How Does Attending to the Client's Bodied Experience of Their Illness in Talking Therapy Open a Gateway to Empathic Depth?

A Hermeneutic Phenomenological Study

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Abstract

Essential to healing in talking therapy is the skilful act of hearing clients' stories of experience and exploring the personal meanings these stories hold. Typically, talking therapists prioritise subjectivity such as thoughts, emotions, and meaning-making in many of their therapeutic approaches with clients, which gives physicality, specifically illness, a less fundamental gaze. This is because Western models of counselling or psychotherapy are influenced by dualistic views of personhood, health, and healthcare. But what happens when the gaze turns towards physicality and illness is given a "voice" in talking therapy, and how does this relate to the therapist's experience of empathic depth? Using the methodology of hermeneutic phenomenology as informed by van Manen, this study explores five talking therapists' lived experiences of attending to physicality and bodied story in clinical practice and seeks to understand how these experiences open a gateway to empathic depth when using a whole person approach to healthcare. Walking alongside the meaning of whole person is a Christian understanding of personhood. A whole person approach to healthcare is a non-dualistic way of understanding what it means to be human. This understanding creates a setting where the whole of a person's being, experience, and story are welcomed, heard, and validated within the therapeutic encounter. Within this non-dualistic way of therapeutic practice, the therapist is invited into a deeper empathic understanding of their clients' experiences. The Covid-19 pandemic of 2020-2022 meant that all the interviews were conducted online. The participants' experiential stories were transcribed by the researcher who was guided by van Manen's method of dwelling with the data and crafting anecdotes of lived experience that capture the essential meaning of data. Out of a dwelling-with and reflecting upon the anecdotal narratives emerged three patterns, or themes, that became the interpretive findings. The first theme focused on attending to the body of both therapist and client and how the impact of this paradigmatic shift in viewing what it means to be human influences professional therapeutic practice. The second theme, empathy as space, focused on the therapists' experiences of empathy within the clinical encounter. The

third theme, home, focused on therapists' taken-for-granted experiences of working with both body and bodied empathy. Woven through these themes are the cross-findings of courage and the therapeutic relationship, which bring the phenomenon of empathic depth when attending to physicality into focus.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Jane Hepburn

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Ehara taku toa, he takitahi, he toa takitini

My success should not be bestowed onto me alone, as it was not individual success but success of a collective – Māori whakatokī (proverb)

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CHAPTER 1: Introduction

In this study, I present the process of researching talking therapists' experiences of bodied story and empathic depth in the therapeutic relationship. Typically, talking therapists prioritise thoughts, emotions and meaning-making in their therapeutic approaches, which gives physicality, specifically illness and/or disease, a less fundamental gaze. But what happens in the therapeutic relationship when a talking therapist uses a whole person approach and attends to physicality, or illness, during talking-therapy? Using a qualitative framework, this study highlights how empathic depth in the therapeutic relationship gains momentum for the therapist when illness is given a 'voice' in talking therapy.

This introduction opens the door into this research thesis. In this chapter I lay the foundation of this study by describing its context and background, and I discuss how my own personal and professional journeys in the field of counselling have invited me to engage in this research. I then discuss the gaps in the literature and how those gaps lead me to my research question. The aim and scope of this study, which provide the study's framework, is discussed and I present the research question. Terms and phrases are defined to bring clarity and understanding to the reader, and the structure of this thesis is presented by introducing each of this study's chapters.

Context of This Study

In my Bachelor of Counselling training, I learned various counselling theories and modalities that focused on thoughts, emotions, behaviour, and meaning-making. Underpinning my learning was a relational understanding of what it means to be human from a theological perspective. I was able to integrate the humanistic modality of Person-Centred Therapy and the post-modern modality of Narrative Therapy through the lens of a theological ontology. Through the integration of theology and psychology, the resulting picture of wellbeing looked like mind, spirit, relationships, and meaning-making, with the counsellor's attention on their own body awareness. Mental health disorders, including

somatic disorders, were taught in the curriculum, however training on the body, specifically illness or disease, was not included.

In my counselling practice, I met with clients who were referred to me by their physicians because their physical illness or disease was persistent and/or not progressing as expected with medication or deemed psychosomatic by the physician. As I began to talk with these clients, I discovered that the bodied story, e.g., the description and client's experience of their illness, was often mirrored in the stories of their relational experiences. The illness was problematic, but the problem was not simply located in the mind of my clients. I had no name for this phenomenon, yet my client's bodies were clearly talking and longing to be "heard" and validated. Eager to learn more, I enrolled in the MindBody Healthcare programme at Auckland University of Technology (AUT). I learned that illness or disease can present with a **story** that is closely aligned to a client's experience(s) in life and that these stories have meaning. Meaning can be expressed as a bodied reality. Broom (1997) calls these the patient's 'other' stories. I also learned that the objective and subjective parts of personhood are not separated components but that persons are multidimensional wholes. I also learned that meaning-making was generally relegated to the subjective part of humanity. In other words, meaning-making activities are generally held separate from illness.

This confirmed my hunches with the clients referred to me and it challenged me to consider what it means to be human from a wholistic, or whole person perspective rather than from a dualistic (mind or body) one. I discovered, to my horror, that a dualistic perspective not only informs the field of medicine but informed my own counsellor training as well! A whole person approach invites an integrated non-reductive way of practicing healthcare, which means that the body, specifically illness and disease, does have a place in talking-therapy. As I engaged in my counselling practice from a whole person approach, I noticed I gained an in-depth relational connection with my clients, and I became more attuned to my clients as a therapist. I wondered if this also happened with other counsellors who practice in a whole person way. This "wondering" has led me to this research.

Background

The most effective factor in talking-therapy is the therapeutic relationship, which develops between the therapist and the client (Azer, 2006; Clarkson, 1995; Martin et al., 2000; Nuttall, 2012). Within the safety of the therapeutic relationship, a talking therapist listens to a client's subjective world: their thoughts, feelings, experiences, relational encounters, and how meaning has been made. The client's bodied world, specifically illness of the body, takes a back seat and seldom has a focus or voice in talking therapy, unless the therapist understands a non-dualistic, whole person approach to therapy. Western approaches to healthcare are influenced by Cartesian dualistic theories. This implies that the theories and models of therapeutic practice are dualistic in nature. This means that talking therapists are fundamentally focused on subjectivity, not physicality. To make this leap across the chasm of dualism necessitates a new paradigm or framework for understanding a non-dualistic whole person approach to therapy. Within the therapeutic relationship, from a Rogerian perspective, there are three core conditions or attitudes of the therapist (Rogers, 1980). The first is congruence, being genuine in the therapeutic relationship. The second is unconditional positive regard, or genuinely and unconditionally caring about the client. The last is empathy, which is the ability to genuinely understand the client. This study examines how empathic depth emerges in talking therapy in the context of a non-dualistic whole person approach to healthcare.

Context Within the Literature

A large body of literature exists on areas of counselling, the body in counselling, and empathy. However, as you move toward the epicentre of the topic of this study, the literature becomes less available. What I discovered missing was literature in relation to empathic depth in connection with a whole person or multidimensional view of what it means to be human; with specific attention to when bodied illness is given voice in talking therapy. In other words, from an initial search, no humanistic literature could be found on the impact of empathic depth when the bodied 'Thou' (Buber, 1970) is invited to participate in talking

therapy. Research in neuroscience has shown that empathy is the result of the firing of mirror neurons in the brain (Iacoboni, 2009). Research on the therapeutic relationship shows a corelation between relational depth and empathic depth (Mearns & Cooper, 2018). But there has been no research on empathic depth in relation to physicality. Therefore, a current gap existed on the impact of empathic depth in the concept of a whole person approach to healthcare and bodied story. This initial review of the literature also revealed a lack of qualitative studies involving bodied stories and their impact on empathic depth. This study will begin to fill in those gaps.

Motivation For This Study

My counselling work sharpens me as a lecturer in a tertiary counselling programme and my lecturing role keeps me sharp as a counsellor. The development of relational engagement for both of my professional roles was a motivating factor for this study. Another motivating factor was the completion of a Master's degree. But there was an underlying motivation for this study, and it emerged out of my own personal journey and a growing awareness of who I am becoming within the context of relationships. This relational understanding of who I am has been a point of difference for my clients and students and is at the centre of my professional work as a counsellor and educator. This point of difference became my motivation, or the 'fire in my belly', that turned my gaze toward a growing curiosity of empathic depth in relationships.

Key Point of Concern

The focus of this research is: How does attending to the client's bodied experience of their illness in talking therapy open a gateway to empathic depth? The phenomenon of enquiry is how empathic depth emerges by attending to physicality in talking therapy. A key point of concern in this study is that the fundamental dualism in therapeutic approaches in talking therapy limits therapists from attending to the rich multidimensional complexity of what it means to be human. Subjectivity and physicality mix like oil and water from a Cartesian viewpoint, yet healing is often an integration of multiple aspects of personhood.

Current approaches in counsellor training are primarily focused on subjectivity with a limited appreciation of the role physicality has in clinical practice. Another key point of concern is that there has been minimal research on empathic depth.

Significance of this Study

To be human is to be multi-dimensional; an emotional, relational, cognitive, spiritual, bodied, cultural, meaning-making, unitary whole. Yet an overwhelming majority of Western models of talking therapy prioritise subjectivity. People are multi-dimensional beings, yet when they go to talking therapy, they do not expect to discuss illness. But illness interrupts and disrupts our being-in-the world. The medical model is primarily focused on physicality, and medical experts have neither the time nor skills to attend to the client's bodied subjective story of illness. But talking therapists do if they have the courage to view what it means to be human from a whole person, multidimensional, unitary approach. What is significant about this study is its view of personhood from this non-dualistic, whole person, multi-dimensional, yet unitary perspective. The result of this understanding of personhood is sound healthcare.

In the literature, empathy is linked to the therapeutic relationship and as the relationship deepens, the description of empathy become richer. However, a significant point this study makes is that empathic depth also emerges by attending to physicality in talking therapy. Another point of significance of this study is how it adds to the literature on the relationship between physicality and empathic depth in talking therapy and to the literature on whole person healthcare. At the time of this writing, there is currently a gap in both.

One of the outcomes of this study is how it has developed and enhanced the material I use for lecturing. I teach Person Centred Therapy (PCT) to students in the first year of a bachelor's degree in counselling. Engaging in a deep exploration of empathy, which is one of the core conditions of Carl Rogers' theory, has been a motivating factor for me in this study. The information gained from exploring talking therapists' experiences of empathy in their work has helped me to develop new and supporting training material for my students

and has helped me to develop new teaching methods for the classroom. Another key outcome is how this research has informed my practice. I have noticed how my work as a counsellor has become more robust. One of the advantages of this is how the quality of healthcare I now provide my clients is benefitting them and their families.

Aim and Scope

Because talking therapy focuses on the subjective aspects of health, an aim of this study is to draw attention to physicality and to gain an understanding of talking therapists' experiences attending to physicality in the context of talking therapy. My goal for this thesis is to bring awareness that physicality has a place in talking therapy.

Another aim of this study is to contribute to the literature pertaining to a whole person approach to healthcare. This includes a specific body of literature on Whole Person Healthcare. There are many meanings of whole person and whole person care, and my aim is to refine a full and rich definition of whole person, how this relates to personhood, and how this relates to healthcare. There is a gap in the literature pertaining to talking therapists' experiences of working with physicality, specifically illness in their therapeutic work. This study adds to the growing body of knowledge that is realising the impact physicality has in talking therapy.

Fundamental to talking therapy is the therapeutic relationship. From a Rogerian point of view, empathy, unconditional positive regard, and congruence are important elements of the therapeutic relationship (Rogers, 1980; Vilkin et al., 2022). This study has a specific focus on empathy and how one might take that extra step beyond empathy. Another aim of this study is to understand how attending to physicality using a whole person approach can deepen the therapists' experiences of empathy in the therapeutic relationship. There is no definable line between empathy and empathic depth. The boundary between the two is not well-marked so this study's aim is to understand how empathic depth emerges by attending to physicality.

The scope of this study is limited to the experiences of five talking therapists whose professional practices in New Zealand use a whole person approach. I interviewed five talking therapists who have experienced the phenomenon of empathic depth while attending to their client's physicality, specifically illness while using a whole person approach in talking therapy. Their stories became the data for this study, and these stories were examined for themes that were interpreted to gain meaning and new understanding of the phenomenon.

Clarification of Terms

There are specialised terms and phrases in this research study that relate to counselling and a whole person approach to therapy.

Anecdote is a short narrative, or vocative examples, of storied experience that makes a point. The participants' lived experiences of the phenomenon were gathered into transcripts, which became the source of several anecdotes used to describe and show the lived-experience of the phenomenon.

Clinical gaze is the act of seeing. It refers to what the therapist focuses on in relation to the theoretical understandings they hold in clinical practice.

Therapist/Counsellor/Psychotherapist refers to a person who provides talking-therapy for the purpose of helping someone attain health and wellbeing. In this thesis, the word therapist is used.

Therapy refers to a form of treatment for someone who is unable to cope with difficult life challenges.

Whole Person Healthcare is the name given to a non-reductive approach to therapy that considers all aspects of what it means to be human, and therefore, healthcare.

Illness is someone's personal experience of suffering from something that makes you sick or unwell and can affect the mind or the body. ***Disease*** is a disorder

of an organism or function identifiable by distinguishing signs or symptoms. For the purpose of this study, the term, illness, is used throughout.

Somatic Metaphor is the term given to a bodily expression of illness or disease.

Overview of the Thesis

This first chapter has been an introduction or the doorway into this study. As the door has opened, I have explained the context of this study by briefly introducing my experience of a whole person approach to talking-therapy and what has led me to this research. The terms that are used within this these have been clarified. I have explained how this journey began for me and what compels me to study the lived-experience of how empathic depth emerges by attending to physicality.

Chapter Two is a review of the literature. Because this study uses a hermeneutic phenomenology lens, this literature review differs from the literature reviews of other methodologies because its purpose is to "portray the taken-for-granted meanings that make up the knowing of practice" (Smythe, 2011, p. 50) not just a presentation of the available literature. Its purpose is to engage the reader on a journey into another layer of thinking. The literature review explores different perspectives of personhood that help clarify the definition of whole person. The therapeutic relationship is explored in relation to relational depth, empathy, and empathic depth. The literature review also includes works outside the field of counselling and psychotherapy.

Chapter Three provides a brief introduction to phenomenology and hermeneutics and identifies the key features of the methodological approach of this study. This chapter outlines the research design and clarifies the methods used to generate data that are rich in the participants' lived-experience.

The findings of Chapter Four hold the structures of the phenomenon, or themes, that emerged from the analysis process. These themes are attending to the body, empathy as

space, and home. Without the themes, the phenomenon would not be what it is. In this chapter, I present the interpreted stories of the participants within the associated themes.

In Chapter Five the themes are discussed including links and engagement with relevant literature. The themes are also drawn together into a cohesive narrative, using the metaphor of *weaving the threads,* that shows how empathic depth emerges by attending to physicality in talking therapy.

Chapter Six concludes with a discussion of the implications and recommendations for counselling practice, research, and training in New Zealand.

CHAPTER 2: Literature Review

> Such journeys open vistas to new journeys for uncovering meaning, truth and essence – journeys within journeys . . . this is the beauty of knowledge and discovery. It keeps us forever awake, alive, and connected with what is and with what matters in life. (Moustakas, 1994, p.65)

This study draws on my own and my participants' lived experiences of the phenomenon, and it also draws on the skillful writings of others. These writings, which include theories, research, and other literary works, provide a breadth of understanding that support the taken-for-granted meanings that inform the knowings in my professional practice. This review explores the philosophies, understandings, and assumptions implicit in a whole person approach to healthcare and to empathy. In keeping with the study's hermeneutic phenomenological lens, my literary search extends beyond the fields of psychotherapy and counselling because the literature in those other fields have valuable implications for how attending to the client's bodied experience of their illness in talking therapy opens a gateway to empathic depth for the therapist. This chapter was written at several points throughout the research process; however, I found it most helpful to review literature during the data interpretation and analysis phase because it allowed me to engage with the fore-understanding I gained from my engagement with thinking and writing. The purpose of this chapter is to provoke thinking (Smythe & Spence, 2012). Therefore, you are cordially invited to share in this experience and to partner with me on this journey of thinking. Let's start at the beginning; it's a very good place to start...

Personhood

Eager as I was to study counselling theories and techniques when I first began my counsellor-in-training, the curriculum in my education, from diploma to Master's degree, invited me to first consider the "who" of therapy: on whose behalf am I becoming a therapist? It was important to first start with this question because it helped me to understand the 'why' of my therapeutic gaze. Working with clients in a counselling setting often means working with people's experiences of dis-ease or mental illness. So, first

understanding ‘what does it mean to be human?’ is important because the answer to that question is fundamental in which pathway is chosen to achieve healthcare outcomes in professional practice. For example, if a client presenting with depression visited a medical doctor, a counsellor, and a physiotherapist, they might come away with three completely different ways of attending to the depression. So, from the perspective of talking therapy, what does it mean to be human, or in other words, what is personhood?

Depending on where you look in the literature, personhood has a multitude of understandings and meanings:

> It was six men of Indostan, to learning much inclined,
> Who went to see the elephant (Though all of them were blind),
> That each by observation, might satisfy his mind.

This famous nineteenth-century poem goes on to say that each of the six blind men took hold of a different part of the elephant and began to describe the elephant by whichever part he was holding. Of course, each described the elephant differently: a wall, a spear, a snake, a tree, a fan, a rope.

> And so these men of Indostan, disputed loud and long,
> Each in his own opinion, exceeding stiff and strong.
> Though each was partly in the right, and all were in the wrong!
>
> -John Godfrey Saxe’s version of an ancient Indian fable

Cartesian View of Personhood

Each of the blind men in this poem defined the elephant by reducing it to whichever part he was able to blindly “observe”. Personhood, too, has been unhelpfully, and helpfully, defined by this reductionist approach, or Cartesian view. Descartes, who proposed an ontological dualism, divided the body into *res cogitans* (a thinking, non-physical thing: mind) and *res extensa* (material substance: body) (Leder, 1984). According to Descartes, the activities of the mind included the essence of self. This meant that the material body, by being external to the self, could ethically be viewed as a machine, making it subject to analysis and invasive interventions, which, up to that point in history, had been prohibited (Leder, 1984). These ideas gave rise to Western culture’s dualistic ideas about personhood,

illness, and healthcare: these dualistic approaches see the mind and body as separate entities. "Dualism would tell us that there is an unbridgeable gap between the physical and the mental" (Bergemann et al., 2011).

Western thinking also shaped our view of persons as separate selves. For example, from a Western perspective, person is understood in fundamentally individualistic terms, meaning that although humans have the capacity to relate to each other, they are "distinct and separate from other people around them" (Mearns & Cooper, 2005, p. 4). In other words, a dualistic view sees people as not ontologically relational; relationships are merely what people do. This view of persons was contrasted by contemporary Christian literature.

Christian Literature

I found myself inclined towards the Christian literature on what it means to be human because as I read, a more wholistic image of the metaphorical elephant emerged. In the Christian literature, personhood is significant because it points to the character and nature of the God who created. From a creational perspective, God, being three persons of Father, Son, and Holy Spirit, commonly known as the Trinity, created human beings in his image. This trinitarian anthropology is understood as the *imago Dei* (Latin for the *image of God*). Grenz (2000) helpfully points out that even though we are distinct from God, "God's personhood confirms us as persons" (p. 55) because we are created in his image. Trinity, although this term is not found in the Bible, is used to describe both the unity (one God) and diversity of God (three persons), which Gunton (1993) explains is derived from the "otherness-in-relation of the Father, Son and Spirit" (p. 6). He also notes that there is a dynamic relationship to all things: "it is perichoretic in that everything in it contributes to the being of everything else, enabling everything to be what it distinctively is" (p. 166). Moltmann (1981) takes this further and adds that "the doctrine of perichoresis links together in a brilliant way the threeness and the unity, without reducing the threeness to the unity, or dissolving the unity in the threeness" (p. 175).

Being image bearers means "to live in reciprocating relationships with God and our fellow human beings" (Balswick et al., 2005, p. 40). Volf (1998) asserts that making and giving space for the other shapes the self; we are enriched by our relationships and this enrichment overflows into our other relations. Vitz (1997) echoes this: "human beings are called to loving, committed relationships with God and with others, and we find our full personhood in these relationships" (p. 30). So, basic to personhood from a Christian perspective is the perichoretic dance of the Trinity and, in the Trinity, relational unity is basic to personhood.

As implied in the imago Dei, we are also spiritual. In the Christian literature, spirituality is not merely something we feel or practice, it is fundamental to our being; we are spiritual beings (Grenz, 2000; Zizioulas, 1975). "The divine creative spirit causes human beings to have life within them and to that extent the spirit is internally present to them, although it does not on that account become a 'part' of them" (Pannenberg, 1985, p. 523). In the Old Testament, the Hebrew word for soul (*nephesh*) has many meanings depending on where it is used: mind, body, will, life. It referred to the whole of the person: the deepest part of the unique 'you'. The Greek word for soul is *psyche* and in the New Testament psyche encompasses the immaterial substance of humans such as emotions, thoughts, passions, dreams, hopes, memories, connectedness, and meaning-making. Pannenberg (1985) explains that nephesh is "simply the bodily being as living . . . but insofar as the soul is the life of its body it is an effect of the life giving spirit" (p. 523). The author of Genesis gives an account of how God called humans into existence as physical beings: "Then God formed the man from the dust of the ground. He breathed the breath of life into the man's nostrils, and the man became a living person" (*New Living Bible*, 1996, Genesis 2:7). The body is important to personhood because "the body is the place within which relationships between God and humanity both hinge" (McMillan, 2016, p. 50). It is in our embodiment that we have capacity to express such things like our uniqueness, presence, relationships, sexuality, emotions, thoughts, and actions. From a trinitarian perspective, personhood emerges through the unity of the relational, spiritual, and psychological dimensions, which exist bodily in

time and space. McMillan (2016) notes that, "while trinitarian theology advocates that human embodiment is central to a theological understanding of personhood, it simultaneously challenges the view that human wellbeing is based exclusively on a person's embodied capacities" (p. 50). This can also be said of the other dimensions of personhood.

Personhood in Te Ao Māori

Personhood can also be viewed from another body of literature. In 2017, the Whanganui River was the first river in the world to be granted legal personhood as a result of the Treaty of Waitangi settlement (Vicente, 2020). According to Te Ao Māori worldview, land, rivers, lakes, and sky are of spiritual significance. The Whanganui River, considered a *taonga* (special treasure), is seen as a living, animate whole that represents the embodiment of creation that possesses *mana* (spiritual power) and *mauri*, the life force that binds together the physical and spiritual elements. From a Māori perspective, the Whanganui River is considered an ancestor, linked by whakapapa, which underpins the relationships between all things. Another view of personhood can be seen in a model of health and wellbeing. Te Whare Tapa Whā, which represent four sides of Māori health: physical (*taha tinana*); spiritual (*taha wairua*); family (*taha whānau*); and mental (*taha hinengaro*) (Ministry of Health, 2015). Therefore, personhood, as understood in Aotearoa New Zealand and influenced by Māori worldview, is wholistic.

Personhood in the Whole Person Healthcare Approach

Whole Person Healthcare was developed by Brian Broom (1997). He describes persons as multidimensional yet a unitary whole. For Broom, the different dimensions of personhood not only include the traditional categories of mind, body, relationship, and spirit but he also extends the definition to include belief systems, family, personal and group histories, and experience. Experience is wholistic and includes "physical, psychological, spiritual and social aspects" (Broom, 1997, p. 25). Broom (2016) adds that humans are also storied beings. Stories, which are events or experiences that happen over time according to a

plot or theme (McMenamin, 2014), are significant in Whole Person Healthcare, with special attention given to metaphor. Stories can be expressed or 'told' verbally and/or non-verbally.

Whole Person Care

It is important to ask what whole person care means because there have been several attempts to define this very thing. In reviewing the literature, I found that most of these attempts either fall into the trap of dualism or they fall short of the fulness of the whole person. For example, a literature review by Thomas et al. (2018) revealed that the terms *whole person health care*, *holistic*, and *biopsychosocial* were used interchangeably and none of the meanings across these terms was consistent with the other. I discovered that for some healthcare practitioners, care of the whole person simply meant adding a single aspect of personhood, for example spirituality (Ferrell et al., 2020; Marques, 2021), mindfulness (Huffaker, 2015), yoga (Wohlmuth, 2021), or dance (Kentel, 2010) to what they are already doing and calling it whole person care. Integrative medicine is an example of where an attempt to "put the patient back together" (Mattai & Hui, 2021, p. 725) is made but the focus is, or it prioritises, illness: physicality. Healthcare that emerges from a Western biomedical model typically uses a positivist or 'scientific' framework to conduct studies. While this is helpful in discovering the effectiveness of therapeutic practices, this model of research captures only the measurable aspect of persons.

Western healthcare emerges out of the Cartesian approach to illness. For example, Werner et al. (2004) tell us that illnesses have been historically classified as either organic or functional (inorganic). Organic illnesses can be quantified, validated, and objectively observed whereas functional illnesses cannot and therefore regarded as psychological. From this Cartesian perspective **i**n theory and practice it asks the question, 'what is fundamental?'. What is fundamental in counselling or psychology is the psyche or the mind. From a healthcare perspective, modern medicine owes much gratitude to Descartes. But Descartes fell short because a dualistic approach gives priority to a specific dimension or aspect of personhood, and it does not fully grasp the fullness of what it means to be human.

Whole person care as influenced by indigenous Te Ao Māori is seen in the concepts of T*e Whare Tapa Whā, Te Wheke, and Te Pae Māhutonga* (Ministry of Health, 2015). These models offer three different understandings of Māori wellbeing and wholistic health. While these models were designed with the Māori view personhood in mind, Durie (2001) notes that it is curious these models are largely underutilized throughout different healthcare sectors across New Zealand. The Ministry of Health (2015) admits that the health system for Māori has underperformed. During the writing of this study, the Ministry of Health (2015) announced the New Zealand health care system's legislative process of reform. A new Māori Health Authority became a separate permanent entity on 1 July 2022 and its purpose is to ensure equitable health outcomes for Māori (Department of the Prime Minister and Cabinet, 2022). As of this writing, Health NZ, which replaced the district health boards, operates health services, including hospitals (Manatū Hauora/Ministry of Health, 2022).

McWilliams (1999) points out that sound healthcare comes as a result of understanding personhood and illness. If personhood is considered from only one perspective, like what the blind men did with the elephant, then the richness of what it means to be human is diluted or lost. From this reductionistic perspective, personhood becomes a set of parts, reflective of a dualistic and linear way of explaining what it means to be human. From a phenomenological perspective on personhood, "bodies are not removed from our emotional-cognitive, relational and social worlds" (Finlay, 2011, p. 30), which closely aligns with Māori and Broom's perspectives. Engaging in a practice with a focus on the whole person then can best be achieved by an approach that is multidimensional, which has the capacity to explore the client's physical and subjective lives. For counselling, healthcare of the whole person means a widening the clinical gaze and attending to all aspects of personhood. Personhood is multidimensional and it follows that healthcare, in best serving the complexity of personhood, must attend to the whole of the person in healthcare. I found literature that demonstrated a truer integration of whole person care, particularly in the areas of trauma (Serlin, 2020; Wilkinson, 2017) and palliative care (Mattai & Hui, 2021). With recent advances in neuroscience (Siegel, 2020), trauma and

end-of-life professionals are coming to understand the wider implications of attending to the whole person. Encouragingly, a growing number of studies in MindBody, or the Whole Person Healthcare integrative approach (Lindsay, Goulding, Solomon, Broom, 2015; Tolich, 2020; BarHava-Monteith, 2018) are also emerging.

There are also studies around body-oriented psychotherapies, which link the mind and the body (Röhricht, 2009) and describe ways to integrate the client's physical body into the therapeutic process (Price, 2005). There is also literature available on the therapist bodied experience (Gibbons, 2011) and the client bodied experience in therapy (Ottoboni et al., 2016). There are many theorists, such as Groddeck (1928), Engel (1977), Griffith and Griffith (1994), and Chiozza (1998) who have influenced the formation and development of a multidimensional approach to personhood and healthcare, upon which Whole Person Healthcare theory has emerged. Research in Whole Person Healthcare is just beginning to develop and other literature in Whole Person Healthcare is relatively small. For example, a recent pilot study using qualitative methodologies demonstrated the non-dualistic ideas of mind and body connectedness in the treatment of urticaria (hives) (Lindsay et al., 2015).

Whole Person Healthcare (formerly known as MindBody Healthcare)

Whole Person Healthcare is a very specific way of providing healthcare. It can be used in both the medical and psychotherapeutic disciplines. Brian Broom, who named Whole Person Healthcare, had difficulty giving an appropriate name to the approach he developed. Originally called MindBody -all one word and with an implied intuitive leap to include all aspects of personhood, the approach was later renamed Whole Person Healthcare. Broom notes that while he has not yet found a precise enough term with no other preconceived meaning, for the meantime, he termed his approach Whole Person Healthcare.

Whole Person Healthcare "honours the rich multidimensionality of persons, existence, relationships, and the world" (Broom, 2013, p. 6). It focuses on the whole person and the connections between development of illness and how a client perceives their

experiences and life events (Broom, 2000). Personal meaning in illness is fundamental to illness development. A client's physical story emerges out of the interchange of meaning between the words used to describe their everyday lived-experiences and their illness. "It sees the patient's subjectivity dimension (and therefore language) as expressing a story that is complementary or analogous to that which the body dimension expresses in illness" (Broom, 2000, p. 163). Illnesses are full of meaning, in other words, they are meaning-full (Broom, 2007). As a counsellor, working with emotional issues and meaning were part of my training, but turning my gaze towards the body and illness and discovering illness was potentially meaning-full was new territory for me.

In contrast to Broom, Louise Hay (1998) believed that illness or disease could be reduced by reversing thinking patterns. She also believed that illnesses represented specific beliefs. For example, she theorised that pain was caused by a desire for punishment or itching meant a feeling of guilt about something that happened in the past. According to Hay, physical symptoms are rooted in specific meaning. The power of Whole Person Healthcare is its openness to explore truth with the client. Broom (2007) tells a story of a client who presented with a chronic facial rash who was 'keeping a brave face' because of her husband's depression. As he pointed out, "this does not give us license to see 'brave face' issues in everybody with a facial rash" (p. 64). Being open and present is important not only to the client's particular story but also to language they use. But not everyone uses the same words to describe meaning. Illness is meaning-full, or full of meaning and meaning is subjective. It is not one size fits all. In addition, there is also another truth: sometimes the cause and perpetuation of illness is physicality. The therapist must be open to both subjectivity and physicality. As Broom (2007) points out, a relationship exists between physical illness, experience, and language. A client's experience of their illness and their expression of language are not necessarily separate. As wholistic beings, we have the capacity to express through multiple aspects of our personhood. Symptoms of illness can be thought of as language that can be expressed as a meaningful story (Broom, 1997). "The words and bodily manifestations both tell the story in their own way and both tell it

eloquently" (Broom, 2007, p. 47). Stories are brought alive through language and a characteristic of language is metaphor.

Metaphor

"The essence of metaphor is understanding and experiencing one kind of thing in terms of another" (Lakoff & Johnson, 2003, p. 5). Metaphor is integral to language, thought, and action. Metaphors live in the world around us and "allow us to understand ourselves and the world" (Lakoff & Turner, 1989, p. xi). A good metaphor is like a lens through which we see the prism of understanding in a new way. We not only see through it, but it expands our vision by allowing us to see a spectrum, a range of colour, so to speak (Oster, 2001). According to Lakoff and Johnson (2003), conceptual metaphors influence the way we think, speak, and act and are the basis upon which we live our lives. "In conceptual metaphors, one domain of experience is used to understand another domain of experience" (Kovecses, 2010, p. 14). The use of metaphor in Whole Person Healthcare can be seen as a portal through which a client's physical story becomes full of meaning or as Broom (2007) calls it, meaning-full.

The therapist is not only attending to the client's physicality, subjectivity, meaning and personal experience in the clinical encounter, but how theory is informing the therapist's practice. Paying attention to their own immediate experiences is another resource for the therapist and provides invaluable information: empathy.

Empathy

As I began to review the literature on empathy, I was overwhelmed by how many variants there are in the meaning of this word. This was confirmed by Cuff et al. (2014) who, in a recent review of literature, identified 43 different definitions of empathy. With such a variety of descriptions, I was mindful to stay on a narrower path. So, I focused on the literature that led me down the counselling and psychotherapy pathway because these definitions best-portrayed the taken-for-granted meaning of empathy in the knowings of my clinical practice.

Goldstein & Michaels (2021) helpfully provided a history of the word empathy, from its linguistic birth in Germany (the word, *Einfühlung*) to its present-day definition, and outlined how the meaning of empathy has developed, or fine-tuned, in meaning over the years. Empathy today has a "perceptual-affective-cognitive-communicative" (Goldstein & Michaels, 2021, p. 11) sense to it that generally meets most current definitions of empathy; it is the ability to directly perceive someone else's experience or perspective, while sensing their emotions and thoughts and feeding back this sensing to the other (Goldstein & Michaels, 2021). This does not necessarily mean that the exact feelings of the other are felt. "Empathy is a rich and dynamic ship on a mission of accurate other-orientation" (Worthington, 2021, p. 512), which implies a collaborative feedback loop with the client. The literature on empathy also cautioned that there is an implied differentiation of self and other in empathy: empathy is not enmeshment. There is an 'as if' (they were the therapist's own thoughts or feelings) quality about empathy that hints of a borrowing, such as borrowing the client's frame of reference (Goldstein & Michaels, 2021).

Carl Rogers (1975), considered the father of person-centred therapy, stressed that empathy is a process and a way of being. Finlay (2006), too, noted empathy as a relational and intersubjective process. She also added that empathy has a *being-with* quality in the present moment with another person in a relational space. Empathy, or what Rogers more commonly called empathic understanding, is the fifth of his six necessary and sufficient conditions of his theories of therapeutic personality change, interpersonal relationships, and person-centred therapy (PCT) (Mearns, 2003; Raskin, 2001). Rogers (1975) kept fine-tuning his definition of empathy as his theory continued to develop, the latest of which stated:

> It means entering the private perceptual world of the other and becoming thoroughly *at home* [emphasis added] in it. It involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person (p. 4).

Rogers intertwined empathic understanding with another of his triadic conditions: unconditional positive regard and for him, these went hand-in-hand. This is clear in his formal theory statement where he identifies the necessary and sufficient conditions of the therapist as that of striving to "*experience* unconditional positive regard towards, and empathic understanding of, the client's frame of reference" (Tudor & Worrall, 2006, p. 199). The two attitudes of empathic understanding and unconditional positive regard can be found across multiple person-centred and non-person-centred ways of clinical practice. Empathy is essential for the therapist to enter the subjective world of another (Evans & Gilbert, 2005; Gilbert, 2010; Rogers, 1951) and empathic understanding contributes to the formation of the therapeutic relationship (Cornelius-White & Ciesieski, 2016). Empathy is also an essential mode of communication.

Empathy has been misrepresented as simply parroting back what the client just expressed. This misunderstanding of responding empathically did not fully appreciate the purpose nor the skill of reflection. Rogers (1975) and Bozarth (2001) make it clear that empathy is a process of being with another, and not a response technique.

The literature from counselling and psychotherapy also included literature from biology and neuroscience. Empathy may have a neurological basis. Iacoboni (2009) argues that empathy is a result of the physicalist activity of mirror neurons that fire when we see the actions of others. He says this enables us to emotionally resonate with others, as if we were making those actions ourselves. Studies have also suggested that empathy can be in our genes and is inherited (Melchers et al., 2016; Warrier et al., 2018). Other studies have shown that empathy is shaped by our early childhood experiences and parenting. For example, a study on rats by Asadi et al. (2021) showed that the quality of maternal care of rats during infancy impacted the expression of the brain-derived neutrophilic factor (BDNF) gene in adult male rats. BDNF is a protein that modulates behaviour in both rats and humans. The research concluded that the adult male rats who experienced a high quality of maternal care in infancy demonstrated an enhanced empathy-like behaviour. This was linked to a high expression of the BDNF gene.

"An important aspect that is distinctive of empathy in the phenomenological sense concerns the appraisal of others not only as embodied beings but also as persons" (Magri & Moran, 2017, p. 6). Edith Stein, a student of and assistant to Husserl, related empathy to how another's experiential world is accessed as well as developing an ethics centred around personhood. She viewed empathy as an intuitive act and as a "non-primordial experience which announces a primordial one: 'When I feel the others' joy, I do not experience it primordially as *my* joy but as a joy experienced by *the other*'" (Magri & Moran, 2017, p. 38). Stein believed that empathy was connected to "affectivity, values, and sociality" (Magri & Moran, 2017, p. 7). In addition, Stein believed empathy was multi-dimensional or multi-layered. Bozarth, too, helpfully described empathy as a "qualitative and holistic experience of the therapist" (Bozarth, 2001, p. 3900).

Empathy has been shown as fundamental to healthy social behaviours and moral development (Sachs et al., 2019). Svenaeus (2017) indicates that experiencing the "suffering of a person who is in need of help" (p. 161) as the beginning place for moral reflection, and empathy has been shown to be an influential concept in moral theory (Hoffman, 2000; Slote, 2007). I found Svenaeus's (2011) ideas on illness as an unhomelike being-in-the-world very helpful and referred to his ideas on numerous occasions. Reflecting on Heidegger's philosophical thoughts on Dasein, Svenaeus discussed the phenomenology of illness and health in relation to wellness.

Therapeutic Relationship

There is a substantial body of literature on the significance of the therapeutic relationship (Norcross, 2002; Tannen & Daniels, 2010) and it spans across multiple disciplines (Cahill et al., 2013; Hawamdeh & Fakhry, 2014). Studies reveal a consistent relationship between the quality of the therapeutic relationship and positive therapeutic outcomes (Safran & Muran, 2003; Zuroff et al., 2010).

There is debate over the essential factors of therapeutic change. One such factor is the therapeutic relationship. However, there has been historic debate on what matters more

in therapy, the therapeutic relationship or empirically supported treatments (Vilkin et al., 2022). How and when the therapeutic relationship fits in therapy is often determined by the theoretical underpinnings of particular therapeutic models. Vilkin et al. (2022) go so far to suggest that the therapeutic relationship be employed on a case-by-case basis. There are several definitions of the therapeutic relationship, and its exact role is unclear.

In safe, trusting, human relationships people feel self-acceptance without fear of rejection or judgement. Rogers (1980) understood this type of relationship as fundamental in providing an environment for people to grow. He believed the role of the therapeutic relationship between therapist and client is central to healing and therapeutic outcomes. Mearns and Thorne (2013) assert that within this unique type of therapeutic relationship, clients can explore their experiences, thoughts and feelings, vulnerabilities, and be heard, understood, and valued. In 1957, Rogers introduced his six necessary and sufficient conditions in his theories of therapeutic personality change, interpersonal relationships, and person-centred therapy (PCT) (Mearns, 2003; Merry, 2002; Raskin, 2001). He theorised that the therapist and client relationship provided the "necessary and sufficient conditions for change to happen" (Merry, 2002, p. 49) and that no other conditions were necessary. Three of those conditions – congruence, unconditional positive regard and empathy – are called the core conditions and refer to the therapist's qualities or attitudes. Unconditional positive regard is what Rogers termed prizing (Mearns & Cooper, 2018).

According to Mearns and Thorne (2013) the therapist's relationship with their self is crucial to the development of the therapeutic relationship. They go on to say:

> If the person-centred counsellor is at home with [their] inner world and comfortable with [their] way of being, it is likely that [their] work with clients will be marked by a number of factors that, taken in sum, point to a healthy therapeutic relationship as conceptualised in the person-centred tradition (p. 43).

The therapeutic relationship is a bodied relationship. When the body is brought into clinical practice, Schore (2021) argues that the therapist's and client's right brains connect.

Shaw (2004) notes that "the therapeutic relationship is an embodied encounter" (p. 272). Shaw's helpful research focused on therapist's lived bodied experiences in the therapeutic encounter and how the body can be seen as a source of knowledge. He says that from a phenomenological sense, one's perception of the world, or lived-experience, is through the senses, which is done through the body: how we know the world is body-oriented. This echoes Merleau-Ponty's thoughts about the body: "It is through my body that I understand other people" (Merleau-Ponty, 1962/2014, p. 186).

Buber's ideas of experiencing the 'other' and meeting the person as a person are a common link between his concept of 'I and Thou' and the therapeutic relationship (Ross, 2009). In relation to the therapeutic relationship, Martin Buber's (1970) main ideas explored what it means to be human. He believed that human life finds its meaningfulness in relationships (Buber, 1970). According to his philosophy, humans relate to the world in a two-fold way; I-It and I-Thou. Both define our being-in and being-with the world. I-It is the "impersonal world to be *used*, [whereas] I-Thou is a personal world to be *met*" (Ravenscroft, 2017, p. 36). Buber maintained that "*to be* is to be in relation with others" (Fife, 2015, p. 212), and to form relationships that are meaningful. Relation is reciprocal. In other words, it is dialogical, and Buber argues that the "longing for relation is primary" (Buber, 1970, p. 78). I-Thou is characterised by unity and wholeness (Ravenscroft, 2017). "To be I-Thou is to stand in relation to another as a whole person . . . and one is made whole through dialogue with the Other" (Fife, 2015, p. 213).

Relational Depth and Empathic Depth

According to Mearns & Cooper (2005) relational depth can be thought of as the blending together of the three core conditions. They note that relational depth is a "responding to the core of the client from the core of oneself" (Mearns & Cooper, 2018, p. 49). Rogers (1980) called this *presence*, of which he said:

> When I am closest to my inner, intuitive self, when I am somehow in touch with the unknown in me . . . whatever I do seems to be full of

> healing. It seems that my inner spirit has reached out and touched the inner spirit of the other [and] profound growth and healing and energy are present (p. 129).

Presence is a significant aspect of relational depth (Tangen & Cashwell, 2016) and can also be defined as "the state of genuine, empathic realness, in which the therapist is fully integrated, receptive, and there for the client" (Mearns & Cooper, 2018, p. 55). For Geller, (2013) presence includes "bringing one's whole self . . . being completely in the moment on a multiplicity of levels" (p. 209).

The above definitions of presence also connect with spirituality. Near the end of his life, Rogers's interest turned to transcendence and spirituality, and he acknowledged that attending to the whole person also included a spiritual dimension (Natiello, 2016). This makes sense in light of personhood. Lived experiences of relational and empathic depth have been described as "like an altered state of consciousness, sense of aliveness, coming from 'core' of being . . . alive, energised, and stimulated" (Cooper, 2005, pp. 90-91). In the Christian literature (see Kim-van Daalen, 2012; Parker, 2008) we see this reflected in the work of the Holy Spirit, who is able to do immeasurably more than all we ask or imagine (*New International Version Bible*, 2011, Ephesians 3: 20).

Descriptions of empathic depth can be found in the literature on relational depth. However, other words are used in place of empathic depth such as "high levels of empathy", "heightened empathy", and "highly somatic empathy". Cooper (2005) acknowledged in his research that a "greater perceptual clarity" (p. 90) was experienced by therapists during moments of relational depth. Mearns and Cooper (2018) argue that at times of relational depth "the therapist experiences a deep sense of resonance with, and immersion in the client's world" (p. 51). Tangen and Cashwell (2016) on the other hand suggest that it is the deepening of the core conditions of unconditional positive regard, congruence, that creates relational depth.

Compassion and Spirituality

The literature defined the difference between empathy and compassion, and compassion and spirituality. Ling et al. (2018) note there are important distinctions between compassion and empathy. Kornfield (2008), posits that spirituality is the root of compassion. He says that "compassion is our deepest nature [and] it arises from our interconnection with all things" (p. 23). In other words, a compassionate act is a spiritual act. Bergemann et al. (2011) helpfully support this idea and go on to say that spirituality is a building block of empathy, a "benevolent understanding of what another is feeling" (p. 99): it inspires acts of kindness. But Bergemann et al. (2011) also warn that just because we can resonate with another, it does not necessarily mean that it is benevolent because *knowing* can be used in manipulative or dangerous ways. They maintain that spiritually when put into practice is kind and compassionate. Worthington (2021) noted that while "empathy is often fundamentally or primarily oriented to the feelings of sufferers, compassion (or sympathy) is fundamentally or primarily oriented to their good" (p. 510).

Reflection

As we can see from the literature, there are many definitions of whole person and whole person care. The Christian, Māori, and Whole Person Healthcare literature helped to clarify the most helpful and robust definition of personhood. For talking therapists this is important because we exist and relate in the world as whole persons. Therefore, talking therapy approaches need to address the whole person. Humans do not merely exist as physical and subjective parts—but as wholes. Our whole being is our physical, subjective, relational, spiritual, cultural, and environmental existence. Health and wellbeing of ourselves as wholes involves the health and wellbeing of each aspect of our being. Physicality is limited in talking therapy because physicality it is not fundamental to the dualistic theories and models of practice in the field of talking therapy. By taking a whole person approach, a new paradigm is possible that allows both subjectivity and physicality to occupy the same

space in talking therapy. The literature indicates that there is a lean towards a whole person approach, although there are differences in how this is applied.

Literature in the field of palliative care values the whole person and whole person approaches, possibly because issues at end-of-life do not focus on a cure, but on the person. Recent advances in neuroscience and the literature on trauma are pointing to the important role of the body in relation to healing. Both these fields are also leaning towards the non-dualistic approaches to healthcare. I am drawn to the ideas around collaborative and integrative approaches to healthcare because they relate to my beliefs about what it means to be human, and these ideas have guided me in my practice and into this study. The fabric of human wholeness is woven by the many threads of mind, body, spirit, culture, relationships, sense of self, experiences, meaning-making, and language.

The literature on empathic depth was the most challenging to find because it goes by several names and is usually found within studies on the therapeutic relationship. Empathy is bodied, yet it consists of thoughts, feelings, and experiences. Physicality and subjectivity are brought together in empathy.

CHAPTER 3: Methodology

> Phenomenological research is important because many professions such as pedagogy, nursing, healing, counselling seem to require not only trainable skills and specialised bodies of knowledge but also abilities that have to do with discretionary, intuitive, pathic and tactful capacities. It seems that in these directions lie the relevant and continuing contributions of hermeneutic phenomenology for the epistemology of professional practice. (van Manen, 1997, p. xviii)

As the above quote implies, counselling is a profession that requires not only specialised skills and knowledge but the capacity to connect with other ways of "knowing" in our relational experiences. These other ways of knowing contribute to the richness of epistemological understandings of professional practice. Hermeneutic phenomenology invites this type of exploration and discovery and that is why I have chosen this methodology for this study.

Introducing Hermeneutic Phenomenology

The aim of phenomenology is to produce insights into human experience by exposing multiple layers of lived experience. Phenomenology seeks to investigate consciousness, or lived experiences, as a description of storied phenomena. This leads to an understanding of the essence of phenomena or the "thing itself". Where phenomenology is interested in how "human subjects experience life-world phenomena" (Kvale & Brinkmann, 2015, p. 18), hermeneutics attends to the interpretation of meaning.

Hermeneutics is the study of interpretation, which is about meaning. Specifically, hermeneutics seeks to look for meaning underneath language (Smythe & Spence, 2012). Traditional hermeneutics involved a set of rules for understanding ancient text. "The interpreter was urged to begin with the language of the text . . . its linguistic, literary, and historical context" (Thiselton, 2008, p. 11). Because the text existed within a specific historical context, the interpreter recognised that interpretation of text was limited. As the interpreter, the task is to form a relationship between the text, or data, and the interpreter's history, knowledge, and tradition.

Hermeneutic phenomenology, then, assumes that people's lived experiences present us with evidence of the world and that meaning requires context to be understood. It also assumes that "knowledge comes into being through language and understanding" (Richards & Morse, 2013, p. 71). As a research method, hermeneutic phenomenology sits within an interpretive paradigm (Grant & Giddings, 2002). We interpret the world in our own different ways, so that what we consider real or true is unique and subjective. Hermeneutic phenomenology is underpinned by an epistemology of constructivism, meaning that "reality or understanding can only be created or constructed" (Lehman & Grabowski, 1995, p. i). Since knowledge is constructed through engagement with the world, or lived experience (Lincoln et al., 2013) and humans make meaning out of lived experience, meaning and truth therefore, are subjective. Ontologically, reality is relative (Denzin & Lincoln, 2013), thus there are multiple socially constructed realities and truths.

Understanding Hermeneutic Phenomenology

Phenomenology, as a philosophy, was born out of a need to respond to the natural sciences in the 1800's. As such, it did not support the Cartesian dualism that separated matter and consciousness or mind and body. Franz Brentano, considered a forefather in the history of phenomenology, believed there was a great divide between the natural sciences (physical reality) and philosophy (mental acts), and he theorised that "everything mental is distinguished by 'intentionality'… which means that every mental act is directed toward an object" (Harman, 2007, p. 17). Edmund Husserl developed Brentano's thinking further by defining phenomenology as "a descriptive philosophy of the essences of pure…lived-experiences" (van Manen, 2014, p. 89). Husserl believed that phenomenology was a rigorous human science serving an epistemological role because it investigated the way knowing came into being, and it clarified assumptions about knowledge and understandings. For Husserl, *being* meant appearing into consciousness (Harman, 2007). One of Husserl's best-known students was Martin Heidegger who worked alongside Husserl at the University

of Freiberg. For Heidegger, our being is primarily "being-in-relation" (Knox, 2012, p. 213) and nothing separates us from the world (Harman, 2007).

Heidegger differed from Husserl in that he placed more value on understanding than he did on description. He recognised three aspects of our ready-made understanding: fore-having – understanding we already possess that helps us make sense of things; fore-sight – understanding that sees in the future; and fore-conception – ideas of what will be encountered (Smythe & Spence, 2012). Heidegger was ontologically focused and believed that the primary emphasis of phenomenology was the meaning of Being (Dowling, 2007). He explored the meaning of human existence and activity as being-in-the-world, which he called Dasein. "Dasein literally means being-there… and the "there" where Dasein exists is called the world" (Harman, 2007, p. 34).

Unlike Husserl's reduction of phenomena to its appearance, or "to the things themselves" (Harman, 2007, p. 42), Heidegger believed that Being had significance and that being-in-the-world was in relation with other things in the environment. Therefore, human experiences, or phenomena, have much more richness, complexity, and depth than they seem to have at first. Being, then, is more than what meets the eye.

Heidegger was interested in how things appear as meaningful things and he characterized his fundamental ontology as hermeneutical. This resonated with Hans-Georg Gadamer, a student of Heidegger's, who further developed Heidegger's work. Gadamer was significantly influenced by Heidegger's (2010) ideas in *Being and Time*. He agreed with Heidegger's development of Dasein and further developed Heidegger's concepts of practical understanding, language, art, and poetry. However, unlike Heidegger, Gadamer was a humanist. In his seminal writing, *Truth and Method*, Gadamer (2013) answered the question: What is understanding? For Gadamer, understanding was a matter of interpretation and language (Dostal, 2021). Gadamer understood hermeneutics as not merely how one interprets text, but as a "way in which beings come to terms with themselves, each other and the world in practice" (Zuckert, 2021, p. 369). Gadamer believed that language and points of view are "bounded by a horizon set in time and space" (Zuckert, 2021, p. 371). "Horizon" is

Gadamer's term for "everything that can be seen" (Vessey, 2009, p. 532). A horizon is what we can grasp within particular limits, which include past events (history) and their cumulative meanings (traditions). When history and tradition are rooted in how we make sense of the world, it becomes difficult to understand new experiences that do not fit our horizon. To expand our horizon, we need to see beyond our range of vision. According to Gadamer, we need to integrate our new experiences with our past learning to help us see or understand things differently (Taylor, 2021). He called this a "fusion of horizons" (p. 226), which is a broadening of the horizon, gaining a new perspective, and new views (Vessey, 2009). The fusion of horizons becomes most evident in language as new words are invented or change meaning, and in interpretation. Language and meaning are co-created through interpretation. Phenomenological insight, or understanding, is gained from a circularity "with the idea of the coherence of the whole and the parts". This is known as the hermeneutical circle where "the movement of understanding always runs from whole to part and back to whole" (Gadamer, 1988, p. 68).

Following in the footsteps of Heidegger and Gadamer, Max van Manen has been guided by the Dutch or Utrecht School of hermeneutic phenomenological philosophy. According to van Manen (2014), "all or much of phenomenology has hermeneutic (interpretive) elements" (p. 26). Influenced by the French existentialists, particularly Sartre, Camus, Levinas, and Merleau-Ponty, van Manen's phenomenological methods are "sensitive to subjective and intersubjective roots of meaning, to the complexity of relations between language and experience, to the cultural and gendered contexts of interpretive meaning, and to the textual dimensions of phenomenological writing and reflection" (van Manen & Levering, 2002, p. 283). In particular to van Manen, being and knowing are grounded in practice which he terms as a "phenomenology of practice" (Errasti-Ibarrondo et al., 2018, p. 1725; van Manen, 2014, p. 15). "When we understand something, we understand it practically" (van Manen, 2014, p. 15). The practice of research becomes practical knowledge.

Reflections on Methodology

This study sought to understand how talking therapists' lived experiences of attending to illness in talking therapy facilitates empathic depth and what this means in the context of clinical practice. This latter point resonates with what van Manen (2021) calls a "phenomenology of practice" (p. 1069). Talking therapy is about experience, meaning-making, and understanding. Thus, hermeneutic phenomenology fits well with my own experiences and understandings in my professional practice. My own epistemological and ontological assumptions about personhood emerge from a Christian trinitarian perspective. This perspective has its roots in my experiences of growing up attending church and Sunday School. It was there that I first learned that the Trinity is one God in three persons: Father, Son, and Holy Spirit. The trinitarian God is a communion of persons in relationship. As we are created in the image of God, we are thus relational image bearers and are understood as persons-in-relation. We are who we are because of our relationships with God and others. How we behave, think and feel depends on "who we are with, what we are doing and why" (Burr, 2015, p. 36) because "human behaviour exists in the context of relationships to things, people, events, and situations" (Richards & Morse, 2015, p. 67). Because reality is relative, our perceptions and beliefs are not the 'whole picture' because "now we see only a dim likeness of things…it is as if we were seeing them in a foggy mirror" (*New International Version Bible*, 2011, 1 Corinthians 13:12). This view has guided me in my understanding of what it means to be human.

As I reflect on the hermeneutic process of meaning-making, I am drawn to Robert Frost's poem, The Road Not Taken. Frost's poem speaks of going off the beaten path to explore another road that perhaps not many others have travelled.

The Road Not Taken, by Robert Frost

Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveler, long I stood
And looked down one as far as I could
To where it bent in the undergrowth;

Then took the other, as just as fair,

And having perhaps the better claim,
Because it was grassy and wanted wear;
Though as for that the passing there
Had worn them really about the same,

And both that morning equally lay
In leaves no step had trodden black.
Oh, I kept the first for another day!
Yet knowing how way leads on to way,
I doubted if I should ever come back.

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I—
I took the one less traveled by,
And that has made all the difference

When taking this road, one beholds vistas or horizons that are now seen from a different perspective thus creating a new perspective of something that has been there all along – it has just been hidden from view. I wonder if this road less traveled has meaning. Implicit in taking a less traveled road is the necessity on the journey to take care: with my participants, my writing and reflection, my interpretations, myself. This is an articulation of the care I take in terms of this study.

Ethical Considerations

Ethics attends to essential values in the collaborative work of research. Values such as accountability, safety, mutual respect, responsibility, human rights and welfare, integrity, and fairness underpin key ethical principles under which research is conducted and presented. Ethical considerations, therefore, were central to the design of this research project. I sought guidance and consultation from my supervisors, relevant post-graduate lecturers, and worked frequently with the AUT Ethics Committee (AUTEC). By closely following AUTEC's key ethical principles and involving AUTEC on my ethics application, my research design took shape, and I watched as these key values emerged in how I conducted my research.

Ethics approval was sought and granted from AUTEC in August 2019 (See Appendix A). However, in May 2020, due to the restrictions of Covid-19 and subsequent health and social practices, I needed to amend my original ethics application to

accommodate online participation for all participants; face-to-face interviews no longer became my only options for gathering data. This included amendment of the information sheet, advertisement, and research protocol documents. The method of data collection changed from face-to-face interviews to video-conferencing using a password-protected online meeting application. The amended ethics approval was received in May 2020.

"Consent for participation in clinical research is considered valid if it is informed, understood, and voluntary" (Ballard et al., 2004, p. 409). A detailed Participant Information Sheet approved by AUTEC (see Appendix C) was sent to all participants who agreed to participate in this study. This provided sufficient information upon which participants could make an informed and free choice to participate. The purpose and expectations of the research were outlined including how data would be gathered and used, how privacy would be protected and how to agree to participate. It also explained that participation was voluntary and that participants had the choice to participate or withdraw at any time. Each participant was also sent a Consent Form, approved by AUTEC (see Appendix D), which was signed and returned before collection of the data.

The rights of participants' privacy and confidentiality were maintained throughout this research project. For example, pseudonyms were used in all written outputs and significant identifying information about the participants was edited. This same process was used to protect the participants' clients' privacy. In some cases, participants' stories about their client experiences were edited to preserve anonymity. Consent forms and digital records were kept in separate and securely stored locations, accessible only to me. All data files are expected to be stored on a secure server for seven years and thereafter deleted.

My relationship to the participants was a professional one and precautions were taken to minimise the possibility of risk. Because this hermeneutic phenomenological study was focused on participants' experiences, that meant it was necessary for participants to share information about some of their exchanges with clients. The therapist/client relationship is one of confidentiality, so it became ethically essential to mitigate any risk of exposure to participant and/or client identification. As a result, all participants were assigned

a pseudonym and the information presented in this study has been disguised. The participants were all qualified professional counsellors or psychotherapists with access to supervision, therefore it was anticipated that no one would require counselling or post-interview support. Because all participants were members of a professional organisation with a code of ethics, there was a professional expectation that we would treat each other with respect, fairness, and honesty at all times. After the video recordings were transcribed, the recordings were destroyed. The transcripts were edited to provide anonymity to each participant and their client stories and then checked by the participant to check for accuracy.

It was important that confidential client information was not disclosed during the data collection process. In the event this happened, the video files were deleted, and the audio recordings were kept in a secure location accessible only to me. In the transcripts, I anonymised identifying information to minimise the potential of the participants', and their clients', identification. I did not offer counselling to any of my participants because they each had access to their own supervisor. This was made clear in the Research Ethics Proposal and Participant Information Sheet.

The steps taken to protect the identity of the participants and their clients is on behalf of care. Van Manen claimed that research is a caring act. He said, "to care is to serve and to share our being with the one we love" (van Manen, 1997, p. 5) and love, foundational for knowing and for human existence, invites a moral or ethical response to one another. Emmanuel Levinas took this a step further by saying that caring for another is a moral obligation or responsibility of the caregiver (Lavoie et al., 2006). In other words, caring for another is our ethical response to being in relationship. Because the research question requires first-hand experiential accounts of the phenomenon I was faced with an ethical problem. The participants' stories of the phenomenon contain confidential information in the context of professional ethical practice. Presenting this raw data as-is would be unethical and unsafe for the participants and their clients. However, using hermeneutic phenomenology as a methodology allowed confidential lived experience to be interpreted, not coded. This meant that the methods used to generate the interpreted stories were centred on meaning,

which allowed fictionalisation of confidential lived experience, thus safeguarding confidentiality and protecting the identities of both client and therapist.

I am Tangata Tiriti, originally from North America and moved to New Zealand in 1993. I received my Bachelor of Counselling degree in New Zealand and have engaged with a range of cultures in my counselling work. My primary intention is to always respect the social and cultural sensitivity of my participants. In the design and implementation of this study I took the responsibility to be informed of the relevant ethical considerations, regulations, New Zealand laws, and the Treaty of Waitangi. I familiarised myself with the Te Ara Tika: Guidelines for Māori Research Ethics (Hudson et al., 2010), a document which is specific to ethics involving Māori participants. This ethics framework outlines "whakapapa (relationships), tika (research design), manaakitanga (cultural and social responsibility), and mana (justice and equity)" (Hudson et al., 2010, p. 4) as primary ethical principles included in my research. Although this research did not specifically target Māori participants, I was hoping to have at least one Māori practitioner volunteer to participate. In the end, none of those who volunteered to participate identified as Māori.

Methods

Participants

The participants for this research were identified as professional psychotherapists or counsellors who work in New Zealand and who also work in a whole person way. There was no reason to exclude participants from participating in this study because the inclusion criteria were specific. The participants were recruited through an initial invitation via an advertisement (Appendix B) through the Whole Person Healthcare network. However, that advertisement yielded only one participant. While this was disappointing, after the first participant's interview I used snowballing as a technique to secure four additional participants. Each participant was a member of a professional body of practice that supports a code of ethics. Various years of professional practice experience was represented by the participants as well as various levels of academic experience. Not all the participants

formally studied MindBody Healthcare at AUT, but all embraced and practiced a non-dualistic whole person approach to their therapeutic practice. All participants had lived-experiences of the phenomenon.

The participants who agreed to take part in this study were all Pākehā female, aged between 40 – 60, and members of either the New Zealand Association of Counsellors or the New Zealand Christian Counsellor Association. Two participants hold Master's degrees, two participants hold Post Graduate Diplomas, and one participant holds a Bachelor degree in talking therapy. The participants have been in clinical practice from 10-30 years and had various number of years in private clinical practice before becoming whole person practitioners. Each participant was sent a Participant Information Sheet and a Consent Form, which were signed and returned to me.

The Interviews

In keeping with hermeneutic phenomenology, I used unstructured, in-depth interviews to collect participants' experiential stories of the phenomenon. An interview is the inter-relational conversation between researcher and participant, and it reveals an experiential view; the subjective account of someone's perspective (Kvale & Brinkmann, 2015). The phenomenological interview focuses on the participants' experiences. Gathering experience is not unlike an archaeological dig. Rather than using shovels or even a small trowel to uncover participant experience, or the essence – the "thing itself", the researcher uses a skilfully crafted brush to carefully unearth the taken-for-granted knowledge of the participant's lifeworld (Kvale & Brinkmann, 2015). In this way the interviewer becomes like a craftsperson carefully exploring and brushing away analysis and explanation to preserve experiential description. The questions I asked were naively curious about the participant's experience. I asked open-ended questions, such as:

> Can you tell me a story about your experience; Would you tell me about another time when you experienced empathic depth; Can you tell me about a time when you engaged with your client in a whole person way; Can you

tell me a story about a client where you noticed the emergence of empathic depth; Would you describe your experiences of working in a bodied way; What was it like for you when . . .; Can you tell me more about . . .

The interviews were about one hour in length and at the end I asked each participant what it was like to tell me of their experiences. All five expressed their thanks about being asked about their work. The result of the interviews was the creation of raw data – a knowledge between me and participants leading to phenomenological understanding (Kvale & Brinkmann, 2015).

I had originally planned to visit each participant at their place of business and record the interview. However, given the constraints of the Covid-19 lockdowns, the interviews took place using an online video conferencing platform called Zoom. The conversations were recorded on Zoom and then the audio and video files were downloaded directly onto my computer. I had serious doubts about conducting the interviews online but given the numerous times face-to-face contact was not possible in Auckland, it was an alternative I came to accept. At first, I felt the irony of researching gateways to empathic depth through bodied stories when my participant and I were not bodily situated in the same location. Our presence to and with each other was through technology: a laptop screen via the internet. I was keenly aware that there was an important element that needed to be re-navigated in the interview process, and this was ritual. There was no ritual of my arriving at my participant's place, no customary greeting of shaking hands, or the hospitality of being offered a cup of tea or coffee. There was no ritual of witnessing whole-body presence and language; we were merely dis-bodied faces on rectangular screens. This did not detract from my participants' talking about their experiential stories, however.

I was also aware that some of my participants' experiences of the phenomenon were both in-person and over the internet with their clients, as many of the participants were also using Zoom to engage with their clients. These interviews and the stories entrusted to me became the data, or text, for this study. There were five interviews in all, and I transcribed

the recordings into a Word document in a table format so I could capture the participants' words and my own.

Data Gathering Process

I have used unstructured interviews, interpretation, and fictional literature to gain an understanding and meaning of the phenomenon. In hermeneutic phenomenology, human experience is interpreted as though it were text. Hermeneutic phenomenology does not follow a precise formula for data collection or analysis although I was thankful that van Manen offers some guidelines for this process (Ehrich, 2005). He claims that a variety of data sources can be used such as personal experience, "experiential descriptions in literature (i.e. poetry, novels, plays, biographies, diaries) and art that will yield experiential data" (Ehrich, 2005, p. 5). Although I did not use fictional literature for any of my findings, I did use appropriate literary sources to help illuminate meaning in the Discussion Chapter.

My primary source of data was from my participants lived-experiences via Zoom. One of the benefits of using Zoom was the ability to record both the audio and visual of the interview. This allowed me to watch and re-watch the participants' body movements as well as their faces such as when they smiled, or how their face softened when I asked questions about their experiences.

Generating and Interpreting Stories

Each interview was rich in the participants' lived-experiences of the phenomenon, and many of the stories the participants told were lengthy. van Manen generates smaller stories out of the experiences, and he crafts short stories, or anecdotes, to do this. Anecdotes are "concrete examples of insights which help to capture experiences" (Ehrich, 2005, p. 5). According to van Manen (2014), "anecdote can be understood as a methodological device in human science to make comprehensible some notion that easily eludes us" (p. 116). Simply put, an anecdote can be thought of as an example of something so that it can be understood. "Examples have evidential significance because the example is an example of something experientially knowable or understandable" (van Manen & van Manen, 2021, p. 1079). For

example, Heidegger used an example of a jug when he reflected on the meaning of 'the thing'. The intention of the anecdote is to provide an evocative example; it is not merely an illustration.

I began this process of unearthing evocative examples by first transcribing each interview, allowing me first-hand to engage deeply, or dwell, with the data. As I read and re-read the transcripts, I felt myself being pulled into my own understandings and ways of knowing as a counsellor. Being familiar with the phenomenon and knowing the professional jargon my participants used and what their words mean from an academic perspective, I felt like I became an obstacle in the search for the essence of my participants' experiential stories. I discovered I was trying hard to locate "the thing" within each transcript so I could exclaim "Eureka, here it is!" thus giving it some substance with a name. I realised my own understanding and "knowing" have shaped me as a counsellor, yet these were limiting me as a researcher; my gaze at the data was at risk of reductionism. It impacted what I "saw" in the transcripts, anecdotes and what I saw as an essence or something essential that reflected the eidetic meaning of the phenomenon. Additionally, as I looked through the transcripts, I wondered where I could have asked more helpful questions that might have added richness to the gathering of data. I was also aware that this was the "counsellor" who was wondering all of this. I felt my counsellor self was obstructing the process and yet I could not separate myself from my own wonderings and noticings. Afterall, my own pre-understandings always precede me in interpreting text. This left me curious as to how I could possibly reflect on the participants' stories without 'me' getting in the way. Surely this was not black or white; I could certainly do both. I needed to share the space; like a dance that allows me to move in and out without stumbling over my own feet, and that also allows me to preserve the integrity of the participant's experience yet allows for meaningful interpretation. I then found this text by Linda Finlay:

> Researcher and participant engage the dance, moving in and out of experiencing and reflection while simultaneously moving through a shared

> intersubjective space that is the research encounter. Then, after the dance, the researcher engages a solo waltz, once again moving in and out of (pre-reflective) experience and reflection as s/he engages multiple meanings emerging from the data. (Finlay, 2006, p. 1)

So, I returned to the first participant's lived-experiences with my dancing shoes on and thought about how I might maintain the integrity of my participant's experience in anecdotal form, being aware that these smaller snippets are not the whole story. I asked myself, "what is it this participant is experiencing about the phenomenon?" and began to write. I wrote and re-wrote the stories until I was satisfied that I had captured the essence of the participants' experience (Giddings & Wood, 2001). I generated 55 anecdotes, or examples, from the interviews. I also wrote a reflection for each anecdote for the purpose of fine-tuning the words, phrases, and the shaping of the anecdotal story so that the participants' stories became alive with eidetic resonance. This process also helped each story's meanings float to the surface, and that allowed me to create the type of anecdote that nicely disguised confidential material yet still accurately represented the essence of the lived-experience.

I persisted in reflecting on the participant's stories to find possible new meanings. Reflection played an important role in this process because it allowed me to go back and notice what I could not immediately grasp in the "here and now" of my analysis. Crowther et al. (2017) call this "looking for what was left behind" (p. 831). This process proved significant for me because the many interruptions of home and work life, caused by the lockdown protocols of Covid-19, fragmented my interpretive process with the data. This process of engaging with the generation and interpretation of stories was a conversation of sorts between me and the text.

Thematic Analysis

The hermeneutic phenomenological method of thematic analysis is a process of first dwelling with the data, then interpreting, identifying, extracting, and grouping data, although this process is not a linear one. It is out of this process that meaningful themes emerged. A theme characterises and captures something of the phenomenon (van Manen, 1997). "The meaning or essence of a phenomenon is never simple or one-dimensional [because] meaning is multi-dimensional and multi-layered" (van Manen, 1997, p. 78). A thematic analysis describes and analyses significant patterns, or themes, within data (Finlay, 2011) and interpretation is used to unveil hidden meanings of lived experience. To unveil these hidden meanings in the anecdotes of my participants' lived experiences, I used three methods as informed by van Manen (1997) that required both reflection and writing. The first method I used captured an overall view to get to what was important, or what was the essence of each story. In this, I kept an attitude of wonder and kept asking myself what stood out for me (van Manen, 1997). Next, I searched for phrases or statements that stood out, the ones that seemed to shout "hey, look at me!" as they endeavoured to leap off the page. Then I searched for specific words looking for possible alternate meanings. I genuinely dwelt with the data and took my time, allowing my dwelling to go deeper and deeper, permitting the data to speak, and not my pre-understandings. During this process, I was companioned by my research question. I found that looking for themes was much like searching for little white spiral shells on the beach. Some were easily spotted, others seemed too small, while others took a bit more turning over and reflection.

Humans are meaning-making beings; "to be human is to be concerned with meaning, to desire meaning" (van Manen, 1997, p. 79). In hermeneutic phenomenology, the discovery of the meaning of text, or participants' lived experience, is "not a rule-bound process . . . but a free act of 'seeing'" (van Manen, 1997, p. 79). At first, I felt overwhelmed by the amount of complex data I had to work with. But, by interpreting, identifying, extracting, and grouping the stories together, several sub-themes emerged. By using the same process with the sub-themes, I identified the following essential structures, or themes,

in this study: Attending to the body, Empathy as space, and Home. Each of these essential themes are discussed in the Findings Chapter.

In hermeneutic phenomenology, making sense of data is understood as parts in relation to the whole. Each of the parts have their own meaning, yet they have something in common with each other. Each part is a reflection of the theme, which contributes to the whole. The circular meaning that arises out this is that the whole is more than the sum of its parts.

Trustworthiness and Rigor

As I dwelt with the data, I shared many of my findings with my supervisors. In discussions about how to write up the findings, I always went back to the data and what the data was pointing to. Reflection occurred throughout the entire process of this thesis. I kept a small journal and many electronic copies of my reflections. After I crafted each anecdote, I wrote a reflection that considered the meaning of the entire anecdote, phrases within the anecdote, and any specific words that stood out for me. This was an embodied lived experience for me. I dreamt about the participants' stories and empathised with their experiences in their clinical encounters. I got to know my participants by their pseudonyms instead of their real names (which I will need to rectify!). In my findings chapter I disguised much of the confidential client information and situations, but I included actual participant quotes within the interpreted anecdotes.

The Reflection Process

The reflection process is not to be under-valued in hermeneutic phenomenology because its purpose is to "grasp the essential meaning of something (van Manen, 1997, p. 77) that is multi-dimensional and multi-layered. It is interesting to note here that van Manen claims that it is both easy and difficult to engage in phenomenological reflection. I found this to be true as I used the process of reflecting and re-reflecting to help clarify the structure of meaning of the lived experiences. In other words, I kept going back to the text again and again to re-examine it with fresh eyes and a new perspective. Looking back, this became an

essential part of the data analysis process because of the many interruptions I experienced during Covid-19. Reflection allowed me to re-visit the data and not only refine my focus but to discover meanings previously unnoticed. “Reflecting on lived experience then becomes reflectively analyzing the structural or thematic aspects of that experience” (van Manen, 1997, p. 78). In the end, it took the lived-experience of hermeneutic writing and being with (and trusting) the process to arrive at the front door of understanding the process of hermeneutic phenomenological understanding, exploring, reflecting, writing, reflecting, and re-writing.

I found writing anecdotes initially challenging. My earliest anecdotes were rather weak and came from my pre-reflective understanding. I revisited this process and began reflecting by re-telling the stories out loud to myself. I wrote them out as I spoke and then engaged in a dialogue with the text. This reflexivity helped me to find some meaning/s contained within the stories. But it was reading about van Manen’s (2021) invitation to think of anecdotes as ‘examples’ where I gained insight, and the art of writing hermeneutic phenomenological anecdotal accounts, and reflections on the anecdotes, came to life for me. The most difficult anecdotes and reflections to write about were on empathy. I noticed that as I joined my participants’ lived-experiences of empathy, I found myself bodily, emotionally, and cognitively impacted and had to distance myself from time to time so that I could re-engage my reflective and interpretive process. Halling and Goldfarb (1991) describe how seriously embodiment should be taken in the research process arguing that “being a researcher … requires that one become fully and thoughtfully involved … as if one is engaged in a dance” (1991, p. 277). Finlay (2011) agrees by calling the process of doing the analysis … “an *embodied lived experience* in itself” (p. 229). My relationship with the text became an intimate one. The thesaurus and textbooks became my new best friends as I endeavoured to bring new life to taken-for-granted words and phrases as I grappled with their meaning. I even began dreaming about snippets of my participants’ stories and would awaken with meaning-full anecdotes. As I was leaving sleep and entering wakefulness, my brain was busy at work. Tinkerbell told Peter Pan about this place:

> You know that place between sleep and awake, the place where you can still remember dreaming? That's where I'll always love you, Peter Pan . . . that's where I'll be waiting. (Spielberg, 1991)

This waiting place between sleep and awake was where Peter Pan could meaningfully experience Tinkerbell without her actual presence. For me, this was the place where I meaningfully experienced my participants' experiences. It was where I was dwelling-with, reflecting, and interpreting the essence of their experience – as if I were present in their sessions with access to all of their experience and personhood. All aspects of my personhood participated in this meaning-making process of their lived-experience. I can confidently say that my experience through this process has been a bodied, hermeneutic phenomenological one.

CHAPTER 4:

Findings

> For human beings, life is meaningful because it is a story. A story has a sense of a whole, and its arc is determined by the significant moments, the ones where something happens. Measurements of people's minute-by-minute levels of pleasure and pain miss this fundamental aspect of human existence.
>
> Gawande (2014, p. 162)

I have shared my journey of capturing and dwelling with the participants lived experiences and interpreting them into meaningful short stories or anecdotes. I have also identified and extracted the essence of these stories and grouped them into sub-themes. The stories within each of the sub-themes have something in common. To arrive at the essential themes, I then identified and extracted the essence from each sub-theme and grouped the sub-themes together into essential themes of meaning.

In this chapter I present the essential themes of meaning as the findings that surfaced from the participants lived-experiences of the phenomenon. Three themes are presented in this chapter. These themes stood out as to what was most important about the participants' lived experiences. These themes are attending to the body, empathy as space, and home. In this chapter I present the participants' anecdotal stories grouped by their smaller sub-themes and a discussion of these follow in the Discussions Chapter. All quotations in this chapter are from the participants who have been given pseudonyms.

Theme One –Attending to the Body

The first theme that emerged through analysing the data in this hermeneutic phenomenological journey highlighted the lived-experience of attending to the body. This theme is about the participants' experiences of attending to the body in relation to a whole person approach to therapy. What emerged from grouping of the stories within this theme were five sub-themes of attending. These included an openness to the body, being present to the body, awareness of the disconnected body, connecting the body meaningfully, and attending to the pace. The participants noted that some of their clients had an immediate understanding of their body and how the body interconnects with the many aspects of

personhood. They experienced other clients that had no understanding or awareness of this. Of these clients, some dissociated from their body, or were body-aware but disconnected from their other aspects of personhood.

Openness to the Body

The participants had various reasons behind their lean towards a whole person approach. Three participants, who have always experienced their bodies expressing emotions, said that these experiences drew them into working with their client's physical symptoms. One of them called herself a "somatiser." Another participant had been a nurse and said, "it's always been important to me…the body hasn't been just a kind of vehicle for us." The third participant said, "I was happy to find a profession where I could constructively use what I am able to sense in my body." The remaining participants were well acquainted with empathy and found that their clients' physicality featured prominently in their clinical encounters. For example, one participant said, "most people with a trauma background, when they come to counselling, don't understand what an impact the trauma has had on them, especially having an impact on their bodies as well."

Widening one's clinical gaze involves the process of extending one's clinical sphere of understanding and the outcome of this permits the therapist to peer around to "see" what else might present itself. Michelle also had something to say about this process:

> It is very tempting to stay away from unfamiliar places. It's like staying on the main path in the forest. However, in doing so, you, as a therapist, "can inadvertently take people away from going where it might be helpful for them, or not attending to the things that need attending to." The edges of our therapeutic 'knowing' are like invisible barriers, and as you approach the edges, it starts feeling uncomfortable for you. That's because when you go tromping through the bushes off the main path you might stumble over a loose rock and hurt yourself or fall off the edge of the cliff. You

> generally don't go wandering into unsafe places unequipped, so you scramble back to the safety of the main path with your client. (Michelle)

Using a whole person approach gives Michelle the freedom to explore other aspects of her clients' personhood. Although the participants work with various client types, implied throughout their work is the notion of suffering. Suffering touches all aspects of our humanity. Michelle also made a significant statement about the whole person in relation to suffering:

> Suffering doesn't happen in isolation. It impacts every part of who we are physically, relationally, mentally, and spiritually. For example, if a client is getting bullied, it can affect their thoughts and emotions. A debilitating physical injury can affect their sense of self, their relationships and internal hopes and dreams for their lives. As I'm sitting with my clients, "I am companioning suffering: I am bearing witness to, and acknowledging, my client's suffering." I don't know any other way to work now. "If I don't know fully what a person is experiencing physically, relationally, mentally, and spiritually, I couldn't possibly be doing this work in a way that is helpful for that person." (Michelle)

Michelle's openness to working in a whole person way enables her to see the larger landscape of her clients' every-day experiences in order to be more helpful to her clients. Because suffering impacts multiple aspects of personhood, Michele said "We need to be curious about another person's world", meaning their whole world. This is very important to her in working with clients and their families. One participant noted that trauma impacts her clients in a similar way. She said that "[trauma] plays out physically, mentally, emotionally, psychologically, spiritually – in every way."

The participants' openness to working in a whole person way opened up their practices to a wholistic way of healing. They began attending to the whole of the person in

their specific fields and in doing so dramatically transformed their clinical practice. Because they were open to the body, the participants were able to invite the body to appear or show itself in their clinical practice. The participants were then able to be present to the body in their therapeutic conversations with their clients.

Being Present to the Body

The participants invited their clients to be present in their own bodies in the therapeutic sessions. This process began by inviting the clients into brief conversations about the body early on in therapy. This helped the participants normalise the body's inclusion in talking therapy. For example, the participants noticed their own bodied responses and shared these noticings, as appropriate, with their clients. They noticed the bodied responses of their clients and reflected these back to their client. For example, Anna noticed when her client "tilts their head or leans back or forward", or when their hand goes up and then she reflected her noticing back to her client. Vanessa notices that she's noting everything her client does including "what they are paying attention to in the room." When a client gets excited about something, Vanessa is noticing how their body becomes animated, then reflects this back to her client.

The participants invited their clients to notice their own bodied responses and to share those in the therapy sessions. They were also intentional about paying attention to bodied expressions of discomfort or illness. A common practice with some participants was discussing or noticing the body in some way in the very first session. For example, in helping her clients become more bodily aware, Sarah normalises bodied responses by connecting them to familiar feelings:

> "I say, 'look . . . when we feel anxious our hearts start racing. If we're angry we might feel heat and tension, or when we feel happy, we smile. If we're enjoying the music, we tap our foot. As you're talking about the experience that you're telling me about, what are you noticing about your body?'" (Sarah)

Sarah encouraged her clients to talk about their physical sensations in her sessions in the hopes that they would begin to trust their body. “People don’t want to be told ‘*It’s all in your head*’” she said, so she takes her time helping her clients take notice of their bodies by validating or legitimising the physical symptom. She shared an experience with one of her clients:

> As I’m with my client, I begin to legitimise the physical symptom right away. “I’m saying ‘Yes’ to everything because my client is saying ‘No’ to the emotional stuff they can’t bear so it then had to go into the body”. I’m attending to the physical symptoms by validating and showing genuine curiosity about the symptoms because this helps to create a greater sense of validation for the client. Once my client is feeling validated, they start relaxing and then they become more open to the possibility that there might be meaning in the physical symptom. (Sarah)

Vanessa also normalises the body in her early sessions. Like Sarah, she, introduces the body’s reactions to emotions in the very first session and invites the client to notice how their body responds:

> From the very first session, I’m talking about the body in relation to emotion. I might say “Some people, when they’re angry, might clench their jaw or their hands What do you notice your body doing when you’re angry?” Or if they’ve told me something that they are anxious about I might say, “When people feel anxious, I notice their breathing sometimes changes. Sometimes they even hold their breath without knowing it. Let’s just take a moment here… as you told me about your experience, what are you noticing about your breathing?” We take our time and I let them explore and experience it for themselves. Some people think it’s rather strange, but others get it right away. (Vanessa)

Inviting the clients to notice their bodied responses helped to usher physicality into the therapeutic sessions. Anna makes it a regular part of her therapeutic practice to inquire about the client's knowledge and awareness of their body. She does this to help her clients become aware of and be present with their own bodies:

> Well, I would say, almost without exception, a regular question for me is asking a client, "Where do you feel that in your body" or "Where do you notice that in your body?" Or sometimes I'll just ask, "What are you noticing about yourself in your body right now as you're telling that story?" (Anna)

These normalising ways of attending to the body and body sensations help make the presence of body commonplace and this accepted way of being in the sessions helps the body become normalised. Vanessa used her own body to model body awareness for her clients. For example, when a client shared a particularly hard and particularly sad story with her, Vanessa said,

> "I softly pat the palm of my hand on my chest right here on my heart." It was like I was teaching her about how affect and physicality are connected. Sometimes I have to be brave because my client might not understand this right away, but this client caught on quickly. I modelled this for her. And then I softly and gently reflected back to her, 'Ohhh, that must have hurt… I can feel my own heart breaking'." (Vanessa)

Normalising the body in the therapy sessions made the transition easier for clients who were seeking relief, to experience wholeness whether they initially found it difficult to address the emotional pain or discomfort, or acknowledge the physical distress, or make the connection between the two. The participants widened their clinical gazes to see important

aspects of personhood being impacted by and having a story to tell about the illness or discomfort.

Awareness of the Disconnected Body

Both Kate and Sarah have seen clients who they describe as "in their head" and disconnected from their bodies and other aspects of personhood, as if their bodies were not present. Kate shared her experience with a client who was so much in her head that her client seemed like two separate people:

> "It was quite visible." When I first saw my client, I was noticing how much she was in her head and disengaged from her body. She was so unaware of her body and just gave me a blank stare when I asked her what part of her body feels the anger. It was really an awkward moment. "It was like she was carrying her head around under her arm. Nothing seemed to exist from the neck down". It was like her body didn't exist, or it was like her chauffeur that took her head places. After months and months of working together, she started connecting with her body. Both her head and her body had storied experiences but, in the beginning, neither one was willing to listen nor share with the other. (Kate)

Sarah, too notices that many of her clients are out of touch with their bodies because they are so engaged with their thoughts or thinking patterns that they become unaware of what their body is doing or trying to communicate.

> "So, I am sitting with a client who is very identified in his head." He has such high expectations of himself and is cut off from his body. "His body had started expressing the hidden dis-owned unconscious parts of his experience that he was unable to own." It's like his body has hold of a megaphone and is announcing very loudly what's going on, but he is wearing ear plugs. So, in the session I slowly begin to help him integrate

> by first helping him learn to trust his body a bit more so he could begin listening to it. Sometimes it takes a lot of courage to hold back and work at a snail's pace. (Sarah)

Sarah's intention with her client was to slowly help bring her client's body into focus so he could start noticing it. The participants also noticed how their own bodies expressed themselves during their sessions with clients. Kate noticed that her energy is impacted when she is with a client who is disconnected from their body. She notices her body becoming tired. Sarah, too, notices how her own body responds when her clients are unable to make psychological connections with what is going on in their bodies. She said, "it's quite common to feel tension in my muscles, often in different parts of my body". Sarah also added:

> "When I'm more embodied as a therapist, I might be taking a breath, or feeling my belly, or I might be going 'Oooh gosh, I've got a bit of a sore back, is that mine or??' I find that if I'm doing that sort of embodied awareness at the same time it's much less tiring and more enjoyable." (Sarah)

Sarah said that her default is to go into her head and when she does this, she finds that by the end of the day she can feel exhausted. But when she pays attention to her own bodied responses, she finds the work more enjoyable.

Connecting the Body Meaning-fully

Anna shared a story about one of her clients who was not only body aware, but she had language to describe what her body felt like:

> In an early session with one of my clients, I was listening to her while she explained why she came to see me, and it included a very emotional story. After a while, she mentioned that she often gets a sore neck and so we

> started exploring that. Suddenly she says, "It feels tight, it feels like a string that's being pulled". And I'm smiling down at myself because I'm feeling shocked inside. I wasn't expecting this. I'm thinking, she knows exactly what this is about. "We were, the two of us, able to talk to that part." We explored that metaphor of the pulled string, and the physical and emotional stories began to connect, and she made huge progress. "I notice myself feeling all bubbly and invigorated as I'm telling you this. It was like I was partnering with her, working side-by-side, and just falling on the coat tails of what was happening. It was like a team of horses, and I was holding the reins. We were going for it!". (Anna)

Anna was quite excited as she recounted her experience to me, and I truly felt her joy and enthusiasm when this happens in her work. She finds it uncommon for her clients to talk about their body pain using symbolic language such as metaphor – especially in the first session. Anna said of this process:

> "Cognition allows those two parts to connect and have a feedback loop then it just kinda happens . . . the client does the work. And when they come back the next time, huge progress is made because they're doing all the work." (Anna)

This client did not see Anna for long because she was able to process the pain in relation to the emotional story. Anna said of this experience:

> "I really feel hope when that connection is made because my belief in integration is one of the really important components of being able to work towards healing. I guess it fits in with my philosophy that if the environment's right then healing will come naturally because that's how we're designed." (Anna)

Anna also said that she uses her own body in helping clients connect with theirs. For example, she said,

> My client said 'I feel it in my throat, and it feels really tight', "and so I actually use my own body … and "I put my hand on my own throat, but I wanted to offer her something she needed, so I used a loving touch on my throat … because that's what she needed. (Anna)

In telling me her stories of lived-experiences with her clients Sarah said, "The body expresses what we can't express."

> I might get someone with chronic pain, or allergy symptoms in their body. They come to see me because of some distress in their life that's seemingly unrelated to what is happening in their body. I'm listening to their story of distress, which often has nothing to do with that symptom, because they're not really aware that there is a connection. I'm also very interested in the symptoms of the pain or allergy. Then together we explore the symptoms so that they might explore the meaning. And I'm listening to the words they use, especially metaphor because metaphor contains meaning. Eventually we arrive at the place where they are open to understanding that the chronic pain or allergy symptoms might be meaningful, that there could be a connection and that some of distress they experience might or could be experienced in their body. (Sarah)

Sarah explained that when she is with a client, she is intentionally curious about their physical symptoms, and she validates those symptoms without pushing her client to find out what something might mean.

> I find it counterproductive to point out why something is going on for the client. It's human to seek understanding but the client is the best author

> and interpreter of their own meaning. Rigid or prescriptive understandings are very unhelpful. For example, "if you are experiencing 'this' it must mean 'that'. I'm thinking of Louise Hay's idea that if you've got a bladder infection you must be pissed off with someone" – Brian Broom would call that meanings reductionism. So, you have to go at your client's pace, and sometimes that has to be very, very slow. (Sarah)

Attending to the Pace

Several participants talked about the slowness in the work, and the need to be gentle and tentative in attending to their clients' physicality. For example, Kate said, "I realise how much the body holds and how we've got to be so gentle with unwrapping that part with people." Vanessa shared this story:

> I was working with one client who had no understanding of his own physical experiencing. Or if he did, he didn't take any notice of it. My work with him was very slow. It was like I was in a mothering role where I was spoon-feeding him into noticing his body. I started off by noticing for him how I was feeling in my body by slowly bending my head toward my left then right shoulder and noticing out loud how that felt in my neck. I'd invite him to do the same thing. After a while he began to pick up on some of this, but it took time. Then we'd do the next thing. And then the next thing after that. Bit by bit, his body was brought into awareness. (Vanessa)

Sarah explained the slowness in her work in relation to safety:

> "I've been learning quite a bit about the neurophysiology of trauma and distress and that idea that safety is primary for our downstairs brain. And somatisation is a primitive response to distress that's too hard to bear. So, safety is the way to soothe that downstairs brain. If there's anxiety of "Is

> the therapist going to push me too hard or make interpretations that are scary or make me feel stupid?" then they won't be receptive to what I'm offering because they're too busy or focused on taking care of themselves with all their defences. It's like soothing an animal. You have to soothe with calmness and love and be quite slow and gentle.

Theme Two –Empathy as Space

The second essential theme that became clear through the data is empathy as space. Within this empathic space metaphors of meaning emerged: empathy as a container, empathy a sense of being-with, empathy as revealing something, and empathy as a space of tension. The participants described varying experiences of empathy. For example, Kate described her empathic place of understanding and connecting as the space around her heart:

> I locate empathy right here in my heart – it's a heart space. "I work more from my heart than my head". If I go up into my head and start thinking I lose my empathic connection. I'm not saying that I don't think in my sessions but ask me what's happening in my heart . . . my heart knows. (Kate)

Michelle spoke of an experience where she actively pursued empathy with a client because her time with him was limited:

> I had a client who was in denial. He had very strong ideas on what he was going to talk about and what he wasn't going to talk about, and he had seen other counsellors. I wondered if they had found him difficult to work with. I also knew that we only had a limited number of sessions, and I didn't want to be just another counsellor in a long line of counsellors. "What I noticed was at times it was quite hard for me. He was very rude to me, he cut me off, he talked over me, he corrected me. So, I noticed my own discomfort". He was doing his best to push me, and probably

> everyone else, away. But what I was saying to myself was, "listen harder, listen harder". I said that over and over to myself. Now I pursued, really pursued, understanding his world. "I took up a stance of curiosity like I never have". Because I knew our time together was limited, "I pursued building relationship and being curious so I could understand where he was coming from". We formed a very quick and a very good relationship. Because I pursued, I found a way of making sense of his world, seeing it through his eyes, and that meant he and I together could make sense of his circumstances. When you're genuinely trying to understand, really pursuing what this means for someone, it allows "all sorts of things to be possible". (Michelle)

Empathy as a Container

In the therapeutic space the participants experienced a knowing of their clients and from this knowing the therapist gained an understanding about what can be safely communicated through reflection, and what must be held or contained for later. All of this knowing came together in a space where the client is felt and experienced. This space acts like a vessel; a container present for the body, emotions, thoughts. Sarah revealed her experience of the container:

> During the session, I'm aware that my client is really struggling to accept that she's not really this ideal image she has of herself. To admit that would be unbearable for her. I'm feeling my muscles beginning to tense up. She has chronic pain but she's resistant to "letting the pain be meaningful". As I'm sitting with her, I'm aware that I'm feeling really uncomfortable. "It's amazing how her stuff gets enacted in my body." "When I feel those things and they don't really make sense to me in my own life then I know they belong to the client." I have a deep understanding of her pain. I'm feeling more of my muscles tensing up, and

> I know it's her stuff, yet I also know the time to reflect this back to her isn't right. Timing is important. I'm thinking to myself, "Ooooh, just hold on", contain it . . . hold it for now. If I reflect my knowing back too soon, she'll become defensive and not receptive to the idea that maybe the chronic pain might have meaning, and the pain and the failure of the ideal self might have a connection. So, I hold these in. I'm containing a lot of "knowing" about my client and some of it just needs to stay with me until she's ready to hear it. (Sarah)

Holding what Sarah is bodily sensing is on behalf of her client's safety. Recognising the boundary between what belongs to Sarah vs. what belongs to her client is on behalf of good self-care.

In the empathic space, the therapist also holds their understanding of the client's unravelling process. This unravelling is not just a "coming undone" but it is a separating process from the notion of self, and it can be a very uncomfortable process for clients. Sometimes we are known by our physicality: *his* cancer; *her* chronic fatigue; *my* pain. Sarah said that "pain is often an intimate thing". She notices that some of her clients personalise their illness.

> "My clients want to talk about their illness"; to have it seen and acknowledged. "Illness is personal and over time it gets constructed into the psyche and it can be a difficult thing to let go of." The clients who are not able to make a meaningful connection with the pain or illness "almost don't want to know because they're very attached to staying the same." Illness changes our view of our self. We get confused about our ideas about identity, who we are. The more the client defends the pain, the more resistant they are to letting the pain be meaning-full. But once the client can bear the risk of becoming unravelled and begin to explore what the

> illness might represent and listen to metaphors that get expressed, "then we might put together the metaphorical meaning". (Sarah)

Empathy as a Revealing Space

While the participants were sitting with and listening to their clients, they were aware that information was being revealed to them. For example, Kate shared this story:

> When I'm sitting with a client and I suddenly feel fear, and my gut might tense up, or I'll feel tension somewhere else in my body, but I have a clear understanding that it's fear that I'm feeling. So then I can start to gently explore that with my client. Or sometimes I get the sense that I'm feeling stuck. When I check these sensations out with my client, 99% of the time they tell me that's exactly what they're feeling, and so then we'll explore that together. I had one client who was absolutely thrilled that somebody else 'got her'. You know, I've even been in sessions with a few of my clients and I'm realising that "I have no words for what it is I'm sensing". What I'm sensing is strong, but I have no words available to me. "And often it's maybe the younger part of my client that's feeling it". They don't have words for what they're feeling because they were too young at the time to understand the meaning. (Kate)

Kate is attentive to what she is sensing and understanding in the empathic space. What is revealed to her connects with her client's lived-experience. This helps Kate to engage in relational depth with her client.

Empathy as a Being-With Space

The participants had experiences of being-with their clients empathically. For example, Vanessa shared this touching story:

> As my client leads me into her story, I am aware that I'm with her in her confusion, I'm with her in her pain, her disappointment, and I'm with her in her fear as her partner comes home drunk again. "She can talk about those experiences and feelings with me because she knows she's safe with me so she's not alone". I'm there with her as "her witness, her validator, and her port of safety." (Vanessa)

Anna discovered that her being-with, or how much she was needed in the work, had an impact on empathy. She gave an example of a client who connected subjectivity and physicality right away and another client who could not bear to connect her storied experiences:

> I experience differences in empathy with my clients. I have one client who understands the connection between subjectivity and physicality and in the very first session she even has this meaningful metaphor for how she experiences the allergy and she started connecting this meaningful physical story with her relational storied experiences. It was exciting and fun working with her but in the back of my mind I'm thinking "she's not going to be seeing me long . . . she won't be needing me because she's really getting this, and this will be her journey". I'm being with this client but I'm experiencing empathy as "less deep [and] less full".
>
> I have another client I've been seeing for a couple of years who is unable to connect her storied experiences of disappointment with how her body is expressing these. When I'm with her, I'm aware that I'm more in the work. I'm noticing her body to her and I'm mindfully noticing mine. There's this sense of togetherness in our exploration. "I really feel like a partner with her in the work". I'm more tentative with her because I'm sensing her fear of failing and so I'm holding what I'm sensing because

> this work needs to be done slowly – very very slowly, until she is open to finding out what her body wants to say. With this client, empathy has depth. We are really connecting. (Anna)

Anna said that the work was easier with the former client than with the latter. I asked her if she could say more about empathy with the latter client. For example, did the depth she experienced mean the empathy was greater. Anna responded:

> You know when you go to see a movie and it's in 3D? You put on those special 3D glasses, and then everything on the screen takes on a whole new dimension? That's what it's like. I don't experience empathy in terms of amount or size, so it's not more or greater empathy. But there's a different quality to it. "There's a definite fullness and potency in that space . . . it's rich. There's a real 3D quality about it." (Anna)

Anna's experiences of 3D empathy came after spending time – her being with – her client. This meant that she was more engaged with her own body during her sessions, and to her empathic bodied responses. She was also helping her client explore and link physical expression of a subjective story by attending to the client's bodied story. She had created a deep relational engagement with her client and she and her client were present to each other in the sessions.

Empathy as Tension in the Space

Sometimes there is a cost to being with another in the empathic space as Vanessa noted.

> "I feel like my head is being crushed, it is really hard to bear sometimes." I had a client once who worked for a relative who happened to be his boss. He was very demanding, impossible to work with, and he wouldn't give my client a break. "My client had neck and back pain and really bad

> chronic headaches." He had used up his sick leave and literally could not afford to lose his job. My client's body was physically expressing his emotional distress. It was excruciating to sit with him because "I was feeling all the emotional distress that he couldn't bear to feel." It was uncomfortable, unbearable for me. (Vanessa)

Vanessa's experience of tension in the space describes what it is like for her to sit in the tension. Sarah, too, has experiences with clients who are very hard to sit with. Because this work is slow and gentle, it can take months of therapy before a client is ready to take a step forward:

> So, there I am sitting with my client, and she is so hard to sit with. She had big plans for her life that involved an outdoor career. All that was cut short a couple of years ago by a painful chronic disability. "She's been very angry and stuck in the unfairness of it all and she's just railing against it and sometimes she just doesn't want to live". She's been very uncomfortable to sit with week after week after week; I'm feeling her despair and rage and denial. "She's not really able to feel her loss and grief, so I feel it all". There's a lot of tension throughout my body and I keep going up into my head. It's very very hard for me in this empathic space. I'm not seeing the light at the end of the tunnel and I'm wondering how much longer this tunnel is. (Sarah)

Theme Three - Home

The third essential theme that emerged through the meanings in the participants' stories was the idea of home. These experiences centred around feeling at home, home as a place of safety and rest, and home as a welcoming place.

Feeling At Home

Because the participants work in a whole person way, they not only felt at home working with physicality in their practice, but they all shared a sense of feeling at home in their own bodies. They were body-aware and had a history of connecting and engaging with their own bodies in their work. This was a comfortable, familiar, and taken-for-granted place for them, as they felt quite at home working with the body. For example, Sarah said

> "I feel quite at home in my body and when I am body-aware in my work, it's much less tiring for me and more enjoyable." I have a tendency to go to my thoughts and when I do I notice myself feeling exhausted by the end of the day. So, I connect back with my body. (Sarah)

This feeling at home with the body is something that the therapists were hoping their clients could eventually experience. Anna explained it as integral to her work:

> There is more than one story that's being communicated. The client arrives with the subjective story and they're usually not paying much attention to the physical story going on. But those stories can be intertwined and the relationship between the two can be intimately connected. When my clients are able to integrate the body's story into the subjective story, they're coming home to wholeness. "It's quite a hopefulness." I find that working this way with my clients is a hopeful way of working (Anna)

The participants also felt at home with their experiences of empathic depth. Vanessa explained that she had always been able to feel what others are feeling and added, "I thought everybody did." She said that she was pleased to find a career as a therapist where she could use this her empathic ability, and it helped her to make sense of what she was sensing.

Similar to Vanessa, Sarah said that what drew her into working with physical symptoms was her own experience of expressing her emotions in her body; she called herself a somatiser.

Kate felt that her ability to feel someone's experiences, thoughts, or feelings was in an all-knowing place within herself, which she located around the area of her heart, and noted sometimes her gut. What I noticed when she told me this was that she had closed her hand as if holding something precious and held her closed hand to her chest. She bodily demonstrated, "this is where I hold this knowledge."

Anna told me of an experience in her training:

> In my first year of training as a counsellor, one of my lecturers had us lie on the floor and to notice what we noticed of any felt sense. I was thinking at the time that it was all very hippie-like, and some of my classmates and I exchanged puzzled glances with each other. But then I remembered that from a Christian perspective, the feeling of God's presence is not just head knowledge. So "I had a sense of what he was talking about." So, I tried really hard, and eventually I began to open myself up and I began to understand what I was internally experiencing. I just kind of emerged. I've integrated this way of working with other modalities and it really makes sense now. Physicality and the felt sense are in the same space now. It's like everything has come home in one place. (Anna)

Some of the participants noticed that with their clients who connected with their bodies right away that felt they could relax and feel comfortable and "feel at home" with their client right away.

Home as a Place of Safety and Rest

According to the participants, some clients are happy to come right in through the front door, while others linger on the porch before going inside. But the pathway needs to

be free of obstacles. “First, though” said Sarah, “they need to feel safe”. She builds safety and trust all along the way. Sarah highlighted the need to create lots of safety because safety then enabled the client to find rest.

> My client was feeling anxious, so I slowed down to create some space for her to feel safe. It’s like taking her to the edge of the swimming pool so she can hold on to something solid. This creates safety and safety creates psychological rest. When she starts feeling more confident, we can start paddling in the water together. So once my client began to feel safe and rested, it enabled her to make space for vulnerability. That’s when she started expressing what was deep inside. When that happened, “she could begin to experience some of emotional distress in her body”, and then we could begin to look at meaning of the bodied distress.” (Sarah)

Vanessa’s experiences of creating safety were similar to Sarah’s. She also used the words ‘respect’ and ‘honour’ to describe her attitude toward her client:

> I am careful to be respectful and honour my clients because many have stories of shame around their bodies. I’m modelling care and love for my client and their body. And I’m showing genuine interest, without judgement, in what their body is expressing. They feel safe and we develop trust. It is out of this trust and the safety created in the relationship that a person is able to be in a vulnerable state with you. (Vanessa)

Home as Sacred Ground

When the participants’ clients were able to integrate subjectivity and physicality, it was like a returning to oneself; a coming back into wholeness – after all, we are born as whole persons. When the participants experienced this, they named this as stepping onto or entering sacred ground or sacred space.

As my client paid more attention to her body in the sessions, the other work we were doing began to go deeper. It was like she was becoming whole again, and the space between us filled with hope. And our connection and my understanding deepened. It was like stepping onto sacred ground. “It’s very honouring, very humbling, and it’s a privilege.” (Kate)

When I’m meeting with a client, I’m reminded that our shared humanity comes first. I met with a woman who was finally able to speak the unspeakable. And when she did, it created a different kind of connection for us – relationally and empathically. We entered a sacred space. “It’s not just me giving to them, the people I meet are giving to me”. It’s reciprocal, and we’re suddenly shaping each other. (Michelle)

CHAPTER 5:

Discussions

This chapter draws upon the three themes presented in the findings of this hermeneutic phenomenological journey. I will next engage in a discussion on these themes by putting them into context and linking them to relevant literature. This allows additional insights and interpretations to emerge, which offers the opportunity to explore parts of the phenomenon more deeply. This leads to a richer understanding of the phenomenon in therapeutic encounters in talking therapy. The themes are then coherently brought together into a unified whole and that will form an emergent landscape. According to Gadamer, the landscape, or horizon, is never complete because "the horizon changes as perception changes" (Vessey, 2009, p. 530). The binoculars through which this particular landscape is viewed relates to the thesis question: how does attending to the client's bodied experience of their illness in talking therapy open a gateway to empathic depth.

Theme One: Attending to the body

Attending to the body captured the importance of first seeing clients as whole persons and then attending to physicality in talking therapy. Merleau-Ponty (1962/2014) called the body the "vehicle of being in the world" (p. 160). Considering their clients from a whole person approach, the participants were able to engage in explorations of meaning with their clients beyond thoughts and emotions. What causes a talking therapist to bring a client's physical illness into the therapy room? Although some talking therapists might "dip their toes" in the water of physicality and illness, the ethical implication of working outside of one's knowledge or competence is significant. The philosophical and theoretical paradigms of practice between those who work primarily with physicality versus those who work primarily with subjectivity are distinctively different. The participants in this study could have kept working within their comfortable zones of competence but intentionally broadened or fused their horizons (Vessey, 2009), to see beyond their own perspectives, to learn, and be open to a new horizon or gaze. For some of the participants, this was a brave

step in taking this shift in perspective and practice. Then, intentionally, the participants normalised conversation about physicality with their clients, gently introducing their clients into awareness, or presence, of their own physicality. For some clients this sometimes meant legitimising the physical symptom, to give license to the physical suffering and not devalue it to "it's all in your head." It also meant working at the client's pace to process and integrate new awareness.

The participants in this study are experienced therapists. Like me, their attention to physicality in talking therapy happened after being in clinical practice several years. To do this work, there were things that had to change first in their clinical practice. These changes were intentional, and they started with the therapist.

Openness to the Body

Being open to working with client physicality and illness encouraged the participants to open their own doors of knowing and intentionally widen their clinical gaze. The clinical gaze, or what Gadamer termed horizon, is that which expands so that more can be "seen" (Vessey, 2009). Horizons "are always gateways to something beyond" (Vessey, 2009, p. 527). For the participants, the gateway meant an engagement in professional development that included tertiary education and/or attending workshops, and some participants even changing their supervisor. For some of the participants, it also meant finding a peer support group of other like-minded practitioners who practice in a whole person way.

The data revealed that once the participants gained new learning and understanding they could not imagine going back to their "old" ways of being in their clinical practices. The participants' narrow horizon had been broadened and they gained a new and welcomed insight (Taylor, 2021). The participants deliberately attended to the body – both their own and their clients in the clinical space. Attending meant being first involved in an openness to exploring physicality in the context of talking therapy. This openness was an intentional move toward working within a more robust definition of personhood, meaning the whole

person, and it involved preparation. People normally do not go to their car mechanic to fix a toothache. This is an extreme example, but it makes the point that clients, generally, would not expect their talking therapist to attend to their illnesses in talking therapy. Illness is usually the jurisdiction of the medical professionals. Metaphorically, it is like trying to fit a square peg into a round hole. The edges of the peg do not allow its squareness to fit through the circumference of the round hole. Talking therapy is like the round hole and Western models of healthcare have defined its shape. But when a whole person approach becomes fundamental to practice, a fusion of horizons (Gadamer, 2013; Taylor, 2021; Vessey, 2009) occurs and the therapists' clinical gaze broadens or lifts. There was a popular song written during World War I entitled "How Ya Gonna Keep 'em Down on the Farm (After They've Seen Paree)?" It is said that the lyrics of the song highlighted concern that once the returning black American soldiers got back home from their experiences of Parisian life and culture, they would not accept the discriminatory status quo back home. Once someone's horizon has expanded, it's difficult to go back to old ways of being and practice. Michelle offered her own summary of this when she said, "I don't know any other way to work now."

Widening one's clinical gaze allows the therapist to see something that was hidden in the earlier gaze. Broom (2007) uses the metaphor of 'cuts' to explain how this works. He argues that if you take a physical cut through the whole (person) then physical elements are what you will observe. Likewise, if you take a subjective cut, you will observe the subjective elements and neglect the physical elements.

Michelle found working in a whole person way helpful because it allowed her to follow her clients into what once had been foreign territory to her. Going further, this also means she can also pay attention to what the client might dismiss as ordinary or seemingly unimportant in talking therapy and, therefore, might otherwise get overlooked: for example, what a rash might represent. Being able to explore these experiences with her clients helps to bring them into her client's awareness. Broom (2007) calls this making the invisible, visible: like shining a torch into a darkened forest.

But there is another meaning implied when wandering into unsafe places, especially when one is unequipped. This has to do with ethical boundaries and knowing the scope of one's professional practice. As social beings, we live with both visible and invisible borders. For counsellors, one of the protocols of professional practice concerns working outside of competence (New Zealand Association of Counsellors (NZAC), 2012; New Zealand Christian Counsellors Association (NZCCA), 2012). When working in a whole person way, all aspects of personhood equally considered.

Suffering is implicit in all the participants' stories: it is the *suffering* client who sits with the therapist in the therapy room. Suffering is an illness experience. Michelle briefly talked about suffering in the context of the whole person. Cassell (1991) defines suffering as "the distress brought about by the actual or perceived threat to the integrity or continued existence of the whole person" (p. 24). Duffee (2020) argues that Cassel does not adequately define distress, which has many meanings. She further argues that in medical contexts, the words *distress* and *suffering* are synonymous, thus making Cassel's definition of suffering circular. But Cassell makes a good point about suffering when he argues that "anything that happens to one part affects the whole, what affects the whole affects every part…all the parts are interdependent and not one functions completely separate from the rest" (Cassell, 2004, p. 241). This connected deeply with Michelle's experience of companioning, acknowledging, and bearing witness to suffering as it impacts all domains of a client's life.

Being Present to the Body

Our bodies relate to the world. As Shaw (2004) noted, the perception of the world is an embodied one, but the participants were noticing that their clients' physicality was in the background of their being-in-the-world. Finlay (2011) warns us that people live the interconnectedness of body-world pre-reflectively – as if on auto-pilot – without thinking or understanding that the body has its own memory and wisdom.

The participants invited their clients into attending to their own bodied experiences and created an opening for this by normalising the body and body awareness in the

therapeutic sessions. This helped to prepare the clients for the therapeutic journey. Not everyone is aware that "the body is always present and is never silent" (Svensen & Bergland, 2007, p. 44). Many clients, for example, ignore or are not present to, or aware of, their bodies, and do not hear what their body is communicating. To describe this part of the process many of the participants used the word "normalise". Normal sets a subjective expectation and this was an intentional practice of the participants. The participants' horizon, or perspective, of a new "normal" emerged from a unitary multidimensional view of personhood. The participants intentionally began to expand their client's horizon of the meaning of personhood because they understood the "essential longing to connect the human story of illness and healing" (Tolich, 2020, p. 120).

By normalising the presence of physicality in talking therapy, especially illness, the participants were able to better-attend to the whole of the client's personhood – a unitary multidimensional whole, thus respecting and honouring the client's personhood and their longing for healing. Michelle had a phrase for this. She called it the "dignification of the other" and she offered this:

> "Seeing the whole person is really important … there would be consequences for the relationship otherwise". People wouldn't talk about what's dominating their life. "I can't imagine ignoring what's going on . . . it's unthinkable!" It comes down to respect . . . no, it's dignity . . . "dignification of the other". (Michelle)

Dignity is defined as respecting and valuing someone's integrity and honour, recognising one's humanity, (Oyola, 2021) and understanding the "inalienable worth of human beings due to the fact of being humans" (p. 489). This is a reminder of how, in the Christian literature, God sees and relates with humanity. A Hebrew word that connects with dignity is *chesed*, which has several meanings, such as love, loving-kindness and beloved. According to the Christian literature, God's relationship with humanity is one of chesed and because we are created in God's image, we have value and worth: dignity. In a study by

Pleschberger (2007) on dignity in issues at end-of-life, one of the outcomes showed that illness threatens people's sense of dignity. This implies that therapists need to have an understanding and appreciation of dignity in the context of the therapeutic relationship, particularly when re-acquainting clients with their physicality.

Disconnected and Connecting

An important skill for talking therapists is listening well to a client's story (Mearns & Cooper, 2005). Listening well includes listening to not just the subjective story of distress but to the client's bodied story. In Whole Person Healthcare terms, Broom (1997) would call this the client's *other* story. Illness can be seen as the expression of a story that is integral to the *whole* story. Illness has meaning. Widening the clinical gaze so that it is not limited to the subjective story only allows the therapist to attend to a significant aspect of healing in the therapeutic encounter.

A key element of the participants' therapeutic work is integrating their clients' physicality and subjectivity. The data showed a wide variety in the participants' experiences of clients' bodied disconnections. Kate's client, who was so disconnected from her body it seemed like she was carrying her head under her arm, and the clients who were described as "in their head" painted a picture of a dualistic, Cartesian way of living. Her client's physicality and subjectivity could not co-exist. The clients' bodies had drifted into the background even though they had something valuable to express (Finlay, 2011). The separation of mind and body impedes the fullness of personhood and "awareness of the importance of the whole being-in-the-world" (Svenaeus, 2011, p. 336). Dasein inhabits the world, which means that it connects with the world, and this is seen as "being-in-the-world" (Ratcliffe, 2013, p. 173). Helping their clients become aware of their physicality, and/or helping them to story their illness and explore what that story might represent enabled the clients to integrate their bodied story into the bigger story of their experience.

Anna's client was able to explore her client's conceptual metaphor (Kovecses, 2010) of the pulled string. The pulled string was an experience-near description that Anna

explored to help her client better-understand the meaning of the sore neck in more detail. By exploring the string story, her client began to connect the meaning this story held with what she was experiencing in another aspect of her personhood. Anna's client knew what meaning the 'string being pulled' held and Anna explored this narrative with her. Anna was being open to whatever her client presented, and she did not direct the meaning-making, but followed the lead of her client, staying with her client's metaphor and what it meant for the client. It is important to stay with the client's process of meaning-making. Meanings reductionism is what Broom (2007) refers to as assigning a limited meaning to every body structure or illness, for example as theorised by Hay (1998). As a talking therapist, Sarah was already attuned to explore meaning with her clients and paying attention to the linguistic use of metaphor. Metaphor can be used to understand one's domain of experience In fact, one domain of experience can be used to understand another domain (Kovecses, 2010). As Broom (2007) points out, a relationship exists between physical illness, experience, and language. A client's experience of their illness and their expression of language are not necessarily separate. As wholistic beings, we have the capacity to express narratives of lived-experience in multidimensional ways. "The words and bodily manifestations both tell the story in their own way and both tell it eloquently" (Broom, 2007, p. 47).

Attending to the Pace

In talking therapy, the body has a legitimate place to sit at the table of wholeness. In fact, the table setting would not be complete without it. But some clients need time getting seated. The participants all agreed that the work is usually gentle and tentative, and can often be very slow, especially for those who have difficulty attending to their own body or their illness. It requires an intentional shift in focus and it "takes time to process the experience" (Svensen & Bergland, 2007, p. 45). "Clinically, it is necessary to invite a slowing of the pace of the verbal dialogue and prioritize bodily experience over content, allowing (mal)adaptive patterns (relational/attachment and/or regulatory) to emerge into consciousness" (Mortimore, 2021, p. 59). The process is slow for another reason. This is because "illness at the very

least, reveals our vulnerability, and this is always tender ground for our meetings [with clients]" (Murphy, 2013, p. 56). Before a client has the capacity to expose vulnerability, they need to know that they are heard, understood, valued, and accepted (Mearns & Thorne, 2013). This happens in the environment of the therapeutic relationship where safety and trust are created and maintained over time (Rogers, 1980). In the therapeutic space, clients are invited to experience their lived-bodies and explore meaning in their bodied expressions. The resulting fruit of this process is like a calling of the client into the presence of the multidimensional aspects of personhood.

As Sarah was talking about soothing the downstairs brain, I was reminded of what the educator Parker Palmer (2007) said about the art of deeply listening:

> If we want to see and hear a person's soul, there is another truth we must remember: the soul is like a wild animal – tough, resilient, and yet shy. When we go crashing through the woods shouting for it to come out so we can help it, the soul will stay in hiding. But if we are willing to sit quietly and wait for a while, the soul may show itself (p. 156).

The participants noted that in this work gentleness and patience are required, much like when trying to help a wild animal who is wounded. Another thing they noted was how the therapist often modelled body awareness, inviting clients into awareness of their own bodies at their own pace.

Theme Two: Empathy as Space

The second theme of empathy as space took on the shape of space as a container that held a sense of something, as a space that reveals something, a space of being-with, and a space that held tension. Goldstein and Michaels (2021) describe empathy as a "perceptual-affective-cognitive-communicative" (p. 11) space, and this is where the participants dwelt in their clients' frames of references with the borrowed perceptions, thoughts, and feelings of their clients (Goldstein & Michaels, 2021). Empathy is multidimensional and "a

multifaceted construct" (Decety & Yoder, 2016, p. 2). It is not only experienced affectively and cognitively, but bodily as well. Merleau-Ponty (1964) claimed that it is the body that enables empathy. He said that "*einfühlung* goes from body to mind . . . it is though [the] body that the other person's soul is soul in my eyes" (p. 172).

Through empathy, Findlay (2006) argues that the Other is experienced as a unified whole and that "the body is the vehicle for understanding the world" (Finlay, 2005, p. 271). She recognises the body as having "its own special wisdom" (Finlay, 2011, p. 38). Finlay (2005) maintains that empathic ways of knowing include those that are bodily-felt intersubjective experiences. A significant aspect of empathic depth is the participants' own awareness and understanding of their own physicality. This was made evident in the participants' lived experiences of attending to physicality.

The participants' experiences of empathy varied. Sarah had called herself a somatiser and for her, empathy is typically felt in her muscles. Kate described empathy as something felt, which Vanaerschot (2007) describes as an implicit bodily-felt sense of "knowing without words" (p. 314). Michelle actively pursued empathy. She intentionally built the therapeutic relationship and empathically connected with her client because she did not have the luxury of time, therefore, Michelle intentionally pursued empathy.

Container

Since empathy is bodily felt, in this sense it is like an open container in that it holds something. The participants each had an openness to their clients without a merging of self-other. Finlay (2006) called this the "dance of intimacy and alterity" (p. 7), where the one steps between intimacy and distinction. Merleau-Ponty referred to this as a "reciprocal insertion and intertwining" where the therapist and client can encounter each other across a bodied intersubjective space. For the participants, this bodied intersubjective space holds knowledge. It holds clients' affective, cognitive, bodily, and perceptual experiences, and the therapist's felt and bodied experiences. "It is the kindred connection from a place of deep knowing that opens your spirit to the pain of another as they perceive it" (Wilkerson, 2020,

p. 386). Sarah demonstrated the extent to which she holds or contains information until it is appropriate to reflect this information back to her client. The space holds understanding of the client's frame of reference, but it discerns and understands "what is mine and what is yours" so that the therapist does not become enmeshed with their client. Aponte and Ingram (2018) call the empathy-identification vs. empathy-differentiation the "right and left hands of the therapeutic handshake" (p. 44). In this way, one might think of empathy as on a continuum with identifying with the client on one end and differentiation on the other. It is important to note that empathy is not about sameness or enmeshment with the other. Stein argues that empathy is not about oneness but involves "an understanding of the difference between I and Other" (Meneses & Larkin, 2012, p. 164).

Empathy as a Revealing Space

Kate specifically shared what was revealed to her through her empathic experiences. This connects with Heidegger's notion of a clearing, which has to do with space "in which entities can 'be', a space or realm of illumination in whose light things can show or manifest themselves to people" (Schatzki, 1989, p. 80). Heidegger called this clearing space *lichtung*, which is also the German word for lightning. Lichtung implies that this space is an energising space where something revealed can be brought to life. This was true for Kate. Once she realised what she was experiencing empathically, she was open to explore this information in depth with her client. In the Christian literature, the revealing space is also known as the work of the Holy Spirit. The Holy Spirit guides, empowers, and equips us to serve (New Living Bible, 1996, Ephesians 5:18-21). Referred to as the counsellor, helper, and advocate the Holy Spirit does "immeasurably more than all we ask or imagine, according to his power that is at work within us" (New International Version Bible, 2011, Ephesians 3:20).

A Being-With Space

The empathic space is a being-with space; being with the Other. Empathy contributes to formation of the therapeutic relationship (Cornelius-White & Ciesieski, 2016)

and in the therapeutic encounter empathy allows the therapist to be present with the client's lived-experiences. Vanessa was a safe companion and witness for her client in her being-with. It is interesting to note that being-with is "central to Heidegger's notion of Dasein" (Crowther & Thomson, 2020, p. 6) and, according to Heidegger, being-in-the-world implies being with others because Dasein refers to people, not just one person. Vanessa experienced her client in her client's life-world. They journeyed together toward wholeness.

Finlay (2006) maintains that empathy is a fluid movement of merging then drawing back (2006, p. 8) – like a dance that moves back and forth. Anna described empathy as something like a continuum where she also finds different intensities of empathy and distancing in this dance-like quality. Her vivid description of 3D empathy was eidetic. It richly stood out as something easy to visualise and grasp. Empathic depth is a subjective term, and it can be found in the literature on relational depth and neuroscience. I was reminded of Cooper's experience of relational depth and how he described his attunement with his client: "like finally seeing the three-dimensional image on one of those Magic Eye stereograms" (Mearns & Cooper, 2018, p. 52).

Tension in the Space

Because empathy is a "holistic experience of the therapist" (Bozarth, 2001, p. 3900), the emotional, cognitive, bodied investment can be exhausting. In addition, this space also holds tension, which is tempered with courage. Tension in the empathy space has significant meaning in its connection to the overall phenomenon. Tension was felt by the participants when their clients did not understand or could not bear to have their illnesses be meaning-full. However, tension, while feeling uncomfortable at the time, is often worth the wait. For example, when tension is applied to olives, the resulting pressure produces a rich and flavourful oil that has many beneficial uses. The olives are first crushed into a fine paste and then wrapped into cheesecloth and placed over a bowl. A heavy weight is placed on top to further press the olives. This is a slow process because it takes time for the fruit to release its oil, which drips out a drop at a time.

The slowness of this process is like the therapeutic process with clients who are unable to connect meaning to their illness and are ignoring the body's expression of that meaningful story. It is within this space of tension that the therapist navigates through what is often unbearable for them and their client. This space of tension relates to the therapeutic relationship and providing an environment for people to grow (Rogers, 1980).

The human body is a source of learning and bodily experience. Svensen and Bergland's (2007) research on the development of empathy by learning through bodily experience found that the therapist's ability to reflect on and communicate their own bodied feelings increased their likelihood of understanding others. This finding showed that the more knowledge the therapist had about their bodied selves, the greater capacity they had to understand another person. This is reflected in the participants' experiences of empathic depth in their bodied encounters with clients.

A Word Before Entering Home. I am aware that meanings are multi-dimensional and multi-layered. People do not always connect the meaning of 'home' with safety, peace, acceptance, belonging, or wellbeing. For example, experiences of abuse in the home from people who are meant to protect us can leave us thinking that home is a place to avoid. Or someone's home may have been a place of chaos or where there was an absence of love. In this thesis, I am using 'home' as a metaphor for that felt space where we can freely be who we are "preserved from harm and danger" (Heidegger, 1971, p. 143) and dwelling in "the secure inner sanctity where we can feel protected" (van Manen, 1997). It is this sense of 'home' that is positioned in this chapter.

Theme Three: Home

Only three of my participants specifically mentioned the word *home* in their interviews, but I discovered that the meanings of home they expressed emerged in the other participants' stories as I reflected and interpreted on their stories. I was particularly struck by this idea of home because it connects with my own sense of belonging and my own sense of self. It is my tūrangawaewae, a firm foundational place of standing.

The participants felt at home in their bodies and invited and encouraged their clients to do likewise. This sometimes took time, and the work was often slow and gentle. The participants also felt at home with bodied empathy, even though this part of the work was sometimes difficult. Connecting their bodied responses with their client's feelings and perceptions was comfortable. Rogers (1975) described empathy as entering another's unique way of being in and viewing the world. He said for the therapist, "it means entering the private perceptual world of the other and becoming thoroughly *at home* in it. It involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person" (p. 4).

Several illustrations of home can be found in movies and literature. For example, in the film, The Wizard of Oz (Fleming, 1939), Dorothy was lost and afraid, wandering in the strange land of Oz. Most challenging for her was that she was disconnected from her family. Her persistent and on-going longing was to go back home. In the end it was the tapping of her ruby shoes and her repetitive melodious chants of "there's no place like home" that transported her back home to the farm in Kansas with the people she loved who so dearly loved her. In the Little House on the Prairie books by Laura Ingalls Wilder, Laura's family moved several times throughout her childhood. Throughout her young life she lived in cities, rural community towns, and on the prairie with no neighbours in sight. But Laura always knew that once the familiar treasures were unpacked and the beds were made, she was home (Bass, 2015). It is interesting to note that neither Dorothy nor Laura spoke of home as a building in a specific location. Home was a multifaceted, experiential, and meaningful place for them. Its meanings included fulfilment, peace, and acceptance, the environment, relationships, a sense of wellbeing, and much more. This is echoed by John O'Donohue (2003) who declares that home is more than a building; "it is the shelter around the intimacy of life [that] allows yourself to be who you are" (p. 195). This suggests that home also connects with safety, belonging and overall, something greater than the sum of its parts.

Feeling At Home

The participants mention that they felt comfortable or at home working with physicality, and bodied empathy. This latter point connects with Rogers (1986) definition of empathy as becoming thoroughly *at home* in the perceptual world of the other. Kate noticed that her body simply reacts, and that it feels natural. Later she replied, "but that's just me, that's who I am". Home is the place that allows you the freedom to be yourself (Heidegger, 1971, p. 143; O'Donohue, 2003, p. 196). Kate's statement connects with an idea that home is the place where we can be who we are. But there is more to home than this because there is a fullness and wholeness to home that pertains to something that feels right.

This idea of feeling "at home" with their own body struck me as significant because what the participants did next was to begin the process of inviting their clients out of their heads e.g., their thoughts, feelings, and meanings, and into their physicality. The participants held the space for mind and body to begin integrating, to come to completeness. It was an invitation to step out of a dualistic way of being and arriving home into the lived-space or place of experiential wholeness. Dasein is at home in the world as "the unified totality – of entities, tied together as a complex network of significant relationships" (Wrathall & Murphey, 2013, p. 8). Some clients heard and understood the calling to come home, while others had no idea, or could not bear the idea, of what this was and got lost.

Homelessness. As I was reflecting and re-writing on the idea of feeling at home, I thought about clients who felt disconnected and disjointed from their bodies and wondered if this embodied homelessness. This also includes the clients who are not aware of their bodies or ignore the significance of illness or what the illness might mean. Svenaeus (2011) reminds us that our home is our life-world and that illness creates an "unhomelike being-in-the-world of Dasein" (p. 336). He goes on to say that "this way of being in the world of illness is best understood as a form of homelessness" (Svenaeus, 2001, pp. 89-90). van Manen (1997) has insightfully noted that "we feel a special sorrow for the homeless because we sense that there is a deeper tragedy involved than merely not having a roof over one's

head" (p. 102). This suggests that the search for home in talking therapy is not so much the practical quest for a cure or to be fixed, but the pursuit of something more meaningful.

Home As a Place of Safety and Rest

Central to the idea of home was the sense of safety and rest. All participants spoke to the importance of safety as many of their clients were initially reluctant to expose their vulnerability without it. Sarah described her client's reluctance to experience the emotional distress in her body until she felt safe enough to do so. Lawson-McConnell (2020) posits that "when emotional safety is present, it can lead to profound healing and growth" (p. 306). She argues that all physical and psychological growth comes from rest. In defining psychological rest, she points to Cozolino's phrase of the "quiet internal milieu" or the quieting of the worrying voice. In Christian tradition, it is a "coming to a place of deep peace, or surrender" (Lawson-McConnell, 2020, p. 311). Once Sarah's client felt safe, she was better able to risk being vulnerable and transparent. She noted that it takes courage to be vulnerable and be seen.

Home As Sacred Ground

The participants' experiences of sacredness were present with empathic and relational depth, and they emerged from working with physicality. Kate said that the feeling of hope filled the therapeutic space as the connection between herself and her client deepened. For Michelle, there was a feeling of shared humanity and reciprocity. The therapeutic space became dialogical in that Michelle and her client met each other, evident by their I-Thou relational encounter.

For Christians, home is sacred ground. It is the place that God created for humanity (*New Living Bible*, 1996, Genesis 1-2). It was their fall into sin that displaced humanity from that original garden home. Home in the present can be understood as the "here, but not yet". Everyday life is impacted by the corruption of God's original intent and design, but Christians understand that there is a better, eternal home yet to come. The last book of the Bible promises an eternal home with God where there is "no more death or sorrow or crying

or pain" (*New Living Bible*, 1996, Revelation 21:4a). Present in the first and last biblical chapters is the idea of *shalom*. The term shalom has come to mean peace, or the absence of conflict, but the concept of shalom goes much deeper. Plantinga (1995) speaks of shalom as "universal flourishing, wholeness, and delight . . . the webbing together of God, humans, and all creation in justice, fulfilment, and delight" (p. 9). I am struck by Plantinga's use of the words "webbing together." For me, this creates a weaving of threads to create a tapestry in which each unique separate, and individual threads are woven together into a flourishing, unitary, yet multidimensional fabric of wholeness. This fabric coherently knits together the ideas of non-dualistic personhood and deep relational engagement. Plantinga goes on further to say that with shalom, God "opens doors and welcomes the creatures in whom he delights" (p. 9). Here we can see that shalom is also a welcoming place. Perfect shalom is found in the original and the eternal homes of human existence. In other words, shalom is the way things were meant to be.

In this welcoming home space, guests are met with hospitality – manaakitanga. It is more than offering a cup of tea. It is an offering of oneself in deep relational engagement as whole persons. I believe it is into this welcoming place of home that clients are invited to dwell. Levinas (1969) declares that "to dwell is not the simple fact of the anonymous reality of being cast into existence . . . it is a coming to oneself, a retreat home with oneself as in the land of refuge, which answers to a hospitality, an expectancy, a human welcome" (p. 154).

Reflection

The therapeutic space is reflected in the idea of home. When the conditions are right, growth happens (Rogers, 1980). It is like a calling to come back home, to a lived space, the place one returns to after being away. We go there for rest. It is a place of belonging that has the things that represent who we are and where we are free to be "us". For those who are feeling disconnected, or homeless, or out on the edge, home is the welcoming place that beckons us back into existence into the company of others. "Welcome home, we've been

waiting for you . . . we've made space for you and welcome you from the bottom of our hearts": *Welcome Home*, a song by Dave Dobbyn (2005), reflects this idea of home and it invites us into the welcoming place.

"Welcome Home" by Dave Dobbyn

Tonight, I am feeling for you
Under the state of a strange land
You have sacrificed much to be here
There for the grace, as I offer my hand
So welcome home
I bid you welcome
I bid you welcome
Welcome home
From the bottom of my heart
Out here on the edge
The empire is fading by day
And the world is so weary in war
Maybe we'll find that new way
So welcome home
See I made a space for you now
Welcome home
From the bottom of our hearts
Welcome home
From the bottom of our hearts
Keep it coming now, keep it coming now
You'll find most of us here
With our hearts wide open
Keep it coming now, keep it coming now
Keep it coming now, keep it coming now
There's a woman with her hands trembling
Haere mai
And she sings with a mountain's memory
Haere mai
There's a cloud the full length of these isles
Just playing chase with the sun
And it's black and it's white and it's wild
And all the colours are one
So welcome home
I bid you welcome
We bid you welcome
Welcome home
From the bottom of our hearts
Welcome home
See I made a space for you now
Welcome home
From the bottom of our hearts

The Cross-Findings

Woven throughout the three themes of attending to the body, empathy as space, and home are two significant connecting strands, or cross-findings, that emerged in each of the

themes. These cross-findings have been mentioned throughout this chapter. When these cross-findings are woven within and throughout the themes, a tapestry, upon which the phenomenon rests, appears. I will first discuss the cross-findings, namely the therapeutic relationship and courage.

Therapeutic Relationship

The therapeutic relationship is visible throughout the themes of attending to the body, empathy as space, and home. It is within the context of the therapeutic relationship where the participants noted the environment for healthy relationship was built. The participants noted the gentleness in the work and the importance of safety and trust before clients could make meaningful connections with their bodied responses. The pace became slow when vulnerability needed time before taking its first steps. All of this was made possible through the therapeutic relationship. Even neuroscience understands that the essence of the human body is relationship. Neuroscience holds that "the body itself is a relational world of sophisticated neural networks which enable our complex social relationships to thrive" (Siegel, 2020, p. 370). This is because we were designed for, and to be in, relationship and connection. This goes back to a whole person definition of personhood and what it means to be human.

From the lived experiences of the participants in this study, we have seen that the body is an active participant on the journey toward empathic depth in talking therapy. As seen from previous research, the more knowledge the therapist has about their bodied selves, the greater capacity they have to understand another person (Svensen & Bergland, 2007). Research also shows that high levels of empathy are experienced at times of relational depth (Mearns & Cooper, 2018), although this might be a confusion of causality as it has been suggested that high levels of empathy create relational depth. Or perhaps the two happen in tandem. However, facilitating and maintaining relational depth in the therapeutic relationship involves courage for both therapist and client.

Courage

To engage in a new way of working in clinical practice and delve deeper in bodied empathic understanding took courage for the participants. This involved letting go of expectations or therapeutic plans in clinical practice (Mearns & Cooper, 2005, 2018). Sarah talked about courage in her work:

> My body feels my client's stuff and then I can sometimes end up feeling just as stuck and then I realize that I have to have a bit more courage because this work, it's a lot about courage. In one session, my client was having this experience of 'my illness is meaningful, and it means that something has to change'. She had to give something up like taking time off work or giving up the idea that she's invincible and to accept her humanity', which is an incredible feeling of loss of that ideal self. "So, it takes courage to be the client and it takes courage to be the therapist. And I have to lead the way". (Sarah)

The word "courage" stood out for me as I listened to Sarah tell me of her experiences of bodied empathy in her work. When she said the word 'courage' during the interview, it was a moment where the word itself became like a lighted match in a dark room, offering a momentary flicker of something that caught my attention, and provided temporary light into an otherwise darkened space. The light began to fade once the conversation turned to her own experiences of empathy, and completely disappeared at some unknown point during the interview. The flame was re-lit for me when I typed the transcript and felt the heat of its flame again. I felt a strong urge to explore this word, 'courage' because Sarah felt courage conveys an idea about the work between therapist and client, especially in the therapist's pursuit of the gateway to empathic depth. This was echoed by Anna:

> I've always had a felt-sense within my body but unsure of how to use that in talking therapy. I didn't know how to integrate the body with my therapeutic work. I guess I was so eager and trying really hard to make it happen. One day, a wise person in my life asked if I could muster up the courage to slow down and . . . just let it happen … just let it emerge. So that's what I did! I stopped trying to make it happen and I let it slowly happen on its own. I started by spending time with my own body and becoming more attentive to that through meditation. Now the physicality and the felt-sense seem to be in the same space." (Anna)

Courage is one of those complex words that is difficult to define because it, too, is multidimensional. Many dictionaries and inspirational quotes try to describe what courage is or what it means to have courage, but these explicit definitions do not adequately capture the common threads of courage from an experiential level. A study on implicit theories of courage described courage as:

> (a) a willful, intentional act, (b) executed after mindful deliberation, (c) involving objective substantial risk to the actor, (d) primarily motivated to bring about a noble good or worthy end, (e) despite, perhaps, the presence of the emotion of fear (Rate et al., 2007, p. 95).

Courage, then, is not just something we have or do not have but something we intentionally act out of, despite any risk.

Rogers (1980) said that "empathy is something offered by the therapist and not simply elicited by some particular type of client" (p. 147). Offering implies purpose or intention -much like the above definition of courage. It appears that empathy and courage may have a close relationship, especially in the context of working with bodied responses to illness. For the participants, the two went hand-in-hand for both the client and the therapist when inviting the body to have a voice in talking therapy.

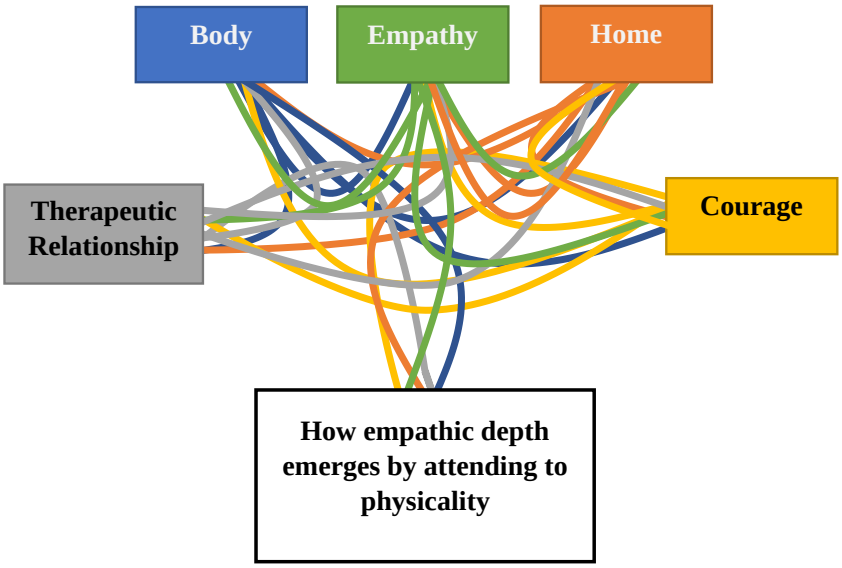
For the client, the bodied illness they bring into the counselling encounter has the potential to voice something meaning-full, or full of meaning. It is the brave therapist who is open to listening to this voice and understanding that oftentimes “it is only with the heart that one can see rightly; what is essential is invisible to the eye” (de Saint-Exupery, 1971, p. 73).

Weaving the Threads

I now present a design for understanding how empathic depth emerges by attending to physicality in talking therapy. The themes in this study interweave with each other and tell a story of the phenomenon separately and together. This is the lived story of how empathic depth emerges by attending to physicality in talking therapy. The story is further voiced and supported by both cross-findings of courage and the therapeutic relationship. I begin the process by weaving the themes together while interweaving these with the cross-findings. This activity is not linear, as it goes back and forth to weave and interconnect the many strands that show the lived story of the phenomenon as illustrated in Figure 1.

Figure 1

Weaving the Threads



As shown in this study, a key element of talking therapy is attending to the body. When considering what it means to be human from a whole person perspective in talking therapy, the body is an important aspect because wholeness would not be complete without it. Western dualistic models of healthcare characterise and separate healthcare by its fundamental aspects. As a result, we find talking therapy prioritising subjectivity, which means that physicality steps into the shadow of being-in-the-world. But illness is "both a disturbance of the physical and an expression of 'experience'" (Broom, 2007, p. 157). This means that physical illness often has an important story to tell. Unless the validity and the voice of physicality, specifically illness, is acknowledged in talking therapy, the expression of the experience of illness can get overlooked leaving ongoing adverse effects on client health. For the participants in this study, their therapeutic practices included more than discussions about experiential thoughts and emotions. By normalising physicality in their conversations at the beginning of therapy, the participants began the practice of bodied awareness with their clients. This was intentional in their therapeutic sessions as a way of bringing the physical aspect of personhood into the counselling encounter.

While working with bodied awareness, the participants noted how important the therapeutic relationship was for creating an environment of safety and trust where the person-centred core conditions of empathy, unconditional positive regard, and congruence could take root and grow. The quality of the therapeutic relationship provided the often-needed time and space for clients to connect with their own physicality or illness. It also took time for clients to process and to allow new patterns of thinking or relating to emerge. The therapeutic relationship connected with the theme of attending to the body as an integral and necessary factor in helping the client find feel safe, find psychological rest, and for the therapist to legitimise physicality's place in talking therapy. Once the body had a legitimate place to dwell in the therapeutic encounter, the participants' clients were then able to attend to their meaning of illness.

One participant noted how it takes bravery to learn new things – for both therapist and client. She noted how courageous it was for her clients to become aware of and connect

with their bodies because these connections were either unfamiliar or painful to make. Another participant noted that it is the therapist who courageously leads the way. For the participants, shifting their practice to a non-dualistic, whole person approach meant that all aspects of personhood could be tentatively held as fundamental. This was a big shift that redefined their meaning personhood and it invited them to attend to the whole of a person in talking therapy. Expanding the boundaries of their reductionist dualistic way of knowing and practice to embrace a non-dualistic, multi-faceted approach that made room for physicality in talking therapy was a courageous step for the participants.

The themes of attending to the body and home joined in an intricate dance with one another. We can see this dance reflected in Svenaeus's (2011) discussion on illness in relation to the being-in-the-world of Dasein. He says, "the life-world is usually our home territory, but in illness this homelike being-in- [the world] gives in and takes on an un-homelike character" (p. 336). This implies that our home territory, the place where we flourish in wellness, is how we were meant to be in the world, and this reflects shalom. The wholistic nature of illness can impact many dimensions of personhood and can separate us from the wholeness of our personhood. It can leave us feeling estranged from ourselves and our being-in-the-world. I feel a sense of sadness about the un-homelike character of illness because it takes away the fullness of our wholeness and how we know ourselves in the world. In its capacity to express itself through physicality, illness longs to be heard and understood because its experience can be meaningful. This story is seldom heard in the dualistic Western model of medical practice, so the meaning of illness goes unheard. The search for home is also a meaningful pursuit where shalom welcomes us in the fullness of our humanity.

Research shows that at times of relational depth, there is a greater experience of empathy, or empathic depth (Mearns & Cooper, 2018). Relational depth is what Rogers termed as presence (Mearns & Cooper, 2018; Raskin, 2001; Rogers, 1975). Presence is "bringing one's whole self into the encounter with a client" (Geller, 2013, p. 209). Presence is meeting another. Home seems to be the place where one is met. The Bible tells us when

the prodigal son returned home, he was met lovingly by his father and welcomed back. When Dorothy returned home to Kansas, she was reunited with the people she loved after being lost in Oz and she was met in love. In talking therapy, deep relational encounter within the therapeutic relationship is also known as being met. The therapeutic relationship is where love and presence meet in authentic existence in an I/Thou encounter.

Home and empathic depth connected within the therapeutic relationship once the participants were located on sacred ground. This is a dialogical space where the impact of I/Thou is deep relational connection. The sacred ground is a welcoming space for the wholeness of personhood. The participants connected with their bodies and understood their clients from this bodied space. The whole of personhood is realised when we enter into relationships with other 'wholes' and something electrifying happens in the space of *lichtung*. Rogers (1986) called empathy a healing agent. He said of empathy, "it is one of the most potent aspects of therapy, because it releases, it confirms, it brings even the most frightened client into the human race . . . if a person is understood, he or she belongs" (p. 376). Belonging connects with the theme of home. The participants felt at home in their bodies and working with physicality in talking therapy was comfortable and a home-like place for them.

Empathy, like personhood, is multi-dimensional. It is a bodied subjective space that is felt affectively, cognitively, and bodily. The participants noted the importance of the therapeutic relationship as a safe place for the client to experience trust. An associated theme of empathy was a being-with space. The therapeutic relationship provided the space where being-with was bodily and empathically experienced. The participants' bodied empathy held understanding and as their clients began to connect with their own physicality, the participants noted a deeper empathy and connection with their clients.

Courage intertwined with the theme of empathy as space. Courage is an intentional act that often involves risk. This connects with empathic understanding experienced by the therapist. For example, in a being-with space, where understanding is revealed but the client

is not yet ready to hear, courage gave the participants patience. As one participant mentioned, their work is a lot about courage.

The metaphor of 3-D was used to describe empathic depth by one of the participants. Empathic depth is something strongly felt, as if it were being brought to life. The space between empathy and empathic depth is murky. The definitions for both are ambiguous and inconsistent. With little to no published research on empathic depth, this posed a challenge for me in this study. However, when I asked the participants about empathic depth, they had a knowing of what it was I meant. This in-between space between empathy and empathic depth is a liminal one. It is an entrance or threshold to the lived-experience of the phenomenon of how empathic depth emerges by attending to physicality. My research question suggests that somewhere in this space a gateway exists. For the longest time I wondered what it was I was looking for in relation to the gateway. Was it a lost key to unlock the gate? Was it the hinges on the gate that prevented the gate from opening? Or was it the gate itself and it simply needed the traveller to find the road that led to this gate. I decided on the latter because by attending to physicality, illness and its story in talking therapy, this particular gate has always been there, but seldom travelled to. Western dualistic models of counselling have hidden both the road and the gate from view. But the participants in this study found the right road and cleared a path for themselves. What I found on this journey is the road to the gate of empathic depth, and it has actually been there all along.

Empathic depth is connected with the theme of attending to the body. The body is a source of learning and a place of bodily experience. Research shows that the therapist's ability to "reflect on and communicate their own bodied feelings increases the likelihood of understanding others" (Svensen & Bergland, 2007, p. 46) which means that the capacity to understand another person increases when the therapist has an intimate knowledge about their bodied self. This was demonstrated by the participants in their own experiences of bodied awareness during the therapeutic encounter. In conjunction with this, the participants confirmed that when giving equal attention to both their own body and their client's bodies

in talking therapy this then resulted in a greater understanding and empathic knowing of their clients. When we communicate that we understand another, it brings us into closer relational connection with each other.

CHAPTER 6:

Conclusions

Through the themes in this study and the interweaving of the cross-findings of courage and the therapeutic relationship, we find ourselves on a road that leads us home. There is more than one road that leads to empathic depth. However, the road the participants in this study chose is a road less traveled by in their respective fields. Armed with courage, honouring the fullness of personhood, inviting physicality, experiencing empathic depth, and with the gentle invitation into relational depth, this is a road that leads to a home situated on a broader horizon. It reflects shalom, the way things were meant to be in our being-in and being-with the world of Dasein. This is meaningfully echoed in the last four lines of Robert Frost's poem, The Road Not Taken:

> I shall be telling this with a sigh
> Somewhere ages and ages hence:
> Two roads diverged in a wood, and I—
> I took the one less traveled by,
> And that has made all the difference

This road, with the whole of personhood as its travelling companion, leads to empathic depth. I hope this road less traveled by will be the one many talking therapists will one day choose to take, and counselling educators choose to teach. In the meantime, for me and the participants in this study, the road less traveled by has been an integrative and transformative process that understands and honours personhood as a multidimensional unity, dares to attend to physicality in talking therapy, and is immersed in meaningful moments of deep relational encounter by attending to physicality, which leads to empathic depth. This road has made all the difference in our lived experiences of professional practice.

Summary of Strengths and Limitations

Heidegger did not follow the epistemological tradition of searching for solid foundations of knowledge. He argued that "we should not begin with a study of knowledge as an abstract, disembodied phenomenon, but with an inquiry into the living, acting, and knowing human being" (Kvale & Brinkmann, 2015, p. 56). One of the strengths of this study

is seeing the living, acting, and knowing human being as a whole being: a multidimensional, unitary whole. As a result, this thesis contributes to the small but growing literature on whole person and a whole person approach to healthcare. Another strength of this study has been showing the dualistic nature of contemporary counselling practices. This was a surprise to me in my training as I had integrated psychology with theology and considered myself an integrated counsellor. Shifting my clinical gaze to consider personhood from a wholistic perspective took practice and courage to take brave steps to invite physicality into the clinical encounter. Finding another road to empathic depth has been another strength of this study. This research highlights the lack of literature on empathic depth, but it also contributes to the small yet emergent literature on the topic.

One of the limits of this study is its focus on therapists only. A client perspective on the lived experience of having their physicality attended to in talking therapy, and on their own experiences of empathic depth during the therapeutic encounter, would add richness and depth to the findings of this study and possibly uncover additional findings. Another limit of this study is that it did not delve into the implications of empathic depth, e.g., empathy fatigue, self-care, and the impact of culture on empathy.

Recommendations

In the process of writing this thesis, several issues arose, and these have implications for practice, research, and training. Some of these factors include gaps in literature. For example, I discovered a few areas that need more research. There are also areas for further exploration and development. These will provide professional development opportunities for practicing counsellors, new material for researchers to study, and new training material for counsellors-in-training and their trainers.

Practice

Research addresses and serves not only everyday life, but professional practice. This is a phenomenology of practice, which refers to "research and writing that reflects *on* and *in* practice, and prepares for practice" (van Manen, 2014, p. 15). It also serves to strengthen our

everyday practice as practitioners. This study contributes to an emerging area of practice. As a result of this study, there are many implications for talking therapists and their healthcare practice.

The first implication is the clinical application of a non-dualistic ontology and epistemology of whole persons. The participants in this study know the world differently because they understand a non-dualistic approach to personhood and have a practical understanding of wholistic healthcare. For example, Western models of talking therapy are reductionistic and narrow focused. Modern and current ways of practice fragment personhood and whole person. These models do not adequately serve clients as whole persons seeking healing. Yet, as counsellors, we meet with whole people in our clinical encounters and engage in conversations of meaning. Notwithstanding the bias I hold because of this study, I point to the healthcare system in New Zealand as a broken one– especially for Māori. Non-dualistic approaches that validate the wholistic, multi-dimensional nature of personhood and whole person, would offer Māori populations and the New Zealand healthcare system a more wholistic and effective response to illness. A non-dualistic approach also seems to offer healthcare opportunities for other populations and cultural ways of understanding health that are not currently given space in terms of the present healthcare system.

van Manen claims that what distinguishes theory from practice is the different way in which one knows the world: “Theory thinks the world, practice “grasps” the world – it grasps the world empathically” (van Manen, 2008, p. 19). Through their practice the participants grasped the world empathically in their new thinking, and they became immersed in their understanding and making sense of what whole person means in talking therapy and healthcare. The clinical application of counselling from a whole person perspective includes professional development in whole person healthcare before undertaking practice within a new paradigm. Professional development for counsellors that highlight a non-dualistic philosophy of practice would help develop and grow counselling practitioners in non-dualist practice.

Empathy contributes to formation of the therapeutic relationship and in the therapeutic encounter empathy allows the therapist to be present with the client's lived-experiences. Studies have shown that empathic depth is related to relational depth within the therapeutic relationship, but this study has shown that there is another road to empathic depth, and it is related to awareness of physicality. Empathic depth by attending to the body, specifically by the therapist attending to and understanding their own body and bodied responses, is significant for practitioners. Ongoing professional development opportunities for counsellors on empathic depth, bodied awareness, and bodied empathy would greatly enhance therapists' understanding of their client's life-world.

Research

This thesis is knocking on the door of research to engage in more studies on empathic depth. Empathy is multi-dimensional and multi-layered, and it has several definitions depending on its use. Empathic depth is something the participants recognised in this study, but it is a term known by other names in research. This invites an exploration of definitive descriptions of empathic depth. In addition, the area between empathy and empathic depth is unclear, which makes empathic depth difficult to identify. To help clarify and understand the significance of empathic depth in healthcare, this invites research on a theory of empathic depth.

Research in neuroscience shows the connection between mirror neurons firing in the brain and empathy, and research on relational depth show that as the therapeutic relationship deepens, so does empathy. While acknowledging the valuable contributions these studies have made on empathy and empathic depth, this study argues that empathy and empathic depth are bodily experienced. The literature in neuroscience and the therapeutic relationship misses this aspect of empathy and empathic depth. Because empathic depth is not often conceptualised as a bodied process, this study calls for more research on empathic depth and its connection with physicality.

More research on integrative therapeutic practices that use a non-dualistic view of personhood in the field of talking therapy would add to the scarce, but emergent, literature. Western dualistic approaches for taking therapy prioritise either the mind or the body in their whole person offering. Therefore, more studies on the whole person as a multi-dimensional, integrative whole would help talking therapists understand the complexity of wholeness and how this understanding of whole person impacts their engagement with clients in professional counselling practice.

Training

An implication of this research for training is for counselling educators to re-examine the philosophical foundations of current counselling models of practice taught in their curriculum. The models and methods used for training are largely dualistic in nature and give minor attention to physicality. A non-dualistic whole person approach includes the whole person – not just the mind, which is an often-prioritised aspect of Western psychotherapeutic modalities of practice. Overall, the pedagogy could be revisited to introduce or critically engage with the concept of whole person in undergraduate and postgraduate programmes. Teaching integrative theories and practices that are more closely aligned with the wholistic nature of personhood would produce counsellors who are equipped and able to better-serve their clients who, as whole persons, seek healing. This study has shown that physicality has a place in talking therapy. Teaching students to understand that the body has wisdom and has the capacity to express subjective experience would equip students to engage with the body in talking therapy.

As seen in this study, attending to physicality has helpful and valuable consequences on empathy. Teaching a theory of empathic depth in undergraduate and postgraduate programmes would help counsellors-in-training learn the power of empathic depth in its relation to healing. Providing students training opportunities to understand and develop bodied empathy would empower students to recognise and use their bodied experiences as a way of knowing. There are already body-oriented practices that are taught in counsellor

education such as mindfulness (de Bruin, 2021), focusing (Sanders, 2012), and/or grounding (Bayne and Thompson, 2018). However, these are not usually seen as a gateway to empathic depth. Teaching with the intention of connecting these body-oriented practices with empathic depth would provide a pathway to, and offer students, an innovative, practical, and transformative learning experience of empathic depth.

My Personal Reflection

Meeting and dwelling with my participants' experiences through the process of reflecting and writing has touched me deeply and I am changed as a result. It already has a positive effect on my counselling and teaching. This, perhaps, reflects van Manen's phrase of phenomenology of practice. As a counsellor and a lecturer, I am interested in more than just learning theory. Therefore, my response to this study is to put it into action and become the "hands and feet" of this research. I plan to write so I can share my findings and locate space within the curriculum to teach the meaning of whole person and the implication of physicality on empathic depth.

When I started this study, I had a hunch where it would take me, but it ended up leading down a different road. My initial focus was on the client's physicality and the therapist's empathic depth. But one of my greatest learnings happened while analysing the participants' stories. As I began to bodily experience the lived experiences of their interpreted stories, my gaze suddenly shifted to my own body, and I discovered a greater capacity for bodied empathy. I did not expect that to be an outcome of this study. My participants taught me something that for them is their everyday taken-for-granted assumption. Their lived experiences have been a gift to me.

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Appendix A

Ethics Approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

29 August 2019
Margot Solomon
Faculty of Health and Environmental Sciences

Dear Margot

Re Ethics Application: **19/259 How does attending to the client's bodied experience of their illness in talking therapy open a gateway to empathic depth in the therapeutic relationship: a hermeneutic phenomenological study**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 27 August 2022.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee
Cc: jhepburn@laidlaw.ac.nz; Brian Rodgers

Appendix B

Advertisement

Searching for Volunteers to Participate in a Masters Research Project

- Are you a psychotherapist or a counsellor and a member of a professional organisation that maintains a Code of Ethics?
- Do you practice using a MindBody whole-person healthcare approach?

If you have answered yes to both, I invite you to participate in my research project.

What we will explore:

How does attending to the client's bodied experience of their illness in talking therapy open a gateway to empathic depth: A hermeneutic phenomenological study.

This is an online interview. If you are interested in more information about this research project, please contact Jane Hepburn at jhepburn@laidlaw.ac.nz

This Master's Research is being conducted by
Jane Hepburn
through Auckland University of Technology (AUT)
Primary supervisor is Francie van Hout
Secondary supervisor is Dr. Brian Rodgers

Appendix C

Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

Date: 8 August 2020

Project Title

How does attending to the client's bodied experience of their illness in talking therapy open a gateway to empathic depth: A hermeneutic phenomenological study.

An Invitation

Thank you for considering an invitation to participate in my Master's study at Auckland University of Technology (AUT). This study emerges out of my private counselling practice and a curiosity about the place of the body, specifically disease and illness, in talking therapy. I began my MindBody journey at AUT in 2012 and graduated with a PG Dip HSc (MindBody Healthcare). This year I decided to take the plunge and complete the Master of Health Science (MindBody Healthcare) by sitting with professional people like yourself who can generate stories of experience that I can then craft into smaller narratives to create data.

My plan is to interview talking therapists so that I may gain an understanding of empathic depth when using a whole-person approach to therapy. The online interview will take approximately 60 minutes. I am using the methodology of hermeneutic phenomenology, which means I'll be asking you open-ended questions about your experiences. After the online interview is over, our conversation will be transcribed and mailed or emailed to you to read over for accuracy.

Your participation is voluntary, and you will be neither advantaged nor disadvantaged if you choose to participate or not.

What is the purpose of this research?

This research is in partial fulfilment of my Master of Health Science (MindBody Healthcare) at AUT. The purpose of this study is to gain an understanding of talking therapists' experiences attending to physicality in the context of talking therapy, and to understand and interpret the meaning of this in light of the therapeutic relationship. Another purpose of this research is to add to the small but growing body of literature that is emerging in MindBody whole-person healthcare. It is likely that this research process and its findings will be presented to the MindBody community after its completion. The findings from this research may be used in subsequent presentations and academic or other publications

How was I identified and why am I being invited to participate in this research?

Five talking-therapists are being sought to participate in this study. You were identified as a potential participant because of your interest in practicing in a MindBody whole-person way, as indicated by your interest in the MindBody Trust Community.

Please Note: Participants must be a member of a professional organisation with a code of ethics designed as a set of principles and guidelines for best practice and ethical values and draws upon the laws of New Zealand and the Treaty of Waitangi.

How do I agree to participate in this research?

If you would like to participate in this research, please contact me via email or phone. I will be very happy to answer any questions you may have. I will then send you a Consent Form, which you will need to sign and return to me.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

You will be involved in an online interview, which will take approximately 60 minutes at a date and time that is convenient for you. This interview will take place using an online video conferencing application called Zoom. I will send you an invitation with an agreed upon date and time. This invitation will contain a link and a password, which will connect us for our interview I will ask you about your experiences of empathic depth while attending to your client's physicality, specifically disease or illness, while using a whole-person approach to therapy. During the interview process you may stop at any time and you do not have to answer all of the questions if you choose not to. You do not need to provide a reason for stopping the interview or choosing not to answer a question(s).

I will record the interview and I may take notes. The Zoom video and audio recordings will be downloaded to the local drive on my laptop. I will remove the video file and keep only the audio recording. I will then have the recording transcribed by a professional transcriptionist, who will be required to sign a confidentiality form. Please note that all identifying information about you and/or your client/patient will be anonymised. The transcript will be returned to you to check for accuracy.

Once you have checked the transcript, I will begin the hermeneutic phenomenological process of data reflection, writing, and re-writing.

The data collected from your interview will be used for the purposes of this research and the findings from this research may be used in subsequent presentations and academic or other publications. The data will be stored on the AUT secured password-protected online electronic storage system. Both of my supervisors and I will have access to this data during the collection and analysis stages. After completion of my thesis, the data will be moved to my primary supervisor's AUT secured password-protected online electronic storage system. The data will be kept for a minimum of six years, after which time it will be destroyed. The recording of the interview will be deleted at that same time.

What are the discomforts and risks?

There is a very small number of talking therapists in New Zealand who practice in a MindBody whole-person way. This could increase your risk of being identified. Also, you might be at risk of accidently disclosing client names to the researcher thus breaking client confidentiality while discussing your experiences. You might also disclose other information about your client that could potentially identify you or your client, or feel under pressure not to reveal identifying information, which might disrupt the flow of your interview.

How will these discomforts and risks be alleviated?

I will anonymise information about you in this study so that your identity will not be disclosed. Before the interview, I will remind you not to reveal identifying information about your clients. If you need to

take your time during the interview to avoid disclosing confidential information, I will work with you to ensure you remain comfortable and supported. Any identifying information disclosed about your clients during the interview will be anonymised on the transcript, which will be sent to you to check for accuracy. For example, if client names are revealed during the interview, they will be changed to pseudonyms during the transcription.

Because the nature of your work means you have access to supervision, it is anticipated that you will probably discuss any discomforts or distress with your supervisor.

What are the benefits?

A potential benefit to you is that this process will allow you space to reflect on your own practice in relation to whole-person therapy and how this complements your theoretical and practical understandings of therapeutic practice. The understandings and meanings that emerge from this research will support the wider body of literature around MindBody whole-person healthcare and professional practice experience and inform the development of counsellor education programmes. One of the benefits to me is the completion of my Master's Degree!

How will my privacy be protected?

I will do my utmost to protect your privacy at all stages of the research! Only the Zoom audio recording will be kept; the video will be deleted to help protect your privacy. Any material that could personally identify you in the findings will be anonymised. I will not disclose information about you to any other participants; only my two supervisors and I will know of your involvement in this research. Your transcript will be identified by a unique number and will be stored on my AUT secured password-protected online electronic storage system, along with a list of participant names and contact information. Consent forms will be scanned and stored separately in the secondary supervisor's AUT's secured password-protected online electronic storage system. The recording of the interview and other data will be destroyed after six years.

I will respect your therapist/client relationship and also do my utmost to anonymise your client information. Because the experiences you will be discussing in the interview involve your experiences with your clients, I will anonymise identifying information about them.

What are the costs of participating in this research?

The cost to you is your time, which includes a 60-minute interview, plus additional time to review your transcript. After the interview, the audio recording will be transcribed and edited, if necessary, to anonymise client information, and sent back to you to check for accuracy.

What opportunity do I have to consider this invitation?

Thank you for taking the time to read this information sheet. I hope to hear back from you right away, I would like to offer you 30 days to consider this invitation.

Your participation in this research is strictly voluntary and I am happy to answer any questions you have before you make your decision, so please contact me! Please remember that if you decide to participate in this study and later change your mind, you are free to do so without any adverse consequences of any kind.

Will I receive feedback on the results of this research?

You might be curious about the findings of this research. I will be very happy to send you a summary of the research findings if you wish. There will be a place on the Consent Form where you can indicate this.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Primary Supervisor, *Francie van Hout, at francie.vanhout@aut.ac.nz*.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Jane Hepburn
Phone: 021 722 672
Email: jhepburn@laidlaw.ac.nz

Project Supervisor (Primary) Contact Details:

Francie van Hout
Phone: 09 921-9999, ext 7191
Email: francie.vanhout@aut.ac.nz

Project Supervisor (Secondary) Contact Details:

Dr., Brian Rodgers
Phone: 09 921-9999, ext 7012
Email: brian.rodgers@auckland.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 29 August 2019 AUTEC Reference number *19/259*.

Appendix D

Consent Form

Consent Form

Project title: ***How does attending to the client's bodied experience of their illness in talking therapy open a gateway to empathic depth: A hermeneutic phenomenological study***

Project Supervisor: ***Francie van Hout and Dr. Brian Rodgers***

Researcher: ***Jane Hepburn***

- ○ I am a member of a professional organisation that maintains a code of ethics.
- ○ I have read and understood the information provided about this research project in the Information Sheet dated 8 August 2020.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that I will take part in an online interview that will be recorded and transcribed, and notes will be taken during the interviews.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: ……

Participant's name: ……

Participant's Contact Details (if appropriate):

……
……
……

Date: ……..

***Approved by the Auckland University of Technology Ethics Committee on* 29 August 2019 *AUTEC Reference number 19/259*.**

Note: Please sign and date this form and either scan or photograph it and return to me. The Participant should retain a copy of this form.