ONE

THERAPEUTIC USE OF SELF

> The person of the therapist is the center point around which successful therapy revolves. (Satir, 2000, p. 25)

What do our therapeutic relationships with clients involve? How do we create a safe space for clients to go exploring? What are we *doing* when we show clients respect and caring, attuned attention or when we challenge them to grow? How is our way of *being* with clients therapeutic?

These questions around 'doing' and 'being' all relate to the idea of therapeutic use of self which can be defined as:

> A therapist's thoughtful, deliberate effort to use their self as a tool, one which embodies a self-aware therapeutic way of being in the service of clients and the client-therapist relationship.

This chapter begins by expanding on this definition. It then moves on to examine how we adapt our use of self, develop a therapeutic alliance and promote 'contact-in-relationship' as our approach shifts in different clinical/theoretical and cultural contexts. The point emphasised is that our use of self and our therapeutic choices (for doing and being) depend on the relational and cultural context, and demand a level of self-awareness. A fluid responsiveness is required, enabling the therapist to attune to the type of contact each client can accept at any given moment. Therapeutic use of self is not something that is predetermined and fixed – it is a process that emerges, moment-to-moment, in response to another.

The chapter concludes with a case study, along with critical reflections, discussion questions and resources – a pattern followed across the rest of the book.

Defining 'use of self'

Therapeutic use of self is the self-aware intertwining of both our *professional* self (the one that uses knowledge, skills and techniques) and our *personal* self (which arises from our history, beliefs/values, personality and embodied lived experience). It involves our therapeutic practices that we've learned and our particular way of maintaining a caring, attuned, holding presence. In other words, therapeutic use of self involves the totality of our being and doing; it is present in our every intervention (see Box 1.1).

The concept of 'therapeutic use of self' first gained traction in the latter half of the twentieth century when practitioners in various healthcare fields took it up. For example, Mosey, an occupational therapist, defined use of self as:

> A planned interaction with another person in order to alleviate fear or anxiety, provide reassurance, obtain necessary information, provide information, give advice, and assist the other individual to gain more appreciation of, more expression of, and more functional use of his or her latent inner resources. (Mosey, 1986, p. 199)

Box 1.1 Research: therapeutic use of self

Sleater and Scheiner (2020) conducted semi-structured interviews with humanistic and integrative therapists about their lived experience of the use of self. They analysed the transcripts and developed a model based on three themes:

1. Connection is the use of oneself to develop and cultivate a therapeutic attachment– for instance, through self-disclosure (which can be overt, inadvertent or unconscious). There is a balance to be struck between spontaneously being oneself and thoughtfully tailoring disclosures, depending on the circumstances and counter-transferences involved.
2. Awareness involves being attuned to what passes between therapist and client in the relationship (embodied or unconscious). Such attunement is grounded in mutuality and awareness of vulnerability. With experience, therapists learn to use the self in such a way as to become authentically involved and emotionally vulnerable, while also maintaining appropriate boundaries.
3. Wellness involves the requirement for therapists to take care of themselves in order to be able to effectively use themselves. It helps to have an expanded awareness of our compassionate 'internal supervisor', to keep track of and enable healthy decisions.

Virginia Satir (1967) was perhaps the first to fully articulate its relevance to psychotherapy. In different writings throughout the 1980s, she challenged practitioners to shift from being merely skilled 'technicians' (whose primary focus is on skills and techniques) or 'clinicians' (who combine skills with practice-acquired wisdom) to become 'magicians' who use skills, practise wisdom and the use of self. In other words, she was urging therapists to move beyond just 'doing' to embrace 'being' by becoming more self-aware and attending to the therapeutic use of self:

> I have learned that when I am fully present with the patient or family, I can move therapeutically with much greater ease. I can simultaneously reach the depths to which I need to go, and at the same time honor the fragility, the power, and the sacredness of life in the other. When I am in touch with myself, my feelings, my thoughts, with what I see and hear, I am growing toward becoming a more integrated self. I am more congruent, I am more "whole," and I am able to make greater contact with the other person. (Satir, [1987] 2013, p. 25)

Satir goes on to liken the therapist's use of self to a musical instrument that requires care, fine tuning and sensitive handling when played:

> I think of the instrument as the self of the therapist: how complete one is as a person, how well one cares for oneself, how well one is tuned in to oneself, and how competent one is at one's craft. (Satir, 2013, p. 25)

Adapting and adjusting therapeutic responses

Research consistently emphasises 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 and Wampold, 2018, p. 1893).

As therapists, we make deliberate choices about how and when to intervene. We continuously adapt and pace the levels of care, formality, spontaneity, emotionality, challenge, support, self-disclosure, intimacy, control and directiveness we offer (see Figure 1.1).

Early in the therapeutic relationship, we might listen in a reserved, empathic way as part of engaging a client in therapy. Then, as therapy develops, we might raise the element of challenge by adopting a more muscular, directive approach. These subtle moment-to-moment adjustments also occur when we meet clients outside the therapy context (at the supermarket, say, or on social media). How should we be? How much of ourselves should we show?

In an introductory contracting session, we may be quite formal and boundaried to show that we are a trustworthy 'professional'. Later, we might

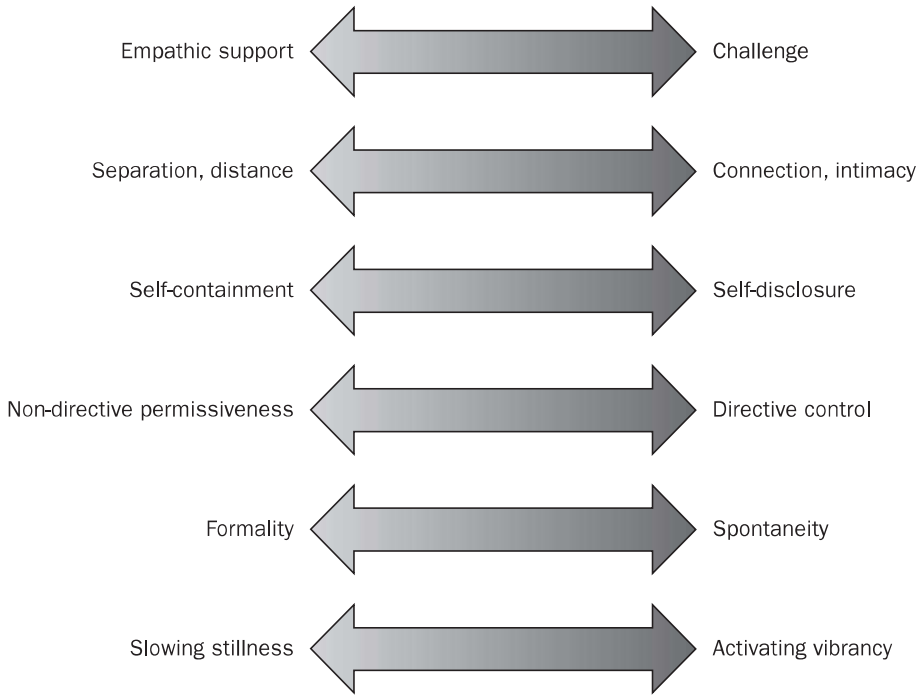

Figure 1.1 Choices of therapeutic 'use of self'

reveal more of ourselves as a 'person' as trust and intimacy grow. Sometimes, we find ourselves being lively and activating; at other times, our pacing may be slower in order to offer clients a space of stillness. For instance, Erskine (2020b) describes his therapeutic relationship with 'Violet' where he changed his approach to become 'softer and quieter' and *be* with her in her silence. This allowed her to be more present to herself. That he changed in response to her was pivotal as it demonstrated to Violet that she could have had an impact on her world.

There's no magic formula here. It's about exercising our professional judgement, minute-by-minute, in response to what we responsively assess is needed.

There is always choice. While our actual *doing* (our intervention) may derive from science, the choices we make regarding the timing, manner, balance and intensity of our intervention are all rooted in our *being* and in our 'art'.

From science we have learned that certain interventions work well with certain people. Norcross and Wampold (2018) summarise the evidence base concerning relationships and responsiveness, and suggest that a complementary style of interaction can be helpful – for instance, less directiveness is beneficial for highly reactive/resistant clients, while more guidance and direction is needed for less reactive clients. Research also favours direct responses to specific client requests concerning therapy preferences, including cultural adaptations. However, research consistently shows the importance of adapting therapy and responding authentically and sensitively to

each person individually, depending on their needs. There are no easy recipes; our art is in the choice and balance of ingredients.

In the dialogue in Box 1.2, the therapist initially contains his (potentially destructive) responses, holding himself back in order to enable the client to be more present. Recognising that something delicate is emerging, he doesn't want to inhibit Jenny's process by inserting his own reactions too strongly or quickly. 'Among the ways that any clinician can do harm is to impose her or his viewpoint on the client rather than supporting the client to develop the viewpoint(s) that serves the client's therapy goals and life commitments' (Reinkraut, 2008, pp. 20–1). Then, the therapist becomes more present himself when disclosing that he is open to her anger. He

Box 1.2 Case example: adapting responses

Jenny (client): When I woke up this morning, I didn't really want to come to therapy.

Therapist: (*Initially, the therapist feels some irritation and wants to say, 'If you don't want to be here, you don't need to come.' But he has enough self-awareness to contain this reaction – which he recognises as coming from a rejected child place – to stay with Jenny's experience.*)

What was happening for you in that moment?

Jenny: Often I wake up feeling angry, I want to say 'no', I just want to stay in bed and do what *I* want to do. But then my grown-up responsible part of me gives me a shake and reminds me what I 'should' be doing. I knew I needed to be here.

Therapist: (*He notes that she sees that responsible part as 'adult' whereas he believes it's Jenny's 'good girl' part. He doesn't correct her or share his different interpretation. He stays with her experience and just reflects back.*)

I'm hearing that part of you didn't want to be here; but another part got you moving and told you to be responsible and go to therapy.

Jenny: Of course I want to be here. I really value you and our work together.

Therapist: And what about that angry part? Are you open to working with that part a bit more?

(*Jenny nods hesitantly, so the therapist proceeds gently, not wishing to overwhelm or scare her further.*)

I noticed that when you initially described your waking angry part you had your fists closed. Can you do that for me now and really try to exaggerate that moment?

(*Both therapist and client hold their fists up tightly like boxers. The therapist does it with her to normalise it and 'be-with' her in that place.*

Initially, her arms are still a bit loose and floppy, and she looks feeble. He encourages her to put some 'muscle' and force into them. He provocatively – but gently – pushes against her arm until she holds her fists strongly.)

If those fists could be talking, what would they say?

(*Conscious of the risk that Jenny might be experiencing him as being too aggressive like her father, he keeps his tone curious and gentle. Later, he will recognise that he occasionally comes across too forcefully, which elicits her compliance, and he wonders if at those points he is inadvertently replaying her history. He takes his initial irritated response to supervision.*)

Jenny: (**Hesitantly**) Go away? I'll fight you if you try to make me.

Therapist: Can you say that again with more conviction? 'Go away. I'll fight you if you try to make me!'

(*Therapist mirrors Jenny's behaviour and words but takes out the questioning tone and invites her to say it again more loudly.*)

Jenny: Go away! I'll fight you if you try to make me!

Therapist: What's happening for you right now? You're looking thoughtful.

Jenny: I'm feeling strong. And I'm remembering my childhood. My father and brother used to fight like this all the time. I couldn't stand up to them. I never did this. When I tried, I was punished and told 'girls don't fight'. I'd end up hiding in my wardrobe.

Therapist: (*Now the therapist is feeling compassion for the 'good', scared little girl who was never allowed to express herself.*) Like you told yourself not to be angry this morning?

(*Jenny nods slowly with this new insight.*)

But what if I said that I'm okay about you expressing your anger here and that I like to see it?

Jenny: It's all right for me to be angry?

(The *therapist smiles softly and nods encouragingly.*)

Now there's a new concept!

carefully reflects back Jenny's words, all the time becoming more directive as he coaches her to express herself.

We can borrow the concept of 'titration' from the field of chemistry to better understand how we adapt our use of self and constantly make subtle adjustments. Titration involves continuously measuring and adjusting a concentration of a substance, one drop at a time, to bring about a given effect. The 'substance' in the case of therapy is our self. (The client too will be engaged in their own titration, adapting their response with us.)

The somatic therapist, Peter Levine, explains how he engages titration with his trauma work by exposing a client slowly to increasing amounts of trauma-related distress to build up their tolerance:

> I started to develop a systematic approach where the person could gradually access these energies and these body sensations … [a] little bit at a time. It's a process that I call titration … The image that I use is that of mixing an acid and a base together. If you put them together, there can be an explosion. But if you take it one drop at a time, there is a little fizzle and eventually the system neutralizes … I use this analogy to describe one of the techniques I use in my work with trauma patients. You're not actually exposing the person to a trauma—you're restoring the responses that were overwhelmed, which is what led to the trauma in the first place. (quotation from Levine in Yalom and Yalom, 2010)

Building the therapeutic alliance

Research has repeatedly demonstrated a robust relationship between therapy outcomes and the therapeutic alliance (emerging collaborative partnership). Relational factors are central to therapy's effectiveness (Cooper, 2008) and the working alliance is often predictive of therapy outcomes (Norcross, 2011; Norcross and Karpiak, 2017). The better the relationship, the better the outcomes, regardless of therapy approach/modality, client characteristics, culture/country and so on (see Box 1.3).

Box 1.3 Research: alliance and treatment outcomes

Flückiger et al. (2018) offer a major meta-analysis of 295 independent studies published over 40 years (mostly from North American and European countries), encompassing more than 30,000 patients engaged in in-person or internet-based psychotherapy. The relation between alliance and outcomes was investigated using a three-level meta-analysis. The results suggest that mutual collaboration and negotiated partnership between therapist and client are hugely significant aspects of psychotherapy across various approaches. The benefits of a strong working alliance for therapy appear to apply irrespective of outcome measures, treatment approaches, patient characteristics and national setting; they apply whether therapy is in-person or internet-mediated. Therapeutic success can be reliably predicted when there is agreement on therapy goals and when therapists respond early to client's motivational readiness to engage or change. A strong alliance is found to result from negotiation and also from prompt action to address any ruptures in the alliance. The authors recommend regular assessments of the alliance during therapy, arguing that this can help pick up unsatisfactory progress and the possibility of premature terminations.

The therapeutic alliance can be understood as the mutual partnership that, while emerging over time, is also infused with each moment of therapy. It expresses itself as a warm emotional bond where the therapist is responsive and encourages collaboration. Enacted in different ways, it reveals itself in the form of mutual respect and trust. As therapy unfolds, the client feels seen and supported; they sense that the therapist is on their side.

The process of building the alliance starts with contracting. Here, aims/goals/processes are agreed and key information is given about the collaborative responsibility for the therapy. The client needs to have a sense of what they are aiming for.

Lack of progress or improvement after the first few appointments should act as a warning to therapists, encouraging them to broaden the discussion with the client about the nature of the goals and processes of therapy (Miller et al., 2005). Forming a solid therapeutic relationship is crucial, for it enables therapist and client to work together through those more challenging moments of therapy when one or other wants to withdraw (Finlay, 2016a, 2019).

The dialogue in Box 1.4 shows the therapist and client discussing the client's use of a 'food-thought-feelings diary'. With alliance-building to the fore, the therapist attempts to move forward with the scheduled treatment plan, but realises she needs to engage the client by responding more directly to the client's concerns and mutually exploring obstacles, without losing track of the therapy focus/goals.

Box 1.4 Case example: adapting to engage

Therapist: So how did you manage with writing your food diary last week?

Client: Well, I did it the first day and then somehow it didn't happen. I couldn't see the point if I'm honest. I just don't have the time. I know my diet is s***.

Therapist: Yes, it's hard to write your diary when you have so much going on. I'm sorry I didn't make the point of doing it clear enough last week. It's not about examining your diet as such; it's more about seeing if there are any patterns to your bingeing.

Client: Well, I already know that it happens in the evening after work when I'm tired and just slump in front of the TV after my meal. Then it starts.

Therapist: Your bingeing? (*Client nods.*) Every night?

Client: Maybe two nights a week it's really bad; two nights maybe are good. The rest of the time I overeat but don't do a major binge.

Therapist: What does a 'major binge' look like?

Client: umm ... It's a little embarrassing.

Therapist: I'm not judging you, just trying to understand your experience.

Client: Well … um … last night it was six mincepies and … um … a 2-litre tub of ice-cream.

Therapist: Have you any idea what triggered that impulse last night and what you felt before, during and after?

Client: After I hated myself. Before and during, I didn't really feel anything – just the craving.

Therapist: The fact that you don't binge every night suggests that something else is probably going on for you when you get that craving. That's one of the things we need to try to figure out together. It's possible that feeling suddenly angry/frustrated or anxious could trigger the binge.

Client: I dunno. Never thought about it like that.

Therapist: Given you're finding writing the whole diary a pain, how about just jotting down any thoughts and feelings you have just at the point when you become aware that you have a craving to binge? Would you be able to do that – just for one week?

Client: I guess so. That sounds more doable.

Therapist: What might stop you doing it?

Client: I may not know what to say.

Therapist: Just a sentence or two about your thinking or feeling would be good, even if it's 'I'm feeling blank'.

Contact-in-relationship

Our use of self is not something we *do* to the client. Instead, it emerges within the specific relationship and evolves as we adapt – over time – to the client's needs and the relational context while they adapt to us. This distinguishes our work from that of digital 'therapist bots' – robots – which formulaically follow predetermined protocols and lack the self-awareness to adjust the approach taken.

What is beneficial for one client could be problematic, even harmful, for another. Reaching out to comfort someone by holding their hand can be experienced as a lovely, supportive gesture. But in another context, or with another individual, it could be interpreted as patronising, invasive or even threatening. While a forceful challenge may help inspire a client to break with past patterns and behave differently, it could also nudge a client into a freeze or flight response. Our art involves attuning to the needs of both client and the therapeutic relationship towards evaluating when and how to intervene (see Box 1.5).

The judgements we make regarding our levels of closeness/distance flow from attending to the therapeutic relationship *and* responding to the client's cluster of relational, developmental and social needs. At any given moment,

Box 1.5 Practical application: titrating levels of intervention

Wosket (2017) offers five levels of intervention, all of them dependent on the degree of mutuality of disclosure the client can tolerate and benefit from. Underpinning this logic is the notion that there is no 'right' intervention. Rather, we try to attune ourselves to the needs of a specific client and choose the degree of relationality and disclosure that is likely to be most helpful. Which option we choose depends on our own way of being (and level of self-awareness) and the relational context.

> Level 1 = You haven't said as much, but I wonder if you are feeling quite vulnerable today ...
> Level 2 = It seems hard for you to talk about your feelings today and yet I sense that you are upset ...
>
> Level 3 = I notice we're not talking about your feelings today and when that's happened before it's often when you have been very frightened or very sad. If you're feeling like that today, I'd like to help if I can ...
>
> Level 4 = It's hard for me to listen to you talk like this when I feel that your words may be covering up a lot of sadness and loneliness. I know that sometimes it's difficult for you to let me see you're upset and to let yourself be comforted there ...
>
> Level 5 = I feel like I want to gather you up in my arms and comfort you. (2017, pp. 55–6)

we need to determine how open or closed to making a connection the client is, whether internally (with themselves) or externally (with the therapist) (Erskine, 2015). The aim is a dual one: to facilitate contact with the client and also to enable the client to be in-relationship with different parts of themselves. This is what is meant by 'contact-in-relationship' through attunement, involvement and empathy (Erskine et al., 1999; Moursund and Erskine, 2004).[1]

Therapy begins as we attune to the client's needs. This includes recognising what areas they are open to exploring initially. Our access to their experience at this point is through the relationship and how we're experiencing them. For example, are they pushing us away or are they asking for something? Then, as (mutual) trust builds, the work inches progressively into more painful or difficult areas. The client is encouraged to connect more deeply with both the therapist and with their own relational needs.

Box 1.6 Case example: contact-in-relationship

Client: My father was like a Nazi; we were all terrified of him. I remember that I was strange already back then. I started to avoid social contacts and had my own world ... In my world, everything was fine.

Therapist: You were strange?

Client: Yes, I felt different from others. I didn't tell you about my inner world. For a long time I felt that you would think I am crazy and will put me in a psychiatric hospital.

Therapist: So you were very afraid of your father, who was often drunk and violent. And at that time you started to live on the other side where everything was OK. So this 'other world' in which everything was fine helped you to survive and keep you sane in the 'insane world'.

(*The therapist acknowledges and validates the client's coping mechanisms, which promotes the client's awareness and acceptance.*)

Client: Yes, it helped me to survive, definitely.

Therapist: (*With a kind and compassionate voice*) Let's appreciate this strategy of a five-year-old that helped you to survive.

(*Another validation, which helps the client to experience self-compassion.*)

Client: I feel touched; I never thought about this in this way ...

Therapist: Maybe this strategy was the most clever strategy to survive in a family where there was no one to hold on to ... (*short pause*) What do you feel now?

(*The therapist conveys the normalisation of the client's past coping strategy.*)

Client: Feel like I would embrace this younger part of me ... telling him I love him and care for him.

Therapist: Just do this; take your time.

Client: (*Crying*) I feel sad for what I have gone through ... (*Pause*) Now I understand that having my own world actually saved my life ... I also understand that I am not there any more. I am safe now. (Žvelc & Žvelc, 2020, pp. 139–40)

This contact-in-relationship is demonstrated in the dialogue in Box 1.6, where the therapist takes a compassionate approach to encourage the client to connect with a younger part of themselves (Žvelc and Žvelc, 2021). At the start, the pace is slow; the therapist listens, attunes and validates the client's experience and offers time for reflection (attunement). This enables the client to contact their grief and acknowledge the value of their own coping mechanisms. By compassionately asking about the client's way of coping and surviving (enquiry), the therapist is modelling acceptance and being present to the

grief, which in turn encourages the client to honour (or even let go of) their protective mechanisms (involvement). By 'normalising' what has happened, the therapist helps the client appreciate and embrace the defensive strategies which have helped them cope. (NB: Italics changed from the original.)

Theoretical influences on use of self

Different theoretical frameworks dictate different types of 'doing' in therapy and promote specific ways of 'being'. For example, in traditional psychoanalysis, therapists typically adopt a neutral stance, receiving projections and transferences, which they then interpret. Cognitive-behavioural therapists take a more directive, psychoeducational coaching approach. Person-centred humanistic therapists are more non-directive and open, bringing their personhood to the fore as they embrace empathetic affirmation while practitioners who lean towards gestalt and existential work may be more directive and/or disclosing of their own reactions.

In practice, such theoretical differences lose their sharpness when therapists take a developmental–relational, systemic and/or integrative (or pluralistic) stance. A contemporary relational, body-focused psychodynamic therapist is likely to have more in common with an existentially orientated humanistic therapist than a traditional Freudian one. A relational cognitive behavioural therapist (CBT) would probably find more commonality with a humanistic/psychodynamic transactional analyst who works with the 'Adult' ego state, instead of another CBT practitioner who follows set protocols.

Research backs up this notion that theoretical modalities do not necessarily determine the therapist's style. Reupert (2008), an Australian researcher and family therapist, interviewed sixteen participants from various theoretical backgrounds (including psychoanalysis, CBT, humanistic therapy, and family therapy) to explore what they brought of themselves to the therapeutic encounter. Some participants described suppressing all personal aspects of self and using their professional parts only, while others identified the self as an inevitable presence permeating every aspect of their work. Interestingly, use of self did not seem to depend on the therapeutic approach they espoused.

Rowan and Jacobs (2002) identify three ways in which the self can be used in therapy: instrumental, authentic and transpersonal. These form a continuum that cuts across traditional theoretical boundaries. In each 'possibility', different assumptions are made regarding the therapist's level of self-awareness and the depth of relational connection with the client.

- The *instrumental self* sees the therapist applying skills and manualised treatments and techniques in goal-orientated ways. Cognitive-behavioural and systemic practitioners, and those engaged in brief therapy, primarily engage this mode, although others (including psychodynamic therapists) can also work this way.

- The *authentic self* involves more spontaneous person-to-person interactions, with active, mutual exploration, self-disclosure and acknowledgement of the co-created therapeutic relationship. While humanistic approaches most clearly engage this way of being, so do other relational-orientated therapies.
- The *transpersonal self* represents therapists who are attentive to what happens 'between and beyond' their own self and that of the client. The therapist tries to let go of assumptions about therapeutic goals to focus on merged boundaries. For example, they might explore the notion of 'collective unconscious', or the idea of 'deep empathy', or the spiritual concept of 'altered states of consciousness'. Some psychoanalytic and existential practitioners operate at this 'soulful' level, as do systemic practitioners who work with intergenerational processes.

Cultural influences on the use of self

When therapeutic use of self is seen through a sociocultural or diversity/difference lens, wider issues concerning professional ethics come into focus.

First, there is the impact of our own cultural background on our values, assumptions and behaviours – for instance, how our values/beliefs lead us to dress and behave in certain ways. But it goes deeper. Perhaps these values lead us to be drawn to or avoid working with certain groups of people. Are you aware of any lurking prejudices you might have about the client's sexuality, ethnicity, race, class, religion, appearance, lifestyle habits, disability and cultural beliefs?

Second, with a sociocultural lens, it's clear that it is insufficient to simply treat the individual in isolation. Instead, we must see the individual in their wider social contexts (be that family, friends, work, culture) and adapt our treatments accordingly. At the very least, appreciating the context gives us an idea of what is going to be meaningful and realistic for the person to aim for.

To give a specific example, we might wish to titrate our levels of intimacy and use of touch. But is touch going to be acceptable to the client? How might they react? Is touch with the opposite sex taboo (given their age, family history, upbringing and both ethnic and class background)? It also works the other way. Might you feel uncomfortable with a new client who tries to hug you goodbye or sends you kisses in a text? These aren't just individual preferences. It's about cultural norms (both the therapy/institutional culture and in the wider society). As Amari (2020, p. 9) notes, a 'relational use of self' involves a 'network of relationships in which practitioners and clients are embedded'.

Therapists are expected to be ambassadors for diversity, inclusion and social justice; there is an ethical obligation[2] to become more aware of the experiences of marginalised groups of people, be sensitive and respectful of others, and to challenge inequalities and discrimination. As these ideas are enshrined in most (if not all) professional codes of practice, we are

invited to embrace them in our therapeutic use of self. In their statement on diversity and equalities, for instance, The United Kingdom Council for Psychotherapy (UKCP) states its mission to promote:

> an active engagement with difference ... that allows competing and diverse ideas and perspectives on what it means to be human to be considered, respected, and valued. UKCP is committed to addressing issues of prejudice and discrimination in relation to the mental well being, political belief, gender and gender identity, sexual preference or orientation, disability, marital or partnership status, race, nationality, ethnic origin, heritage identity, religious or spiritual identity, age or socio-economic class of individuals and groups. (UKCP, 2017)

In other words, we are professionally obliged to cultivate a reflexive awareness of our attitudes, developing a cultural sensitivity and some cultural knowledge regarding each client we see (see Box 1.7). We might even be called to engage explicitly in anti-oppressive practice. We need to do this,

Box 1.7 Practical application: cultivating cultural competence

The aim of cultural competence is to increase awareness of difference/diversity while minimising cultural barriers in communications with clients and colleagues. While it is impossible to fully understand every client's cultural background, it is still possible to show sensitivity to, and openness about, what seems important to them. The following research-supported guidelines (adapted from Soto et al., 2019) may be helpful:

1. Explore the impact of each client's cultural background/experience trying to actively learn their perspectives.
2. See the individual in their complexity rather than reducing them to stereotypes.
3. Aim to understand both internal and external struggles which are created by different social identities (gender, race, ethnicity, religion, sexuality ...).
4. Ensure therapy adapts to clients' cultural identities/values.
5. Cultivate awareness of own cultural values, assumptions and potential prejudices. Assume your cultural perspective is different from the client's.
6. Consult colleagues who have the specific cultural experience/knowledge to help interventions be more culturally appropriate.
7. Conduct therapy in the client's preferred language (maybe utilising interpreters with appropriate training/cultural knowledge).

not out of a political correctness, but because it concerns our ethical integrity and humanity in relationships both inside and outside the therapy room. And it's also worth noting that Norcross and Wampold have thoroughly reviewed the evidence base and conclude that 'therapists expressing cultural humility and … cultural responsiveness [show] markedly improve[d] client engagement, retention, and eventual treatment outcome' (2018, p. 1902).

Case study

Ania is a single mother with a four-year-old daughter called Zofia. Polish by birth, she immigrated to the UK and married a British man who left her when she was pregnant. Without social support, it was challenging for Ania to bring up her little girl alone. She was helped by a network of new friends she made at a mother-and-toddler group. When the Coronavirus pandemic and 'lockdown' hit, Ania and her child became isolated and mutually dependent. When lockdown was lifted and it was time for Zofia to start going to nursery school, Zofia refused to go. Her behaviour became problematic: she began wetting the bed and had frequent tantrums. Ania herself became anxious and felt a failure as a mother. She approached her local women's Counselling Centre and was given ten sessions of weekly individual counselling. The columns below shows the progress of the therapy and the counsellor's use of self at the different stages.

Table 1.1

The Story of Ania's Therapy	Analysis of Therapeutic Use of Self
Contracting: In their initial phone call to arrange an appointment, the counsellor offers Ania the choice between online and in-person work. Ania expresses her preference for online counselling, explaining that she's still anxious about going outside into the world. However, she also admits to feeling quite anxious about going online as she isn't technologically savvy. The counsellor talks her through the process, and they have a quick try-out of Zoom to make sure she knows what is required.	*Therapist use of self can be seen from the first moment of contracting when care is taken to contract for online work. Her* ***attuned attentiveness*** *to Ania's needs concerning her worries about both going outside and doing online work is important.* *The counsellor needs to feel comfortable with online work too.*
During contracting, care is taken to ensure that Ania has a safe, private therapy space at home. It is agreed that Zofia could be looked after by the next-door neighbour an hour a week. As this would be the first time in several months that mother and daughter are apart, this step alone proves a helpful therapy intervention. They initially contract for five sessions, with the aim of reviewing Ania's progress at the end of that period when they will decide whether to continue for a further five sessions.	*The counsellor understands the importance of Ania having a safe, private space at home to work in. She is creative when she takes the slightly unusual step of inviting Ania to have a quick 'go' at Zoom before the first session of therapy. She does this in order to reduce Ania's anxiety.*

(*Continued*)

Table 1.1 (Continued)

The Story of Ania's Therapy	Analysis of Therapeutic Use of Self
Weeks 1–2: In the first session, the counsellor listens empathically to Ania's story and the challenges she has faced as a single mother. Together, they recognise the ways in which Ania's current anxiety and profound loneliness are related to the existential threat posed by Coronavirus and the recent isolation of lockdown.	*The counsellor's 'use of self' here is largely **'instrumental'**. The aim is to build the alliance and modify behaviours given the problematic environment. While a problem-solving, psychoeducational approach is adopted, the therapist still maintains an empathetic, relational stance which moves into an **'authentic'** approach.*
The counsellor's initial formulation centres on the 'understandable separation anxiety' experienced by both mother and daughter, who (the counsellor suggests) have become overly attached (enmeshed?). Together they devise a programme that encourages Ania and Zofia to spend increasing periods apart over the next few weeks. The counsellor suggests that Zofia attends a play group and spends time with different friends.	
Week 3: Ania expresses fear of going outside in the world post-lockdown and the counsellor offers some anxiety management and self-care advice.	*The counsellor is careful to be compassionate rather than judgemental. She seeks to counteract Ania's sense that she is somehow 'at fault' for creating the separation issues. She takes care to 'normalise' Ania's experience. As part of her relational stance (in 'authentic' mode), the counsellor admits to having anxieties herself. The timing of this normalising self-disclosure is important. Rather than share this information about herself at the start of therapy, she waited until she was more confident about how the disclosure would be received.*
Ania then starts to cry in response to feeling that the therapist is being so nice to her and that she doesn't deserve it. She feels 'at fault'; she sees herself as a bad mother who has 'caused' the separation anxiety in her child. The counsellor emphasises that many parents are likely to be experiencing some separation anxieties at this time. She encourages Ania to connect more with her friends from the mother-and-toddlers group. She also briefly shares her own fears of going outside to public areas.	
Week 4: Over time, it becomes easier for mother and daughter to be apart. The counsellor and Ania discuss creative ways to introduce the idea of nursery school to Zofia and to associate it with positive things. They decide it would be helpful to walk past the nursery gates each day on the way to the park and talk about the fun things Zofia will be doing when she starts going again in a few months' time.	*The counsellor and Ania have formed a good alliance and, at this point, are working well together to explore the problems and solutions.*
On their fifth session review, Ania expresses feeling grateful and that she definitely wants to continue for the remaining five sessions. She shares that she doesn't know how she's going to manage without the support of her therapist once their work together is over. Concerned that Ania might be getting too dependent on her, the counsellor suggests that it might be helpful to have the remaining sessions every other week, so that Ania can gain confidence in her own coping abilities.	*Increasingly, the counsellor is encouraging Ania to draw on her own resources and ideas for problem solving.* *The counsellor tries to manage the risk of Ania becoming too dependent on her by engaging some distancing strategies. Suggesting that the latter sessions should take place every two weeks helps Ania to become more self-reliant.*
Sessions 6–10 and ending: In the last five sessions, the focus is on consolidation of the progress made with Zofia's (and Ania's) independence and socialisation. They continue to work on developing Ania's resources to cope and consider ways she can live a more fulfilled life.	*The celebration of Zofie's and Ania's progress offers important validation. By focusing on her wider social supports and life-after-therapy, Ania is reminded of her ability to manage without her therapist.*
Ending: In the last session, Ania and the counsellor review their therapy experience and celebrate Ania's progress in managing both her own anxiety and the separation from her daughter. They talk about the future and how Ania can continue to use her self-care and anxiety management resources.	

Critical reflections

> Expertise is less about mastering the therapy method and more about the relationship, responsiveness, and commitment to improvement. (Norcross and Karpiak, 2017, p. 73)

This chapter has emphasised the complexity of our therapeutic use of self, highlighting how we negotiate complex relational–social boundaries between client and therapist. The science and art of therapy are expressed in the clinical judgements we make regarding when and how to intervene as we fluidly engage varying levels of support/challenge; separation/distance; connection/intimacy; self-containment/self-disclosure; non-directiveness/directiveness, and more.

As I reflect on the complexity of this process, I am awed by the artful way we continually negotiate subtle experiential and relational layers. I am reminded about Storr's words that 'psychotherapy will always remain more of an art than a science' (1990, p. 69).

When we 'go with the relational flow' and trust the therapeutic process, the use of self is like Satir's deft playing of a finely tuned musical instrument. Together, client and therapist find themselves immersed in a duet of co-created music. Yet, while moments of connection can feel magical, our craft skills and strategic techniques can be reflected upon, observed and learned as the micro-communications identified in the case study above.

If we are using ourselves as our primary tool of therapy, it is critically important for us to be reflexively self-aware of our being and doing (see Box 1.8) and to examine our approach with an ethical–professional lens. Without such awareness, therapists run the risk of reproducing reductionist,

Box 1.8 Practical application: reflecting on one's self in therapy

Thinking about your own practice, it's worth taking time to reflect on how you use your self. Hint: think about your *being* and *doing*. You may find the following self-inventory questions helpful (adapted from Edwards and Bess, 1998; Dewane, 2006):

- Why do I like being a therapist? What personal needs are met?
- What special qualities or abilities do I offer clients?
- How do my beliefs affect the way I work?
- What traumas or life challenges have shaped my worldview and might be triggered in work with clients?

- How easy is it for me to just 'be with' clients and not rush into 'doing' or 'performing'?
- How does my theoretical model of practice influence my work?
- How do I adjust my levels of intimacy, disclosure, spontaneity, support and challenge with different clients?
- How do I react if a client resists, or is critical of, their work with me?

habitual, routinised ways of working. Even worse, therapists' needs and power dynamics may be unhealthily acted out, turning care into harm, and we don't want therapy to repeat patterns from individuals' histories of manipulation, violence and/or powerlessness (Finlay, 2019).

Part of what we need to factor in with our use of self is the wider relational–social context. It's not just about responding to the individual. We need to recognise the complexity and impact of the client's social–cultural identities and how that mixes with ours. If we are to play ourselves like a musical instrument, we need to consider the person we are in a duet with, and understand the acoustics of where the music is to be played.

In short, we need to move away from a view of the use of self as an internal/individual act towards seeing it as a dynamic, ethical and reflexive process that is profoundly relational (Amari, 2020).

Discussion questions

1. 'Use of self is both our "science" and our "art".' What does this mean?
2. Write five statements starting with 'I am' describing the nature of your being when you are with clients. Analyse how you show these being aspects in your everyday doing practice.
3. How different are you in different contexts? For example, how does your 'being' change when you are with different individual clients who have different backgrounds; or when you encounter a client in a different public space; or when you work in-person versus online?

Resources

Book: *The Therapeutic Use of Self* by Val Wosket. Classic, seminal book exploring the topic.

Book: *On Being a Master Therapist* by Jeffrey Kottler and Jon Carlson. Compelling read as these master therapists dialogue in an informal, brutally frank way while drawing on a wealth of resources. They nail the key ingredients for being an accomplished therapist.

Book: *Integrative Psychotherapy: The Art and Science of Relationship* by Janet Moursund and Richard Erskine. Readable text which beautifully explains the theory/practice of integrative therapy focused on the therapeutic relationship. The verbatim transcript of a therapy session demonstrates their ideas in practice.

Lecture: The role of self in psychotherapy (presented by Brandy Klingman). Available at: www.youtube.com/watch?v=ooOGOgTgSOU

Video: Interview with Irvin Yalom on the Art of psychotherapy. Available at: www.youtube.com/watch?v=ZdTFqpItd8I (I recommend watching any/all of his demonstration videos).

Notes

1. The model here is an integrative psychotherapy one drawing on several theories, including transactional analysis and developmental theory. Other therapists drawing from different theoretical approaches may understand the process differently.For example, some gestaltists use the concept of 'contact' slightly differently.
2. We also have legal obligations. For instance, in the UK, the Equality Act of 2010 prohibits unlawful discrimination, harassment and victimisation.