Reflexively Exploring the "Therapeutic Use of Self:" A Response to Richard Erskine's Five-Chapter Case Study of Allan

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Abstract

This commentary seeks to open up dialogue and debate about the *therapeutic use of self* in integrative psychotherapy. Reflexively responding to Richard Erskine's (2021a, b, c, d, e) touching and inspiring five-chapter case study of Allan, I examine some of the key processes that occur at each phase of long-term therapy, from the initial stage of assessing and engaging the client in therapy, to making contact, building deeper integrative connections (with self and the therapist), and eventually entering the final ending phase. While my model of integrative psychotherapy mirrors that of Richard Erskine, the probing undertaken here raises questions around our respective commitment to existential-phenomenological ways of working over approaches drawn from other theoretical frameworks. But while our stances may be subtly different, I salute Erskine's exquisitely artful use of self, as revealed in the titrated choice and timing of his interventions.

Keywords: Therapeutic use of self, integrative psychotherapy, therapy process, phenomenological inquiry, reflexive dialogue

I sit down with anticipation to read the five chapters comprising Richard Erskine's latest writings about his work with Allan (Erskine, 2021a, b, c, d, e). His abstract explains how this case study explores depression as a "presenting symptom that reflects an isolated attachment pattern, a core feature in the personality of psychotherapy clients who rely on schizoid process as a form of emotional stabilization." I am aware of my sense of curiosity and excitement. Richard's case studies always inspire; engaging with his text will be a stimulating challenge.

A distant self-critical voice calls out warnings. Richard has invited me to use the work as a "springboard" and share my ideas around psychotherapeutic

process. This invitation is a huge honor. But what if I can't make sense of the process? Worse, what if I have nothing to say, nothing to contribute?

Ah. I smile to myself and find my ground once more. This feels a familiar place—a parallel process. That cocktail of assured curiosity and excitement, blended with a touch of (reasonable) professional self-doubt and (less reasonable) personal shame, is exactly my experience every time I sit down with a new client and prepare to go on a journey with them. This time, I'm readying myself to go on a journey with Richard and his client Allan. I don't know where we're going, or what new vistas will be revealed. But I am eager to step aboard, keen to embrace this opportunity to reflect deeply on psychotherapy process and practice.

I reflect momentarily on my current grounded place which parallels my stance at the beginning of every therapy encounter. The key ingredient here is to grasp and hold a phenomenological attitude. Yes, I think to myself, that is something immediate and specific that I want to talk about. My own approach to relational integrative psychotherapy is similar to Richard's—this is not surprising since he was one of my early teachers. But there are also points where we subtly diverge—mainly concerning his use of psychoanalytic concepts (against my own strong leanings towards existential phenomenological theory and practice).

This lens of focusing on Richard's therapeutic use of self (rather than commenting on Allan's process) with the emphasis on phenomenological insights feels right. I feel an easing in my body, my excitement builds. I have no idea where this journey will take us, but, just like the start of therapy, I have opened myself to embracing and exploring whatever should unfold.

In this paper, I seek to open up dialogue and debate—both with Richard Erskine and with our psychotherapy community—about the *therapeutic use of self* in integrative psychotherapy. The commentary that follows is a response to Erskine's (2021a, b, c, d, e) five-part account of his therapy with a client called Allan. I've structured my narrative in terms of four phases (the ones typically engaged in long-term therapy). First, there is the initial stage of *assessing and engaging the client* in therapy. Then the focus is on *making contact* (where the client contacts both the therapist and themself). As therapy proceeds, the process of *making connections* and integration becomes figural; then therapy can then proceed towards *endings*.

Assessing and Engaging the Client

Richard's first impression of Allan is of a shy, pleasant man who is either withholding responses or slow to respond. Through gentle questioning, Richard learns that Allan is a 50-year-old, "diligent" bookkeeper who has lived in the same apartment

since he was a child. His father had died when Allan was in kindergarten. Allan has never married and has lived with his mother until her death (from cancer) four years previously. Although he attends church every Sunday, he remains socially isolated. Mostly flat in his presentation, he comes to life when talking about his hiking and camping vacations in the wilderness (Erskine, 2021a).

Reading Richard's initial evaluation of Allan, I experience a mixture of reactions. There is so much that calls out for attention in just these few evocatively crafted pages. Not only do we meet Allan, but Richard also models a *phenomenological attitude* (of attunement, openness, and descriptive inquiry). He also engages *clinical reasoning* and demonstrates how to be *reflexively present*. All these processes, which I discuss below, underpin this initial assessing-engaging phase, where both client and therapist commit to the work.

Phenomenological Attitude

The phenomenological attitude is open, non-judgmental, and filled with wonder and curiosity about the world. It seeks to hold prior assumptions apart. For therapists seeking to infuse their work with such an attitude, the immediate challenge when entering a therapeutic encounter is to remain open to new understandings: to be present and empathically open to the client, ready to attune to them and to simply go exploring. It's important to "bracket" (Husserl, 1936/1970) knowledge and assumptions. Taking its cue from phenomenological philosophy, this bracketing is best understood as non-judgmental focused openness, where we are trying to see clients and their lives with "fresh eyes" (Finlay, 2008, p. 29, 2016a, 2022). It's about bracketing in order to be present, while resonating to what is emerging relationally in the here-and-now (Finlay, 2013, 2021).

In his first three assessment sessions with Allan, Richard reveals this ready-to-receive, non-judgmental approach, even if he does not explicitly call it a phenomenological attitude. He is busy opening himself to his client and attuning to Allan's being. "I did not understand his internal processes," Richard says, "but I listened for the covert meaning in his stories. I needed to be patient, attentive, and attune myself (the best I could) to his indistinct and subtle affects" (Erskine, 2021a, p. 30).

Richard favors *phenomenological inquiry*, and we see this throughout the therapy and his other writings (Erskine, 2015). For me, phenomenological inquiry is a part of a broader, sustained phenomenological attitude that goes beyond asking questions to being an attempt to describe the "is-ness" of self-states that are emerging (Finlay, 2021).

Novice therapists can all too easily see phenomenological inquiry as simply a technique of asking questions about the client's experiencing in the here-and-now, missing its broader philosophical significance. I suspect Richard has his own philosophical commitments, ones which probably go beyond my preferred humanistic,

existential framework. However, based on his previous writings, I believe he privileges phenomenological inquiry over historical inquiry (Erskine, 2015, 2020b).

Phenomenological inquiry aims to raise the client's moment-to-moment awareness of their intersubjective experience, meanings, issues, and needs (current and archaic)—all aspects that may have been pushed down or defensively disowned. Through the therapist's respectful questioning and listening, the client can become curious about their own self and gain new insight: the first step towards self-acceptance and growth. For me, the key here is *how* the questions are posed. Especially when working so delicately at the contact boundary with individuals with anxious, avoidant, or isolating attachment patterns, any questioning needs to be done with care and curiosity, ideally with both therapist and client working together on the answers.

Richard notes that with many depressed clients he relies on phenomenological inquiry to focus attention on the client's experience, rather than on their observable behavior. In previous writings, he has explained how to use questions or statements that focus on *bodily* ("What's happening in your body just now?"), *cognitive* ("What sense do you make of that?"), *affective* ("What are you feeling?"), and/or *relational* dimensions ("What's it like to be sitting here telling me that story?") (Erskine, 2020a).

Through his exquisitely patient inquiry, Richard slowly builds a picture of Allan's life. At work, Allan diligently applies himself while being disapproving of his "time-wasting" co-workers. When not at work or attending church on Sundays, Allan takes to the streets of New York City, spending his evenings walking through neighborhoods and observing people from a distance. Saturdays, he sets off alone to hike nature trails. His life is devoid of family, friends, and the warmth of human contact.

Like Richard, I feel sad as Allan's story unfurls. "I felt an emptiness, like a vacuum, in my belly when I imagined that Allan's world was deprived of intimate contact with people," is how Richard describes his feelings. But Richard does not seem to find it easy to tune into Allan's experience. He ruefully acknowledges that in the first three evaluation sessions, his phenomenological inquiry mostly elicited evasion or a non-response. This causes him to wonder if such inquiry might be "more of a hinderance than a help" (Erskine, 2021a, p. 30). I feel some sympathy for him. Those early sessions, marked by Allan's deflections or silent responses, must have been challenging.

Richard keeps reminding himself to be patient. Could there be some irritation and frustration lying beneath the surface—reactions he has not expressed or perhaps does not want to show? He sounds admirably calm. I know from my own work that I can get frustrated and irritated in similar situations and need to redouble my effort to hold on to some compassion and patience. What helps me is supervision or consultation where I can have some space with a valued peer colleague in which

to vent and regroup, reminding myself to focus compassionately on the likely terror that lies behind the withdrawal rather than reacting to it.

But there is more here. Is Richard indicating that for some clients (Allan among them) phenomenological inquiry simply does not work? If so, I am not sure I would agree. After all, if Richard had not asked all those vital questions, would he not already be giving up on Allan? I think there is value in showing Allan some of the routes they might take over time, even if the questions look too unappealing or treacherous at that moment. Even if Allan is not responding, the questions are being posed and they can be held in the space, in anticipation of a time when he is ready to take them up. I agree, of course, that care must be taken to not be invasive with the questioning. Part of my version of phenomenological inquiry would be simply to reflect back: "Is it difficult to say what you're feeling just now?" Equally, I might engage phenomenological description (what Richard calls "therapeutic description") to begin to raise awareness of the client's process, initially providing some words for the client that they don't yet have, for example, "I sense it is difficult for you to speak about feelings just now" or "I'm sensing there is some scare here. Is that possible?"

I would argue that phenomenological inquiry engaged by a therapist with genuine non-judgmental openness, interest, curiosity, and empathy (i.e., the phenomenological attitude), is an invaluable core stance at all times, even as other therapeutic techniques may be employed. The manner of delivery will emerge and evolve within the specific relationship—over time—as we adapt to the client's needs and the relational context, *and as they adapt to us* (Finlay, 2022). It is hard to tell from Richard's selective narrative, but I would say the bits of inquiry he has already engaged will prove extremely valuable.

Richard's account suggests that he (appropriately) experimented with different kinds of interventions including how he worked towards making more directive suggestions about how Allan might change his behavior or do things differently. Allan's silent responses and/or defensive deflections were in their own way an effective form of communication. Richard evidently heard the message Allan was conveying through his silences, as he changed course and returned (for the time being at least) to gentler, non-invasive phenomenological inquiry:

> I increased my use of phenomenological inquiry, particularly my inquiry about his affect and body sensations. Although he was slow to answer, he usually identified tension in his neck and chest. Somehow that led us to talking about his difficulty in expressing any emotion to people. He said, "I want to remain private. I don't want anyone poking their nose into my business." I asked if that included me. Allan answered, "Yeah, sometimes your questions are too damn invasive." I responded, "What happens inside you when I ask such questions?" Allan shrugged his shoulders and remained silent for the remainder of the session. During the next couple of sessions, he struggled to describe how he

> became physically tense, expecting me to criticize whatever he said, and how he quickly searched "for the right answer." (Erskine, 2021a, p. 33)

I am struck by this passage—it feels relationally significant. Not only is Allan's difficulty with expressing emotion apparent, but Allan also tells of being primed and alert to the slightest whiff of criticism. Recognizing this watchfulness, Richard grasps the importance of not suggesting any behavioral change that might imply a judgement of sorts. His strategy of simply engaging more inquiry strikes me as helpful since it shows acceptance of Allan's being and choices. As Richard notes, psychotherapy is not happening if the client is simply giving what they perceive to be the "right" or expected answers.

I appreciate Richard's flexibility here. He is responding relationally—titrating his therapeutic use of self to mesh with what Allan is ready to tolerate (Finlay, 2022). Research consistently underlines the importance of tailoring therapy to the individual (Norcross & Wampold, 2018).

In addition to the way Richard is adapting to Allan, I hugely respect his humility and openness to learning. I like the way he allows his client to take on the role of teacher:

> I often overlooked the significance of these subtle signs of the schizoid process. It has taken me a number of years to become sensitive to the unspoken story of such clients, a story replete with fear, shame, disavowed loneliness, self-criticism, and a compulsion to isolate. Allan was one of the clients who taught me to listen for the therapeutically significant story encoded in what such individuals do not say. (Erskine, 2021a, p. 37)

Clinical Reasoning

Richard notes that Allan fits the picture of a "schizoid" client. I appreciate Richard's rejection of the diagnosis of "depressive disorder." Like other existentially oriented therapists, I resist reductionist, dehumanizing medical model categories, preferring instead more intuitive, phenomenological ways of seeing the client in the context of their relational world (Finlay, 2016a).

While diagnosis can be informative, it's important to ask what we might miss if we view just through that lens. The lens of "depressive disorder" may lead us simply to peer *within* the person and thereby miss viewing them in the context of their depressing life circumstances. And is there a risk of unduly pathologizing Allan rather than acknowledging it's his way of being and/or our way of seeing him? "When we totalize others, when we reduce them to objects of our knowledge, i.e., to easily labelled categories and stereotypes, we have violated their inherent worth as good in themselves" (Sayre & Kunz, 2005, p. 227).

George Atwood and Robert Stolorow (2016, p. 104) also wade into this debate:

> The features of experience and conduct formerly regarded as symptoms of reified psychiatric categorizations or as expressions of decontextualized psychoanalytic character types then become understood as inseparable from the multifaceted relational fields linking the patient to other people, which includes the participating presence of the observing clinician.

Instead of diagnosis, Richard offers a *formulation* of Allan's situation, namely that encoded in Allan's self-descriptions and behaviors are "unconscious relational patterns" that are being lived out in his daily life (flatness, avoidance, and disavowed affect). Apparently devoid of intimacy, these relational patterns are leading him to "despair" and a longing for "peace and quiet." Richard senses that something vital is missing from Allan's life. But he's not yet sure what it is other than appreciating the schizoid process is one of splitting off from the vital and vulnerable Child self (Erskine, 2001, 2020b).

For my part, I want to hold lightly to this initial formulation (interpretation?). With my reservations about the extent to which anyone can know another, I also want to try to see Allan without reducing and fixing him as a "schizoid patient" who might be treated by pre-set therapeutic formulae. As Yalom (2001) states, taking diagnostic systems and protocols too seriously may "threaten the human, the spontaneous, the creative and uncertain nature of the therapeutic venture" (p. 5).

Knowing Richard's work, I know that he too is reluctant to label another and would work against applying prefabricated protocols. When he uses terms like "schizoid," he is talking about a protective withdrawal process arising as part of a style or pattern of behavior rather than a fixed and pathological "disorder." At the same time, I'm aware of Richard's North American cultural context, where diagnosis is needed for insurance purposes and is often the starting point of framing clinical needs. There is a clear contrast here with my British context and my own experience of private practice. It seems Richard lives more comfortably with psychodiagnostic labels than I do.

Richard also turns away from taking a fuller phenomenological attitude in his reflections about "schizoid process" and his formulation of what might constitute Allan's "unconscious relational patterns." I suspect I might have done the same—although I would have been working harder to bracket the idea that Allan had a schizoid process. It is here that the difference between theory and the practice reveals itself. It is virtually impossible to completely hold back our assumptions or understandings—a point phenomenological philosophers (e.g., Merleau-Ponty, 1962) stress (Finlay, 2021).

There is a balance to be struck between employing our presence, power, judgement, and expertise as therapists while holding on to unknowing. It takes discipline and courage to sit with uncertainty and not-knowing; it is not easy to let go of power and control towards trusting the process of the therapy encounter (Finlay & Evans,

2009). Richard reveals this in his sincere wish to let Allan's story unfold in the way that it needed to:

> I was curious about Allan, but my inquiries were only partially effective. He answered my questions but often with reticence. I wanted to know him, to know the depth and extent of what he felt, what he had lived as a boy, and how he managed his life. It was necessary to continually remind myself to be patient, to just let his story unfold. (Erskine, 2021a, p. 33)

I agree with Richard that seeking to lift Allan's (so-called) "depression" was unlikely to be a particularly fruitful approach. However, Richard seems to have further concerns about Allan's engagement and their lack of a mutual, affect connection. I, too, wonder about this. It is often the case that some kind of therapeutic alliance is in place by the end of the third session of therapy. Indeed, research indicates that this is necessary for positive outcomes (Norcross & Lambert, 2019). That Richard agreed to carry on with the therapy suggests that he sensed some element of hope, even if it remained vague and intuitive: a sense of the possibility of something positive emerging from the collaboration.

And, importantly, Allan himself seemed more than prepared to commit to weekly therapy for a year. It was essential that he made this commitment. It was an implicit acknowledgement that he was not intending to commit suicide (a lurking risk factor Richard rightly checked out). Without mutual commitment on both sides, it would not have been ethical to proceed (Finlay, 2019).

Richard does not say it explicitly, but I have a sense that Allan would not be an easy client to work with. I am reminded that therapy can be hard work—for both client and therapist. Therapy with a client who is flat and lifeless in presentation and who dismissively avoids talking about emotion poses particular challenges where it is hard to keep present and engaged. I am touched by Richard's care and the way he reflects deeply as he makes an "emotional commitment" to meet Allan weekly for a year:

> I wanted our psychotherapy to enhance the quality of his life and provide him with a desire to live. I walked home from the office that night questioning myself: "Was I wanting more for Allan than he wanted or was willing to do?" I knew what was possible in an in-depth psychotherapy, but I had no evidence that Allan knew the commitment, perseverance, and time that would be required to make some fundamental changes in his life. (Erskine, 2021a, p. 32)

The power of this commitment, along with Richard's candor, uncertainty, and doubts, should not be underestimated.

Being Reflexively Present

Erskine (2015; Moursund & Erskine, 2003/2004) notes there is a duality to the therapist's presence: a simultaneous attending to client and to self (in terms of being emotionally available and self-aware). The therapist de-centers from their own needs, making the client's process the primary focus. Here the therapist is mindful of the client's experience, watching every little gesture, listening to each word, and being with the client's silence. At the same time, the therapist's history, relational needs and sensitivities, theoretical stance and professional experience all enter into building therapeutic presence (Erskine, 2011; Erskine et al., 1999).

More than a duality, however, I would argue that the best relational work in psychotherapy is characterized by a *triality* (or, to apply my preferred metaphor, seeing with three eyes). As Richard has indicated, one eye is focused firmly on observing-sensing the client; the second eye is engaged with reflexively observing-sensing oneself. The new third eye element is an explicit monitoring of what is happening "between," concerned with the emerging relationship. Here, I follow Hycner's (2017) dialogic gestalt approach, which underscores the need to be present to all these three points of focus. Sometimes we are deeply immersed in holding a client's story; then we switch our attention to our own embodied experience and also towards reflexively monitoring what is happening in the relationship. We focus on ourselves and the relationship, not out of narcissistic motives, but reflexively as a way of furthering our appreciation of the client's process.

I believe that Richard engages this three-way focus when he makes his regular, explicit *sensorial searches* of his own internal process while monitoring the moment-to-moment dynamics of the relationship with Allan. At these times he recognizes the importance of maintaining his own vitality and curiosity (particularly in the face of any deadening deflections from Allan).

Being *present* in this way involves being grounded in one's own embodied self in order to receive the client's experience (Geller & Greenberg, 2002). Opening ourselves to whatever is emerging moment-to-moment in the therapeutic encounter in open, alive, curious ways is central to our work as therapists (McWilliams, 2017; Schneider, 2008). It is about being present to new possibilities, ready to be awed and surprised as we touch—*and are touched by*—the other. Placing our trust in the therapeutic process, we strive to be energetically present, inviting, alive to creative possibilities, and ready to share ourselves as we join with our client and go exploring (Finlay, 2016b).

Richard's "relational needs" work (and I include here his writing colleagues) (see Erskine, 2020a; Erskine et al., 1999) attests to the importance of being focused on the therapeutic relationship while being solidly grounded, attuned, aware, and responsive in order for the client to feel adequately held and attended to. It can also be powerful for the client to see they have impacted the therapist. The less the therapist is present, the more anxiety-provoking the situation is likely to be

for the client, who may feel shame and/or abandonment in the face of therapist withdrawal or perceived lack of interest. In turn, the client is likely to want to withdraw and/or dissociate. In other words, "the presence of the therapist invites the client to be present" (Finlay, 2022, p. 39).

Richard has written elsewhere (2001, 2020b) about being the security-in-the-relationship and engendering a sense of security in the client so that they do not need their self-created withdrawal defense. The point I would stress here is that this is a co-created—relational—process. The therapist does not just create a "safe space." Instead, somehow the therapist needs to involve and negotiate with the client, trying to work out together what would be a safe space.

With Allan initially struggling to be fully present to himself and his therapist, Richard's presence becomes more important. He needs to be present as a safe presence in order to invite Allan to be present. He does this by holding a welcoming therapeutic space where Allan can feel accepted, respected, and empathized with. In a way, Richard is like a welcoming, gracious host who offers a special kind of spacious hospitality (Finlay, 2022):

> The guest… client comes seeking sanctuary, a safe place of protection where wounds can be carefully cleansed and healed. But where is the sanctuary, if not fundamentally in the heart of the host or therapist who is willing to face this living encounter and courageously open to it? (Kapitan, 2003, p. 74)

Making Contact

> The challenge to the therapist is to meet the client at that point of contact in a manner that encompasses that resistance, rather than threatens it. It is to genuinely see the resistance as a point of contact between rather than as merely an oppositional force. (Hycner, 1991/1993, pp. 151–152)

Over the course of the first year or so, the therapeutic alliance between Richard and Allan builds. As the two men explore Allan's world together, their contact deepens. They are engaged in something of a dance at the contact boundary as they explore the space between intimacy and distance, insight, and resistance. At first, their dance is stiff, the steps uncertain. But then their ease with the movement builds. Richard glides through a series of improvised steps with Allan, movements whose sharp shifts of focus and rhythm are more reminiscent of a tango than a graceful waltz. At times they move together; at other times Allan pulls away and then is gently brought back.

A question lies between them: *just how close is it safe to be*? Would their tenuous interpersonal connection prove sufficient to prevent Allan reverting to his old isolated/isolating patterns? Richard recognizes that Allan's avoidant withdrawing pattern is part of his survival strategy in the face of an unresponsive, critical mother.

With this compassionate empathy to the fore, Richard takes care to be patient and respectful; he strives to lessen the likelihood of Allan closing down. I applaud this approach: honoring Allan's defenses is, paradoxically, likely to result in him relinquishing them.

In this critical dance-of-contact phase, four dimensions of the therapeutic use of self stands out for me: *dwelling, resisting contact, transference,* and *titration.*

Dwelling

The art of engaging a proper phenomenological attitude and inquiry involves a special attentiveness that dwells with the situations the client describes and attends to (even magnifies) details (Wertz, 2005; Finlay, 2021). The aim is to focus on the implicit meaning of the situation as it presents to the client. At the same time, the therapist takes a slowed, savoring approach which involves intuitively sensing, moving with, empathizing, responding, and resonating with their whole body-self. George Atwood and Robert Stolorow (2016, p. 103), both phenomenologically oriented psychoanalysts, characterize dwelling as an "active, relationally engaged form of therapeutic comportment" geared towards healing emotional wounds. In dwelling, they say, we don't just seek to understand the other's world. Instead, "one leans into the other's experience and participates in it, with the aid of one's own analogous experiences" (p. 103).

Time and again through the case study, I see Richard sensitively embodying this dwelling approach (though he may not use that word or see it, as I do, as being linked to the phenomenological attitude). For instance, I really appreciate the way that Richard engages Allan's dreams (over the years). He does this in a layered way, excavating meanings when it seems Allan is ready to face them. These dream analysis sequences are powerful, and I suspect pivotal, as Allan learns about the richness of his internal world.

Early on in therapy, whenever Allan mentions a dream, Richard invites him to find his own meanings. Allan appreciates this; as he notes later on in therapy, "You allowed it to be my dream, my meaning" (Erskine, 2021b, p. 44).

In his account, Richard suggests that he might have offered interpretations about Allan's intrapsychic life had he had more information. My view is that interpretation would be an unnecessary embellishment and that working phenomenologically is sufficient at any stage. Interpretations, I feel, take away from the very dwelling inquiry which was now beginning to bear fruit. As Richard acknowledges, what is important is the client's meaning and growing awareness.

Allan's tortured inner world is further revealed in his disclosure that when he leaves the therapy session, the volume of his self-criticism rises. Richard makes a point of working with such insights, showing that he is resonating with Allan's affect or unarticulated relational needs:

> I encouraged him to let me hear what was happening inside him, even to shout the criticisms out loud. When he finally spoke, the forcefulness of his words was lethal: "I'm useless," "I'm a weakling," "No one's interested in me." (Erskine, 2021b, p. 48)

This gestalt technique of amplifying inner dialogue, Richard notes, is effective precisely because intrapsychic conflict is diminished when it is externalized (Baumgardner & Perls, 1975; Perls, 1973).

In time, the source of those shamed/shaming judgements is traced to Allan's disdainful, fault-finding mother. This insight emerges as Allan acknowledges that his trust in Richard is precarious; it seems that Allan has *expected* Richard to criticize him. Richard explains how Allan is transferring emotional memories of his mother's responses onto his therapist and is perhaps compensating for the damaging effects of his mother's criticisms by imagining Richard's criticism. However, we do not learn how exactly this is communicated to Allan. I find such interpretations are best delivered cautiously rather than authoritatively and best posed as an open question for exploration.

Resisting Contact?

Allan's reluctance to talk about his relationship with his mother speaks loudly to Richard. But given the intensity of Allan's pain and anger, it is crucial that Richard continues to be patient while persistently trying to access Allan's feelings.

In the initial stages of therapy, Allan remains reticent, unwilling to modify his behavior or talk about his feelings and early life experiences. Weekly therapy sessions seem to follow the same pattern, one in which Allan simply shares his stories about his irritations at work, night treks in the neighborhood or his nature hiking. It seems that it was important to him was to stay with the familiar and safe—his routines helped to stabilize and protect him. It is not clear from the narrative if Richard made attempts to bring the functions of Allan's repetitions to his awareness.

Unlike many therapists, Richard notably avoids the term "resistance" when he talks about Allan and his response to therapy. The fact that he does not critically label Allan as resistant is significant. The concept of resistance in psychotherapy has been hotly contested, with different schools having different understandings of what it is and how to work with it. Since its introduction to the psychoanalytic field, there is general agreement that resistance can be understood as a defensive, protective response to threat.

However, if we take a humanistic-relational perspective, we understand that interpersonal contact is always a co-creation (Erskine, 2015). This being the case, resistance cannot be understood just as a refusal by one person to engage. I would challenge this pathologizing characterization of the client as the "problem." Rather than seeing resistance as unidirectional, negative and an oppositional move by a recalcitrant client, I prefer the gestalt approach to seeing resistance as a potentially wonderful *creative adjustment* that needs to be respected, honored, and even celebrated. Then, it can be gently managed (McFerran & Finlay, 2018). The relational therapist will want to create a safe-enough space where client self-protection is met with non-judgmental compassion. By naming, not judging, the battle between avoidance and self-insight, therapists can establish themselves as able to contain expressions of the subjective life of the client, which then allows these expressions to emerge more freely (Atwood & Stolorow, 2014; McFerran & Finlay, 2018).

I am interested in Richard's observation that initially he did not attend to the sarcastic swipes Allan aimed in his direction. I see this as evidence of Richard's experience (and robustness) coming into play. While we all have a need to feel helpful (we may even yearn to be needed or appreciated), usually experience helps us to avoid taking criticisms too personally. It's likely that any negativity or rupture has arisen out of a relational process to which *both* client and therapist are contributing. Reflexively exploring underlying dynamics more deeply will help enrich the work and strengthen the awareness or choices of both therapist and client.

Richard rightly starts to probe the function of Allan's habitual criticism of both himself and others. Do Allan's projections offer momentary relief from his own raucous self-criticisms? Are his criticisms the active outward expression of all that he has introjected from his mother and sister? Exploring these questions explicitly in therapy results in Allan having a profound insight: that his self-criticism is a way of drowning out his mother's voice:

> We talked about how his self-criticism became more prevalent and vociferous than his mother's and a distraction from the emotional pain of a mother's words. His posture changed, and the tension in his face and shoulders relaxed as he cried. (Erskine, 2021b, p. 52)

Transferential Responses

From his previous writings, I recognize that Richard's therapy model of *contact-in-relationship* (Erskine et al., 1999) is in play. It is a model that draws on transactional analysis, behaviorism, gestalt therapy, systemic, relational psychoanalysis, and developmental-attachment theory.

Perhaps the biggest challenge for any integrative psychotherapist is how to blend competing—even contradictory—perspectives (Finlay, 2016a). One

potential contradiction in Richard's model is the place of psychoanalytic understandings of unconscious processes and transference. Humanistically inclined therapists reject the idea that unconscious, irrational, instinctive forces determine human behavior. Some even deny the existence of an unconscious as such, preferring instead to talk about material that is not yet in conscious awareness. I wonder where Richard sits in this debate as he attempts to straddle psychoanalytic and humanistic assumptions. Perhaps he manages to avoid the problem of contradiction by his use of transactional analysis, since that theory is implicitly integrative and smoothly blends interventions that works with both archaic and here-and-now needs. From his other writings (Erskine, 1991), I understand that he follows Berne's (1961) early TA formulation, seeing transferential transactions as "externalized expressions of internal ego conflicts between exteropsychic and archeopsychic ego states" (p. 66). More specifically, transferential transactions may be both a projection of Child needs and intrapsychic conflict, and an overt transaction from either exteropsychic or archeopsychic ego states.

I do not disagree with Richard here as my model of working draws heavily on his model and the use of transactional analytic concepts and processes. However, it can be problematic when practitioners inadvertently misuse the model by naively claiming to be simultaneously psychoanalytic, behavioral, *and* humanistic in their approach. More critical discussion is needed about precisely *how* competing theories, with their contradictory underpinning philosophies and assumptions, can or should be integrated (Finlay, 2016a).

I like Lynne Jacobs' dialogic gestalt approach where she finesses apparent contradictions in her concept of "enduring relational themes" (Jacobs, 2017). Here, she highlights how clients' patterns of relating derived from historical experience can become embodied-emotional perspectives on the world. She embraces a thorough-going humanistic focus on the intersubjective here-and-now without assuming that past relationships somehow get unconsciously displaced onto the present. Transference and countertransference are reframed as a co-created relationship of mutual responding where the histories of both therapist and client shape our hopes, longings, or dreaded expectations. This position, focusing more on the relationship as opposed to an individual's intrapsychic world, would probably find acceptance with many contemporary relational psychoanalysts and relational integrative psychotherapists more generally.

I suspect Richard would feel comfortable enough with Jacobs' position. At the same time, he is explicit about his work with transference and his psychodynamic interests. In this case study, I'm interested in the way Richard usefully and clearly categorizes his countertransferential responses as *reactive, responsive,* and

identifying (Erskine, 2012, 2013a, 2013b). That he deeply and reflexively challenged himself to explore his internal experience is significant, and I appreciate his honesty in recognizing his own unrequited relational-needs and identifications, as well as his desire to offer relational healing.

Allan's developmental attachment history is palpably present, both in his own responses and in those of Richard. Richard treads carefully, given the way inquiries about Allan's childhood have been largely rebuffed ("I don't remember my childhood"). He is forced to fall back on his own observations and "intuitive sensings" of possible unconscious relational patterns from childhood. In session after session, as he listens to Allan's detailed stories of his nature hikes or nightly "low-down" treks, it seems that Richard gets the message that he needs to show a "fatherly" interest. "I began to form a developmental image of Allan as a 6- to 8-year-old boy, a child without a father to take an interest in his adventures" (Erskine, 2021a, p. 34).

This developmental image, Richard says, evoked feelings of compassion within him and increased his interest in Allan's stories. He took care to ask factual questions about Allan's hiking and to use his face and body gestures to indicate that he was present and attentively engaged. I feel touched when I hear that Richard *wants* to go hiking with Allan, to smell the forest, to see the woodland trail, to be a companion. I appreciate his care in listening so intently. I feel happy for Allan that he has finally found someone who can mirror, witness, and validate him—and be the companion he has never had.

I am aware of my own powerful developmental image of a caring father and (no longer lonely) little boy walking hand-in-hand through the woods. I recognize that my own enduring relational themes have become figural, and that in a parallel process this could be understood as my own reactive and identifying countertransference.

Titration

The somatic therapist Peter Levine (2011) has developed a systematic approach to working bodily with trauma which involves helping clients progressively access bodily energies and sensations a little bit at a time to build up their tolerance. Borrowing from the field of chemistry, he calls this process "titration."

We can observe titration in action in the way psychotherapists constantly adapt their therapeutic use of self, making subtle adjustments (Finlay, 2022). Research consistently emphasizes the importance of adapting therapy to the individual. "The clinical reality is that no single psychotherapy is effective for all patients and situations no matter how good it is for some" (Norcross & Wampold, 2018, p. 1893).

"As therapists, we make deliberate choices about how and when to intervene. We continuously adapt and pace the levels of tenderness, formality, spontaneity, emotionality, challenge, support, self-disclosure, intimacy, and directiveness we offer" (Finlay, 2022, p. 3). Early in the therapeutic relationship, we might choose to engage more phenomenological inquiry and/or description, and simply listen in a reserved, slow, quiet, empathic way. A client's withdrawal (to self-stabilize) might be supported and even encouraged. As therapy unfolds, we may become more present, animated and/or inject more challenge or self-disclosure (Finlay, 2022).

Throughout the case study, we see Richard making subtle adjustments in his approach, adapting to what Allan can tolerate. When even phenomenological inquiry proves too much, Richard eases back to be simply an appreciative listening-witnessing ear for all of Allan's stories. When Allan experiences Richard as too invasive or critical, Richard again backs off and is respectful of Allan's silent withdrawal.

Of course, it is not always that easy to attune to the precise level of tenderness, silence, empathy, challenge, directiveness, and so on that the client can handle. Some clients can find too much attentiveness overwhelming and invasive; feeling unworthy themselves, they become uncomfortable with too much warm appreciation (Finlay, 2022). Allan, it seems, found any inquiry about his affect uncomfortable (or confusing?), which resulted in him deflecting by changing the topic.

It seems that Richard got the balance about right. He helps Allan begin to express himself by accepting the deflections or silences in a non-judgmental way. I suspect any other approach (e.g., being more directive or challenging) would have resulted in Allan disengaging (although perhaps a cognitive-behavioral therapist would disagree with me).

As the months and years of therapy go by, I again appreciate Richard's artful titrating of his therapeutic use of self where he invites relational connection and makes contact with Allan's vulnerable parts. Sometimes he leans in and offers challenge, and at other times he pulls back to give more space to Allan. He continuously adjusts his responses—relationally.

We can see Richard regularly and reflexively monitoring his use of self. This is particularly evident at times when he realizes his intervention may be a mistake. Importantly he does not beat himself up:

> I was disappointed in myself because I had missed the significance of his various criticizing comments. But, unlike Allan, I did not chastise myself. Instead, I wondered what was happening within Allan, what was unexpressed, and the functions of his criticisms of others. (Erskine, 2021b, p. 51)

I am struck by this passage where Richard states he does not chastise himself (unlike Allan). I suspect this more self-accepting stance grows with experience. We all make mistakes. It is part of the process—possibly even a necessary part. It is

best to view our so-called mistakes with curiosity and compassion and see them as potential opportunities. Many arise out of therapists' genuine concern; if at times we try too hard it is because we care. Ideally, we catch any errors, repair any ruptures, and manage arising wounds over time. Both therapist and client have the opportunity to learn and grow (Finlay, 2022).

Making Connections

> The client is becoming whole. Contact with the self, with all its complexities and capacities, so long split and fragmented, is being re-established. Feelings and thoughts and perceptions rush in, often with surprising intensity. And each of those long-repressed, long-hidden parts of self has a kind of fragility, like a flower bud freshly opened or a butterfly newly escaped from its hard cocoon. (Erskine et al., 1999, p. 172)

Integrative psychotherapy aims to facilitate a sense of wholeness in a person's being and functioning at intrapsychic, mind-body, relational, societal, and transpersonal levels (Finlay, 2016b). We strive to enable our clients to gain insight into their experience and to have a sense of feeling at home with self and ease with others (i.e., both internal and relational integration). There are, of course, limits to the extent to which any of us can be deemed "whole," but integration remains the driving spirit of our project—particularly so in the case of longer-term work.

Relationally oriented therapists believe that healing integration occurs through relationships (with the therapist and with others). The therapeutic relationship acts as a particular catalyst, enabling a client's growth. It is the unfamiliar experience of being deeply connected in a relationship that allows previous ways of being to be understood and laid to rest, enabling new ways of being to be brought to life. In latter stages of therapy, the focus goes towards helping the client own previously disowned parts, find ways to emotionally self-stabilize, and become aware of new possibilities and life choices.

The case study demonstrates this theory beautifully. Over the years that follow, trust, intimacy and connection between Richard and Allan deepen, just as Allan's connection with himself solidifies. For me this distinguishes the most artful level of relational integrative work: where the client's connections *both* externally and internally are enabled (Finlay, 2016a).

Richard and Allan begin to more closely examine and work through the effects of Allan's mother's disapproval at each developmental age and his efforts to hide from her. Using the relationship with Richard as a microcosm of his world, Allan is able to allow the surfacing of issues around trust, shame, and feeling criticized. As Allan connects with his archaic experience, his self-criticism becomes louder. At

last, he can acknowledge his shame and the harsh intense grip of self-criticism is loosened.

The work Richard and Allan engage in is so profound that there is much to comment on and explore further. I would like to open up two aspects: *working creatively* and with *multiple parts of self.*

Working Creatively

> The flow of therapy should be spontaneous, forever following unanticipated riverbeds; it is grotesquely distorted by being packaged into a formula that enables inexperienced, inadequately trained therapists (or computers) to deliver a uniform course of therapy. (Yalom, 2001, p. 34)

Curiosity, warmth, passion, permissiveness, courage, and heart-and-soul commitment are among the qualities that often animate the best relational work. It is important to remain creative rather than follow therapy recipes. We need to engage our own vitality if we are to help enable another's to come forth. Being mechanical or formulaic in our work stultifies the dynamic, growth-enhancing potential of therapy (Finlay, 2022). As Yalom (2001) advises, we should create a *new therapy* for each patient, one tailored to their needs.

Richard shows this creativity again and again. I would like to highlight three instances shown in the way he: 1) challenges Allan to talk about his relationship with his mother, 2) works with another dream, and 3) encourages Allan to withdraw to a safe internal space.

Being Challenging. Firstly, I appreciate the way Richard makes a few deliberate inquiries about Allan's relationship with his mother in each session. That deliberately provocative challenge of his brought a smile to my face. Although Richard does not openly liken their relationship to a battle, there is certainly a battle of sorts (a battle for Allan's soul?) at work.

Richard's persistence eventually pays off—Allan shares more about his early life; his awareness of the impact of his mother's abusiveness grows.

> I continued to inquire about his body sensations, and it became evident that each time he held his breath for a moment and then sighed that he had heard an internal criticism such as "You can't do that" or "People don't want you bothering them." With several phenomenological inquiries, Allan was able to tell me that it sounded just like his mother's disapproving voice. We talked about how discouraging it was to constantly relive his mother's criticism. I asked him to make those comments again, and loudly, like he was talking to little Allan. He repeatedly yelled his mother's words, then he lowered his head and was silent

for several minutes. When he again looked at me he had tears in his eyes. (Erskine, 2021b, p. 52)

In this quotation, the embodied creativity of Richard's interventions is revealed where he makes direct contact with Allan's vital, vulnerable Child self (Erskine, 2001, 2020b). He has shown some courage in bringing that somewhat scary mother into the room. But the intervention has poignant results. At last, little Allan has a witness for his mother's abuse.

Allan now feels safe enough with Richard and sufficiently protected to let his mother appear. In Richard's place I might have considered engaging psychotherapy with his introjected mother, perhaps as a future possibility when the solidity of the therapeutic relationship is more firmly established. Otherwise referred to in the literature as a "Parent Interview" (Erskine, 2015; Moursund & Erskine, 2003/2004), this technique offers a way of giving in-depth therapy to the introjected Other (e.g., internalized Parent ego state) with the aim being for the client to experience a resolution of the intrapsychic conflict. I wonder if this also was Richard's thinking. Such carefully calibrated timing of interventions is characteristic of the work of "master" practitioners.

Dream Work. Secondly, Richard's creative approach is demonstrated when he works with another of Allan's dreams. When Allan explicitly asks Richard for his interpretation of one particular dream, it seems important for Richard to try to respond to this request. Richard hears a young boy ask his father, "What does it mean?" Somewhat challenged, Richard tries to find a heart-to-heart way to offer a "duplex transaction" (Berne, 1961), where the therapist talks simultaneously to the client's Child and Adult ego states. This is not easy to do, and I'm reminded once more of Richard's considerable sensitivity and skills.

I am touched by his intuitive spontaneous empathetic approach where he reflected back the story of the young boy (taking the form of a locomotive train) who carried a heavy load and was stopped in its tracks by a threateningly "large faceless woman" (possibly representing his "Mother").

That Richard and Allan dwell with this dream over several sessions is important. I appreciate Richard's decision to properly record the dream as Allan was telling it so that details can be pulled out in subsequent sessions.

Eventually, Allan is ready to hear the message of the dream more directly:

> I said, "It must have been impossible for you as a young boy to have a real face-to-face contact with your mother, particularly if she was criticizing and misdefining you. It seems that your mother could not face your uniqueness and vitality. Nor was she sensitive to your vulnerability… but she was able to stop your locomotion. Just like in the dream where the faceless woman stopped the steam locomotive." (Erskine, 2021c, p. 64)

As Allan's trust in Richard and connection to himself slowly grow (i.e., external and internal relational connections made), he is able to face his shame and demons and begin to find his uniqueness and vitality. Up to this point Allan discloses he had held back a shameful secret: that on his night-time neighborhood treks he follows women.

The story that eventually unfolds over several sessions is thoroughly heart-rending. It turns out that spotting a woman, and following her, allows Allan a few moments of fantasy: the make-belief that she might be kind to him. The question he has repeatedly asked into the silence is "Can you love me?" Over time, Richard and Allan come to interpret the mantra of "Can you love me?" as a lament. Through this question, Allan has been facing the reality and grief of being an unloved, neglected yet controlled child who yearned to be loved.

Initially hearing about Allan's stalking behavior, I could feel my alarm stirring. Richard was clearly also concerned and confronted a huge ethical dilemma. Weighing up the risks, he made a choice to stay with patient empathic listening rather than being more directive, critical or challenging (Finlay, 2019). While I feel uncomfortable about this decision (like it seemed Richard did), I agree with Richard's therapeutic response given the women were not—it would appear—being actively damaged. And I wonder if, in Richard's place, I would have been able to contain my judgements and aversion to Allan's potentially threatening obsessive behavior with women. I would be interested to hear more about Richard's process of navigating this delicate and tricky ethical dilemma.

Encouraging Withdrawal to a Safe Internal Space. Thirdly, I value the way Richard employs a special creative strategy of actively encouraging Allan to withdraw to a safe internal space *during* sessions. Then, he shows a touching attunement to Allan's silence. This is perhaps the most significant and powerful technique Richard uses when working with schizoid processes (see also Erskine, 2001, 2020b).

Richard becomes aware that in highly charged emotional moments during therapy, Allan seemed to withdraw, automatically returning to a private internal place. By inviting a deliberate withdrawal, he raises Allan's awareness of this approach to emotional self-stabilization and regulation. Recognizing the safety of this space, Richard encourages Allan to withdraw at will during the therapy sessions. It seems that Richard saw this process as a way for Allan to internally hide and keep himself safe lest someone damage his soul once again—a vital ingredient when working with schizoid process. Together, they make the discovery that, watched over by a caring, attentive (but non-invasive) presence, Allan could safely get in touch with many painful and suppressed memories. They also discover that, after being replenished by his private space, he is more relationally contactful and spontaneously vital.

I appreciate the way a therapeutic space has been opened up through Richard's attunement to silence, allowing Allan's memories to surface *in their own time*.

Allan has also been given a new resource: a space where, rather than engaging in defensive withdrawal, he can explore his past in more positive and helpful ways.

Multiple Parts of Self

During the fourth year of therapy, Allan is beginning to feel less depressed and self-critical. Is it now time to wrap up the narrative and celebrate the progress? Or is there more work to be done? What is in Allan's best interests?

Such are the questions Richard now confronts. But at this point he discovers that Allan is hearing his mother's critically harsh voice ever more loudly. For this reason, Richard suggests one further year of work. It could be beneficial, he thinks, to begin working explicitly with that introjected Parent.

Many of us routinely refer to different metaphorical selves within us (such as our "Inner Critic" or "Rebellious Adolescent"). Sometimes it can feel like different parts within us are at war with each other (such as the conflict between the "Industrious Student" part of self and the "Playboy" who just wants to have fun). For some people, the internal splits are more extreme and disturbing, for instance, when a suicidal part acts out in self-destructive ways. Sometimes an individual might embody different personas in dissociative ways without conscious memory of their actions (as in dissociative identity disorder) (Finlay, 2022).

In the field of trauma work, different theories that embrace multiplicity of "selves" tend to subscribe to the idea that people who have a history of trauma show evidence of internal fragmentation (e.g., splitting or dissociation), even if they have perfectly crafted, adaptive social selves which they show the world or do not have an actual dissociative identity disorder. Here, we might include theories such as: transactional analysis and ego state theory (Berne, 1961; Watkins & Watkins, 1997), internal family systems (Schwartz, 2001), self-pluralistic perspectives of person-centered and experiential psychotherapies (Cooper et al., 2004), and parts work in gestalt therapy. The metaphorical representation of selves or parts-of-self in these therapies can be a useful way of containing the fragmentation and exploring problematic aspects (which may or may not be owned) towards integration (Finlay, 2022).

In the case study, Richard doesn't talk explicitly about using the metaphor of parts of self, other than mentioning "Little Allan," and then latterly in the in-depth way he engages Allan's internalized "Mother" therapeutically. His version of working with parts here is thus to think in terms of transactional analytic ego states. (See Erskine, 1991, for an in-depth elaboration which applies Berne's [1961] original definitions to integrative psychotherapy.)

While it is difficult to spot clear differences between what I can see of Richard's practice and my own, I suspect that, with Allan, I would have done more to engage

parts work early on and more explicitly, beyond thinking in terms of ego-states. Parts-work figures regularly in my own relational integrative practice (Finlay, 2016a, 2022) when I work somatically and existentially with longer-term clients, particularly when shame and trauma are involved. The question for me is which parts of the client (and myself!) are coming forward. Who is talking to whom? Our relational connections are usually multiple with different attachment and relating styles between us being revealed.

"The theory makes sense to me as it mirrors my internal landscape and my own therapeutic journey" (Finlay, 2022, p. 135). I see parts in myself and perhaps that sensitizes me to see them (or look for them?) in others. "I appreciate the way that parts work calls forth an integrating, self-compassionate, creative energy. When a new part comes forward (and is recognized by my client or myself), the moment of insight can resemble an inspirational epiphany" (Finlay, 2022, p. 135). With this integrating awareness the client becomes aware of the possibility of choice, change, and escape from habitual ways of responding. The ability to turn down the volume on cacophonous choruses of strident voices becomes a realizable goal (Finlay, 2022).

DeYoung (2015) has highlighted the role of relationally validating connections based in "right-brain-to-right-brain communication" when working with clients who experience chronic shame. Highlighting the role of respect and compassion when working with chronic shame, DeYoung recommends engaging multiple parts of self:

> Bringing shame to light often illuminates a needy part of self who is despised by a tough, independent part of self. Listening respectfully to both parts and helping each to find compassion for what drives the other brings better balance and harmony to the whole self system.… Parts of self can find space to speak the unspeakable about need, longing, and humiliation, and in their speaking and being heard, integration happens. (2015, pp. 132–133)

Work with the parts which represent internalized Others is potentially the most powerful, transformative, imaginal technique we have at our disposal. I know from his previous work that Richard is a master when it comes to this way of working (Erskine, 2015; Erskine & Moursund, 1988/2011; Moursund & Erskine, 2003/2004).

While hugely aware of the healing promise of therapy with internalized Others, I'm also mindful of its potential to be intense, stirring, disorientating, and unsettling. This is not an intervention to be used superficially as a technique or gimmick. It needs to be handled carefully so that plentiful time and space are given to processing the material. I know from my own experience how terrifying it can be to have the problematic internalized Other come into the therapy space. The therapist needs to ensure the client feels safe and supported while the internalized Other is being worked with. At the same time, the "Parent"/Other needs to be acknowledged

and respected for their own struggles while being challenged to take responsibility for the impact of their behavior.

Richard did all these things—of course. But I am struck afresh at the care he took *initially* to explain the process; then again, *during* the work he took care with his sensitive, tactful handling of both Allan and his "Mother;" and *after*, he gave plenty of time to explore the revelations. In particular, Richard worked with Allan's Child's response to work with this "Mother," enabling him to express what had not been previously expressed, helping to free his Child confusion and the old attachment bonds. That the work was layered, and carried on over several sessions, is particularly interesting to me. Most of my previous experience with this sort of work has been as a one-off "Parent Interview" and I am now intrigued about the possibilities of engaging in-depth psychotherapy with the introjected Other and discovering how this way of working may unfold when engaged long-term on an ongoing basis.

I also appreciate Richard's evident skills in helping Allan work through some of his relational trauma, his sense of betrayal and anger at the neglect and disparagement he received. I particularly like the empty chair work where, first, Allan's "Mother" was invited to explain her treatment of Allan and challenged to take responsibility for it. Then Allan was invited to take cathartic step of sitting in the chair and replying to his mother.

Richard's summary shows something of the extraordinary, completed gestalt that was achieved:

> In sessions that followed, Allan and I went over each conversation I had with his introjected mother. He talked about how her coldness and criticism had permeated his life. He went into detail about his mother's voice being "consistent and insistent." We again examined how his self-criticisms had been a way to block out his mother's voice. I talked to Allan about "the loyalty of a little boy" and how he stayed attached to his mother by disavowing his anger and believing her definitions of him. Allan was happy that he seldom heard her critical voice in his head now. (Erskine, 2021e, p. 84)

Endings

The decision about when to end long-term therapy is never easy. Then a further layer of difficulty must be worked through to ensure the end is handled in a constructive, healing way. Clients and therapists alike face the challenge of separation and the grief that results from severing a special bond. Ending therapy can also trigger a re-experiencing of past loss, rejections, and unresolved grief (Finlay, 2016a, 2019). It is not surprising there are sometimes missteps along the way. Either therapist or client may begin to think it is time to end. Then suddenly it isn't. They may disagree, tussle, or find a way to compromise. Richard and Allan also had to face this negotiation.

The key process in this ending phase involves enabling a client to work through any arising pain. In strategic terms, it is about allowing the client to deal with unfinished business. Therapy should not add to the list of client's experiences of problematic endings (Finlay, 2016a).

I am intrigued to learn that Richard builds in a summer break vacation when doing long-term work—something I have never done (choosing instead to take a week or so off periodically). I now see that having a formal, built-in break offers interesting grist for the mill. For one thing, there is an opportunity to practice the eventual ending process, which could otherwise be avoided or resisted. This happens, for example, when clients ask, "Can we keep in touch?" or—worse—when a therapist says, "Come back if it doesn't work out." Any ending, says Romanyshyn (2006, p. 31) is "always a petit mort." Even if we don't go as far as thinking in terms of death and grief, at the very least, having a summer break can offer time for reflection and therapy can be re-set accordingly.

Perhaps helped by their formal breaks, both Allan and Richard seem well prepared when the end of therapy eventually occurs. That Allan was leaving therapy because he was moving away to fulfil a dream helped with the positive forward-looking momentum.

I am not sure I can say the same about being prepared for the ending myself; I am aware that I want to find out more about Allan. Is he enjoying his new life? Has his photography taken off? Has he found some nice nature trails nearby? Has he made some new friends or supportive acquaintances? Ruefully, I acknowledge to myself that I am not quite ready to let them go. (And, yes, this is another parallel process—I often feel something similar at the end of therapy.)

Richard does not expand on what the loss of Allan means to him personally. He does not mention if part of him was reluctant to let Allan go, or whether he was tempted to invite a continued correspondence. Maybe I project my own difficulties with endings here. After all, Richard had many months in which to work through the ending.

Yet at the end of his writing Richard strikes me as retreating a little abruptly into theory. I wonder if that intellectualization helped him move away from the loss and grief he might have been experiencing. Perhaps, too, the act of writing up his case study was another way to "let go" while also celebrating Allan's growthful journey.

I respect Richard for ensuring what sounds like a good (relationally connected) ending with Allan. As he says of the last few sessions:

> In each session he cried as he expressed his gratitude for the quality of our relationship. During those final sessions I was sad and glad: glad that Allan was creating a new life and sad to be saying good-bye to both the man and the neglected little boy, both of whom I had come to love. (Erskine, 2021e, p. 85)

I find it almost unbearably poignant to hear Richard say he had come to "love" Allan. I appreciate his authentic honesty and the way he both owns and gives voice to the special kind of love we can feel in the therapy room—one that we do not often talk about publicly. That love stands as a testament to their profound relational work. I wonder if Allan was eventually able to feel he was truly loved by Richard—both the man and the little boy.

As therapists, we carry the privilege and the responsibility associated with endings. Our role is to help clients face the pain of the goodbye as part of embracing life. We celebrate the client's growth with them as they take their new discoveries into the rest of their lives. And then we need to let go with *grace* (Finlay, 2016b, 2019).

I am honored by this opportunity to work with this story of Allan's therapy. Like others, perhaps, I feel privileged and humbled to have been given such an intimate glimpse into Allan's trauma and to have witnessed the healing process, in which the accumulated impact of his neglect is healed through the therapeutic relationship with Richard. Dwelling with their story has helped me identify both with Richard and with Allan. I had a strange sense of being a part of their relationship where tendrils of vicarious healing unfolded for me as well.

I started this project of dialoguing with Richard's writing with excitement and curiosity, and yes, some uncertainty. I believe I have managed to unfurl some interesting aspects of their journey and learned more about the therapy process (a lifelong quest!).

There is much more, had space allowed, that I might have said, but I hope I have conveyed the deep respect I feel for Richard's work. It's not just that he engaged some wonderfully attuned and care-full therapeutic interventions with the right balance (for Allan) between inquiry and challenge; it's the artfulness of his exquisitely sensitive choice and timing of those interventions and the way he uses himself therapeutically, in service of Allan's growth.

Their work has touched me deeply and, although I leave it now with some sadness, I remain grateful for and enriched by Richard's gift.

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