MALE PARTICIPANTS' EXPERIENCES OF RECEIVING CONTACT DURING GROUP-BASED PSYCHOTHERAPY INTERVENTIONS: A MULTIPLE CASE STUDY

by

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Abstract

This research study examined male participant's experiences of receiving contact during group-based psychotherapy interventions. According to the literature, there is no empirical information on the effects of receiving contact, specifically with male therapy groups, and inclusion of receiving contact as an intervention variable for trauma processing. A qualitative multiple case study research design was used, and included analysis to identify contact experiences, and frequencies of common contact codes from the participants. The overall outcomes of this study revealed that receiving contact during trauma processing has significantly positive reparative effects in affect regulation while engaged in heightened past trauma event arousal states, and simultaneous activation of adaptive cognitive, affect and sensorimotor responses, and positive integration and awareness of the self. Additionally, contact experiences suggest it has a direct positive influence on diffusing socially constructed maladaptive male gender roles, and influencing men's relational awareness of adaptive and authentic attachment bond experiencing.

Preface

The work conducted in this thesis is in compliance with the University of British Columbia's Research Ethics Board's standards for ethical research.

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To My Grandfather,

Mr. John Andrew Jones (1919-2009)

Chapter 1: Introduction

There is extensive empirical research focused on receiving touch amongst humans that demonstrates forms of physical contact (hereafter referred to as "touch" or "contact"), with one another are vital for our survival. Many of these studies discuss giving or receiving of contact is integral in the development of relationships. Specifically, contact at neurological and physiological levels facilitates an experiential sensory process responsible for activating inter and intra-relational attachment processes, which is essential to the integration of one's relationship with self and the environment, and establishment and improvement of primary attachment and social bonds with others. Given the overarching influence of contact for humans, it is remarkable that limited research exists focused on the application of contact in group-based counselling psychotherapy settings.

The existing literature has focused on the ethics of contact and predominantly discusses the controversial tensions that argue against its use, such as: (a) inadequate formalized training on the uses of contact-based interventions may risk exploitative and abusive interactions with the participant; (b) many reviews express concerns that using non-erotic contact may cross professional therapist / client boundaries and affect therapeutic alliance and attachment processes; and (c) discrepancy in determining effective and measurable application of contact integrated into traditional psychotherapeutic interventions. These issues concerning contact largely contribute to the discrepancy between its empirically known benefits, and are limited due to its nonexistent presence in the counselling psychology community. While there are emerging research studies on contact in individual counselling psychotherapy environments that demonstrate favourable process of change outcomes for the client, the literature reveals limited directed study on the effects of contact in male group-

based counselling psychotherapy modalities. Furthermore, there is no research on how contact affects the client's processes of change in male, group-based therapeutic enactment interventions.

This multiple case research study proposed to explore the male client's (hereafter known as participant) experiences of receiving contact during group-based process of change psychotherapy interventions. The purpose of this research study was to develop initial empirical knowledge and understanding of the male participant's experiences receiving contact while participating in a group-based psychotherapeutic process of change known as Therapeutic Enactment (T. E.). T. E. is an experiential multimodal group-based therapy intervention process that facilitates the participant's integration of positive adaptive affect, cognitive, and sensorimotor responses during trauma processing. The outcomes derived from this study's analysis identified areas for further research, particularly within relational, or attachment bond focused aspects of the trauma intervention processes. Additionally, the information generated from each participant's interview excerpts further reinforces what is known about the use of contact, and informs the counselling community of the inherent benefits of applying contact with the clients on its specific applications within group-based, and individual therapy interventions.

Field (2010) claims, the effects of contact are deemed essential for individual and social bonding achievement related to complex interpersonal social connections. Forms of touch and contact facilitates feelings of contribution and productivity, connection with one another and community, trust in oneself and in others, and contributes to bonding and experiencing compassion for others and ourselves. However, "despite the skin being the largest sense organ in the body, it has been the most neglected as a topic of research"

(Barnett, 2005, p. 115). The literature also reports that absence of human to human contact is detrimental on multiple levels. This is further summarized in Field's (2010) report on touch in socio-emotional and physical health contexts, that in western culture, we are hesitant about physically touching each other as part of our social bonding interaction, and the author elaborates on this point claiming the consequences to the absence of contact with one another generate many socio-cultural difficulties, physical health issues, and emotional problems. For example, research consistently reports a lack of positive contact causes more aggressive behavior among people in western society. The neurobiological effects of touch are shown to be profound, and science is increasingly discovering both the facilitative benefits and developmentally limiting consequences related to contact. Barnett (2005) states:

> Human relationships shape the brain structure and that experience, such as touch, activates specific neuronal connections, creating new synapses and strengthening existing ones. Lack of care, and lack of stimulation can lead to 'pruning' where connections are lost and neurons may die. New synapses are created through the activation of genes that cause the production of the proteins necessary for neuronal growth. For example, it was found that children who only experienced restricted play or were rarely touched, developed brains that were twenty to thirty percent smaller than normal. (p. 119)

Receiving and giving forms of contact play an essential role in humans' development of self awareness, interpersonal connections, and in relationship with the environment. As Peloquin (1989) states:

> Touch fulfills several functions of the self. Through touch one communicates, tests the reality of the world, affirms connectedness [triggers awareness] and comfort with

> others, and manifests the self as a person. Adults satisfy the urge by formalizing it [touch]. One takes uninhibited modes of infant intimacy, and by fragmenting and stylizing them transforms them into socially acceptable forms. (304)

Peloquin's review of contact reveals an essential area of focus for my study, which was to explore the role of contact within the context of a highly masculine socialized culture, (male military veterans), and experienced through the application of group-based interventions incorporating intentional and direct forms of contact.

From the socio-cultural perspective, western culture has created gendered social norms, and as previously stated, regardless of the known essential benefits of contact between humans, have constructed arguably detrimental social barriers to giving and receiving contact in our society, particularly where it concerns men in contact with one another. Wong and Rochlen (2005) claim, "according to this perspective, boys and men internalize cultural messages about what it means to be male. Included in these messages is the sentiment that being emotionally expressive is an indication of femininity and weakness and should thus be avoided or minimized" (p. 62). However, this is contradicted in the research demonstrating the importance of human to human contact and its benefits to emotional and social development. Contact plays a combined role in the non-verbal components of interpersonal communications, as Peloquin (1989) states:

> Touch, then transcends being an activity or a gesture; touch is an essential function of selves who are being, learning, embodied, and therefore feeling-in-the-world. It is not surprising that touch is so widely used in language and so poignantly imaged in literature. Touch is a manifestation of ourselves. (p. 303)

As a consequence to gender social norms, men in western society are generally constrained in their expressivity to limited and superficial forms of contact, and in this manner, are negatively affected in their physical and mental health, social bonding, and restricted in their experiencing of the psychologically and physiologically integrative benefits associated with giving and receiving contact. As revealed in the literature, there is extensive research that supports further study focused on the role of contact in group-based therapeutic modalities. This research study highlighted how contact plays a significant role in facilitation and integration of affect, cognitive, and sensorimotor responses, and revealed that as much as men require contact in infancy and developmental years, it is as essential amongst male adults, and vital to the overall integrative therapeutic processing experience. Additionally, this study provided seminal evidence for further exploration in developing specific uses and forms of contact within other therapeutic environments, potentially including individual counselling interventions.

The purpose of this multiple case research study was to develop initial empirical knowledge and understanding of the male participant's experiences of receiving contact during group-based process of change psychotherapy interventions. The analysis focused on exploring the question, what were the male participant's experiences of receiving contact during group-based psychotherapy interventions?

Chapter 2: Review of the literature

2.1 Significance of contact in human development

This multiple case research study explored the male participant's experiences of receiving contact during male group-based process of change psychotherapy interventions. A review of the literature, focused on the primary importance contact has in our lives in relation to human development, identifies several key theorists and studies that present essential and relevant information conveying how contact forms the basis of our developmental processes, is necessary to facilitate social bonding, and plays a vital role in our relationship within socio-cultural, and enviro-social paradigms. Through each of these lenses, the benefits of contact throughout human developmental stages as a critical social bonding behaviour is evident to our very survival as a species. The following literature review discusses the role of contact, and its importance to human development in the context of the neurobiology and physiological development, cognitive, affect, and sensorimotor processes in human to human contact, socio-cultural influences, and enviro-social paradigms.

Review of the literature consistently presents the significance of receiving contact for humans is essential to our existence. Montagu (1971) states, "In the evolution of the senses, the sense of touch was undoubtedly the first to come into being. Touch is the parent of our eyes, ears, nose, and mouth. It is the sense which became differentiated into the others, a fact that seems to be recognized as the age-old evaluation of touch as the mother of the senses" (p. 1). Gallace and Spence (2009) extend beyond Montagu, to include biological and enviro-social development aspects claiming that, touch is the first of our senses to develop, and therefore affords us with our most essential means of contact with the external world, and in their review, further claim that the sensory receptor responses through tactile stimulation

interacts with the responses from our other senses such as auditory, visual and kinesthetic (tactile and motor development activity) processing.

Specific to the enviro-social context, Field (2010) summarizes, "Touch is ten times stronger than verbal or emotional contact, and it affects damned near everything we do. No other sense can arouse you like touch. We forget that touch is not only basic to our species, but the key to it" (p. 57). Contact is therefore essential to our developmental lives, plays a critical role as a survival mechanism, and communication medium from which we interact with ourselves and others, and our environment, and the complexities in the effects of contact in both giving and receiving it is extensive as demonstrated in research.

The various uses of contact for humans provide us with many forms of nonverbal communication, and interpersonal forms of contact plays a significant role in managing our overall emotional well-being. Our social interactions reveal that even the most brief touch from another person can produce strong emotional responses ranging from feelings of safety and comfort, to extreme anxiety and despair (Gallace & Spence, 2009). For example, Changaris (2010) discusses there are many benefits of receiving contact as they occur at the neurobiological and physiological levels within the body, and in his recent research on incorporating affect regulation theory (a theory positioned to re-integrate regulation in the brain, body, and self), and trauma processing incorporating contact, through the combined effects activates the human's affect state at neurobiological levels, and a repair of brain functions is possible. He further claims that the restoration of disrupted regulation patterns in affect, cognitive, and sensorimotor responses could be mended through the use of incorporating touch in therapeutic interventions and within appropriate therapy conducive settings (Changaris 2010). Further support for this evidence is provided by Field (2010),

stating that research findings support several primary benefits of human contact in early development through to maturity stages of human life, which has the effect of reducing cortisol (a stress hormone) levels, and thereby reducing the symptoms of anxiety and depression, and ensuring healthy psychological and physical development. Additionally, at the biological levels, contact in various forms also has the effect of increasing dopamine, oxytocin, serotonin, and adrenalin, and consequently has a reparative benefit to the human condition, especially when under stressful states (Changaris 2010; Field 2010).

As previously discussed, forms of contact plays a significant role in the earliest stages of human development. Montague (1971) states, "The skin, like a cloak, covers us all over, the oldest and most sensitive of our organs, our first medium of communication, and our most efficient protectors" (p. 1). From the lens of human development in the enviro-social context, Field (2011) and Changaris (2010) elaborate on the role of contact in human's socio-emotional and physical well being, and discuss several benefits to contact as it relates to early and advanced stages of human development, attachment, and social interaction contexts. Throughout pre-birth stages, the fetus is in constant communication with its surroundings, and the developing skin is able to sense the presence of movement, and feel the sensations of variations in pressure. For example, studies reveal that during the developmental fetus stages, tactile stimulation is received through the mother's abdominal wall while contained within the amniotic fluid of the womb (Changaris 2010). Continuing with the human developmental perspective, Changaris (2010) states that contact has the effect of increasing birth weight and length of the infant, including other developmental benefits such as reducing the asymmetry between the frontal lobes of the brain – a developmental condition that is believed to be connected with depression. At newborn stages, constant stimulation is received by touch

during breastfeeding, and when being massaged and held by the caregiver (Changaris 2010). In their review of attachment theory, and the role of affect regulation, Schore and Schore (2008) claim that, "non-conscious attachment dynamics is therefore interactive psychobiological regulation. At the most fundamental level, attachment represents the evolutionary mechanism by which we are socio-physiologically connected to others" (p. 11). Field's (2010) research integrates with these attachment formation and relationship findings, noting that caregiving touch is demonstrated to be essential to the infant's growth and development as a calming mechanism to reduce symptoms of pain and discomfort. There are consequences to prolonged periods of contact deprivation at the developmental stages of infancy, and significant negative effects are reported in MacLean's (2003) research on the negative impact of institutionalization on child development. Field (2010) cites this research as an example of the importance and necessity in the frequency of contact received by infants, and the developmental deficiencies and delays to both cognitive and neurodevelopment for those infants who do not receive adequate contact from other humans.

Contact in the context of social development is essential because in moments of contact with another we engage our sensory and visual cues, activating at the neurobiological and physiological levels a process that connects our emotional states to the emotional responses in others (Changaris 2010). From the neurobiological perspective, contact, Changaris (2010) claims, "is as vital as food, and a great communicator of emotions, and experiencing a positive emotion following a stressful event has the effect of reducing cortisol levels, and symptoms of stress" (p. 168). Related to this research, "recent studies have established that emotions can be identified from the simple experience of a stranger touching you on your arm without having any other cues (verbal or behavioural) from that person" (Field 2010, p.

370). For example, in a study conducted on encoding and decoding touch revealed that, "different kinds of touch were used to signal different emotions, and the receivers were able to identify the emotions with accuracy ranging from fourty-eight percent to eighty-three percent" (Field 2010, p. 370). The significance of this study demonstrated that the range of results were comparable to the accuracy of results revealed in studies for decoding facially (behavioural) and vocally (verbal) communicated emotions (Field 2010). Additionally, studies conducted using contact in the interpersonal and social development domains consistently demonstrate that human to human contact is essential to our social development and social bonding or relationship forming (Field 2010).

"That because the skin is the site of events and processes crucial to the way we think about, feel about, and interact with one another, touch can mediate social perceptions in various ways" (Morrison, Loken & Olausson, 2010, p. 305). In terms of human functioning in these domains, it is further evident from the research in the extent literature which forms of contact plays an essential role throughout broad aspects of our lives: connection to our environment, importance in social interactions and intimacy, and critical in engaging in and performing leisure activities. For example, Morrison, Loken & Olausson (2010) summarize the value of touch in enviro-socio contexts, and that the "types" or classifications of touch are also essential to our relationship with self, other, and environment stating, "the cutaneous senses"—especially touch—are crucial yet often overlooked mediators of social interaction contributing not only to sensation but to emotion. Social touch may be tentatively divided into the operational categories ''simple'' (as in a tap), ''protracted'' (as in a hug), and ''dynamic'' (as in a caress) (p. 306). The important social roles of the affective processes of contact can be regarded from the perspective of social neuroscience, and major functional

roles for social touch that include affiliative behavior and communication (Morrison, Loken and Olausson, 2010). "Touch and pain related representations also provide a basis for intersubjective representations, influencing the understanding of others' sensory, emotional, and mental states" (Morrison, Loken & Olausson 2010, p. 312). Field (2010) reveals in her review of touch that Montague (1971) stated touch and love have been interpreted as "indivisible". Expanding on this, Field (2010) claims that, "one of the five expressions of love is through physical touch", and a study identified that "several forms of romantic touch have been noted including holding hands, hugging, kissing, cuddling, caressing and massaging" (p. 371). The findings of this study demonstrated that physical affection was strongly correlated with satisfaction in the relationship and with a partner (Field, 2010). In their review focusing on the science of interpersonal touch, Gallace and Spence (2010), claim that while there is some research that has analyzed the physiological and neural areas of interpersonal touch, the cognitive aspects of this topic appear to have been almost entirely neglected by researchers. They further conclude that the research has yet to demonstrate the characteristics of touch that is needed in order for it to be perceived by a person as interpersonal (pleasant/unpleasant) rather than as mechanical, and therefore neutral in its effect (Gallace & Spence 2010).

It is from these theorist's perspectives and range of studies on the effects of human to human contact, that we see sufficient evidence to support how receiving contact is critically essential to human functioning: engaging the individual in affect, cognitive and sensor-motor processing, and informing the individual and others through sensory activation, emotional queues and responses necessary to communicate with the self, environment, and others. Related to these findings on the significance of contact, was the focus of this research study,

which explored the male participants' experiences of receiving contact within group-based psychotherapy interventions. Within the analysis of the participant's T. E. interview excerpts of receiving contact is information related to the activation of affect, cognitive processing, and sensorimotor responses, and findings to support that contact is essential to the integration of relationship with self, improvement of primary social bonds, and increased interpersonal connection in relationships with others, and one's environment. Additionally, the outcomes of this study support the overall importance contact plays in therapeutic interventions focused on trauma processing. Specifically, that the application of contact has the potential to engage the participant in experiential awareness processing domains, and facilitates the progressive transition toward adaptive affect, cognitive, and sensorimotor integration.

2.2 Contact in psychotherapy environments

> The languages of the senses, in which all of us can be socialized, are capable of enlarging our appreciation and deepening our understanding of each other and with the world in which we live. Chief among these languages is touching. The communications we transmit through touch constitute the most powerful means of establishing human relationships, the foundation of experience. (Fosshage, 2008, p. 38)

Human to human contact in all of its forms is essential to our communication with the "self" and others, and a powerful conduit to initiating and facilitating human emotions, thoughts and behaviours - critical to our survival. The literature on human to human contact in psychotherapy environments ranges significantly in perspectives from historically based discussions on the origin of its use in psychotherapy, "influenced by healing traditions dating as far back as thousands of years" (Durana, 1998, p. 271), contact in therapy and practitioners' positions for and against its inclusion within various therapeutic modalities, to

focused debate on the ethics of intentionally incorporating contact as part of the therapeutic intervention process. There is also extensive research in the literature on the problematic aspects of contact in therapy (Bonitz, 2008). The controversial significance of contact in therapy settings is driven primarily by a multifaceted interaction of theoretical justification, cultural norms, and ethical perspectives in Western culture. Furthermore, forms of contact are often interpreted as sexual intention, or as signal of demonstrating power over others (Bonitz, 2008).

In Durana's (1998) review of touch in psychotherapy, the following summarizes where it is positioned in the research:

> There is no consensus about the benefits of touch in psychotherapy, nor are there clear clinical and ethical guidelines regarding its appropriate use. The use of touch as an ethical and clinical issue has not been sufficiently addressed in clinical training and supervision. Little attention has been paid to the use of non-erotic touch clinically and in research. Today, although used in some forms of therapy, touch and forms of contact has been excluded by many approaches of mainstream psychotherapy. Minimal attention has been paid to the use of non-erotic touch clinically in practice, and in research. Furthermore, the use of touch as an ethical and clinical issue has not been sufficiently addressed in clinical training and supervision. (p. 269)

Westland (2011) elaborates on Durana's research, stating that using contact in psychotherapy is a difficult subject to assess and discuss due to, "confusion about the purpose of using touch, lack of experience among psychotherapists in the use of touch, and misunderstandings about who actually uses touch in psychotherapy" (p. 18).

Westand's (2011) review of contact in psychotherapy raises several issues contributing

to its controversial aspects, and includes factors such as psychotherapist's fear of sexual misinterpretations or physical aggression in the application of touching the participant. The confusion and controversy surrounding the use of contact in psychotherapy resides within its interpretation. Being among the most powerful of human senses, contact elicits a variety of emotions, thoughts, and behaviours for both giver and receiver in contact with another. Furthermore, variations in contact pressure, and context in encoding and decoding the touch sensations, emotional attunement to the interaction with another at the time of receiving contact, and conditioned responses residing within each individual, lend to difficulties in identifying with assurance that contact will be processed and understood consistently (Westland 2011). From a practitioner's perspective, interpretation of contact is often misunderstood for some of the following reasons: it is sometimes not definitive if we are thinking about contact in a symbolic manner (caregiving or nurturing), as an intervention to be used in regulating and calming the participant's anxiety (physiologically focused), or as an intervention to elicit catharsis. These may all be positive applications of contact in psychotherapy, however, depending on the therapeutic perspectives held, there are multiple ways of interpreting and positioning the uses of contact in the psychotherapy community, and within the therapy environment (Westland 2011).

Over the decades contact in psychotherapy, and the controversies associated with its application as an intervention contributed to the, "common assumption that [psychotherapists] do not touch, and indeed are not supposed to touch" (Westland 2011, p. 19). Discussions in the psychotherapy community about using contact raise issues pertaining to violations of boundaries between therapist and participant. However, Westland (2011) reveals psychotherapists who touch are no more inclined to behave unethically in using touch

with participants than those who do not touch their participants. Therefore, the influence of social norms in Western culture, combined with, "the gradual erosion of customary boundaries" (Westland 2011, p. 20), provides the connection of contact to sexual violation in psychotherapy. Westland (2011) also provides examples of additional arguments supporting refraining from using contact in psychotherapy in the following: it may be used in a manipulative manner, and negatively influence the participant's dependency and autonomy in the therapy process, and it may negatively heighten the participant's emotional states. Lastly, Bonitz (2008) summarizes on the use of contact in psychotherapy environments, "in the Western tradition of verbal psychotherapy the use of touch, despite its recognized therapeutic effects has been highly controversial ever since Freudian times … its use, however, is also associated with a potential for harm, for example in the form of sexual exploitation of participants" (p. 391).

Given the extensive research on the misunderstandings and ethical problems associated with contact in psychotherapy, however countered with the positive effects of forms of contact in therapy environments, continued research is needed to identify specific and empirically valid uses within various therapeutic interventions. Specifically, the literature provides extensive anecdotal claims by participants as to their positive experiences receiving contact, combined with what we know of the integrative neurobiological effects of touch sensations, and responses in affect, cognition, and sensorimotor processing, may inform both practical and reliable forms of touch to be adopted and incorporated into certain therapy practices and interventions modalities. The challenges, however, for the researcher are summarized by Phelan (2009) who states:

Touch is linked to a subjective quality and this varies accordingly. What is desired by

one person, may not be desired by another. The same sensory stimulus, like a tap on the shoulder, can seem like encouragement for one person, whereas for another, it could seem like a reprimand. (p. 104)

Setting aside the controversial and debatable issues concerning contact in psychotherapy and its influences, a review of the literature on contact in psychotherapy provides a rich historical and evolutionary perspective on how contact became accepted within some theoretical modalities and certain therapy settings, and also includes studies on cultural perspectives and religious influences as foundational to either its inclusion or exclusion in psychotherapy (Durana, 2004). For example, specific historical studies on contact and its presence in therapy identify Freud's work as a benchmark. Among the first who supported the use of contact between therapist and participant, Freud incorporated caressing the participant's neck or forehead, which was thought to enhance the participant's responses during hypnosis. However, he later abstained from having any form of contact with his participants, necessary from the detached stance from the participant in psychoanalysis (Durana 2004). Phelan (2009) discusses Ferenczi who used contact, which often included hugging and holding as a means of facilitating repair of the participant's early childhood trauma experiences. Additional psychotherapists who used contact in therapy interventions include Fritz Perls, Wilhelm Reich, and D.W. Winnicott (Phelan 2009).

There appears to be limited research focused on analyzing the specific benefits to using contact in various psychotherapy modalities, and consensus is evident from practitioners and researchers that within certain contained therapeutic settings the application of contact by the therapist provides strong support of positive outcomes for the participant. However, as Phelan (2009) states, "it [contact] remains a neglected aspect of discussion in

the psychotherapy arena, as well as training and education for most psychotherapists" (p. 97). Durana's (2004) research claims that practitioners' promoting the use of contact report that when it is appropriately used, and applied in a timely manner, forms of contact in therapy supports and enhances the participant's overall change process. Bonitz (2008) expands on Durana's review, highlighting several benefits of contact, which have emerged out of relatively recent stages of psychotherapy analysis over the last four decades. For example, during the 1960s, attachment theory, focused on the patterns of development between mother and child, identified that a lack of attachment for the mother could be countered through fostering a "secure base" by using contact as a means of helping to foster the secure attachment for the participant (p. 395). Further evidence in support of the benefits of contact in therapy are raised in Durana's (2004) review of touch in psychotherapy where he states that contact is identified as having, "three essential purposes in psychotherapy settings: it communicates acceptance and worthiness when the participant is overcome by feelings of unworthiness; it can supply symbolic mothering when the patient is not able to communicate; and it can help the patient establish contact with external reality when overcome by anxiety" (p. 271). Related to these three purposes of using touch also reside benefits in the context of trauma processing. For example, as Durana (2004) states, "touch may help the patient tolerate pain and alleviate the shame that interferes with working through issues at a deeper level. The sense of safety and trust in self and others may help in the interpretation of a fragmented ego" (p. 272). Phelan's (2009) research discusses several studies, which generated common outcomes, and reinforce the positive aspects of contact in psychotherapy, and its therapeutic benefits as part of the intervention process. He summarizes the research findings in the following:

> Contact generated a perception of likeable and responsive; increased positive evaluations of therapists when contact was used; and touching the shoulder or back of the participant gave feeling of trustworthiness and greater expertise; and contact promoted greater self disclosure and self exploration. (p. 105)

Additionally, Phelan (2009) reviewed several studies that raised the importance in the effect of contact between the therapist and participant, noting that, "a participant's response to touch is based on a complex interaction of perceived intention, expectation, and prior experience" (p. 105). Phelan (2009) concludes in his review of contact stating that the literature identifies some techniques and modalities that contributes to effective outcomes including contact as a therapeutic intervention, and appears to be most useful when the participant and therapist consent to its application, and when the participant's interpretation of its intent reside in symbolic forms of nurturing or enhancing communication. Furthermore, Phelan (2009) adds that when these components existed, the therapeutic outcomes transitioned toward greater self esteem, and reinforced trust and bonding between participant and therapist.

In relationship to the experiencing of contact from therapist to participant, a study reported in the review of the literature conducted by Fosshage (2000), identified four themes experienced by participants who received "touch experiences" in psychotherapy, and was perceived as highly beneficial if: the participant had a sense of control of the contact; touch seemed to be in response to the need in the participant rather than the therapist; the incidents of touch were discussed and processed afterward; and when the intervention was compatible with the level of intimacy in the therapeutic relationship. The benefits of receiving touch in this study demonstrated positive participant responses. For example, touch enhanced the

integrative therapeutic processing in affect, cognitive and sensorimotor states. In the context of group therapy processes of change specifically conducted in T. E. interventions, an analysis of the participant's experiences receiving touch and contact, further informed by the relationships between applications of contact during various stages of within-group trauma processing.

The literature reviewed on contact and individual therapy provides minimal research studying the specific application or intention of contact by the therapist to the participant, including the direct benefits received by the participant's cognitive, affect, and sensorimotor responses through the experiencing of non-erotic touch or contact. However, the literature does support a shift in acceptance of touch in individual therapy settings, primarily through the influence of humanistic oriented therapies, and its application in nonsexual examples: hand holding, hugging, and patting on the back (Bonitz 2008). In the context of prevalence of touch in therapy, the literature reveals that therapists practicing humanistic based orientations rather than psychoanalytic approaches are more likely to incorporate touch and contact into the therapy sessions. Phelan (2009) includes that within the humanistic approaches in psychotherapy, aspects of touch are an accepted form of intervention, however, within the psychoanalytic arena, touch is deemed inappropriate. Specifically, in terms of its presence in therapy practice, female therapists use touch more than male therapists, and therapists trained in the effective uses of touch and contact, and identify with it as "healing" are more likely to use touch and view it as a positive component to the therapeutic process (Bonitz 2008, p. 399). Durana's (2004) review expands on this and discusses touch having positive outcomes to participant self disclosure; revealing a significant (positive) relationship between touch and self disclosure; and through appropriate touching, participants engaged in deeper self-

exploration and expression; and touch enhanced feelings of connection and closeness to others in encounter group settings. Westland (2011) further refines Durana's applications of touch in psychotherapy adding that within the range of reasons for including it in therapy settings, and indication of evidence of minor consensus of its inclusion in some therapeutic modalities, the following categories may include touch and forms of contact: for traumatized participants; for those who are emotionally and physiologically dysregulated; for those emotionally defended; for those with childhood developmental deficits and traumas; for the embodiment of aggression and pleasure; for increasing energy flow; for deepening experience in relationship; and for real relationship.

Phelan's (2009) research identifies several paradigms whereby the application of touch and forms of contact are deemed acceptable and integrated within a therapeutic modality, and describes the following categories of "touch-based" components: embodied psychotherapy (focuses on the multi-facets of the participant – body symptoms, sensations, feelings, energy, and spirituality); bonding psychotherapy (a group therapy process using gently holding touch to reinforce attachment repair); thought field therapy (a combination of breathing and relaxation exercises in combination with tapping on specific pressure points); gestalt therapy (uses a range of emotions and behaviours, including eye contact, physical touch, and movement); neuro-emotional technique (normalizing unresolved physical/behavioural patterns in the body through touch to the participant's arms and back); and psychodramatic bodywork (uses guided dramatic action to assess symptoms and issues present in an individual or group).

Many features of social interaction are non-verbal, consisting of subtle variations of facial expression that set the tone for the content of the interaction. There are also

> non-contact variable that contribute to the overarching experiencing of contact for the individual. For example, body postures and movement patterns of the therapist… also may reflect emotions such as disapproval, support, humour, and fear. Tone and volume of voice, patterns and speed of verbal communication, and eye contact also contain elements of subliminal communication and contribute to the unconscious establishment of safe, healing environment. (Schore & Schore, 2008, p. 13)

Based on what we know of the influences non-verbal responses and their interpretation of meaning has within the client therapist relationship alliance, the present research conducted on the cognitive, affect and sensorimotor responses associated with giving and receiving contact, suggests beneficial application within the therapeutic settings, as an activation component to promoting enhanced non-verbal communication experiencing, and further integrating the client and therapist relationship

2.3 Male socialization and help seeking in civilian and military contexts

In the context of Male Gender Role Socialization (MGRS) in western culture, we are able to readily locate male gender role strain in civilian contexts, and the intensely, overtly demonstrated forms of masculinity ever present in military environments. The following provides the conceptual components of MGRS as a means of contextualizing the effects of masculinity, and the effects of help seeking for males in western civilian and military environments. Further evidence is discussed that supports this research study's focus on the experience of receiving human to human forms of contact – in the context of facilitating integrative processes necessary to resolving trauma symptoms, reframing and reclaiming one's relationship to self and others.

Gender role socialization, and the construction of gender norms for males and females in western culture, occur throughout developmental years, and are reinforced into adulthood. The effect of socialization, for many men in western society is disintegration of fully experiencing primary emotions, and the healthy, normative responses associated with them. For example, Mahalik et al (1998) state, "male emotional socialization from the framework of the gender role strain paradigm, many boys are required to block their feelings and restrict the expression of their vulnerable and caring emotions" (p. 247). Addis and Mahalik (2003) submit that gender role socialization paradigms are first understood through the lens of how men and women learn gendered attitudes and behaviours from socially constructed values, norms, and ideologies about what it means to be a man or woman in western society. This is further elaborated in the literature, which reveals two primary focuses of research on masculine gender role socialization: ideologies and belief systems, and the extent to which the male endorses and internalizes these gendered norms; and the negative consequences to adopting certain constructed masculinities (Addis & Mahalik, 2003). Courtenay (2000) explains that, internalizing that men should be mentally tough and emotionally inexpressive can have consequences to the health and well-being of the male individual. Furthermore, the internalization of the meanings of masculinity is actively created in various forms and settings in western society. For example, Addis and Mahalik (2003) describe male athletes who continue to compete while suffering from injury, and do not express feelings of physical pain, or suffering, are valued and prized by others for their commitment, dedication to competing, and intense focus, and toughness. The effect this "conditioned and socially constructed" functioning in western society for men creates an

internalized conflict: reinforced masculine identity, and dismissal of self-care (Addis & Mahalik (2003).

From the perspective of how males are socialized in western cultures, and the effects male gendered norms have on them ranging from all ages, as individuals or collective male populations, Brooks (2001) claims that traditional male gender role socialization (MGRS) influences men's beliefs and behaviours, and predisposes male participants to conceal their private experiences, maintain personal control, convey stoic presence, and value action over personal introspection. MGRS is further dissected within the construct "gender role", defined as, behaviors, expectations, and role sets defined by society as masculine or feminine which are embodied in the behavior of the individual man or woman and culturally regarded as appropriate to males or females (Sharpe & Heppner, 1991, p. 323). Gender role conflict is defined as "a psychological state in which gender roles have negative consequences or impact on the individual or on others" (Sharpe & Heppner, 1991 p. 324). Essentially, O' Neil proposed that, "the traditional male-role socialization provides contradictory and unrealistic messages, resulting in considerable internal conflict" (Sharpe & Heppner, 1991 p. 324). The overarching purpose of this research study was aligned conceptually in the following context as stated by Addis and Mahalik (2003), "a contribution toward exploring how the socialization and social construction of males in western society transact with social psychological processes common to a variety of potential help-seeking contexts" (p. 5).

It is essential to understanding MGRS that role socialization paradigms begin with the assumption men and women learn gendered attitudes and behaviors from cultural values, norms, and ideologies about what it means to be men and women (Addis & Mahalik, 2003). For example, Addis and Mahalik (2003), described that men are influenced by normative

masculinity messages that are communicated through the use of three categories of norms: descriptive, injunctive, and cohesive masculine norms. Descriptive masculine norms operate when a male observer sees what most men are doing in a situation. For example, because men often hide or mask feelings of depression, depression should be perceived as relatively non-normative because it is not frequently observed. Injunctive norms also influence the perceived normativeness of a problem by providing the cultural shoulds and should nots of masculinity. For example, norms such as the idea of men as *sturdy oaks* (i.e., men should be strong and independent); lastly, cohesive masculine norms influence perceptions of normativeness when men observe how popular men act, think, and feel. As such, when men perceive that popular male figures are wealthy, happy, healthy, and confident, it fosters the perception that being poor, feeling depressed or physically weak, and lacking self-confidence are non-normative (Addis & Mahalik, 2003).

Ashfield's (2012) perspective on male socialization proposes the concept of attaining "Manhood" in Western society through what he describes as the following:

> A code calibrated to cultural requirements that often demands emotional detachment, stoicism, toughness and strength. It may require men to ignore even potentially life-threatening consequences in order to ensure material production and provision, and to protect community and family, all prerequisites for human community's survival and prosperity. It should be an intolerable contradiction and injustice to demand of men the performance of roles (to benefit us all) that generally lead to greater ill-health and an earlier death than women, whilst at the same time calling for men's feminization and de-masculinization. (p. 25)

Ashfield (2012) expands on the implications of manhood and the role it plays in western society as a socially constructed identity – to serve society's needs, and to provide context to be male - masculine. He submits that the acquisition of manhood and possessing a masculine social identity are very challenging for a number of essential reasons. As a construct, male masculinity serves society's purposes for manhood never to be fully attainable, because it is a powerful device of social usefulness (Ashfield 2012). He elaborates, manhood is never a final or certain state of being, and there is always the potential threat of it being taken away, such as how society used the images, and embodiment of masculinity through propaganda and communications occurred during World War One:

> British recruitment propaganda and strategies of the First World War were a transparent example of this. They idealized manhood, holding it out as a promise to young men and as a reward for steeling themselves against danger and fear in order to get them to enlist in the army and go off to war. Recruitment posters extolled the bravery, courage, and national pride associated with military service, and shamed those who were reluctant to join up. The White Feather campaign was used to great effect in threatening disqualification from manhood of any young man who refused to enlist. The white feather, which was most commonly handed out by women, was used as a potent symbol of cowardice. Men who received the white feather were swiftly ostracized, and sometimes even threatened with physical violence. (Ashfield, 2012, p. 24-25)

In keeping with the culture of MGRS, men in western society, and the military, the literature discusses several important aspects of how the combination and interplay of these domains exacerbates the negative socially constructed gender roles among military men, and

therefore magnifies the health risks associated with performances of masculine identities, and the repression of expressing distress, including resistance to help seeking. As Westwood et al (2012) state, "traditional male socialization underpins the foundation of military culture" (p. 276). Green et al. (2010) elaborates on the relationship between masculine gender roles and military culture claiming that the culture in the military has developed to support a highly masculinized environment that promotes hegemonic masculinity:

> Hegemonic masculinity is a culturally influential form of masculine behaviour that confers authority and leadership, as well as control, over women and less powerful men. Hegemonic masculinity, within much of the military environments has been shown to be grounded in rugged warrior ideal in which toughness, controlled aggression and endurance are paramount. Masculinity is publically tested and must be constantly proven, illustrating how competent performances of masculinity which conform to group norms are central to identity and how presentation of gendered identity is always a work in progress. (Green et al. 2010, p. 1481)

Given the hyper-masculine environment within the military culture, demonstrated through overtly presented forms of socially constructed male gender roles, and operating often simultaneously internalized gender role conflict in the form of repressed affect, resides the critical barrier for male help-seeking. Green et al. (2010) claims that the stress of conflict experienced by this highly masculinized environment provides an example for further examination of the association between socially constructed masculinities, and open expressions of distress. "Combat is stressful and for some sufficiently traumatic to lead to the development of somatic symptoms which may become chronic, disabling and refractory to treatment. There is a strong and positive association between the total killed and wounded in

armed conflict and the number of psychiatric casualties. Men in the Armed Forces are often unwilling to ask others for help for mental health problems" (Green et al. p. 1481).

In relation to the military culture, male restrictive emotionality and resistance to help seeking, is often the effect of trauma and trauma related symptoms on the male. Specifically, in the context of traditional masculinity and conformity to constructed male socialization, trauma and related symptoms are often experienced as a loss of control over oneself, and consequently, a failure to conform to one's self identity (gender norms), and therefore, internalized as a failure in masculinity – a failure to conform to expectations, and socially constructed roles in society (Fox & Pease, 2012). This is further defined in the following:

> For a man traumatized by violence, there is a form of internal disintegration or rupture as a central dimension of his identity is no longer attainable. Moreover, what was a resource is no longer available. Not having acted as a man is expected to, his ability to participate in that conversation about manliness is compromised and uncertain – leaving a gap or emptiness in his sense of self. (Fox & Pease, 2012, p. 20)

As Fox and Pease (2012) report, the literature places the male experience of trauma as a feminine construct in its perception of trauma related symptoms such as feeling helpless, weak, not in control of self, irritability, aggression and anger, and treatment of its symptoms as a contrast to the traditional forms of masculinity. They elaborate, claiming that the language used to describe PTSD (feelings of intense fear, hopeless or helpless, and horror), may consequently be internalized by the traumatized male, creating feelings of shame, inadequacy, and an inability to communicate as a man (Fox & Pease, 2012). Fox and Pease (2012) explain, "a man experiencing trauma is then, from the perspective of this conversation, seen to be exhibiting feminine traits – as not being himself" (p. 21). They

elaborate and claim trauma is essentially social, because:

> The man's identity is formed and practiced with others who share the same expectations and the same language. The man can no longer be himself, can no longer be a man, and can no longer hold himself out as complying with the accepted expectations of manhood. (Fox & Pease, 2012, p. 21)

For the veteran soldier, there is a further exacerbation, due to the intensified training that exaggerates masculine behaviour and expectations, such as not being able to meet the expectations of being a man; therefore the veteran soldier is unable to fulfill the expectations of being a soldier – a further loss of identity (Fox & Pease, 2012).

The literature does reveal that socially constructed norms in males can be de-constructed, and in the context of help seeking, and gender specific psychotherapy environments, focusing on factors that facilitate the therapy engagement process may benefit male outcomes in health, well-being, relationships, and integration of "self" for men in western society. For example, identifying that these highly structured and foundational "ways of being" for men can be reframed to adapt to new enviro-social contexts, and even becomes permanently adopted. Addis and Mahalik (2003) reinforce the perspective that men are generally able to reframe the socially constructed norms when they observe and perceive a non-traditional norm to be accepted amongst other males, such as when they perceive an opportunity to reciprocate help.

Within the context of certain action based group therapy interventions the notion of "reciprocity" is a function of participating in the group's intervention activities, and has the effect of inclusion for the individual group members, and reinforcing group cohesiveness through mutually supportive and equitable participation among group members. Therefore, in

the context of gender socialized roles, and reframing the traditional experiencing of these norms, requiring reciprocity in helping transactions can be seen or experienced by the male as a way of preserving the socialized status both by avoiding indebtedness and by marking oneself as a strong and competent man (Addis & Mahalik, 2003 p. 11). This explains, in part, why men's groups often place reciprocity in help giving as a centerpiece of therapeutic work such as in the Veterans Transition Program (VTP) which includes therapeutic enactment group therapy modalities and process-experiential action-based interventions, requiring the participation and collaboration of all group members (veteran soldiers, para-professionals, and therapists), to engage in peer support roles throughout the progressive transition stages of the program. As in the VTP, men are more likely to seek help when there is an opportunity to reciprocate. Additionally, one of the most important functions of all-male groups is that they allow men to witness, and then replicate the level of self-disclosure necessary for therapeutic change (Brooks, 2001; Powell, 2006). This is a key example of how male group therapy environments, and action based intervention modalities are effective in their outcomes because they leverage the traditional male, socially constructed norms such as strength, sturdiness, reliance, and responsibility in the individual group members. Furthermore, this group support (therapy) process has the effect of facilitating "socially integrated engagement" with other group participants and reinforcement of "reconstructed", positively applied and adaptive gender norms. For example, an overarching component of the VTP's therapeutic enactment intervention modalities facilitates the "deconstruction" of negative male gender norms (normalizing the effects of negatively constructed, maladaptive male gender norms), and through participant peer support, incorporates "reconstruction" of positive and adaptive male gender norms. This male gender norm transformation process is

executed by building in action-based support roles that emphasize, for example, verbal communication, body movement, and forms of contact, throughout the intervention, and group activity processes. As a result, the VTP's intervention modalities allow the male participant to retain his "social status", however, the reciprocity concept, and built-in peer to peer reinforcement of positive gender norms, facilitates the "deconstruction" and "reconstruction" of gender roles for the male participants, and leads to effective integration of positive reframed gender socialized norms, and successful outcomes in transition from military to civilian life.

Reinforcing this study's research focus is the specific literature on male help seeking which discusses the need for therapists and counselling interventions to be aware of "male compatible" counselling approaches. For example, several researchers suggest that men respond more favourably to group counselling rather than individual therapy (Englar-Carlson, 2006; Johnson & Hayes, 1997). Powell (2006) elaborates that this may be because most men function in friendships often distinguished by activity sharing, and therefore, an all male group counselling setting may provide a familiar environment to external male social settings. Furthermore, the literature indicates that therapy interventions with men have positive engagement process and outcomes that are action and goal oriented, or performance based (Ipsaro, 1986; Johnson & Hayes, 1997). Therefore, instead of attempting to elicit emotional engagement through shared affect, as in predominant psychotherapeutic modalities, in the early stages of action-based therapy, men may achieve what Englar-Carlson (2006) refers to as "intimacy by doing." These theorists reveal that through a combination of socially constructed (traditionally gender normed) environments, such as all male therapy groups, combined with action-based intervention modalities that incorporate

male gender socialized norms, engagement in therapy, and beneficial outcomes are possible due to leveraging these otherwise gender restrictive socialized norms, and reframing the gendered experiences.

However, what we know of the effects of trauma events experienced through primary trauma (such as receiving direct threat, emotional / physical abuse and injury), and secondary trauma (experienced vicariously – witnessed threatening event, or hearing narrative of threatening event from others) are the progressively damaging effects of the maladaptive trauma symptoms, often described as post traumatic stress disorder, post traumatic response, occupational stress or fatigue. The effect of experiencing the trauma event for the individual is often a resulting disconnection process between one's cognitive, affect, and sensorimotor integration, and therefore affecting the integrative processing of these essential components which facilitates healthy responses to threatening socio-enviro events, and functional engagement and connection with others and self. Additionally, for the male, and particularly male veteran soldier, socially constructed gender norms reinforce limitations and restrictions of affect expression, a necessary function in helping to process trauma experiences. "In addition to reports relating certain clusters of symptoms to depression in men, researchers have found correlations between gender role conflict and depression in men" (Rabinowitz & Cochrane, 2003, p. 133).

A positive therapeutic approach to processing negative affect is identified in Pascual-Leone and Greenberg's (2007) "emotional reorganization" model for restructuring maladaptive feelings. This model focuses on how clients might process highly aroused states of negative feeling through a process of sequential affective meaning states. However, the model relies firstly on the therapist's skill in assisting the client's affect responses, and

articulation and expressivity of global distress (secondary emotion), such as pain, hopelessness, isolation, and confusion. For the traumatized traditional male gender role client, and particularly in combination with a hyper-masculine culture most profoundly apparent within military environments, this effective model of "emotion changing emotion" may be hindered or rendered ineffective as a grounded intervention approach.

In exploring how the veteran soldier's relationship with the trauma event/s and symptoms, Fox and Pease (2012) review of this literature revealed a study that explored the influence of ideas of masculinity, and recovery from combat trauma. The study consisted of conducting interviews with United States Vietnam Veterans being treated for PTSD in an inpatient program, and explored what social resources the veteran men used to make meaning of their Vietnam experience. The interview processes also included writing and narrative recall of their experiences in childhood, and adulthood prior to Vietnam deployment. The research found that through "the narratives of the veteran soldier's experiences, and by stressing the uniqueness of the combat experience, and PTSD's relationship to it, the narrative language provided a masculine aura" (Fox & Pease, 2012, p. 22). As a result, the veteran was able to attribute his engagement in the therapy process because, "he had become hypermasculine, and not, as often attributed to women, because he was mentally weak" (Fox & Pease, 2012, p. 22). The study confirmed that the effects of PTSD:

> Still leave men with a sense of failure and a lack of confidence in their ability to proceed to control their lives. It affirms the veteran's unique identity as having engaged in profoundly manly endeavour of combat, as having engaged in the ultimate test of manhood, which few men face, however, it implicitly denies the merit of that experience as it is founded on a demonstrated lack of those very qualities that, in

traditional terms, define a man. (Fox & Pease, 2012, p. 23)

The psychological and physiological effects of trauma as evident in PTSD symptoms, and the research on the psychologically damaging effects of trauma symptoms for veteran soldiers:

> Intense fear, helplessness or horror, and a consequential inability to master oneself and one's circumstances, may then leave many men ashamed and unable to speak as men. In the absence of a new sense of self, in particular a new language of masculinity, it may leave the veteran without a vocabulary for successful action or agency (Fox & Pease, 2012, p. 23).

This study's findings, based on the narrative and social engagement interview processes used, counters that which Rochlen (2005) reported in his review of therapy research developments for men, "men's socialization process as one that promotes the avoidance of emotional expression, the absence of weaknesses or vulnerabilities, and the need to solve problems without the help of others" (p. 628), and provides further evidence that restrictive socially constructed male gender norms may be positively affected through a progressive deconstruction, and positive reframing therapeutic process. This study further identified that through an interview process of inquiry, and narrative recall of one's life events: integrating childhood, pre-military, military, and post military service experiences, helped the veteran soldier to validate his identity as a man, and locate the language that effectively describes his self and relationship to others, and in relationship to the community.

From an attachment theory perspective, processing trauma and recovery of its symptoms is conducted, as described in the previous study, and reinforced in the following where Tummala-Narra et al (2007) claims, " Recovery from trauma is further conceptualized as a multidimensional phenomenon, highlighted by multiple recovery criteria: authority over

memory, integration of memory and affect, affect tolerance, symptom mastery, self-esteem, self-cohesion, safe attachment, and meaning making" (p. 5). Taking this integration process further, is it possible that the experience of receiving human to human contact, may help facilitate the integration cognitive, affect and sensorimotor domains, and accelerate the male veteran's ability to acquire adaptive responses and communication of his experiences in: relationship to the trauma event; experiences in relationship to trauma symptoms; and in relationship to self and others? The present research does not discuss the therapeutic effects of receiving contact for male group-based psychotherapy environments, nor does the research provide information on whether or not the application of contact contributes to the deconstruction of unhealthy masculine gender norms, and reconstructing of healthy norms through integrative attachment and social bonding experiences. However, as Peloquin (1989) claims, "touch can also affirm connectedness and comfort with others, enabling the self to feel a person" (p. 304).

There is limited research that takes into account the influence of male gender roles, constructed masculinities, and men's experience of trauma in the context of help seeking in the military, and for the veteran in civilian society, limited male gender specific therapeutic interventions exist that leverage the male gender roles in positive frames. Much of the research on these subjects discusses the problems and issues for veteran soldiers experiencing post combat trauma: isolation, depression, and maladaptive behaviours. Furthermore, "depression signals vulnerability, attracts significant stigma, and directly contradicts the strength and power synonymous with masculine ideals" (Oliffe & Phillips, 2008, p. 196). Given this evidence, there appears to be significant support and justification for the findings of this research study. As Fox and Pease (2012) state:

Karner (1994) appears to be the only researcher who has focused on the relationship between trauma and masculinity in terms of a self / social narrative. It was this experience of the failure to conform to their (the male veteran soldier) understanding of masculinity – with its demands that they master potentially overwhelming personal threats as well as to protect the weak and innocent (which women and children are expected to be) that constituted the veterans' trauma, rather than the traumatic events themselves. For those veterans, their contradictory experiences of their selves, as young men, as soldiers, and as veterans in civilian life, rendered their claims on masculinity suspect. Their experiences had not given them any resources to narrate a 'good man' view of themselves." (p. 26)

Chapter 3: Methodology

As discussed, the literature consistently demonstrates the benefits to receiving and giving touch for humans, and is essential for our survival. However, there is limited emerging research provided on specific applications of touch and contact within individual psychotherapy settings, and few studies of participant's experiences receiving contact in group-based therapy modalities. From individual psychotherapy perspectives, and within the cautions in the use of touch in psychotherapy environments, Ogden, Minton and Pain (2006) claim that:

> It can be an efficient, useful, effective intervention, and there are specific clinical purposes for its judicious use. Touch can help build new somatic resources or support awareness of existing resources. The use of touch can facilitate the learning of new actions and postural patterns. The participant's reaction [to touch] will tend to reflect his or her automatic translation of the sensation in the context of past experiences of touch. Experiencing a particular sensation in a part of the body that has been injured or abused may remind the participant of past trauma. As therapist and participant mindfully explore participants' automatic reactions to touch, and the meaning of the reactions, a new experience can be facilitated and the habitual response transformed" (p. 204).

Ogden, Minton and Pain (2006) discuss from the research, the applications of touch within individual psychotherapy settings, and provide evidence to the benefits of using it, "the effective use of touch in therapy can anchor the participant to the here-and-now and to the relationship with the therapist, not catapult the participant back into trauma-related implicit memory states" (p. 204). While there are some reputable and valid evidence of the

benefits of touch in individual psychotherapy settings as discussed above, to date, there is no empirical research conducted on male military veteran soldiers' experiences receiving touch or contact during group-based therapy interventions or processes of change modalities such as specifically applied in T. E. group activities.

This qualitative research study was conducted using a bounded, multiple case study method, and examined the experiences of three male military veteran soldiers who attended the Veterans Transition Program, and participated in several therapeutic enactments, and group-based intervention activities involving receiving of contact from the other group members, and lead VTP therapists.

From a qualitative research perspective, Polkinghorne (2005) submits:

> The data required to study experience require that they are derived from an intensive exploration with a participant. Such an exploration results in languaged data. In the context of qualitative research, the meaning of data is linked to the 'sense data' of observations. The purpose of qualitative research is to provide evidence for the experience it is investigating. (p. 138)

The multiple case study method provides detailed descriptions of real events, and opportunity for in-depth exploration of the experiences of such events. As Ash et al (2006) state, "the goal is to gather enough information in different ways so that the multiple sources of evidence help the investigator paint an accurate picture. Analysis consists of gaining a broad view of the data as well as finding patterns and themes" (p. 296). In this multiple case research study we obtained information from varied sources: participant's therapeutic enactment and research interviews, researcher's observations during the enactment intervention process, and debriefing discussions with the participants.

In keeping with the conceptual qualitative study framework such as that reported by Polkinghorne (2005), this research study used the multiple case study methodology as defined by Stake (1995), who claims, "case study is the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances" (p. xi). Stake (1998) points out that crucial to case study research are not the methods of investigation, but that the object of study is a case: "as a form of research, case study is defined by interest in individual cases, not by the methods of inquiry used" (p. xx). Stake's (1995) case study approach, in alignment with understanding the specific case itself, is based on what he describes as, "when we get curious about a particular agency, or when we take responsibility of evaluating a program. We need to learn about that particular case. We have an intrinsic interest in the case, and we may call our work *intrinsic case study*" (p. 3). He elaborates on this point, stating that, "in intrinsic case study, the case is pre-selected" (Stake 1995, p.4). Stake (1995) also emphasizes that case study is focused on what he calls "particularization": the concept of analyzing one case, learning and understanding it in terms of what the case is and what it is about. This research study engaged in a multiple case analysis process that, through the participant's narrative, identified patterns of touch and contact based experiences: collective and isolated feelings, cognitions, and sensorimotor responses during various group-based interventions and therapeutic enactment modalities.

The three cases were bounded by four data sources for each participant: two, 3 hour post group therapy intervention interviews; video recordings of the participant's therapeutic enactments; and researcher's observations over an intensive two week group-based therapy program. The primary source of research data consists within several hours of video recorded interviews of each participant engaged in a narrative process with a researcher interviewer

using a form of "interpersonal process recall" method of inquiry: audio and video recordings of the participant's therapy intervention experiences were reviewed with a researcher who helped the participant recapture "in-the-moment experiences" of significant events that occurred for the participant during the group-based therapeutic interventions. Interwoven within these recorded group-based enactments, whereby the participant was the lead participant, are key moments when the participant is in human to human contact with individual group members, or more than one group member at the same time. It is in these experiential moments of receiving touch and contact that this research study explored, and identified the participant's experiencing through cognitive, affect, and sensori-motor responses, and the meanings of the contact for the participant. Through an analysis process of reviewing the interview recordings between participant and research interviewer, an exploration of discovery took place.

Analysis of these cases considered the overarching concepts of Gilligan's Listening Guide (2003). As Gilligan et al (2003) describe:

> The Listening Guide is a method of psychological analysis that draws on voice, resonance, and relationship as ports of entry into the human psyche. It is designed to open a way to discovery when discovery hinges on coming to know the inner world of another person. (p.253)

The Listening Guide method is comprised of multiple steps that are intended to, "offer a way of tuning into the polyphonic voice of another person" (Gilligan et al, 2003, p. 254). The focus of the audio and video review process is elaborated by Gilligan et al (2003) discussed that the Listening Guide method is a means of enhancing the intricate and multilayered forms of expression of human experience, and takes into consideration the interconnection between

the self, relationship, psyche, and culture. Given the focus of this research study, Gilligan's Listening Guide was an effective method to use in identifying the variations in the participant's experiencing of touch and contact throughout his therapy process, and offered a seamless transition from the viewing and listening procedure, and transitioning into the thematic analysis stage of the study.

This research study also incorporated the concepts of data analysis developed by Braun and Clarke (2006). As Braun and Clarke claim, "thematic analysis is compatible with both essentialist and constructionist paradigms within psychology, and through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data" (p. 5). This multiple case study explored the participant's experiences of receiving contact, and through analysis method, contact codes were generated within receiving various forms of human to human contact during group process of change therapy interventions.

Braun and Clarke (2006) explain that the thematic analysis method is a research exploration process designed to identify, analyze, and describe patterns or themes that exist within the acquired data. In terms of "theme identification", Braun and Clarke (2006) provide a definition that helps clarify and refine its context, "a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (p. 10). For the purposes of analyzing the contact experience information, this method was most suitable to this research study as it supported the analysis process necessary to effectively identifying and refining the participant's experiencing patterns directly related to receiving touch and contact, and provided a compatible framework from which to generate evidentiary information in support of further

research on this specific topic. The data analysis stage of this research study conceptually followed the initial code generation stages as described by Braun and Clarke (2006) in the following:

Phase 1: Familiarizing with the data: repeated review of the recorded information of the participant's enactments, and interviews, and group observation notes; transcription of participant's narratives related to his experiencing of touch and contact.

Phase 2: Generating initial codes: producing initial codes from the transcribed and observed data that are related to the experiencing of touch and contact; organize the codes into groupings that are meaningful and related to each type of described "experience of touch and contact" (Braun & Clarke, 2006).

This research multiple case study applied the three essential data analysis processes described above, and generated a series of experiential contact codes directly related to the narrated excerpt experiences of each participant receiving touch and contact. An independent researcher validated the contact codes, analysis information, and participant responses.

3.1 Ethics

This secondary research data was obtained in part from a parent research study focused on analyzing the overall experiential effects of participating in the Veterans Transition Program, over a period of ten days, and included analysis of the breadth of experiences of the male veteran soldier participants during therapeutic enactment interventions, and group-based activities. All participants of the parent research study, which included the three participants described in this multiple case research study, and this thesis document, provided full consent, and their confidentiality was retained in accordance of the terms of the parent study's consent documents. In addition, for this multiple case research

study, and thesis document, the three participants as described in chapters four and five, provided full written consent to the specified research and analysis described in the consent documents, and conducted and presented in this thesis. Ensuring each participant's identifiable information was withheld retained each participant's confidentiality. To further mitigate the risk of exposing the electronic videos of the participant's therapeutic enactments, and post enactment interviews, all relevant research information, including identifiable information to external contacts or entities, audio tapes and related information resided within locked cabinets, required security code access to electronic computer files, and resided within locked offices of the principal investigator and co-investigator. Each participant had a period of five days to consent to the data being included in this research study. Participants, following their written consent, were permitted to withdraw from the study at any time until this research study was completed.

Chapter 4: Analysis of findings

4.1 Background

This research investigation analyzed the experiences of men receiving contact during group-based psychotherapy interventions. The study specifically focused on three Australian male military veteran soldiers during their re-experiencing and processing of significant traumatic events within therapeutic enactment (T.E.) group-based interventions.

T. E. is a multi-model, action-based, experiential group therapy intervention that has been demonstrated as particularly effective in the treatment of military related traumas (Westwood et al 2010). A foundational component of T. E. is the intentional application of contact between participant and therapist, participant and group participants, and other group participants. Contact interactions are dependent upon the nature of the re-enacted trauma event, and uniquely adapted to meet the specific integration processing needs of the participant. The contact applied may be defined within the T. E. environment as "directive contact" – contact which is applied to move the participant or participating group member into enactment position during the intervention scenarios, and "supportive contact" – using contact to reinforce relational security, safety, attachment bonds, and as means of affect regulation.

The three military veteran soldiers each experienced their T. E., and are identified as "participant" in this research study. As a member of the VTP therapy team, and a researcher to this investigation, the author to this study was either chosen to assume a role in the enactments, or attended as a supporting group member, participating as a witness and research focused observer to the participant's therapeutic processing. Additionally, a professional documentary film crew, under written consent by the attending VTP veteran

soldiers videotaped each participant's T. E. Within twenty-four to thirty-six hours following each T. E., an independent researcher, and the author to this study separately interviewed the participants on their T. E. experiences. This research study's investigation and analysis is based upon a review of the independent researcher's video taped interviews, participants' T. E. video tapes, and the author's observations during the T. E. intervention sessions, where the participant expressed his experiences receiving contact during the T. E.

Consistent with Braun and Clarke's (2006), thematic analysis for qualitative research in psychology, using an inductive approach and latent analysis, the author reviewed and isolated the participants' contact excerpts in the videotaped T. E. interviews, and correlated those excerpts with the author's observations of the participant's experiences from their videoed T.E. intervention session. The author's observations examined the participants' behaviour responses, body language, verbal expression, voice and tone, and noticeable affect responses to receiving contact during the enactment intervention process.

The following examples illustrate the male participant's experiences of receiving contact during group-based psychotherapy interventions conducted during various therapeutic enactment modalities.

4.2 Participant 1

4.2.1 Contact context: trauma issue and presenting problem

The participant's primary caregiver was his grandmother who represented the only actively present "parent figure" during his childhood and adolescent years. During group therapy sessions, and while engaged in his therapeutic enactment process, the participant expressed that his grandmother was very important to him, and provided essential care and nurturing, unconditional love, safety, discipline, and structure during his critical development

years. The participant further described his grandmother as the only person in his life whom he felt listened to, understood, and supported in his interests. Sharing and describing some of the stories of his relationship with his grandmother, the participant expressed that she taught him to be a caring, respectful and responsible to himself and others. Furthermore, the participant expressed that his identity, confidence, and compassion was reinforced as a result of his relationship with his grandmother.

However, the sudden death of his grandmother, which occurred during his early adult years, represented a significant trauma event for the participant. Specifically, her death severed an attachment bond of a primary caregiver, and eliminated an essential relationship bond. The psychological effects of this trauma event resulted in progressive decline in the participant's self esteem, and self efficacy. During the VTP group therapy activities, he expressed feelings of anger, sadness, pain, emptiness, and regret that he was not able to tell his grandmother how important she was to him as she was the only person he could trust in his life.

The participant's unprocessed trauma was further exacerbated as result of a severe injury that occurred during a rugby match while playing for the Australian Navy rugby team. Over the duration of his athletic career, he suffered from repeated shoulder injuries causing irreparable tissue and bone damage, and consequently resulted in pre-mature retirement from elite international rugby competition. The participant never returned to the game he loved. He described that soon after his forced retirement, he felt his sense of personal identity, value and recognition ceased to exist. He lost the friendship and bond of teammates, and the feelings of being supported by them on the rugby field. He missed the feelings of belonging, and safety among his mates who together supported each other, and worked together to

practice and compete. The participant's relationship with the grandmother and his status as an elite athlete were two essential foundational components that he relied upon for security, care, love, self esteem, identity, supportive male bonding relationships, confidence, value, and recognition as examples.

The loss of both of these core attachment-based relationships created concurrent decline in the participant's physical and psychological health functioning, and he spiraled into chronic depression. In the years that followed, the participant experienced multiple comorbid symptoms associated with this illness: decline in self-esteem and self-efficacy, diminished motivation, gambling, alcohol and drug addiction, marital discord, engaging in criminal activities, increased isolation and withdrawal, and feelings of hopelessness. Upon reflection and self disclosure during VTP group therapy activities, the participant expressed feelings of deep guilt and sadness regarding how profoundly his life had changed since the death of his grandmother and physical injury, and he had an awareness of the intense pain and anger that he had been feeling and carrying for many years since. He also expressed wanting to reclaim his old self – the confident, strong, and athletic man that he once knew, but felt the weight of his psychological and physical impairments were too great and holding him down. The participant also expressed deep frustration in not knowing how to reclaim the feelings and self awareness he once had for himself when his grandmother was still alive. He missed his grandmother deeply, and wished she were still alive so he could once again feel her love and security, and reclaim the self-esteem and confidence he once had.

4.2.2 Therapeutic enactment setting

The VTP therapy team created a re-enactment scene whereby the participant would engage in a relational dialogue including contact (holding the grandmother's hand throughout the enactment) with his grandmother (a female group member chosen to portray his grandmother). The intervention design helped to initiate an integrative trauma repair process focused on resolving the participant's trauma due to the death of his primary caregiver. The T. E. intervention required the assistance of other VTP group members who were assigned key relational support roles to assist in re-enacting the traumatic event, which involved the participant saying good-bye to his grandmother who lay on her death bed - enacting an unfinished narrative.

As the participant had previously described to the therapy group, for many years since his grandmother's death, he carried unresolved negative feelings due to the loss of this primary attachment bond. The therapy team determined that the participant's enactment needed to focus on working through core unresolved negative feelings, while regulating the participant in moment-to-moment responses and self awareness: regulated integrative processing of participant's expressivity (noting voice projection and tone), cognition, non-verbal behaviour, and affect.

Specifically, the enactment focused on facilitating the participant's expression of an unfinished narrative: to tell his grandmother what he was not able to tell her since her death, express how much she meant to him, how much he valued his relationship with her, and how difficult his life has felt since her death. Simultaneously, the enactment intervention facilitated the therapeutic effect in helping the participant work through his unresolved anger, sadness, and guilt issues as a direct result of the loss of his primary caregiver who provided a

caring, secure, nurturing and loving environment for the participant during his childhood and young adolescent years.

4.2.3 Therapeutic goal

The overall therapeutic goal of this T. E. intervention was to facilitate the participant's expressivity of blocked affect, and cognitive distortions due to relational trauma, through verbal dialogue, and visual and contact interactions designed to integrate and reinforce the participant's corrective affect, cognitive processing, and self-awareness. The T. E. intervention also helped engage the participant in a corrective (integrative) process of trauma repair through re-experiencing the death of his grandmother. Therefore, the intervention needed to facilitate an interpersonal interaction, and intrapersonal experiencing of the attachment break between the participant and primary attachment individual, and his childhood environment – recreating a meaningful and symbolic setting to help reinforce the re-experiencing process, and incorporate complimentary visual queues related to the participant's memory recall of his relationship with his grandmother.

The specific intervention involved the participant engaging in a gestalt-based verbal interaction using sentence stems with his grandmother, and simultaneously incorporating contact between both participants as a means of instilling relational connection and stimulating sensorimotor processing. Throughout the intervention, the therapy team focused on the participant's affect regulation, reinforcing corrective (positive adaptive) responses using resource instillation, strength confrontation, and interpersonal awareness between participant and grandmother as a means of facilitating his integrative experiential process.

4.2.4 What occurred

The participant was positioned next to his grandmother who was lying on a table top (described symbolically as her deathbed). Prior to commencing with the intervention, the therapy team guided the participant to sit next to the table, face his grandmother, and to hold her hand. After doing this, the participant independently leaned forward, and with both arms resting on the bedside, held his grandmother's hand in his right hand, focused his eye contact on hers, and awaited further direction.

A lead therapist positioned himself at the participant's right side, and placed both of his hands on his right shoulder and upper back, while an enactment group member sat on the left side of the participant, and placed his right arm across the top of the participants left shoulder and upper back. The intentional placement of therapist and group member to be at close proximity to the participant, and in contact is to provide "relational and supportive backing" (an additive physical and visual presence of another during the enactment process), and relational support for the participant while in a state of trauma processing. Under the direction of the second therapist, positioned on the other side of the table, next to the grandmother, and leaning close to her face, said statements to the grandmother who repeated these words to the participant, and looking directly at him, in the following dialogue: "You brought me humour, grace, and courage, and now you brought to me my great grandson. And I love you, and I always will. I wish I could have said goodbye to you in person, but I couldn't. And I'm so glad you came because I know you love me. When you lived with me, you gave me a whole new hope, a whole new reason for living, and a love I didn't know from many people."

4.2.5 Researcher's observations

The researcher's observations during this enactment intervention identified the following affect, behavioural and physical responses that occurred during the dialogue described above, and experienced in the moment of the participant's receiving of contact. Prior to receiving the grandmother's dialogue, the participant was visibly engaged: leaning forward close to his grandmother, maintaining consistent eye contact, and gently holding his grandmother's hand. The grandmother caressed the participant's hand while she spoke, using her pointer and index fingers. As the grandmother's dialogue proceeded, the participant's head began to lower, and he looked down, disengaging eye contact from time to time. His face began to appear flush, and his eyes began to tear. His breathing began to increase and go shallow. At the moment when the grandmother said the following, "I wish I could have said goodbye to you in person, but I couldn't", the participant's head dropped down and turned to the left, his eyes closed, and he began to express tears, and releasing of emotion. In that moment the participant's hand shifted from gently holding his grandmother's hand to a very firm and clenched grasp. The participant continued to express tears and emotion as she continued her dialogue. He did not speak in response to what she said.

4.2.6 Participant's contact excerpts

During his T. E. interview, the participant recalled his experiences in the moment of receiving contact during the intervention concerning saying goodbye to his grandmother.

4.2.6.1 Excerpt: 1

Researcher: "Do you remember those times when David (lead therapist) or Marv (lead therapist) might have been moving you?"

Participant: "The biggest thing I remember, probably the only thing I remember was holding Bobo's (grandmother) hand when she was lying there on her deathbed, and I didn't want to let her go."

4.2.6.2 Excerpt: 2

Researcher: "You remember her (the grandmother's) hand?"

Participant: "Holding her hand was uhm… like I was actually holding her hand. And just holding her hand and feeling the warmth again."

4.2.6.3 Excerpt: 3

Researcher: "You feel the warmth holding your grandmother's hand?"

Participant: "Just holding her hand again, feeling the warmth. I could smell her. I could sense her. It was like whenever I was in her presence, not her aura, but her love, her care. I could feel everything about who she was, and I remember when I was holding her hand, it was like all those things again, and it's still with me, and so I feel like I am still there."

4.2.7 Contact codes

The participant's excerpts, recalling and describing his experiences receiving contact during the intervention revealed the following coded contact themes for each of the three excerpts:

1. Love, Sadness, Safety
2. Warmth

3. Warmth, Love, Care, Scent (Smell)

4.3 Participant 1

4.3.1 Contact context: trauma issue and presenting problem

The participant expressed that his relationship with his ex-wife was highly manipulative, and predominantly involved conflict based communications, whereby both persons would engage in heightened arousal interactions involving argumentative, abusive, defensive, derogatory, and accusatory comments toward one another. The participant expressed that following these emotionally charged interactions his resonating feelings about his ex-wife were extreme frustration, anger, guilt, and shame due to his loss of self control and confidence.

The participant described that his interactions with his ex-wife often caused him to act out in maladaptive coping behaviours: feelings of extreme anger leading to verbal and physical altercations and violence directed toward other people, or destruction of personal property. These maladaptive response behaviours, caused the participant to adopt unhealthy coping strategies: often self medicating using alcohol and marijuana to escape from the realities of his negative feelings, numb the pain of his depressive state, and regulate his activated affect, cognitive, and behaviour responses. The contributing consequences of alcohol and drug abuse for the participant, manifested in gambling addiction, ongoing financial problems, and promiscuous sexual behaviours with others ultimately, placing him at health risk.

Upon reflection during his enactment dialogue, the participant identified several key patterns of thoughts, and behaviours in his relationship with his then wife at the time that confirmed his realization that he did not love her, nor respect her as a person. During the

participant's enactment intervention, he was asked what was it about her that he was attracted to when they met, and why did he commit to her in marriage? The participant responded that he recognized she was a woman that needed help and care, and he felt he was good at providing this for her. At the time, the participant also indicated that in the early stages, the relationship felt right for him, however, he was also aware of his conflicting feelings about her, but did not feel strong enough to act on them.

A contributing factor that affected the participant's relationship with his wife was her attachment to her mother. From the participant's relationship perspective, and specific experiences described during the enactment intervention dialogue, his wife's relationship with her mother often created manipulative conversations and behaviours toward the participant. Specifically, the participant expressed a feeling that both mother and then wife were perpetually conspiring against his wishes and importantly, not respecting his needs. The effect of the mother and daughter's relationship toward the participant was a feeling of not being heard or understood, and that he was not of priority or of importance to his wife. As a consequence, the participant experienced strong feelings of resentment, and anger towards both of them. Furthermore, the abusive and manipulative behaviours of the mother and daughter toward the participant contributed to his feelings of low self-esteem, and loss of personal and relational control over his life.

During the enactment, he expressed that his son is the most important priority in his life going forward, and felt the need to establish a healthier relationship with his ex-wife: greater understanding between one another, respectful communication, and mutual recognition and support for their son's welfare. However, due to the participant's past experiences with his ex-wife, he feared inevitably losing his relationship with his son because

he did not feel he could trust that she would accept his wishes. He felt apprehensive his ex-wife would not accept the realities of his true feelings: that he never really loved her. He expressed fear that as a consequence to speaking his truth, she would then act out in revenge, and not allow him parental access to their son.

It was therefore, the participant's hope that upon speaking to his ex-wife in person, and confessing his true feelings about her, they could gain clearer understanding for each other, and proceed in an amicable and collaborative co-parenting relationship with their son. The participant felt ready to confront his ex-wife with these issues, however, he did not know how to do so in a respectful, calm and clearly spoken manner that would communicate his needs and feelings, and ensure he was being heard and understood.

4.3.2 Therapeutic enactment setting

The participant's relationship with his ex-wife, and recognition that he likely never felt love and respect for her throughout their marriage, including the negative effects of the dysfunctional attachment bond between the ex-wife and her mother, contained several key issues that the participant felt a need to resolve. Specifically, the participant was withholding his true feelings about his ex-wife during their marriage – that he never really loved her, nor respected her. He was increasingly feeling the need to confess this to his ex-wife, and importantly, speak his truth, honour his feelings, and explain his negative behaviours throughout their relationship. In the participant's words, "I need to get it off my chest. I've been carrying this around with me since the first day that I met her, and throughout all the cheating and lying, and manipulation." Underlying this statement, the participant wanted to convey his honesty and displeasure about not feeling respected, heard or understood during their relationship, and especially when he really needed to feel her support and trust.

The therapy team determined that as an initial step to the participant's reparative process, he would benefit from an intervention that incorporated an integrative experiential communication between his ex-wife, and with the support of his role playing grandmother and role playing son as supportive witnesses.

The intervention design required the participant to sit facing his ex-wife (the participant chose the co-leading therapist to assume this role), and to clearly convey his confessions about not ever loving her, being unfaithful, and how he felt being manipulated and mistreated by his ex-wife and her mother for many years. Following this dialogue and therapeutic processing, the intervention design shifted to the participant conveying his desire for an amicable relationship with her that would place their son as a priority going forward, and to seek her agreement to cooperating as co-parents to their son.

4.3.3 Therapeutic goal

Therapeutic goal of the T. E. intervention was to establish a relational interaction between the participant and ex-wife that would facilitate a re-experiencing of maladaptive affect, cognitive, and behaviour responses, and help the participant formulate in the moment adaptive and corrective interactions while immersed in a challenging confrontational interpersonal interaction. The objective of the intervention was to create an embodied experiencing for the participant: intrapersonal awareness, and interpersonal processing of corrective cognitive, affect and behaviour responses while engaged in situational dialogue involving maladaptive responses from his ex-wife. The interaction and dialogue would allow the participant to release the thoughts and feelings that had been suppressed for many years.

To reinforce the participant's integration and adaptive processing, the therapy team designed the intervention to emulate sufficient resistance, manipulation statements, and

emotionally charged responses from his ex-wife as a means of helping the participant re-experience a familiar negative interaction. The participant was then simultaneously coached by the lead therapist through verbalizing corrective sentence stems that were then repeated by the participant to his ex-wife.

To accomplish the intervention objectives, the interpersonal dialogue focused on key directive statements that represented corrective and adaptive communication skills, and as the intervention proceeded, incremental processing of corrective affect, cognitive, and behaviour responses occurred. Throughout the intervention, the therapy team methodically interacted with the participant to regulate and integrate his self-awareness of the embodied positive changes in affect, cognition, and behaviours.

4.3.4 What occurred

The participant was seated, and positioned facing his ex-wife who was also seated approximately three feet away and facing him. The participant chose a co-leading therapist to assume the ex-wife role for this intervention. The lead therapist was seated next to the participant, very close to his left side. He was directed to look at his ex-wife before the dialogue began as a means of grounding him in the intervention setting, and asked to be aware of how he was feeling in the moment. The participant expressed feeling uncomfortable, but ready to proceed. He was then directed to look at his role playing grandmother and son who was both seated at distance among other intervention witnesses. In that moment, the lead therapist said to the grandmother and son, "Do you see what he (participant) is about to do? He is going to be honest with her (ex-wife). Do you think he can do this?" They both answered with a calm and confidant, "Yes". The lead therapist said to the participant, "So, you've got your resources." In that moment, the participant turned his

head to face his grandmother and son, and requested that he be able to face them during the dialogue with his wife. The lead therapist decided instead to include them in the intervention setting, and were directed to sit behind the ex-wife, on her left side, and within clear in eyesight of the participant.

Throughout the intervention dialogue process, the therapy team methodically conveyed gestalt-based sentence stems to the participant, and reinforced the participant's integrated experiential processing through self-awareness queues, whereby the participant was instructed to repeat the specific statements that contained direct, affirmative, self assured, and conviction weighted language, and used effective voice tone and resonance.

The intervention dialogue commenced with the lead therapist sitting next to the participant. The lead therapist leaned close to the participant and in a soft voice asked him to say the following: "What I need to tell you is …" The participant then completed the sentence stem, saying to his ex-wife the following, "What I need to tell you is that I've never loved you." This core statement by the participant facilitated a significant release of dialogue as he proceeded to speak of many memories of events and incidents in their relationship that represented evidence he did not love her, and supported his feeling that he should not have remained with her for so many years.

After the participant spoke of several situations that represented their incompatibility, the lead therapist, still seated next to the participant, asked him to pause for a brief moment (approximately 3 to 5 seconds). This intentional pause represented a shift to occur in the intervention dialogue, and marked a "lead-in" to the participant's transitioning into asking for forgiveness, explaining his behaviours of the past, and formulating his decision to sever the maladaptive emotional attachment to his ex-wife. Following the brief pause, the lead

therapist then asked the participant to say the following, “But now I owe you an apology.” The participant repeated this sentence, and then the following: “I need to say I am sorry, but I was kind of messed up then, and I lost my way. And I still had a heart, but my thinking wasn’t clear. And I think you tapped into my sympathy. I thought it was the right thing to do, and now looking back, I have to tell you again I should never have married you. I should never have strung you along as long as we met. And I just have to get this off my chest. I am saying my truth now, and I’m not proud of it.”

As the intervention dialogue transitioned to the participant re-defining his relationship with his ex-wife going forward, the lead therapist simultaneously assisted with the participant’s resource installation, and embodied integrative experiencing and processing. The lead therapist sought feedback on the participant’s progress from his grandmother and son as they observed, and asked each of them how he was doing, and what were they noticing about his interaction with the ex-wife, and how were they feeling about what they were hearing and observing. The participant was then requested to look at his grandmother and son as they responded. For example, the lead therapist asked, “What is the one thing he is trying to do? Is it easy for him to do?” The son replied to the participant, “You’ve got your grandmother’s grace. Isn’t that one of your wishes? And that’s what I’ve heard, and that’s what came through throughout this entire conversation.” The lead therapist turned to the participant and said, “So you said the truth here didn’t you? You said what you needed to say. And look at these people (pointing to other group members who were present as witnesses to the enactment intervention) they witnessed this, …these people.” The participant expressed that he felt very confident and self-assured about his meeting with his ex-wife, and that no matter what she tried to do, would remain calm, and tell her the truth.

4.3.5 Researcher's observations

The researcher's observations during this enactment intervention identified the following affect, behavioural and physical responses that occurred during the intervention dialogue described above, and experienced in the moment of the participant's receiving of contact. As the intervention dialogue began, the participant appeared slightly hesitant, and anxious: his hands clasping and unclasping, he spoke quickly, and in soft, broken sentences – his words did not flow steadily from one to the next. The participant's eyes shifted from side to side, and often looked away from his ex-wife and down to the floor. His head appeared slightly down as he sometimes looked at his feet when he spoke to her.

However, the participant's body language, tone of voice, and eye contact shifted in the moment following the intentional pause in the dialogue that marked a transition to the participant's apology statements. In that moment, the lead therapist leaned closer to the participant, his right arm placed round the upper back of the participant's chair, and in contact with the participant's upper back, and the therapist's right leg in contact with the participant's left leg. The participant began to speak with a stronger, elevated voice, in a direct manner. His sentences flowed steadily, as he formulated what he wanted to say next to his ex-wife. He appeared to rely less on the lead therapist's sentence stems, and spoke from his own thoughts and feelings, expressing and explaining how he felt, and what he thought about his relationship with her. The participant leaned forward slightly, and his head lifted up to directly face his ex-wife. His eyes held steady towards her as he spoke. His hands and arms appeared relaxed in a casual position with his forearms resting on the top of his legs. From the moment of receiving contact, throughout the remainder of the intervention dialogue, the participant appeared calm, relaxed, and confident, sitting and speaking to his

ex-wife. He shifted from a hesitant and nervous stance, to one of engagement and self-assuredness.

4.3.6 Participant's contact excerpt

During his T. E. interview, the participant recalled his experience in the moment of receiving contact during the intervention concerning speaking his truth to his ex-wife.

4.3.6.1 Excerpt: 1

Researcher: "Marv has got his arm around the back of your chair, and his shoulder is against you. Were you aware of that at all?"

Participant: "Ya! Ya, I remember Marv sitting there. His leg was against mine as well. His arm around my back had the feeling like you've got a mate next to you. Mateship. Holding someone up. There's support, and strength. By Marv putting his arm around me, it was another natural feeling of it's time to play and toughen up, and be ready to play. Quiet confidence."

4.3.7 Contact codes

The participant's excerpt, recalling and describing his experiences receiving contact during the intervention revealed the following coded contact themes from his excerpt:

1. Mateship
2. Support
3. Strength
4. Focus / Motivation (Inferred)
5. Confidence

4.4 Participant 2

4.4.1 Contact context: trauma issue and presenting problem

There were two primary traumatic events (the second is discussed in the sections that follow) that the happened to this participant, a medic while serving in the Australia military, while stationed overseas in Malaysia. Both of these trauma incidents were directly related to one another as a matter of circumstance, and consequently deeply affected the participant for many years as he struggled with the psychological difficulties of PTSD symptoms. The psychological implications of the participant's trauma experiences created a condition known as survivor's guilt or syndrome: a psychological condition that occurs when the individual internalizes and interprets themselves to have done something wrong by surviving a traumatic event when others have perished. Survivor's guilt is identified as a significant symptom of posttraumatic stress disorder, and typically prevalent among many military veterans.

The participant described the details of experiencing the first trauma event to the therapy team and VTP participants recalling a military vehicle accident involving five of his fellow soldiers, some were his close friends. All five men were killed while driving to a local village, located in close proximity to the military base. The participant informed that up to this day of his enactment intervention, he had suffered from horrific nightmares related to the loss of his "mates", and constantly experienced feelings of deep guilt, shame, and direct responsibility for their deaths. As the participant's enactment intervention proceeded, he described an overview of circumstances of his trauma incident. The following is a summary of the participant's memory recall of important details to this event, and contains information directly related to his trauma issues and presenting problems.

The participant was commander of a military unit at a base stationed in Southeast Asia. While there were many services and provisions, this particular military base was not equipped with standard civilian communication services available such as telephones for personal calls. To help accommodate the soldiers, on occasion, military crew vehicles would transport personnel a short distance to a local village where they could place personal calls using public telephones to family members overseas in Australia. There was usually one scheduled afternoon departure from the base to the village, however on a specific day, the participant described authorizing a second departure that would leave in the evening. A critical discussion occurred on that day which would seal the fate of five fellow soldiers, and deeply affect the participant for many years afterward.

The five soldiers, realizing the time differences for their family residence locations in Australia, and the likelihood partners and children would be home at night (local Australia time), met with the participant and requested his approval for an additional village departure that evening. The participant approved and authorized their request. During the enactment intervention and debriefing discussion, the participant expressed that he felt good about being able to help his "mates", and knew how important it was to be able to communicate with family and friends, especially when isolated overseas with limited contact opportunities.

The participant boarded the crew transport vehicle, choosing the afternoon departure, left the military base to telephone his family back home, and returned to the base shortly after placing his calls. That evening, the five soldiers, along with eleven other military personnel, boarded the crew transport vehicle for the second scheduled trip to the village. However, this transport vehicle while en route to the local village was involved in a fatal head on collision with a bus. Back at the military base, the participant was notified of the serious accident, and

with the assistance of several fellow soldiers was immediately dispatched to the scene to secure the crash site area and provide first aid to victims. Upon arrival to the accident scene, the participant described seeing "carnage": blood covered the inside of the damaged vehicle, dead soldier's bodies were laying on the ground, and some of the others severely wounded soldiers being attended to by military personnel. The participant assessed the status of each of the critically wounded men. To his horror and disbelief, it was evident there was nothing he could do for four of the soldiers. Showing no vital signs, these four men were all fatally injured in the accident. However, a soldier in his unit discovered that the fifth soldier was still alive, and called this to the attention of the participant. He immediately took action, using his field medic skills, applied cardiopulmonary resuscitation (CPR), and artificial respiration (AR). It was the participant's hope that if he could stabilize the critically wounded soldier – his friend, they would be able to transport him to the nearest medical facility. However, while engaged in CPR and AR, the participant realized his soldier friend's injuries were too severe due to internal bleeding and severed primary arteries in his neck. To the participant's dismay, with each sequence of CPR chest compressions, and manual breaths into his mouth, the man's blood would either pool into the soldier's throat, or accelerate out of his open neck wounds. In this moment, CPR and AR were the only options available to the participant, but both resuscitation techniques were ineffective. After an intensive attempt to revive the soldier, the participant assessed the situation and concluded that further first aid intervention efforts would be futile - there was nothing more the participant could do to save him. In a complete state of shock, he knelt on the ground as his fellow soldier's vital signs rapidly flat-lined. All five of his fellow soldiers, his "mates" were dead.

The participant's memory recall of his state of mind and feelings in that moment was of absolute helplessness and responsibility for the soldier's deaths. As he described, being a trained military medic, his primary job was to protect, provide first aid treatment, and save his fellow soldiers who were injured. However, as he described in the details of this evening, he was unable to execute what he was trained to do. He recalled feeling in complete state of shock from the horror, and experiencing numbness throughout his body. Feelings of direct responsibility for what had happened, and witnessing five of his mates lying dead at the accident scene, and feeling overcome by the reality that there was nothing he or anyone else could do for them.

He recalled his friendships and experiences with each of his five "mates", and was haunted by feelings of many things left unsaid, and that he regretted not saying to each of the soldiers prior to their deaths. For example, the participant discussed with the VTP group members that there were still some relational conflicts left unresolved in his mind and important things that needed to be explained, and clarified to the five soldiers. He also regretted not expressing the meaningful qualities and influences each of these men had on him, and how important each friendship had meant.

The participant expressed that since that terrible accident, and throughout the many years that had since past, he experienced deep unresolved guilt and shame. Additionally, he discussed how responsible he felt about what happened to the five soldiers that evening, and constantly had recurring intrusive thoughts and nightmares related to his feelings of direct responsibility for their deaths: if there was something he could have done differently on that day, would this have changed the course of events, and if so, would these men be alive today?

He also expressed with a sense of defeat and sadness, the luck of the circumstances on that day. He told the VTP participants had he chosen the evening departure with the other soldiers, he too would likely have been killed. The participant also disclosed his experiencing deep feelings of guilt because while he felt fortunate to have not been involved in the accident, he continued to feel responsible for what happened: he authorized the evening departure for the men. Furthermore, he experienced recurring feelings of sadness, anger and regret because in his attempt to assist and accommodate his fellow soldier's personal needs, a terrible event occurred, and had he not authorized the second departure, the five mates would still be alive. Lastly, he felt helpless not being able to revive any of his mates. He felt that he and his medical training had failed these five men. The affect this trauma event had on him was an increasing loss of confidence and self-esteem in his abilities and competence as a field medical specialist.

Over the years following this event, the participant developed symptoms associated with posttraumatic stress disorder, and these trauma symptoms began to increasingly affect his daily functioning. For example, ongoing negative coping behaviours affected his daily performance of workplace duties to the extent he was not only demoted and re-assigned to a lower position, but also restricted from further professional promotions: he could no longer apply for positions of advancement in the military. As a result, the participant's military career was severely compromised. As a consequence, the participant's maladaptive symptoms escalated: the recurring nightmares and memories of the trauma event, contributed to the participant experiencing relationship and marital discord: conflicts and arguments with his family, children, and close friends.

In summary, this trauma event caused the participant severe PTSD symptoms, and perpetual experiencing of maladaptive feelings of responsibility for the deaths of the five soldiers; unresolved guilt, anger, and sadness due to distorted cognitions and affect responses associated with decisions made that day, and feelings of helplessness. Additionally, perpetual experiencing of debilitative anxiety, depression and maladaptive coping behaviours with PTSD symptoms increasingly took its toll on the participant's overall well being, self-esteem, and confidence.

4.4.2 Therapeutic enactment setting

To initiate an integrative trauma repair process focused on helping to resolve the participant's trauma due to the death of five fellow soldiers, the VTP therapy team designed a re-enactment scene, whereby the participant engaged in relational dialogue with each of the five soldiers. This procedure enabled him to complete unfinished narrative, and re-experience a dynamic processing of cognitive, affect and sensorimotor responses. The relational dialogue incorporated both gestalt sentence stems, identified core relational attachment interactions between the participant and each of the five soldiers.

To establish an integrative processing of unfinished narrative, and unresolved affect experiencing, the participant's T. E. intervention required him to recall and communicate individually to each of the five soldiers (as if they were alive today) what was for example, most important, memorable, meaningful, and influential about his relationship with each of the men. The T. E. intervention procedure involved each of the five soldiers to be brought forward on separate occasions into the witnessing group circle, and stand at one or two feet, face to face with the participant.

The intervention's enacted narrative process was constructed such that each of the men were given opportunity to express their thoughts, emotions, and awareness in the moment physical interaction as they spoke of the trauma incident, importance of the relationship and friendship between one another, and additional unfinished narrative related to significant influences each man had on the other. In the enactment intervention process, the participant spoke first, while the soldier listened, and then responded to what he heard the participant say to him. An example of the participant's relational dialogue, enacting unfinished narrative, including gestalt sentence stems, is described in the following intervention interaction:

Participant: "The pain that I carry when I knew you were dead …was in my heart, because what hurt me the most …was that I didn't have you in my life anymore, …and I couldn't prevent your death."

Soldier: "I need you to know that I am in your heart, …and it would help me if you could tell me what part of me lives in your heart."

Participant: "Your spirit lives within my heart, …and I will take that with me forever."

Soldier: "And that means my death isn't in vain."

Participant: "I am so sorry …that you had to go on the night trip…because I went earlier, …and I am living in your death, …and that's the heavy thing in my heart. And when I see you look like this (standing before me), …I feel the pain and the guilt for surviving. …And I just need to say that, …even though I know it was not my fault, …I need to be allowed

to tell you, …the guilt that I feel for surviving …because you were such an alive man."

4.4.3 Therapeutic goal

The overall therapeutic goal of this T. E. intervention incorporating unfinished narrative involving relational dialogue, was to help the participant release maladaptive cognitions and affect responses due to his PTSD symptoms, and begin to reinforce an integrative processing of healthy, adaptive responses, including reframing and meaning-making of recurring confusing thoughts and feelings about the traumatic accident. The participant had expressed feeling deep guilt and responsibility for the deaths of the soldiers, and not being able to express the thoughts and feelings he had about each of the five men. Incorporating an experiential processing in the intervention to facilitate the expression of the participant's suppressed thoughts and feelings, would require an integrative approach to releasing the distorted cognitions and affect, and reinforcing corrective experiencing through enacting the unfinished narrative process.

4.4.4 What occurred

In a similar relational dialogue process constructed for participant 1, this T. E. intervention involved the participant's participation in a gestalt-based relational interaction with each of the five soldiers. However, this participant's intervention was designed to promote dynamic relational interaction: the participant and participating members engaged in their dialogue while standing, and had full range of body movement to express their words, and emotions. To help facilitate the trauma experiencing process, the two lead therapists attended to both participant and soldier, and supported each man through their dialogue, and gestalt sentence stems. Additionally, the lead therapists incorporated the application of

intentional moments of contact (placing their hand on the participant's or soldier's back, or standing next to each man, with their shoulders in contact) as a means of instilling support and safety, reinforcing relational connection, and stimulating sensorimotor processing throughout the interaction. Throughout the intervention, the lead therapists focused on attending to the participant's affect regulation, reinforced the participant's corrective responses to the soldier's statements, and helped the participant express his unfinished narrative to each soldier as a means of facilitating the participant's integrative experiential processing.

The participant was positioned in the middle of the room with a lead therapist, while the VTP group members were seated, forming a large witnessing circle, and surrounding the participant. To begin the intervention process, the participant and lead therapist walked slowly together, side by side in the internal perimeter of the seated group members, as the therapist asked the participant to describe one of the five soldiers. As a note, the T. E. model uses a combination of conversational dialogue and movement (walking) process, in support of the therapist and witnessing presence of VTP group members, effectively activates a re-experiencing of many of the cognitions, affect, and sensorimotor responses that, for example in this case, the participant has been suffering with over the years from the death of the soldiers. Specifically, this initial dialogue and movement procedure initiated two primary components necessary in the therapeutic enactment model: (1) an integrative activation of cognition, affect, and sensorimotor responses as the participant listened and responded to the lead therapist's inquiry, and sentence stems, recalled his relationship with each of his fellow soldiers, and described into the witnessing group the details that were meaningful to him and; (2) affect and sensorimotor regulation - using continuous movement in the form of walking

and talking helped the participant feel a continuous sense of physical, visual and spatial contact with his surroundings. For example, as the participant described the significant details of his relationship with each soldier, he would see the witness participants sitting in the group, all there to support him, and would see their facial expressions which may mirror similar emotions he is experiencing in the moment, thereby facilitating a normalization of the participant's affect experiencing. He would also have an awareness of the close presence of a safe and trusted person (lead therapist) walking with him as he recalled difficult images and events, and lastly, he would have an overall sense of physical and emotional presence of not being alone as he moved into his re-experiencing of the difficult trauma event.

At this time in the intervention process, the lead therapist asked the participant, through specific open ended questions, and combinations of relational, cognitive, and sensorimotor inquiry, to tell the witnessing group members what he wanted to accomplish in doing the T. E.:

Therapist: "Todd, I would like you to say into the group, what I want to do today is, what I want to leave behind or pick up, or let go of. So, why don't you start it."

Participant: "Fellas, what I want to do is say good-bye to some mates that I didn't get to say good-bye to, and what I hope to gain from that is to drop some baggage, some guilt…

Therapist: "Some baggage, some guilt, and something else I think you'll notice will be gone, is you know, the nightmare? So, if you could drop some baggage, drop some guilt, and soften the nightmare, what might your life be like, and how would that possibly be better?"

Participant: "In a lot of ways, I'm not going to be in a shell. I'm going to become how I used to be, and better relationships."

As the dialogue continued, the therapist transitioned his questions to asking the participant to choose, and introduce one of the witnessing group members who would represent one of the dead soldiers the participant would like to bring back and speak with (the participant identified a total of five group members who assumed the role of one of the dead soldiers). The lead therapist requested that the chosen soldier stand and face the participant. At this time, the participant was invited to tell the soldier what he was not able to say to him (unfinished narrative): to express to the soldier what his relationship meant to him, and to disclose key memories, and significant events that occurred between the men, and that were meaningful to the participant. As this processes proceeded, the lead therapist incrementally added sentence stems for the participant to repeat to the soldier. These sentence stems progressively shifted the focus of relational dialogue to the participant's expression of his guilt and sadness due to the loss of the soldier, and the guilt associated with the loss of their relationship. This stage of the model elevated the participant's experiencing of relational (attachment) affect, and trauma affect, including reactivating the participant's cognitive and affect responses originally experienced at the accident scene, and witnessing the dead soldier.

Under the direction of the lead therapist who stood on the participant's right side, and using gestalt sentence stems, asked the participant to repeat and complete each sentence in his own words to the soldier. The following is an example of the participant's interpersonal dialogue with the chosen soldier which occurred up to the moment of the participant receiving contact: "I am carrying guilt about your death because… when we first met, you uhm, betrayed my trust. You lied to me. You did something that you said you wouldn't do.

Uhm, of course I wasn't very happy about that. I resented that… I resented it, and it took me a long time to get over. And while we were overseas, my attitude toward you started to soften, and I thought for a couple of weeks we had made a connection, and we were on the same page, and uhm, and uhm, then you died. So, I've been feeling guilty that you passed away… What I regret most is… not having the opportunity to tell you that, because in our relationship there was a lot of friction, and a lot of tension up until that point. So, I regret not being able to tell you, and I regret not being able to say good-bye to you. But I'm doing that now… And as I do that… I'm telling my truth… I'm beginning to… feel light. I needed to say that to you… because I was starting to care about you… and I didn't want you to die… carrying that resentment." With the second lead therapist standing close, and at the soldier's left side, the soldier responded having heard what the participant just said to him in the following dialogue: "I believed that part of the friction we were feeling in the beginning was because of the position that you were in. It was tough, giving us direction. And I also felt connection in the last few days." The participant responded: "I hear you, but right now, I need to let you go… And all I need you to hear me say is I'm sorry I didn't get to talk to you and express the way I feel. But now I have… and this is being witnessed by… the other service people, and people who understand me. So letting you go… I will be able to move forward… as one less weight on my chest, and my back… I need you to let me go. Can you let me go?" With the assistance of the second lead therapist, the soldier responded back to the participant: "I can let you go, and I have the same regrets. And it's not your fault."

4.4.5 Researcher's observations

The researcher's observations during this enactment intervention identified the following affect, behavioural, and sensorimotor responses that occurred during the dialogue

described above, and experienced in the moment of the participant's receiving of contact. Prior to receiving the dialogue that activated the participant's intense releasing of emotions, he was showing indications of experiencing elevated affect arousal and sensorimotor responses during his narrative interaction described above, "And while we were overseas, my attitude toward you started to soften, and I thought for a couple of weeks we had made a connection, and we were on the same page, and uhm, and uhm, then you died. So, I've been feeling guilty that you passed away… " As the participant began to speak this statement, his voice tone softened and slowed down, and following his words, "were on the same page", his voice started to slightly stammer. The participant's hands began to twitch and shake at his side, and he then broke eye contact with the soldier, his head dropped down, and he looked at the floor. The participant's face began to appear flush, and his breathing quickened. Throughout this initial interaction, his eyes appeared to tear. The participant also displayed visible signs of elevated affect at this stage in the relational dialogue interaction.

The lead therapist, standing at the participant's right and facing the solder, placed his left arm around the participant's upper back, and gripped the top of his left shoulder. He asked the participant to take a deep breath (as a means of regulating affect, and helping him to focus his thoughts in the moment). The therapist then asked the role playing soldier, "Do you hear him?" to which he replied, "I do." In this moment, the participant was alternating his eye contact between a non-specific gaze to the floor (to the right of the soldier), and then directly into the soldier's eyes. The participant's facial muscles appeared to show increased tension around his mouth, and eyes. The lead therapist removed his left arm from the participant's shoulder, and proceeded to feed the sentence stems to the participant. Throughout the relational dialogue described above, and up to the moment when the soldier

states, “I can let you go, and I have the same regrets. And it’s not your fault.” the participant appeared to visibly fluctuate between subtle releasing of affect, and sensorimotor responses, and sporadic attempts at suppressing of his emotion (consciously holding back his expressed feelings), and corresponding body movements. For example, in moments when the participant is speaking to the soldier, he frequently used his hands to emphasize his statements. However, in the moments when the soldier is speaking to the participant, he positioned both arms and hands directly at his side, and stood tall, as if at attention. The participant’s fingers often moved and clenched as he received the soldier’s statements. Additionally, his mouth appeared tense as he listened to the soldier’s replies, and his lips clenched from time to time, in synchronicity with the clenching of his hands and fingers.

The lead therapist, now standing behind the participant, at his right, and in contact, (the therapist’s chest touching the participant’s upper right back), asked the participant to hear what the soldier was about to say to him. The soldier stated the following: “I can let you go, and I have the same regrets. And it’s not your fault.” In this moment, the participant was in direct eye contact with the soldier, and standing tall. Upon hearing the soldiers’ words, “…And it’s not your fault”, the participant’s eyes closed tightly, his face flushed and clenched, frowned in an expression of sadness, raised his hands to his face, and at that moment intensely released his emotions, expressing tears. In that same moment, the lead therapist, standing at the participant’s back, and to his right, had placed his left arm around the participant’s back, and tightly grasped his left shoulder. Additionally, the therapist’s chest was in contact with the participant’s upper back as the he expressed the releasing of deep emotion. The lead therapist’s embrace, and the participant’s releasing of emotion lasted

approximately ten seconds. The lead therapist gently let go of the participant, and stepped back slightly to the right of him as the interaction continued.

4.4.6 Participant's contact excerpt

During his T. E. interview, the participant recalled his experience in the moment of receiving contact during this intervention concerning the death of the soldier, and the guilt associated with this loss of friendship in the following excerpt.

4.4.6.1 Excerpt: 1

Researcher: "I noticed that Marv is really holding on to you. What was that like? Did you notice it?"

Participant: "No. But I think that subconsciously I noticed it, and it gave me strength. But you know, ten years ago, no way would I ever have allowed another to do that no matter how good their intention was. And another thing, that's key is I felt safe there."

4.4.7 Contact codes

The participant's narrative, recalling and describing his experiences receiving contact during the intervention revealed the following coded contact themes:

1. Strength
2. Confidence
3. Safety

The participant recalled and discussed a second moment of experiencing contact that was meaningful to him during this T. E. intervention.

4.5 Participant 2

4.5.1 Contact context: trauma issue and presenting problem

The second, and related trauma event that the happened to this participant also affected him for many years, and contributed to his psychological difficulties associated with PTSD symptoms. The following summarizes the participant's relationship with the fourth deceased soldier, and re-enacted trauma event, and relational dialogue that occurred up to the moment of his receiving contact. The participant had established a close friendship with one of the five soldiers that had died in the accident. Consequently, the participant experienced a significant attachment break, and felt shame, anger, and guilt for his friend's death. Specifically, this particular event caused the participant, as he described, to experience recurring nightmares, intrusive thoughts, and elevated anxiety connected to the death of his friend, and the circumstances surrounding the trauma event. He described that the intrusive images and visions of this trauma event, reinforced his feelings of survivor's guilt.

4.5.2 Therapeutic enactment setting

The enactment process for the participant's second trauma event was set up identically to his first enactment, whereby he engaged in relational dialogue with one of the fellow soldiers that died in the accident. The enactment's specific intervention's intention mirrored his first: focused on helping to resolve the participant's trauma due to the death of his (friend) soldier, and engaged him in interpersonal and relational dialogue with the soldier. Like his first enactment, this intervention enabled him to complete unfinished narrative, and re-experience a dynamic processing of cognitive, affect and sensorimotor responses. The relational dialogue also incorporated gestalt sentence stems, and helped identify the core relational attachment interactions between the participant and soldier.

4.5.3 Therapeutic goal

The therapeutic goal of the second relational interaction between the participant and fourth soldier was identical to what was described in the T. E. intervention above (the participant enacted unfinished narrative and therapeutic processing for each of the five deceased soldiers): to enact the unfinished narrative, and process maladaptive cognitions and affect, through expression and experiencing of relational dialogue. The participant described the characteristics of the fourth soldier as an influential, competent, and highly confident man. The participant and soldier were good friends, and his relationship extended beyond the camaraderie of military friendship bonds. These men also shared and experienced in each other's personal lives, which created a closer relationship bond.

4.5.4 What occurred

The following dialogue between the participant and soldier during the intervention reveals the importance of this relationship for the participant, and evidence of the strong attachment bond between the two men. Additionally, the interaction between the two men as they engaged in relational dialogue, also captured the participant's core challenges in coping with his friend's death, and the trauma symptoms associated with the loss of this significant relationship.

The participant's relational dialogue identified the primary cognitive narrative, and affect experiencing, directly connected to the trauma event: the death of his friend, and subsequent maladaptive coping behaviours and emotions related to his loss. Additionally, the therapist's strategic use of sentence stems, as a means of therapeutically activating episodic memory recall, assisted in facilitating the participant's releasing and processing of the painful memories of witnessing the death of his friend. As the intervention progressed the participant

shifted to letting go of the burden of carrying the negative cognitions and emotions of the trauma event. As in the previous intervention examples, two lead therapists assisted and directed the relational dialogue. One therapist was positioned next to the participant, and standing at his right side. The other therapist was positioned next to the soldier, and standing at his left side. An example of the relational dialogue is presented in the following interaction leading up to the participant's experiencing of receiving contact, and contains components of the progressive and integrative aspects of the T. E. process:

Participant: "It is good to see you again. When I look at you I'm reminded of… your sporting ability, your ability to lead your soldiers well, to teach them, to nurture them. I just feel a really strong connection with you. And we were born a day apart. And we got along really well even though there was a (military) rank difference, but it didn't seem to matter. I really appreciated getting to know you, and having you in my life. You have made a difference to me. The biggest difference you made in my life was… I got to see how you were as a father. And what I saw was… someone who was a strong and compassionate man, who cared for his kids, and loved his kids. And that is what I wanted to be… as a father. But I lost my way… for a number of years… But as I look at you now… I'm back here today to pick up… what I need to be a strong, loving father. And I am reminded of you… and I can take that with me. But what I really want to say now… that I'm most sorry that you didn't get to meet your second boy. Because he hadn't met you… he has missed out on meeting such a great man. Such a man,

who was respected, thought of as a legend. He's missed out on all that. And missed out on having you as a father. So what I promise to you… if your son ever asks me… or would require of me… to tell him what his dad was like… I would be so proud to tell him. And I promise I will do that… In fact, I might even honour that when he is ready, and then your life, your legacy will go on… as best I can through me. I promise that to you."

Soldier: "It is good to see you again… I need you to hear one thing… that whatever it is you saw in me as a father, it is in you too… the compassion is in you."

Participant: "I know what you want to see in me… but right now I am struggling."

Soldier: "If you can't see it in yourself, it is what I see in you… and I'm not bullshitting you. Can you hear that?"

Participant: "I can. … But I can't quite believe this yet, but I will work on it"

Soldier: "And someday I hope you'll see it in yourself, and I want you to hear my words… that it is in you. And that set aside, I also want you to know the accident was an accident and not your fault. Can you hear that?

Participant: "I can hear that. I need to say… when you had your autopsy… it was difficult and painful… but I stood there… for you… because I was protecting you. I was guarding your soul. And I was thinking of your family at the time."

Soldier: "I know, and I want to thank you for that… and I am honoured to know that you were looking out for my family, and that they know you were my soul-mate… and I thank you. It took a man… with courage… and a big heart… to stand there… with five of his mates… to go through what you had to go through in those autopsies… and I want to thank you."

Participant: "I don't want to carry that anymore… I don't want to carry the pain of the autopsies anymore. Because if I carry the pain of witnessing these autopsies… I would suffocate. I am giving this back over to where it belongs… and you can take that with you. Can you carry that?"

Soldier: "I will always carry that… and I want you to let go of the autopsies as well… and I want you to remember me… as I was when I was alive and full of piss and vinegar. Can you work to do that?"

Participant: "I can!"

Soldier: "Then can you also work now to live your life to the fullest starting today, and back to get your old self, giving your love to your kids? When you look in the mirror… can you give this love to yourself?"

Participant: "I will try. …And now I'll say good-bye… I have to do this… to be able to move on."

Soldier: "Part of me doesn't want to."

Participant: "But I need to let you go now… I need to let you go because… you meant the world to me."

Soldier: "I live on in your heart… do you know that?"

Participant: "I know that."

Soldier: "As you have lived in my heart… we were like brothers… we were born at the same time, same place."

Participant: "I am grieving your death… and I'm not hiding… the pain is excruciating… you don't need to say anything… and my allowing myself to feel the pain… says something about my attachment to you… and this is how I need to let it go… not block it out or deny it… the pain is excruciating… and I need to be allowed to have that… and to get that back."

Therapist: "Is that true? Is it excruciating?"

Participant: "Yes. … I'll see you Buddy." (The participant and soldier embrace, hugging each other tightly)

Soldier: "Good-bye"

4.5.5 Researcher's observations

The researcher's observations during this intervention identified the participant's affect, behavioural and physical responses that occurred immediately following the dialogue described above, and in the moment of the participant's receiving of contact from the fellow soldier. During the participant's dialogue with the soldier, nearing the end of their interaction, the participant's voice tone and volume, progressively slowed down, softened, and went quiet to a gentle whisper, in the moment when he said good-bye to the soldier.

Throughout the relational dialogue, the participant was in a state of releasing of suppressed emotion. There were visible changes to the participant's appearance as he incrementally transitioned from narrative and expression of trauma related memory recall, to

processing the releasing, or "letting go" of these memories, and then articulating and expressing emotions congruent to his moving forward with hope and confidence, and finally saying good-bye to his friend. The participant's facial muscles shifted from appearing tense, and contracted, to relaxed and smooth (especially noticeable across the participant's forehead and cheeks). His eyes appeared more open, and his eye contact with the soldier appeared softer, relaxed, and less intense as the intervention progressed. The participant's body language – his posture, appeared to relax as his arms and hands became less clenched, and rested calmly at his side, and his shoulders dropped slightly.

In the moment following his dialogue expressing to his friend that the pain is "excruciating", the participant paused, and took a deep breath. He then looked down briefly at the ground. The participant then raised his left hand to his face and wiped his nose. Exhaling his breath, he looked at the soldier, took another breath, and then leaned forward, took one step, and embraced the soldier in a close and visibly meaningful embrace (a hug).

As the men began to lock in their embrace, the participant's arms reached around the top of the each side of soldier's shoulders, and around his upper back. His left hand tightly grasped the wrist of his right hand – clasped together in a tight grip that pulled the soldier's upper body forward into him. The participant then closed his eyes, and pressed his face into the base of the soldier's neck, (where his neck meets the collar bone). The soldier, in that same moment reciprocated his embrace, and wrapped his arms around the participant, under his arms, holding him tightly around his lower back, and patted his back intermittently. The two men were locked in a meaningful embrace that lasted for approximately twenty seconds, as the participant again expressed tears and released more intense emotions. During the embrace, the participant appeared to be welcoming and experiencing a moment he had been

waiting to take place for a long time: the sense of, at last, he is saying good-bye to his friend, and letting go of the deep pain, and terrifying images he had carried for so many years.

4.5.6 Participant's contact excerpt

During his T. E. interview with the researcher, the participant recalled his experience in the moment of receiving contact in the following excerpt.

4.5.6.1 Excerpt: 1

Researcher: "What was that hug like for you?"

Participant: "It felt like I was being hugged by a father, and I was the son."

4.5.7 Contact codes

The participant's excerpt, recalling and describing his experiences receiving contact during the intervention revealed the following (inferred) coded contact themes:

1. Loved
2. Safety
3. Comfort

4.6 Participant 2

4.6.1 Trauma issue and presenting problem

During the pre-enactment briefing with the VTP participants, and prior to commencing the participant's second enactment intervention, the participant described the circumstances and images he witnessed while traveling in a three vehicle military convoy to a hospital. It was these images, in combination with the experiencing the death of the five fellow soldiers, only a few days prior, that negatively affected him, and further reinforced his maladaptive thoughts and negative coping behaviours attributed to PTSD symptoms. He specifically expressed that this specific trauma event created his deep feelings of guilt, loss of

self-esteem and confidence, and consequently, he called into question his skills and abilities as a military medic and commander.

The participant's second traumatic event occurred only a few days following the death of the five fellow soldiers. The participant, in command of a group of soldiers from his unit was assigned the responsibility for transferring the five deceased soldiers from a lesser equipped medical facility to a larger hospital. It was determined the larger medical facility would be better equipped to house the bodies in the morgue (not available at the smaller hospital) in preparation for their final transfer back to homeland Australia. The soldiers travelled to the hospital using three military vehicles: two open flat-deck military trucks and one canvassed roof crew transport truck. The transfer excursion time to the larger medical facility was estimated to take a few hours and the participant's transport convoy was scheduled to depart in the evening.

Prior to the participant's enactment intervention, he discussed feeling honoured to be charged with the responsibility of care and oversight of his fellow deceased soldiers, and expressed to the group he performed this task to the best of his ability, ensuring that each of the bodies were not mishandled in preparation for transport and during the drive to the hospital facility. He expressed that the bodies could not be formally readied for transport – no military issue body bags or coffins were available, and consequently, they could only be covered with white bed sheets, and each body placed in the back of one of the two open air flat-deck trucks. The participant described that all of the deceased soldier's clothing were still soaked in their blood, and covered in dirt from the accident, and the white bed sheets wrapped over each body quickly became blood soaked and stained.

The participant remembered feeling that there was something very disturbing and wrong with what he was witnessing. He expressed being very aware throughout the trip to the hospital that these four soldiers did not have to be riding in the back of the flat-deck trucks with the dead soldiers. He also remembered feeling numb as he watched his fellow soldiers in the flat-deck trucks, as he shifted in and out of thoughts of the memories of each of the dead soldiers, and the images of their accident scene from a few days ago.

He did not remember thinking about it while driving at the time, but in the hours and days that followed, realized there was more than enough room for the four soldiers to ride with him in the crew transport truck that evening on the way to the hospital. He described that while revisiting the traumatic events in his mind that he tried to rationalize why he had not taken action to help the four soldiers. He thought that perhaps his inability to experience an immediate awareness and concern for the welfare of these men was due to the shock of experiencing the loss of the five soldiers only a few days prior. However, he could not ignore the recurring traumatic images of the four soldier's discomfort, and his increasing feelings of being directly responsible for condoning a prolonged, emotionally traumatic, and stressful situation. Importantly, the participant disclosed this was a trauma event that did not have to happen, and he felt he had the ability and responsibility to take action to correct what was clearly very wrong.

The participant expressed that since this traumatic event, he had experienced deep guilt, regret, and shame for not taking control of the uncomfortable situation to resolve the problem, and this incident contributed many of his PTSD symptoms. For example, since this incident, the participant expressed experiencing recurring nightmares about what happened on that evening. The vivid images of the soldiers riding in the trucks with the dead soldiers

haunted him almost every day. He elaborated and expressed feeling physically and emotionally paralyzed at the time, and was therefore unable to resolve the disturbing situation in that moment. He regretted having endured a very disturbing, uncomfortable, and traumatic situation, knowing he and four of his fellow soldiers did not have to experience, if he had the ability in that moment to stop the convoy, and request the four soldiers ride with the others in his vehicle.

4.6.2 Therapeutic enactment setting

The therapy team designed a re-enactment scene and intervention whereby the participant would release his deep feelings of guilt, and shame, through the sharing of his trauma event and subsequent re-enactment experiencing with the participating group members. Additionally, the intervention design and re-enactment process would help the participant assume a directive role in helping to set up the scene of that evening's events. This required him to not only re-experience the trauma event, but also assume control over certain key aspects of what occurred that evening. Throughout the intervention, the therapy team focused on the participant's awareness of cognitive, affect, and sensorimotor responses, and assisted with the participant's "meaning-making" of the trauma event - requested him to verbalize and express through emotion and body movement, his interpretations and feelings about the events that evolved during the convoy to the hospital.

Specifically, the participant's intervention included his recollection and assessment of the re-created and re-experienced original trauma situation and circumstances, and then to create the set of circumstances that he would have preferred to happen that evening - what he wished he could have done in the moment to resolve the traumatic situation. The therapy team requested the participant to formulate the preferred situation firstly in his mind, and

then to narrate his solution to the participating group members. Specifically, the therapy team asked the participant to re-create the new scene, and have him incrementally direct, and collaborate with fellow soldiers to re-create a corrective solution. The therapy team helped the participant process his preferred solution, assisting him in integrating the rationale of his decision, and embody his cognitive, affect, and sensorimotor responses.

Throughout the enactment intervention, the therapy team attended to the participant's activated arousal states, noting and regulating his arousal responses, and helping integrate cognitive, affect, and sensorimotor experiencing. This interactive and relational processing assisted in facilitating the comparative experiencing of maladaptive distortions adopted by the participant following the trauma event, and integrating his adaptive and corrective responses to the trauma event circumstances: helping the participant experience the differences between what had originally occurred on that traumatic evening, and his new awareness of cognitive, affect, and sensorimotor responses to the preferred solution.

4.6.3 Therapeutic goal

The overall therapeutic goal of this T. E. intervention was to help the participant re-experience, through episodic memory recall (conscious retrieval of a unique event), and integrative experiential processing of cognitive, affect, and sensorimotor response awareness, identifying and processing the core trauma experiences that occurred that evening. Specifically, the intervention process assisted the participant in embodying the re-experiencing of the trauma event using visual images (positioning of chairs, people, and blankets), and relational dialogue interactions. This intervention was designed to facilitate incremental corrective processing, and sequential experiencing of core corrective event circumstances so that the participant could reclaim his strong sense of self: confidence, self-

awareness, compassion, and competence as a skilled commander, caring man. For example, requiring the participant to assume a "director" role, and set up the trauma scene, with the assistance of the participating group members, and therapy team, engaged his feelings associated with episodic memory recall, and re-activated the feelings connected to self-esteem, confidence, competence, and compassion. Therefore, the purpose of dynamically engaging the participant in this manner was to increasingly integrate his positive adaptive cognitions and affect that have been blocked due to the effects of the trauma event, and maladaptive PTSD symptoms.

4.6.4 What occurred

The lead therapist instructed the participant, to the best of his memory recall, to direct the participants to set up the enactment scene: to re-create the position of the military trucks to one another, and the seating arrangements of the soldiers positioned in each vehicle. While he did this, the participant was asked to describe the specific details that occurred during the transport of the five deceased soldiers bodies. Specifically, four soldiers (two men seated at the tailgate seats located in the back of each flat-deck truck) were positioned to sit with the deceased soldiers, (three in one truck, and two in the other). The participant and lead therapist then stood at one end of the room, and scanned the set up details of the scene – checking to make sure everyone was in their correct locations, and assumed the body positions resembling what the participant observed on that evening.

The participant then described in detail what he most remembered from that evening, as he narrated his experiencing in the moment, and with the assistance of the lead therapist physically and psychologically inserted himself into the re-enactment scene. For example, the lead therapist asked the participant to position himself, seated next to the driver in the

truck, and to describe what he remembered experiencing on that evening. Inserting the participant into the enactment activated his trauma affect experiencing, and initial integrative processing of cognitive (through narration of the trauma event) and trauma related affect awareness. The lead therapist attended to indications when the participant's physical and verbal responses became excessively elevated, and regulated him by requesting that he slow down his narration, or stop speaking and breath deeply while focusing on a visual point in the enactment scene.

The participant recalled the images of the blood soaked bodies, and visibly uncomfortable soldiers accompanying them. He described the following excerpt to the participants: "Blood is coming through the white sheets, and the sheets would flap about. On a couple occasions one of the soldiers would come over and fix up the sheet so it was over the man." These images appeared in and out of his sight in the evening darkness as the headlights of his truck sporadically illuminated the horrific scene throughout the drive to the hospital. The participant expressed what was most difficult for him throughout the drive was witnessing the extreme discomfort in the four soldier's faces, and their avoidant body language as they leaned as far away as possible from the deceased soldier's bodies covered in blood stained white sheets. He specifically remembered the expressions of fear in the faces of these men, and what he was witnessing clearly indicated these soldiers did not want to be there. They appeared scared and traumatized. The images of their discomfort were most evident when from time to time the soldiers reluctantly had to reposition the blood soaked sheet that had blown askew. As each soldier reluctantly reached for the sheet, he would purposefully look away from the dead body, and hastily reposition the sheet to cover him up.

4.6.5 Researcher's observations

The researcher's observations during this enactment intervention identified the following affect and behavioural (physical responses) that occurred for the participant, specifically experienced in the moment of the participant's receiving of contact from the lead therapist. The lead therapists asked the participant to stand next to him (at the back of the room, and facing the back of the military vehicles), and with the group members seated in their assigned locations in the military trucks, said the following: "Would you people (participating group members) freeze in the position he (the participant) wants you. And you (the participant) come back here. David B. (one of the four soldiers positioned in the back of the truck with the deceased soldiers), you need to be looking out the back. You want to be avoiding the bodies at all costs."

In that moment, the lead therapist, now standing behind the participant and to his left, placed each hand on the participant's left and right upper arms, and held them in this position. The participant stood quietly with not much movement. He asked the participant, "Is that right?" The participant replied, "Yes". The therapist then asked the participant, "So what do you see? Describe what you see." The therapist let go of the participant's shoulders and stepped back slightly. The participant briefly observed the enactment scene, leaned forward, then paused, and turned his head toward the lead therapist and asked, "Uhm… can we have the lights off?" The lead therapist began to walk to the light switches located on the back wall, to the left of where they are both standing. The participant then turned his head back to the enactment scene and faced the group members now all in a static position. In that moment, the participant stood tall, leaned forward, and raised his right hand in an upward motion as if to be reaching forward toward the participants with an open hand, and said the

following, “What I see is a real look of discomfort on all the soldier’s faces.” His right arm dropped down to his side. The lights then began to turn off sequentially, and the room faded to dark. Now, only vague outlines of body images can be seen in various locations of the enactment scene, as the participant continued with his narration of the recalled trauma event that had haunted him for so many years. “The headlights in the vehicle that I’m travelling in are not quite high enough to shine brightly in, but I can still see their faces (the participant’s voice softened). Uhm, they are really uncomfortable, (the participant’s voice tone then became louder, and slightly forceful) but I want to be there, and we had just gone through the shock and trauma of losing our mates, and we’ve got a job to do as we are moving them to the next hospital.”

4.6.6 Participant’s contact excerpt

During his T. E. interview, the participant recalled his experience in the moment of receiving contact:

4.6.6.1 Excerpt 1:

Researcher: “What did it feel like in your body?”

Participant: “Marv’s hand on my back… gave me a bit of more strength. It felt like I had a bit of support, and I wasn’t there by myself.

4.6.7 Contact codes

The participant’s excerpt, recalling and describing his experience receiving contact during the intervention revealed the following coded contact themes:

1. Strength
2. Support
3. Not Alone

4.7 Participant 3

4.7.1 Contact context: trauma issue and presenting problem

The third participant in this research study was a veteran soldier, who served as a military chopper pilot and captain in the South Africa. There were several traumatic events that the happened to this participant during his youth and early adult years, and he recalled to the VTP group members the most profound trauma incident that occurred during his early childhood. As a consequence, he was deeply affected for many years throughout his adulthood, experiencing significant marriage and relationship discord, and relationship conflict issues with family and friends.

He expressed to the VTP group members the horrifying images, and emotions that would unexpectedly revisit him, causing intense anxiety arousal, feelings of anger, fear, confusion, and difficulty trusting others. He expressed that when he was very young, between three and six years old, having a very close relationship with his father (primary male attachment bond). As a child, he admired his father very much, and wanted to be a businessman just like him. The participant recalled as a child, he would demonstrate his entrepreneurial business talent for example; selling to his father some of the vegetables the participant had hand picked from out of their garden. He described how his father would play along with him, negotiating a selling price for the vegetables, to which the father would pay him. The father and son relationship was very strong, and the participant recalled other meaningful memories of he and his father spending time together – just the two of them at play.

As a young child of approximately 8 years old, the participant's parents sent him away to a private boarding school. Deemed a reputable learning facility, his parents believed

it to be the best institution to help with his dyslexia, and related learning challenges. He recalled the boarding school was quite a long traveling distance between his home and the school, which meant he could only visit with his parents every two weeks on the weekends. He remembered his parents telling him that the financial expenses were significant to attend this school, and it cost a lot in fuel to drive the distance to see him. The effect this situation had on the participant left him feeling alone, afraid, betrayed, and very neglected. He expressed that he felt homesick almost all the time while at the school, and he really missed his father. The participant added that many times he felt confused thinking his parents seemed to not care about him anymore, and that he was a financial burden.

The participant suffered from a severe primary caregiver attachment break due to the separation from his parents, and their neglectful behaviours. As a result, the participant lost the foundation of relational attachment feelings of love and safety in the father – son bond. The betrayal of love and safety by the parents created a breech of trust for the participant, and he consequently developed maladaptive feelings of anger, frustration, confusion, and deep sadness. Additionally, the participant's negative feelings were further reinforced in his relationship with his younger brother. He disclosed that he developed feelings of resentment and anger toward his brother because he was able to stay at home, and in his words, "He got to spend time with my parents and be safe with them at home while I was left alone. They (his parents) had no idea what I was going through."

In addition to the trauma experienced from the attachment break with his parents, the participant disclosed that throughout his stay at the boarding school, the headmaster had repeatedly raped him. The resulting psychological issues that developed for the participant from this terribly abusive trauma event were prolonged high anxiety and uncontrollable

arousal states, deep feelings of shame and guilt, fear, anger, confusion, and betrayal of trust. Furthermore, the consequences of this repeated threatening event further reinforced maladaptive cognitions and affect coping behaviours. The participant disclosed that up to present day, he would frequently find himself revisiting these horrific traumatic images, unexpectedly re-experiencing debilitating uncomfortable thoughts and emotions, often while engaged in interpersonal interactions and situational circumstances in his adult life. The participant elaborated that often he would feel "triggered": experiencing intense anxiety and feelings of fear and anger.

Many years later, when serving as a chopper pilot in the military, the participant was involved in commanding a top secret military operation that required him to fly his helicopter at night, navigating only by compass heading (no map references). Flying the chopper, carrying a co-pilot and support troops, he had to land the craft in pitch darkness, within highly volatile and life threatening in enemy territory. Once landed, and the chopper engine turned off, all soldiers had to remain seated and silent (absolutely no words with fellow soldiers, nor radio communications permitted) until the reconnaissance operation soldiers arrived to their location on foot to be extracted from the site.

The participant described to the VTP group members that while sitting in the darkness and silence during the mission, he began to feel intense recurring trauma-related emotions, similar to those experienced from his childhood at night in the boarding school. He disclosed that during that military mission he had felt abandoned, and questioned his trust in his superior officers back at the base. He explained that because this was a covert and secret mission, if something happened to them, the military would not acknowledge their presence, nor would they send aid to their rescue. He was responsible for these men in the chopper, and

they were all alone, and this reminded him of being alone and afraid as a child living at the boarding school – unable to trust any of the adults, and feeling his life was in perpetual danger.

The participant discussed his feelings of fear and anger due to not knowing exactly where they were flying on that mission, navigating only by compass heading and time. With no other reference points such as a map, and being surrounded by the darkness of the night, he was again reminded of the fear he felt as a child, and that at any time the enemy could emerge from the surrounding foliage and attack. The participant expressed that his anxiety was very high on this mission due to not knowing what might happen next, and feeling vulnerable – he felt exposed, not safe, and if they were attacked, he would be unable to effectively defend himself. He disclosed that these "danger-charged" feelings were very similar to the traumatic arousal states he experienced, as a child at the boarding school, recalling that at any time the headmaster would emerge from the darkness and enter his room.

The participant's trauma experiences described above depict how pre-existing (childhood) trauma events, and events that occur in later years may trigger manifested PTSD symptoms: recurring maladaptive cognitions and affect responses connected to the original trauma. In the participant's case, he experienced a significant relational attachment break that occurred in early childhood; consequently affected by the feelings of abandonment, fear, anger, betrayal, shame, and loss of the loving and safe relationship he once shared with his father. Furthermore, the participant was emotionally and physically abused by an adult charged with the responsibility for providing, safety, care, and trust in overseeing his well-being. This violation created maladaptive cognitive and affect distortions: negative feelings

associated with his self esteem, experiencing heightened anxiety in interpersonal situations, and difficulty trusting others. The participant further internalized his trauma experiences, and felt that his "environment" was an unsafe place. The overall impact of the trauma events was the feeling that he could only rely on himself to survive, and that he was on his own.

4.7.2 Therapeutic enactment setting

The participant's T. E. intervention was focused on establishing a dynamic relational and interpersonal interaction and setting that would initiate an integrative trauma repair process focused on helping to resolve the participant's maladaptive trauma related PTSD symptoms. Specifically, the participant's trauma experiences and subsequent relationship with his family created suppressed and internalized maladaptive cognitions and affect responses which affected the participants ability to effectively communicate his needs, and be in healthy relationships with others. Therefore, the participant's intervention needed to contain interpersonal interactions that both engaged the participant in challenging his self confidence, and reinforced his self assurance through the use of his voice and body language. The specific integrative components of the intervention were the following: incorporating dialogue requiring the participant's voice to be heard, his feelings to be understood, and to experience a strong embodied sense of self through the validation and support, and safety and comfort of others.

Given the parameters described above, the VTP therapy team designed a T. E. intervention whereby the participant engaged in interpersonal and relational dialogue with his pre-trauma childhood self, described what he was like as child (at play and spontaneous), witnessed himself in moments of memory recalled engagement with his caregivers (parents), and then witnessed the transition from being a happy, carefree child, to an angry, confused,

frustrated, and aggressive child (demonstrated acting out behaviours described by the participant when he was at boarding school). He participated in the intervention through both observation and direct active engagement in the interpersonal dialogue between his child double and father (group members chosen to assume these roles), and then progressed to dialogue between the participant's adult double, and the father. The dialogue focused on the participant's cognitive and affect responses, and the therapy team noted and attended to regulating his activation and arousal states.

The intervention required the participant to engage in face to face relational dialogue between his father and himself (initially to use the participant's double to engage the father in dialogue), and facilitated the expression and releasing of his negative thoughts and feelings of sadness, anger, resentment, betrayal, and shame, associated with how he felt he was treated as a child. Lastly, using a gestalt based activity, the participant was requested to physically "give back" to his father the most relevant negative emotions he was carrying inside for so many years: abandonment, shame, and betrayal. A group member represented each core negative emotion, and the participant, along with the participant's double, were required to physically select and bring to his father the individual representing the chosen emotion.

To facilitate the processing and embodiment of releasing the core negative emotions, the participant engaged in a narrative to the father, telling him why it was unfair for him to be burdened for so many years, and why he is "giving it back". The participant's double participated as a relational support for the participant, and engaged with the father to block his denial and deflection words at any time while the participant was speaking. The rationale for this activity in the enactment intervention was to help the participant integrate his feelings

of self advocacy, related cognitions, affect, and sensorimotor responses in a dynamic interpersonal engagement with his primary caregiver, and to verbally release the suppressed thoughts and emotions associated with how he was treated as a child.

4.7.3 Therapeutic goal

The therapeutic goal of this T. E. intervention involving dynamic activity: body movement, physical interactions and body positioning with other group members, narration of enacted (experienced) relational situations, and interpersonal dialogue, was to help the participant release maladaptive cognitions and affect responses due to his childhood trauma event, and related PTSD symptoms. The enactment intervention focused on integrative processing as a means of facilitating healthy adaptive responses: releasing the anger and sadness through verbal expression, and transitioning toward feelings of a strong sense of self. Interwoven throughout the enactment intervention was the inclusion of meaning-making dialogue to assist in releasing of confusing or disturbing thoughts and feelings about the participant's childhood trauma events.

4.7.4 What occurred

This participant's T. E. intervention involved his participation in a gestalt-based relational interaction with his parents, and younger brother, and was designed to promote dynamic relational interaction: the participant and participating members engaged in their dialogue while standing, and had full range of body movement to express their thoughts and emotions. The participant was positioned with an assisting therapist a few yards away to observe the dialogue interaction between his father and child double. The participant's double engaged the father in a discussion whereby he expressed his anger and frustration

about being sent away to boarding school, and feeling afraid and confused why they did not visit him.

The father and participant double were engaged in an activated dialogue (elevated volume in voice and expression): the father expressed strongly that it took too long to travel back and forth to the boarding school, and the cost of fuel was too high. The dialogue proceeded with the following interaction:

Father: "The school is costing us a lot of money. The drive is costing us money. Do you how many kilometers we have to drive back and forth, and it takes so long. That is time away from working on the farm!"

Child Double: (Raising his right hand up to the chest height of his father, in a stop signal manner), "Stop Dad. You're saying I'm less important than your money."

Father: "No, no, no! You don't understand, you are more important to me, and it costs a lot..."

Participant: "Stop Dad! Stop! What I do want to say is I don't feel as important. And you've got to also know that's how I feel."

4.7.5 Researcher's observations

The researcher's observations during this enactment intervention identified the following affect, behavioural and sensorimotor responses that occurred during the dialogue described above, and experienced in the moment of the participant's receiving of contact.

As the father and participant's double engaged in dialogue that focused on the financial cost of fuel to drive back and forth from their home to the boarding school, I (as assisting therapist) observed the participant becoming increasingly activated: his face

appeared flush and eyes began to tear. In that moment, the researcher as assisting therapist, placed his left arm around the participants back and placed his hand on his shoulder. The participant's body felt very warm, and his body slightly shaking from affect arousal, and sensorimotor activation. He began to express tears, and his lips trembled slightly. I interrupted the father and child double interaction, and asked the participant, "What just happened?" In that moment, the participant expressed the following, "No, because…fuck, they were always so tight with money, and he had so much of it!" As the participant expressed these words in the direction of the father and child double engaged in an interpersonal dialogue, and in a forceful tone of voice, his right and left hands motioned upward in front of him, and then he brought them quickly down to his side at the end of his statement, as if to be emphasizing his feelings of frustration and anger about their finances and lack of care.

4.7.6 Participant's contact excerpt

During his T. E. interview, the participant recalled his experience in the moment of receiving contact during this intervention concerning confronting his father to express his feelings about how he was treated as a child: abandoned, betrayed, and angry.

4.7.6.1 Excerpt: 1

Researcher: "So in this moment where James puts his hand on your shoulder, what did you notice when he touched you that way?"

Participant: "The pain. It felt like someone was there for me because the only way my… uhm… I had to act out because I wasn't getting any love."

4.7.7 Contact codes

The participant's excerpt, recalling and describing his experience receiving contact during the T. E. intervention revealed the following coded contact themes:

1. Pain (memory recall of feeling angry, sad, betrayed, abandoned, and unloved)*
2. Support

* The participant expressed these emotions through verbal and observed affect responses during his dialogue in the enactment intervention, and subsequently during enactment debriefing discussion.

4.8 Contact codes across participants

In reference to each of the participant's experiences of receiving contact during their T. E., the following provides a summary of what it meant for each participant in experiencing its application while engaged in a group-based therapeutic process of change.

4.8.1 Participant 1

Receiving contact during the participant's first T. E. intervention had the effect of re-activating and re-experiencing key cognitive and affect responses through memory recall of the core attachment bond relationship with his primary caregiver (grandmother). Specifically, the participant's experiencing of contact while engaged in processing the profound loss of this important relationship had the effect of facilitating the participant's integrative cognitive and affect awareness processing, and reinforcement of his most core thoughts and emotions about his relationship with the grandmother which he was able to recall and describe in detail. One example of the facilitative memory recall effect receiving contact had for this participant is described in his T. E. interview excerpt: "Just holding her hand again, feeling the warmth. I could smell her. I could sense her. It was like whenever I was in her presence,

not her aura, but her love, her care. I could feel everything about who she was, and I remember when I was holding her hand, it was like all those things again, and it's still with me, and so I feel like I am still there." The experience of receiving contact for this participant, specifically while engaged in processing a primary attachment-based relationship, had the effect of enabling the participant to access his most primary emotions in connection with the significant other: warmth, love, and care.

The first participant's experience of receiving contact is markedly different in his second T. E. where he confronted his anger and guilt, and communicated his needs. He also spoke his truth: to declare and express his true feelings for a significant other in his life (ex-wife). The participant had suppressed expression of his true thoughts and feelings about his marriage – that he should not have gotten married because he did not love his wife. During the intervention the participant's experiencing of contact was expressed in his T. E. interview as having the effect of re-activating his feelings of support, strength and confidence. Additionally, his experiencing of contact in the moment of confronting what needed to be said to his ex-wife, indicated cognitive, affect and sensorimotor activation through body memory recall: being in contact with another activated familiar sensorimotor responses, and in combination of the participant's experiencing of episodic memory recall facilitated his feeling supported and engaged to accomplishing a goal.

It is therefore this researcher's opinion that the contact received during the participant's enactment intervention, specifically activated his body memory of being in contact with another (male), and facilitated the feelings of episodic memory recall of his past experiences in athletic competition: men in contact with one another in the scrums on the rugby pitch, and in contact next to one another while sitting close on the player's bench. For example, the

participant's use of language and metaphor in the following excerpt has the tone of being motivated and engaged in a task, competing with other teammates, overcoming challenging situations, and focusing on achieving the goal: "Ya! Ya, I remember Marv sitting there. His leg was against mine as well. His arm around my back had the feeling like you've got a mate next to you. Mateship. Holding someone up. There's support, and strength. By Marv putting his arm around me, it was another natural feeling of it's time to play and toughen up, and be ready to play. Quiet confidence."

The experience of receiving contact for this participant, specifically while engaged in processing his anger, guilt, communicating his needs, and expressing his true feelings to a significant personal in his life had the effect of enabling the participant to access feelings of mateship (not feeling alone), support and strength, focus and motivation, and confidence. The participant's experience while receiving contact with another created an overall feeling of forward movement and acceleration – accessing the positive and beneficial affect experiencing of the self that had been blocked and suppressed for many years due to the trauma events and maladaptive coping behaviours. The participant was therefore able to reclaim those suppressed positive emotions, and gain a stronger sense of self – to re-experience the once suppressed feelings of strength and confidence.

4.8.2 Participant 2

The second participant's contact experiences as described during his T. E. interview conveyed for example, in the moment feelings of strength, safety, and confidence, while engaged in processing the loss of a significant other, and releasing emotion through unfinished narrative dialogue. Specifically, the participant's shoulders and upper arms were being held firmly by the therapist while in the moment of experiencing and releasing intense

emotions. The contact had the effect of holding the participant in place – standing upright and grounded with both legs straight and feet firmly placed supporting his weight. The physical presence of the lead therapist, and the feeling of his body in contact with the participant instilled the feeling of safety in knowing that the lead therapist was there for him, and to help him work through a very difficult emotional experience. Furthermore, there was an affirmation for the participant that in that moment of expressing intense affect that had been suppressed for many years, through the application of contact, he was able to recall in his memory, and re-activate, a stronger sense of self. This is conveyed in his excerpt: "…it gave me strength. But you know, ten years ago, no way would I ever have allowed another to do that no matter how good their intention was. And another thing, that's key is I felt safe there."

The participant's contact experiences also brought forward feelings of not being alone, comfort and safety, and love. The trauma events and maladaptive coping behaviours due to PTSD symptoms, resulted in the participant's steady decline in self-esteem, and validation: he increasingly felt incompetent and not of value as a soldier or civilian. The participant's experiencing of contact while engaged in an intervention process that required him to draw on his commander related competency skills (communicating instructions, and directing the actions of others), had the effect of activating feelings of strength, support, and not being alone. The physical presence of another (receiving body contact from the lead therapist) during the intervention facilitated the participant's relational memory recall of: receiving from others their confidence in his communication and direction skills, and re-experiencing feelings of being a valuable and competent leader, through the active engagement and support from the group members.

The participant revealed the impact of receiving contact as it related to his ability to access the affect necessary to achieving the task at hand for his enactment: to recreate the scenario of the trauma event, direct others in positioning props and persons, and narrate what happened for others and himself at the time the trauma occurred. The effects of receiving contact are described in the participant's following excerpt: "Marv's hand on my back… gave me a bit of more strength. It felt like I had a bit of support, and I wasn't there by myself."

The participant's contact experience during one of his T. E. interventions facilitated feelings of being loved while engaged in completing unfinished narrative concerning the death of a significant other (male friend) – a significant relational attachment break. The participant's T. E. interview excerpt reveals this in context: "It felt like I was being hugged by a father, and I was the son."

The participant and group member (chosen to assume the role of his soldier friend) embraced in a meaningful and lengthy hug following their relational dialogue during the T. E. intervention. It may be inferred that the participants' experiencing of trust and comfort from the group member, in addition to the caring embrace (contact) between these two men, likely activated in combination his body memory and episodic memory recall of familiar attachment bond with a trusting, caring and loving person from another relationship: his father, or another significant male primary caregiver in his life.

4.8.3 Participant 3

The third participant's experience of receiving contact activated the releasing of suppressed emotions caused by being abandoned and betrayed by his parents during his childhood. Throughout his childhood and adult life, he suppressed deep anger, sadness, and

shame, which negatively affected his identity and relationships: socially, professionally, as a father and man in society. The participant described feeling alone, unloved, and not valued or important to others for much of his life. Consequently, as he described in his enactment, he felt no one cared for him, nor could he count on or trust others. Therefore, if he were to survive in the world, he would have to do everything entirely on his own.

The participant's experience receiving contact (feeling the assisting therapist's arm across his upper back and shoulders) in the moment of processing negative childhood memories of the traumas facilitated accessing of affect and sensorimotor responses which enabled him to immediately respond in defense of his "self". Specifically, while in contact with another, he experienced memories of painful recalled images of his past trauma events, negative affect and sensorimotor responses associated with accessing these suppressed emotions, and also embodied integrative processing of positive affect responses. Simultaneously, the effect of receiving the contact while activated (heightened state of arousal) in re-experiencing in a traumatic state, facilitated feelings of being supported by the presence of another (man), and generated awareness of internal strength and self-confidence, which enabled him to forcefully project his voice and incorporate body language to openly emphasize his expressed anger, sadness, and frustration toward his parent figure (father). The participant experienced an integrated processing of the pain of his childhood trauma, and the support of another (feeling not alone).

The participant's description of what it felt like to receive contact revealed the sequential integrative processing that occurred for him while witnessing the relational conflict between his father and child self during the enactment intervention. As described above, and in detail in his T. E. intervention, he first accessed and responded to the

overwhelmingly painful feelings of his childhood, and then powerfully expressed these suppressed feelings with confidence for the first time in the presence of others. The participant's T. E. interview supported this information in the following excerpt when he received contact by the assisting therapist: "The pain. It felt like someone was there for me because the only way my… uhm… I had to act out because I wasn't getting any love."

4.8.4 Summary of contact codes across three participants

In summary, the results of this research study's investigation of the male's experience receiving contact while engaged in a group-based therapeutic process of change, activated the participant's cognitive, affect and sensorimotor responses, and positively contributed to the integrative processing of each of their trauma events. Specifically, receiving contact while engaged in group-based T. E. trauma processing interventions generated predominantly affect centric themes, and are focused on attachment bond or significant relational oriented characteristics.

The results of the contact codes are summarized in Table 1. The codes are assigned totals based on the frequency of occurrence as described by the participants during their contact interview excerpts. Additionally, an assigned ranking number identifies the codes with the most to least frequencies combined across all three participants.

Table 4.1 Contact codes by frequency

Contact Codes By Frequency			
	Contact Codes	**Frequency Totals**	**Frequency Ranking**
1	Love / Loved	3	1
2	Sadness	2	2
3	Safety	3	1
4	Warmth	2	2
5	Care	1	3
6	Support	3	1
7	Strength	3	1
8	Focus / Motivation	1	3
9	Confidence	2	2
10	Comfort	1	3
11	Mateship / Not Alone	2	2
12	Pain	1	3
13	Scent	1	3

Table 2 summarizes the contact codes, which are grouped by total frequency, and assigned a ranking number based on how often the specific code was expressed by the participant, as it related to their experiencing of contact during their T. E. In reference to the role of receiving contact, the most common contact codes shared across the three participants were feelings of love, safety, support, and strength.

Table 4.2 Common contact codes across three participants

Most Common Contact Codes By Ranking Across All 3 Participants	
1	Love / Loved, Safety, Support, Strength
2	Sadness, Warmth, Confidence, Mateship / Not Alone
3	Care, Focus / Motivation, Comfort, Pain, Scent

The second highest contact code grouping was feelings of sadness, warmth, confidence, and mateship or not alone. Lastly, the contact codes that occurred with least frequency were feelings of care, focus and motivation, comfort, pain, and scent.

Chapter 5: Discussion

5.1 Receiving contact findings supported in the literature

Many of the findings in this research study are consistent with what has been previously reported in the literature concerning the benefits of receiving contact, and its necessity for human's attachment bond formation, and for our survival. Specifically, the study's findings support the importance of inter-relational contact as beneficial to promoting one's self awareness, essential to relational attachment formation with others, a necessary component to developing self awareness and identity formation, and influential in socially constructed gender norms. Within the therapeutic context, this study's findings revealed common similarities of its effects within trauma processing interventions, attachment repair, and male group therapy environments. For example, the participants expressed experiencing feelings of being loved, safety, support, and strength. These emotions are foundational to the reparative and adaptive process, shifting from insecure maladaptive to healthy attachment bond relationships with others. As previously stated by Fox and Pease (2012):

> Intense fear, helplessness or horror, and a consequential inability to master oneself and one's circumstances, may then leave many men ashamed and unable to speak as men. In the absence of a new sense of self, in particular a new language of masculinity, it may leave the veteran without a vocabulary for successful action or agency. (p. 23)

The outcomes of this research study suggest that receiving contact during the re-experiencing of a trauma event has the effect of creating positive affect regulation, and integrated positive responses for the participant. For example, analysis of the participant's

enactment videos, and interview excerpts identified receiving contact had a calming and focusing effect during arousal states, facilitated specific memory recall, and activation of cognitive, affect, and sensorimotor responses. These findings are consistent with the research of Changaris (2010), Field (2010), Fosshage (2000), Gallace and Spence (2010), Montagu (1971), and Phelan (2009) as examples.

Current research on the application of contact in therapeutic settings explores its potential for primary emotion identification through progressive attunement to the client's affect and sensorimotor responses. The research conducted by Ogden, Minton, and Pain (2006), also discussed that with its relevant application, contact has the effect of creating new somatic resources, or supporting awareness of existing resources. The contact information generated from participant's excerpts are consistent with its impact on somatic resourcing in that all participants claimed to experience positive somatic responses as a result of receiving contact, and that it had the effect of facilitating subsequent reparative cognitive and affect awareness responses, which contributed to greater awareness of self: shifting posture; promoting feelings of support, strength, and confidence; and facilitating meaning making of their trauma experiences.

Throughout this research study, the author makes reference to "integrating trauma processing". Many of the theorists studying trauma processing discuss the negative effects of experiencing various forms of trauma, often causing symptoms of negative cognition and affect responses, and dysregulated and maladaptive coping behaviours (Changaris 2010, Field 2010, Tummala-Narra 2007). Additionally, the research conducted by some of the trauma theorists claim that dysregulated states of being as a result of trauma symptoms, prohibits positive adaptive integration of cognitive, affect, and sensorimotor responses

necessary for healthy relationships with self, others, and one's environment, unless there is a progressive therapeutic intervention focused on processing the trauma experience, and engaging with the participant's cognitive and affect states throughout the re-experienced trauma event. As van der Kolk (1996) states:

> The key element of the psychotherapy of people with PTSD is the integration of the alien, the unacceptable, the terrifying, and the incomprehensible into their self concepts. The aim of therapy with traumatized patients is to help them move from being haunted by the past and interpreting subsequent emotionally arousing stimuli as a return of the trauma, to being fully engaged in the present and becoming capable of responding to current exigencies. In order to do that, the patients need to regain control over their emotional responses and place the trauma in the larger perspective of their lives – as a historical event that occurred at a particular time and in a particular place, and that cannot be expected to recur if the individuals take charge of their lives. (p. 417)

The findings of this research study suggest that the application of contact during re-enactment of trauma events had a combination of positive affect regulation, and integrative experiencing, influencing the participant's self awareness of cognitive, affect, and sensorimotor responses. For example, in this research study, each participant described experiencing regulated affect states while engaged in high arousal activation during their re-enacted trauma events. Specifically, the participants stated that receiving the contact while re-experiencing their past trauma events made them feel calm, supported, and confident, and not alone. These outcomes suggest that receiving contact while experiencing intense and heightened arousal states, and emotionally charged moments of trauma processing, may have

helped to facilitate a reparative progression from maladaptive responses to positive and adaptive cognitive, affect and sensorimotor states. Additionally, the contact information generated from this study appear consistent with Westland's (2011) research regarding the application of contact for the purposes of deepening the experiences in relationship and attachment bond processing, stabilizing arousal responses, and helping to calm those who are emotionally defended and dysregulated.

The analysis outcomes of this research study, also suggests support for Changaris' (2010) research, specifically where it concerns the participant shifting from maladaptive and fragmented experiencing of cognitive, affect, and sensorimotor responses, due to impairments in one or more of these functions, into demonstrated states of integrated processing of the re-experienced trauma event, and an integrated "self". For example, this research study's analysis of each of the three participants identified a therapeutic progression as they moved from dysregulated states of being, to regulated and congruent adaptive responses, suggesting an integration process occurred. These findings further suggest an integrative relationship to the benefits of receiving contact, and support the research of Changaris (2010) who claims that receiving of contact has integrative benefits, and reparative effects at the neurobiological and physiological levels. He expands further on the integrative effects of contact stating that the restoration of disrupted regulation patterns in affect, cognitive, and sensorimotor responses could be mended through the use of incorporating touch in therapeutic interventions and within appropriate therapy conducive settings. Given the regulation of affect, reparative and adaptive progression experiences while engaged in high arousal states, is it also possible that receiving contact may accelerate the trauma processing and adaptive integration process, especially among male clients?

There were several specific affect responses that occurred for the three participants in moments of receiving contact. In each contact occurrence, an accessing of emotion was later described in their T. E. interview excerpts. This may suggest that receiving contact while engaged in the group-based therapeutic enactment trauma intervention process, may have a direct effect of accessing emotional experiencing: releasing of suppressed emotions, and facilitating awareness of experiencing new emotions and congruent responses. Given the existing research on the therapeutic effects of contact, does receiving contact in a group-based therapeutic enactment intervention context promote the awareness and integration of primary emotion identification, and further contribute to the client generating new insights and awareness during progressive stages of trauma processing for attachment based issues? Furthermore, does the cognitive, affect, and sensorimotor experiencing associated with receiving intentionally applied contact promote greater meaning making, especially pertaining to attachment bond, and relational trauma issues?

The outcomes of this research study suggest there may be a connection to one's ability to establish deeper awareness and meaning of their cognitive and affect responses as a result of the contact while engaged in trauma the re-enactment intervention process. For example, Durana (1998) claims that receiving contact communicates feelings of acceptance and worthiness, and depending on the context of the attachment break symbolic mothering when the individual is unable to communicate. Additionally, he discusses that contact has the effect of helping the participant establish connection with others, and the environment and when overcome by anxiety.

This research study's findings suggests that receiving contact during moments of processing attachment related trauma may have the effect of activating memory recall of

familiar attachment relationships, and activating related positive cognitive and affect responses. These contact responses are consistent with the research of Changaris 2010, Field 2010, and Gallace and Spence 2010. The outcomes of this study also support what may be deemed as "comparison experiencing" in processing of the cognitive, affect and sensorimotor responses in moments of receiving contact. For example, the participants' receiving of contact activated memory recall and awareness of a negative attachment relationship, and in the same moment became aware of a positive attachment affect, and sensorimotor response. These findings further supports Durana's (1998) research, and demonstrate the reacquisition of positive attachment relationship variables, affect awareness and integration. For example, the participants described their experience of receiving contact activated feelings of being supported, not alone or isolated, being cared for and loved, and feeling safe. Additionally, participants were consciously aware of being in contact with another during their enactment interventions while engaged in re-experiencing the past trauma event. This information may further support that receiving contact in moments of trauma processing is a positive therapeutic factor in helping to counter the negative attachment related thoughts, emotions, and behaviours, and may further facilitate the initial transition toward positive attachment states. For example, prior to their enactment interventions, and receiving contact in a therapeutic context, each participant displayed negative behaviour responses, and maladaptive emotional states of being consistent with PTSD symptoms: sadness, fear, high anxiety, and feeling alone or disconnected from self and others. The "contact experience" described by the participants, counters their maladaptive states, and indicates significant positive adaptive progression in cognitive, affect, and sensorimotor integration.

For each of the three participants in this research study, their trauma events contained moments where they found themselves dissociated, disconnected from others, unable to verbalize their emotional pain, and unable to effectively communicate their needs. These issues negatively affected their lives in relationship to self, others, and their environment. Furthermore, each of the three participants revealed their maladaptive symptoms: dysregulated in affect, and fragmented in cognition and expression prior to engaging in their therapeutic enactment. However, the receiving of contact during their enactment intervention process appeared to regulate their adaptive forms of affect expressions, and related thought processes (supported by their clear speech patterns, articulation and sentence formation). This information supports Durana's (2004) claim that, "touch may help the patient tolerate pain and alleviate the shame that interferes with working through issues at a deeper level. The sense of safety and trust in self and others may help in the interpretation of a fragmented ego" (p. 271). Given these outcomes, does receiving contact under therapeutic conditions of relational attachment processing potentially reactivate suppressed feelings of trust and safety in relationship to others and their environment, and therefore support acquiring essential components of being in relationship to the self, and others, specifically pertaining to congruent communication characteristics: verbal and non-verbal communication?

In the context of male group therapy environments, and the influences of male gender role socialization in western society, the findings of this research study supports the research of several theorists. Is the intentional presence of contact between traditional male gender role group members a primary factor that contributes to influencing the perceptions of adhering to traditional masculine gender role characteristics? For example, given the outcomes of this research study, there may be supportive factors that relate to the

deconstruction, reframing, and reconstruction of acceptable male gender norms. Addis and Mahalik (2003) discuss the relationship between observed behaviours and perceptions of socially constructed male gender norms. Specifically, they claim that for the most part, men are able to demonstrate an ability to reframe socially constructed norms when they observe and identify a non-traditional male norm to be accepted amongst other males. In our western culture, giving and receiving forms of contact, for example, as described in this research study, are not typically considered to be traditional male socially constructed and accepted norms.

Giving and receiving contact in T. E., such as intentionally touching each other's shoulders, arms, back, or embracing in close contact while expressing emotions, in an intimate therapeutic environment context, are considered non-traditional male norms. Furthermore, according to the male gender role research conducted by Kierski and Blazina (2009), claim "the fear of the feminine (FOF) heightens the awareness and adherence to gender normative behaviours often resulting in a range of uncomfortable experiences for men such as: helplessness, vulnerability, dependency, loneliness, lack of personal influence, and lack of certainty" (p. 157). They expand on the consequences of maintaining, "FOF can work simultaneously as the impetus for the use of psychological defenses; buffering men from experiencing these same uncomfortable feeling states related to gender role violations. This is achieved by causing various degrees of distraction, disconnection, and dissociation from affect, even in regard to minor gender role offences. This means from the point of view of FOF, there are strict dividing lines between masculinity – femininity" (p. 157). Lastly, they claim that overtly adhered to FOF among many traditionally socialized males, "leads to a turning down the volume of emotions; if this is incorporated as a long standing strategy to

regulate affect, it may result in what some have named, normative alexithymia" (p. 157). However, the research findings in this study supports that under appropriate male group-based therapy conditions, the application of contact may influence how traditional male gender norms are deconstructed, and reframed, and may have an additive contribution to facilitation of trust formation, more effective communication and expression of emotions amongst one another, and deeper intimacy (meaningful attachment bonds) in relationship to other men. These findings may also support further refinements of the T. E. model, and when and how much contact is used during the intervention modalities. Therefore, does contact within the T. E. intervention modalities function beyond its current applications such as (directive contact) physically moving the participant into position during the interventions, or as (supportive contact) affect regulating approach used in moments when the participant is releasing emotion, or engaging the participants in body movement and interaction with others and the therapeutic intervention environment? The findings of this research study suggest that actively observing, experiencing, and processing contact has the effect of dismantling highly engrained masculine gender role socialized norms, and facilitating reframed awareness and experiencing of male group members experiencing of self and other males - integrating relationally in non-traditional gender role ways of being.

The findings in this research study pertaining to males in group-based therapeutic environments supports the research that incorporating forms of action such as body movement, involving other group members in the participant's trauma re-enacted trauma event scenarios, and action-based engagement, cooperation, and support of one another's needs, lends to effective male group therapy outcomes. Does the inclusion of receiving contact in male group-based therapy environments contribute to positive and meaningful

relationship experiences among male group members, and thereby help to create the trust and cohesion necessary to achieving the inclusion and intimacy required for effective process group approaches? The T. E. intervention modalities described in this research study are consistent with the literature which indicates that therapy interventions with men have positive engagement processes and outcomes that are action and goal oriented, or performance based (Ipsaro 1986, Johnson & Hayes 1997, Powell 2006). Additionally, as previously stated in the literature review, unlike most traditional psychotherapeutic approaches that focus on engagement through reciprocal affect, Englar-Carlson (2006) claim that action-based therapy modalities may contribute to men experiencing emotional intimacy with one another by engaging in the physically dynamic and interpersonal activity intervention process. The outcomes of this study suggest that there may be a valuable relationship between action-oriented therapeutic interventions, and the application of contact during specific moments of relational and affect processing, especially amongst males.

5.2 Unique findings from receiving contact

Analysis of this research study revealed several unique findings that do not appear in the literature, specifically regarding traditionally gender socialized males receiving contact in group-based psychotherapeutic environments. These unexpected, and positive findings appear to support outcomes related to accelerated activation of memory recall and affect awareness, episodic memory recall, and responses associated with primary attachment bonds, and experiencing of deeper relational awareness of significant others, and contributed to affect integration and meaning-making within trauma processing interventions. Additionally, receiving contact generated findings that may contribute to effective group cohesiveness and trust formation, particularly among male psychotherapy process groups: expediting the group

building processes, facilitating trust formation within trauma groups, and collaborative participation factor in achieving effective group trauma processing interventions.

Receiving contact while engaged in trauma processing, may have had the effect of accelerating the participant's affect awareness state, and facilitated integrative conceptualization (meaning-making) of relational attachment issues, including clearer memory recall of the past trauma event details. Prior to receiving contact from the therapists or other group members, the participants showed characteristics of dysregulation and incongruence of cognition, affect, and sensorimotor responses. Specifically, they each had difficulty effectively communicating their thoughts and emotions leading up to and including various trauma related moments during their interventions. However, upon receiving contact during the re-experiencing of their past trauma event, the participants were able to access the primary affect, clearly express their emotions, and communicated their thoughts. It is important to note that the participants were able to achieve deep accessing of affect, and expressivity congruent with their primary emotions, while engaged in a highly intensive re-experiencing of their past trauma event. Alternatively, prior to their receiving contact, each participant demonstrated maladaptive functioning – cognitive and emotional expression of secondary maladaptive affect responses. Therefore, is it possible that contact created simultaneous experiencing of arousal regulation, an accessing of familiar positive attachment experiencing, and engaged the participant in experiencing familiar (adaptive) responses, or contributed to experiencing a new way of being? To what extent does contact play a role in integrating these facets of experiencing while engaged in extreme arousal and trauma processing states?

In the context of memory recall and positive attachment bonds, each participant's T. E. interview described experiencing congruent cognition and affect responses, and clarity concerning the relationships and details associated with their past trauma events, including articulation of specific understanding surrounding significant attachment breaks, death of loved ones, and the horrors of combat. On several occasions, the participants discussed that in the moment of receiving contact, they experienced a positive shift in cognition, affect and sensorimotor awareness. This was apparent when the participants described and demonstrated memory recall of their attachment bond experiences that they had otherwise not been aware of prior to receiving the contact. Based on the participant's descriptions, is it possible that receiving contact while engaged in trauma processing creates an interruption in conditioned maladaptive responses, and activates suppressed emotions, or subconscious cognition, and affect awareness states? This study's findings suggest subconscious experiencing of affect – non-conscious attachment regulation of dysregulated affect states while receiving contact, and appears to further suggest that past affect and cognitions previously not brought into consciousness is activated and brought to awareness.

The research in the literature indicates that contact responses have the effect of activating familiar relational memory, and facilitating calming sensorimotor responses, and these positive contact experiences may further link us through memory recall processing to significant individuals of our past, and present. Why then is this neurological and physiological processing response generated by contact identified as a unique finding for this study? Specifically, many trauma affected males possess significant affect regulation challenges, and consequently, it is difficult for them to engage in a therapeutic process that involves progress toward integration of cognitive, affect, sensorimotor responses, and

positive, healthy relationships with self and others (Fox & Pease, 2012). However, this study's findings revealed that receiving physical contact activated combinations of positive affect, sensori, and cognitive awareness, related to memory recall of positive attachment bond experiences otherwise blocked (suppressed) through the past trauma experience and maladaptive coping behaviours. An example of this is revealed in the first participant's experiencing of contact while enacting unfinished narrative with his grandmother in the following interview excerpt: "Just holding her hand again, feeling the warmth. I could smell her. I could sense her. It was like whenever I was in her presence, not her aura, but her love, her care. I could feel everything about who she was, and I remember when I was holding her hand, it was like all those things again, and it's still with me, and so I feel like I am still there."

Some of the outcomes of this study are also uniquely positioned because contact applied in the therapeutic context of hyper-masculine gender socialized men, and relational trauma processing interventions conducted in male psychotherapy groups has not currently been conducted, and so far does not appear in the literature. Furthermore, the positive effects of receiving contact may appear to be commonly shared in the research, particularly as it relates to attachment formation and relational bonds, however, the application of contact between male group members, participants, and therapists is exclusive within group counselling psychotherapy environments, and appears to have the effect of deconstructing traditional gender norms among males in the psychotherapy context. Additionally, contact applied in male gender role socialized groups may have the effect of positively influencing adherence to such maladaptive socially constructed norms, and may contribute to facilitating new ways of engaging relationally for men.

This research study's findings suggest that if contact is positively embraced within a hyper-masculine culture such as the military, what can we expect of the effects of contact in civilian male group therapy environments? The application of contact appears to dispel the traditional gender socialized norm responses, and male social behaviours concerning male-to-male contact. These findings also suggest the possibility that group members witnessing the receiving of contact vicariously experienced positive attachment responses - integrated responses derived from witnessing the contact, imagining its effect, and through memory recall generated positive affect and sensorimotor responses. For example, observations of witnessing group member's non-verbal responses as they witnessed giving and receiving of contact by enactment participants, indicated an experiencing of these in-the-moment interactions. In some circumstances, several witnessing group members had visible affect responses to the participants contact between chosen group members. Lastly, the familiar attachment qualities of contact experiencing may collectively accelerate group participant cohesion, thereby leading to effective trauma processing interventions that posses highly supportive, engaged, and integrated group members.

The information generated from this study supports the powerful influence of the contact experience, and administered under specific therapeutic conditions, may have the effect of accelerating trauma processing interventions, and re-integrating suppressed adaptive cognitions and affect. This simultaneous memory recall, affect awareness and cognition processing, may therefore have significant benefits in the group therapy context, particularly in the areas of normalizing the trauma experience, and sharing familiar or common attachment memory recall events. If receiving contact has the effect of reducing trauma related stressors, and interrupting maladaptive affect responses, thereby facilitating positive

affect regulation, is it therefore possible that contact experiencing in the same moment facilitates a re-activation process of engaging adaptive rational cognitions, and contributes to congruent affect responses?

This research study revealed on several occasions, receiving contact activated self awareness, and conceptualization of the trauma experience, and facilitated integrated processing of adaptive cognition, affect, and sensorimotor responses: each participant recalled and effectively described their experiencing of significant attachment relationships, and meanings of their relationships to these individuals. This particular finding seems to suggest contact had a direct positive effect in facilitating the participant's relational communications while engaged in re-experiencing a trauma event, thereby facilitating a positive adaptive and integrative response.

Lastly, this research study revealed a unique finding that suggests an olfactory response related to familiar attachment bond memory recall may be activated from a contact experience. Specifically, one of the participants described awareness of the scent of his primary caregiver (deceased grandmother) in the moment of receiving contact by a group member selected to portray this person during the enactment intervention. The significance of receiving contact that generated an olfactory (scent) memory recall response was that it subsequently had the effect of activating a cascading of positive attachment memories, and personality characteristics associated with the participant's deceased grandmother. Therefore, does receiving contact suggests an acceleration of the processing of affect, memory recall and integrative experiencing of positive attachment responses is possible through alternative sensorimotor pathways? How did receiving contact activate an olfactory

response that subsequently generated a flooding of recalled positive attachment-related memories of the primary caregiver?

The present research on olfactory responses identifies that episodic memory – "the conscious retrieval of contextually unique events" (Gottfried et al 2004, p. 687), involves multisensory domains, and therefore "involves the recollection of information spanning sensory domains and levels of emotional complexity" (p. 692). However, the research on olfactory responses does not indicate receiving of contact is directly responsible for generating the recall of a familiar scent associated with a significant attachment bond relationship. Is it possible that a therapeutic intervention of a re-enacted attachment bond relationship, that also includes interpersonal dialogue and contact, has the effect of activating an olfactory response of the attachment figure's scent?

The research indicates that, "the most contentious issue in human olfactory processing is the role of verbal mediation – that is, the extent to which linguistic and associative semantic processing occurs during olfactory sensory processing, and what its importance to higher levels of olfactory cognition is. A number of researchers have claimed that verbal codes are operative in odor memory to a degree comparable to visual and verbal memory" (Herz & Engen 1996, p. 301). This research may be related, however, it does not indicate that an odor recall response is directly activated as a result of the verbal mediation. Given the existing research in this area, is it possible that relational processing that includes attachment based dialogue, human to human contact, and visual images, collectively contributed to the olfactory recall response? What other contributing factors and variables existed in the participant's attachment bond with his grandmother that may have enabled this unique identification of her scent when the familiar odor was not present in the enactment

room? How did holding the hand of his role playing grandmother contribute to this powerful olfactory (sensory) activation, response, and interpersonal memory recall experiencing? As Herz and Engen (1996) state, "the most pronounced singularities of odor memory appear to be in the evocativeness of odor-associated memory and its relation to emotion" (p. 308).

5.3 Implications for practice and future research

Research studies focused on the application of contact in therapeutic environments have raised several important considerations that directly relate to cautions against the use of contact, primarily due to an adherence to both socially acceptable norms and traditional therapeutic practices and interventions. Specifically, arguments against the use of contact in therapy is discussed from several perspectives, for example: the inherent risks associated with intention and interpretation of contact between client and therapist; diversity of experiential processing of contact affected by independent and codependent variables for each individual, therefore creating difficulty in achieving consistent intervention outcomes; limitations and inconsistencies in establishing universal training modalities for contact interventions; and limited understanding of the integrative therapeutic processing of core variables associated with the development and effects of trauma on individuals, influences of attachment bonds, gender role socialization, and applied skill and expertise of the therapist.

This research study identified multiple findings that are supported in the research literature, specifically pertaining to affect arousal regulation, attachment bond formation, activation of memory recall, and male group therapy dynamics. There were also several unique outcomes that may suggest receiving contact has a complimentary, and directly beneficial component to integrating cognitive, affect, and sensorimotor processing in therapeutic interventions. In addition, there were several positive findings that appeared to

counter the trepidation of using contact as part of an intervention approach. Furthermore, information generated from study suggests it may be a valuable intervention component in the context of trauma processing for male group-based psychotherapy interventions.

Given this study's outcomes, there were several primary implications to consider for future research that may further inform the psychotherapy community concerning inclusion of contact in therapeutic practices: applying contact as an integrative and progressive approach to accessing primary affect, and expressivity of adaptive emotions during trauma processing; contact as a primary factor to accessing memory recall of familiar attachment bond relationships, such as conceptualization (meaning-making) of trauma experiencing, and intrapersonal / interpersonal awareness; applying contact in group-based therapy interventions as a means of activating vicarious experiencing of attachment-focused memory recall among group members, and acceleration of group member cohesion during trauma interventions; and including contact during group-based interventions as a means of reconstructing adaptive socialized male gender norms and reinforcing the authentic self.

Additionally, the outcomes of this research study have generated further inquiry and considerations for future research focused on contact within specific process experiential and emotion focused psychotherapeutic approaches. For example, Emotion Focused Therapy (EFT) may be most suitable to incorporating contact-based interventions. For example, the client's experiencing of intentionally placed contact may compliment progressive moment by moment stages of the EFT model which is focused on moving the client from secondary emotion – global distress; identifying the primary maladaptive emotion – for example, fear and shame; and expression and integration of the primary adaptive emotion – for example, assertive anger, and sadness (Pascual-Leone & Greenberg 2007).

The information generated suggests that receiving contact during moments of re-experiencing trauma events has the effect of interrupting the cycle of maladaptive responses, activating alternative cognitive, affect and sensorimotor awareness, and facilitating adaptive conceptualization and expressivity, otherwise not previously or consciously experienced. Therefore, does receiving contact, while engaged in high arousal states more precisely activate and accelerate the integrative response process? Furthermore, given that contact is an implicit biological necessity to human development in relationship to self and attachment formation to others (the experiencing of contact is essential to formulating and defining relationships) is it therefore a necessary component to include in traditional therapy practices? Does the application of contact facilitate a comprehensive integration of cognitive and affect processing, and therefore accelerate working through intrapersonal and interpersonal maladaptive issues? Research studies that explore the presence of contact and non-contact under controlled therapeutic intervention modalities may generate further insights and findings concerning specific therapeutic outcomes such as moving from maladaptive affect to adaptive affect responses.

As previously discussed, there are multiple variables that pose limitations on establishing consistent contact responses for recipients, specifically related to variations in client's experiencing of self and others, including relationship and attunement between therapist and client. However, this research study's findings suggest that, within the male group-based psychotherapy environment, common experiences of contact were shared while engaged in trauma processing intervention modalities. Therefore, what may we expect from further research focused on the application of various forms of intentionally placed contact during specific stages of trauma processing? Additionally, what factors contribute to the

acceptance of receiving contact among male (or female) group members? To what extent does the experience of receiving contact play a primary (dominant) or secondary (contributing) factor in the integration of cognitive, affect and sensorimotor processing in therapeutic interventions? How does one participant's receiving of contact affect other group members with respect to trauma processing, (vicarious processing as a witnessing group member) normalizing the trauma experience, and overall group-building and group member bonding dynamics?

The contact experiences described by the three participants in this research study suggests it is a beneficial component for accessing positive memory recall of attachment bond relationships, and reinforcement adaptive affect awareness and responses. What may we expect from a T. E. study that analyzes various types of contact frequency, contact placement on different parts of the body, and applying variations of contact pressure? Given that touch and contact does not exist in isolation – it is interrelated to verbal, and non-verbal (visual queues) responses and interpretations, is it possible to establish a controlled research study for T. E. contact-based interventions that will generate consistent and reliable effects during trauma processing?

Lastly, the application of contact in this study was conducted in male-group-based psychotherapy intervention settings. The participants were considered to be of traditional male gender role socialization culture, and for a significant period of time in their lives, functioned in the hyper-masculine culture environment of the military. While the outcomes of this research study cannot be generalized to the greater male population, several specific findings do suggest that receiving contact under therapeutic trauma processing conditions is beneficial to the western society male population. The presence of contact, and its application

within group-based psychotherapeutic settings suggests a direct effect of contributing to the deconstruction of male gender role / socialized norms. Additionally, contact appears to be beneficial to the formation of attachment bonds among males within the group therapy setting, and perhaps a vital component to facilitating positive, action-based engagement with one another. Again, this finding seems to support Englar-Carlson's (2006) research pertaining to men effectively engaging with one another through "action-based" therapy settings, referred to as "intimacy by doing".

Receiving contact further suggests that it facilitates immediate accessing of primary affect awareness while engaged in high arousal states. Additionally, receiving contact while re-experiencing past trauma events appears to support integration of cognitive, affect, and sensorimotor processing, and congruence in expressivity of previously suppressed emotions. Given this research study's findings, is it possible that receiving forms of contact may be an essential component to positively integrating the therapeutic relationship between unlocking maladaptive male gender norms, and engaging in effective trauma processing?

5.4 Conclusion

In conclusion, this multiple case research study has generated more questions than answers, and therefore has met its overarching intention and objective: what can we further learn from the experience of receiving contact during group-based psychotherapy interventions? Furthermore, what results may we expect to find from other diverse populations and cultures that receive contact in therapy? What will be required of the counselling therapy community to adopt helpful forms of contact within traditional therapeutic approaches? How do we manage the ethical issues concerning touching and other forms of contact in therapy? As practitioners, what are the next steps to developing mastery

of applying contact within integrative psychotherapy modalities, and can we ensure consistency in "contact" training therapy programs?

The outcomes of this research study have shown common characteristics of the effects of receiving contact as demonstrated in the literature, particularly regarding attachment, affect regulation, and integration of cognitive, affect, and sensorimotor responses. Furthermore, the unique information described informs that receiving contact, as a therapy intervention variable, may enhance the integrative processing required to working through maladaptive responses, and progression toward adaptive experiencing. This study's receiving contact outcomes also indicates the potential for deeper group building, and cohesion, and further supports the literature regarding men's positive experiences in group therapy contexts through activity-based interventions that include reciprocity, and adoption of non-traditional male gender norms.

The limitations of this study include the following: small number of participants observed; participants were not randomly selected; participant's T. E. and intervention modalities, and receiving of contact varied across participants; and the participants were from a specific male masculine culture (military) and population. These limitations raise several questions such as: What results may we expect under controlled studies for receiving contact in male group-based psychotherapy interventions? Would there be similar contact experiences described using other male populations?

The strengths of the research study are identified as the following: receiving contact amongst traditional male gender role participants had overall positive outcomes; the deconstruction of maladaptive gender norms, and reconstruction of adaptive norms was demonstrated during trauma interventions using contact; the male participants discussed

several intervention situations where they consistently moved from limited emotional expressivity to integrated affect responses, and attributed their transformative experiencing to in the moment contact awareness. This information suggests that receiving contact during trauma event processing has a positive influence on activating and facilitating adaptive responses and awareness of self and others. Further research focused on various forms of contact in psychotherapy group settings is needed to develop greater understanding of its benefits and implications, especially pertaining to men in therapy, and trauma processing interventions.

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