P17
		it's very disturbing to be to be seen in that way	P16
		It can make you… make me really self conscious (patient analysing his body)	P14
		So I think they'd become very aware in those situations of the power imbalance, which they are aware of anyway, and mostly trying to reverse it, as you well know, working with children, but it can be very frightening with traumatised children and traumatised anybody. The power imbalance, the power imbalance of the couch, and one sitting ones lying is also relevant. And many people who have been abused or have had really, you know, very frightened find this proximity, really frightening, and would be much too close	P16

Group Experiential Theme 5: Bodymind split

a The therapists's body communicates something important and/or a truth

#1	*And it just suddenly comes to you to your gut and to head really like this is not okay*	P6
	And literally, my stomach went braaah p12	P12
	it really helps me to tune in to something-about something's different today, or, you know, I found myself sat very still, as I say, like, with my legs crossed	P7
	I think we are used to being a bit sort of, we can be quite crass here (use of humour)	P18
#2	*And so I'm very aware that what I think and what I conjecture, isn't actually always accurate. And I really need to listen (to my body p13)*	P13
	Bodies don't lie, I think I could have a thought in my mind, and then touch a body and feel something, it could be different. And then I'd be like, Ah, I've got it wrong.	
	younger adult is saying 'they're fine'..... But my body is really feeling something quite distant, you know, quite different	
	I was noticing in the room, a feeling in me of being incredibly watchful, vigilant p9	P9
	My body is what I wake up- and feel- and see	P3
	I move in my body, eat in, sleep in my body experience relationships and friendships and life ***in*** *my body*	
#3	*I was a bit taken in by this kid, thinking like, fine, like they're lovely, they're great, they're not disturbed. (Body says something different)*	P37
	I must be really disturbed by what's going on…but I feel absolutely fine	P15
	I feel kind of very neutral or don't feel much—don't feel projected into at	

b Defences against mind and body integration

#1	*I don't know if maybe our own bodies and private selves are sort of split off a bit here*	P18
	I think we are used to being a bit… we can be quite crass here (use of humour)	P18
	But what are we to do? We really have to put a boundary up—I've always worked in these environments. I might be a little bit cut off from that. In a helpful way	P17/18
	Friend or foe?"	P3
#2	*My body is what I wake up in—and feel—and see*	P7
	And my body seems to… be part of my identity and also something that is constantly changing—with my identity, I guess. And it feels like something that… is very much part of me, it is me. But I'm very aware of how it is constantly changing, and I am constantly changing. I experience relationships and friendships and life in my body	P7
	I put my clothes on and do my teeth and, you know… but I'm not so thinking about my body	P8
#3	*It involved a lot of physical restraint, and to survive, you had to cut off—you just had to cut off your body and you had to make your body like a machine*	P36
	Often the body becomes the area of treatment rather than it feeling like the whole person	P30
	As soon as it comes to the body, I think, well, it's not real unless I have science to back it up. It becomes medicalized somehow	P32
	Too much of the body stuff is polluting—polluting something, maybe	P29
	God, there's loads that I don't know. And that is hidden and unprocessed within the body as well	P10
#4	*I don't distinguish body and mind… it's a completely Descartes era, as Damasio would call it. Mind and body are the same or interconnected. I don't even like the language (of body and mind as separate)."*	P4
	People are so alienated—divorced from their bodies a lot of the time, which means that they're divorced from their minds	P12