PSYCHODYNAMIC-INTERPERSONAL THERAPY

PSYCHODYNAMIC-INTERPERSONAL THERAPY

A CONVERSATIONAL MODEL

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Core Model and Introductory Psychodynamic-Interpersonal Skills

Introduction

This manual focuses upon the minute interactions between therapist and client. It gives beginners to psychotherapy some answers to the following questions: 'But what do I actually say now?'; 'What do I actually do?' For more experienced therapists, it may provide an opportunity for reflection upon not 'What do I say?' but 'How do I say?' something.

The model comprises three stages with 13 distinct but interlinked components or competencies (see Table 4.1 for a listing). Some of these components are generic to all psychotherapies but, when taken as a whole, they constitute a specific and definable model of therapy. The competencies are divided into the three stages according to the ease with which they can be learned and practised independently. In this chapter, following a brief description of the core components of the model, the Stage 1 competencies of the model are delineated. The Stage 2 and 3 competencies are described in the following two chapters – Chapters 5 and 6 respectively.

Once learnt, the competencies can be practised and refined, just as a musician practises scales. A key concept is that of deliberate practice formulated by Ericsson (see Ericsson and Lehmann, 1996) in which he proposed that people become experts by hour upon hour of very deliberate practice. Evidence suggests that this also applies to being a skilled therapist (for example,

Chow et al., 2015). It might be supposed that this phenomenon is just a reflection of a practitioner's cumulative caseload, making us all more skilled with age. However, deliberate practice is more about the time and work put into training outside the time spent with a client. That will invariably involve repeated self-scrutiny and self-monitoring of audio files or video recordings of therapy sessions; supervision; and individual rehearsal and practice for all therapists, regardless of their level of competency.

Table 4.1 The three competency stages and associated skills for psychodynamic-interpersonal therapy

Competency stage	Competencies	Components within competencies
Stage 1: Introductory skills (4)	**The four Stage 1 competencies:**	
	1.1 Statements	
	1.2 Picking up cues (4)	
		1.2.1 Verbal cues
		1.2.2 Vocal cues
		1.2.3 Non-verbal cues
		1.2.4 Cues in the therapist
	1.3 Negotiation	
	1.4 Understanding hypotheses	
Stage 2: Intermediary skills (4)	**The four Stage 2 competencies:**	
	2.1 Focusing on feelings (here and now)	
	2.2 Metaphor and living symbols	
	2.3 Language of mutuality ('I and we')	
	2.4 Linking hypotheses	
Stage 3: Advanced skills (5)	**The five Stage 3 competencies:**	
	3.1 Explanatory hypotheses	
	3.2 PI therapy rationale	
	3.3 Sequencing of intervention	
	3.4 Relating interpersonal change to therapy	
	3.5 Patterns in relationships	

This should not jeopardise the genuineness of the therapeutic relationship; rather it should enhance the therapist's ability to tune into the person he/she is 'being with'.

The manual itself has existed as an informal document and previous versions have been used in research studies. These earlier versions were written in collaboration with Robert Hobson, and this version also draws heavily upon his book *Forms of Feeling* (1985). This manual focuses upon using the model in a brief framework and is based upon our experience of using it in an intensity of one session per week, usually in a 16, 12, eight, four or three session (i.e. two-plus-one) format.

Russell Meares, who co-founded the model with Robert Hobson, has developed the model for use in a long-term and intensive format for clients with borderline personality states, where there is a greater emphasis on reparative work of the self and the development of a sense of coherence. Readers who are interested in using the model in a long-term therapy and with an intensity of two or three sessions per week, should consult *Borderline Personality Disorder and the Conversational Model: A Clinician's Guide* (Meares, 2012a).

The core psychodynamic-interpersonal model therapy

PI therapy is designed for the therapy of clients whose symptoms and problems arise from difficulties or disturbances in interpersonal relationships. It is, therefore, not problem-specific, and it can be used in its basic format to help individuals with a variety of symptomatic complaints. The practical workings of the model can be enhanced by tailoring it to certain conditions (such as depression and medically unexplained symptoms), but the basic underlying process is similar no matter which particular symptom complex the client is experiencing. This is an advantage as clients rarely experience one pure psychiatric disorder. Instead people commonly present with complex multi-symptomatic complaints.

Hobson referred to the process of therapy as 'personal problem solving' (Hobson, 1985). By this he meant the discovery, exploration and solution of significant problems that are brought alive in the therapy. The model assumes that past emotional deprivation, hurts and failures result in difficulties in expressing personal feelings in an appropriate way. Current and past hurt is avoided, resulting in the development of troubling symptoms and behaviours. Hence, PI therapy can be seen within the context of psychodynamic and relational therapies.

PI therapy has at its heart the development of a 'feeling language' between therapist and client. By this we mean a way of talking and exploring emotions with people that 'feels alive' in the conversation and includes symbolic resonances. As discussed in Chapter 1, Hobson differentiates between the kind of language that we use to describe objects (which he refers to as 'jam-jar' language), and the kind of language we use to describe

feelings (Hobson, 1985: 19). There is an important difference between a client who talks 'about' things, and a client who talks 'with' the therapist as a person, and shares with him or her 'alive' experiences and feelings, and it is the latter form of communication that the model tries to promote.

The term 'forms of feeling' that Hobson used as the title of his book refers to more than an experience of raw emotion. Hobson referred to complex images, thoughts, processes, memories and experiences that are linked with specific feeling states and personal relating, and ordered in differing levels of coherence. Staying with a feeling, which is one of the central actions of the model (see later), is not just about sharing raw emotion. The intention is to stay with the feeling to see what emerges; what images, memories and complex experiences are linked or connected in some fashion to that particular feeling state. Key problems with interpersonal relating often lie at the heart of these processes, which are captured symbolically by a particular image or memory.

This aim of personal problem-solving occurs through the discovery, exploration and solution of significant problems that are brought alive in the therapeutic conversation. A central feature of the model is the promotion of a symbolic attitude, which is captured by helping clients to *stay with feelings*, and through this to see what emerges. The emphasis is about *how* a conversation is developed, rather than *what* is actually discussed. Key actions of the therapist, described below, were developed by Hobson and his colleagues with the specific intention of generating a *feeling language* from which previously warded off feelings can be faced and assimilated and problems can be identified, explored and resolved. The process involves:

- staying with immediate experiencing;
- working with symbolic language, ideas and images to order and understand experiencing in relation to others;
- owning experiences, and responsibility for actions, and minimising avoidant behaviour; and
- active learning in sessions of different ways of ordering experiences, managing feelings and relating to other.

The process is collaborative and progresses according to the client's needs and wishes, and at a pace that is therapeutic. Hobson used the term *aloneness-togetherness* to capture an ideal form of a collaborative relationship (Hobson, 1985: 194). This is one where there is intimate sharing of feelings and experiences between the therapist and client, yet both retain their individuality and their own inner space. The therapist will disclose little personal information or personal problems, but is an active participant in the relationship with the client, sharing experience and using his/her own intuitive feelings to identify with the client's feeling state. Hobson differentiated aloneness from isolation and loneliness, and togetherness from non-differentiation or fusion.

A great deal can occur between two people within a few minutes, but often important signs or signals or opportunities to explore feelings are missed. Audio or video recording sessions and playing them back enables the therapist to identify and recognise these missed opportunities, and gradually over time to become more receptive to the *minute particulars* of the conversation.

The three competency stages

The competencies are divided into three stages. Stage 1 competencies enable the therapist to establish a close and supportive relationship with the client, and begin to pick up and discuss feelings. Stage 2 competencies encourage the development of a feeling language and a deepening of the therapeutic relationship. Stage 3 competencies are concerned with interpersonal problem-solving once a feeling language has been established.

- Stage 1 competencies are relatively easy to learn and simple to execute. If used collectively, they comprise a powerful tool for establishing a feeling of being understood by the client. They can be used in low-intensity work, without the other model components, to facilitate rapid development of a problem, followed by problem solution. They can be taught to health professionals with no prior knowledge or training in psychotherapy.
- Stage 2 competencies involve a deepening of the relationship and more intense work and can also be learnt quickly by individuals who have good interpersonal skills. However, regular supervision involving recorded sessions from several different clients is required to develop them fully.
- Stage 3 competencies involve the layering and linking together of feelings, ideas, relationships and problems in a cyclical and evolving process. Supervision, using audio recordings, is necessary to develop these skills. Health professionals with a prior training in therapeutic work (e.g. a counselling diploma, or psychodynamic training or CB therapy training) can often learn the components of the model quite quickly, provided they feel a 'natural affinity' with this particular way of working.

Stage 1 competencies

1.1 Statements

The therapist uses statements rather than questions. Questions tend to make the therapeutic situation more one-sided and also tend to push clients into an intellectualised mode as they try to respond or struggle to find an answer. A statement suggests a starting point, and it encourages the client to rest in an experience from which something may emerge. These statements are made in a tentative manner.

Box 4.1 Questions and statements

Using a question

CLIENT: Sometimes my sister just takes over, she's so bossy.

THERAPIST: In what way is she bossy?

CLIENT: Well she tells me how I decorate my house, and she tells me which men I should go out with, and she…

Using a statement

CLIENT: Sometimes my sister just takes over, she's so bossy.

THERAPIST: That sounds difficult.

CLIENT: Yes it is…it makes me feel so frustrated…and…angry.

In the above example the use of a question results in the client giving the therapist more information, whereas the use of a statement results in three important benefits: the client feels understood, it creates an atmosphere of reflection, and from this the client's feelings regarding her sister emerge. Further illustrations of the use of statements are given below:

Box 4.2 Using statements

Example 1

CLIENT: When I got home, I'd barely got through the door, and they [her parents] said they were off to stay the weekend at friends, they just don't seem to care…

THERAPIST: …you felt very let down.

CLIENT: I so wanted to see them,…I felt so hurt.

Example 2

(Early on in the first session, after a long pause)

THERAPIST: It's a bit difficult all this…coming to see someone like me…

CLIENT: Well, yeah, I didn't know what to expect…I don't know what I thought it would be like…it just feels strange.

It is common when people start learning to use the model that they find using statements, rather than asking questions, quite difficult. It is not that questions are forbidden in this model, but rather that statements are generally preferred. There may be times when it is appropriate to use a question if the therapist requires a direct response from the client. Someone who is learning the model should focus on trying to use more statements and fewer questions than they do usually. As they do this, they often begin to see the value in using statements as these help to keep the focus on feelings, and there is a natural shift towards using fewer and fewer specific questions.

1.2 Picking up cues (listening and noticing)

In any model of psychotherapy, it is important that the therapist is vigilant and attentive to what the client is experiencing. This means trying to appreciate, understand and tune into what the client is saying in his/her words, tone of voice and behaviour. In this model, listening is a major part of the work of the therapist. Listening is 'an active process of perceiving and paying attention to a multitude of verbal and non-verbal cues and by an imaginative act, creating possible meanings which can be tried out and modified in a conversation, or dialogue, that aims at understanding' (Hobson, 1985).

Verbal cues

Verbal cues refer to when the client alludes to how he or she is feeling.

Box 4.3 Picking up verbal cues

Example: Fails to pick up a verbal cue

CLIENT: Sometimes I just get so sick and tired of all the hassle.

THERAPIST: What kind of hassle?

CLIENT: Well…it's someone at work…etc.

Example: Picks up cue

CLIENT: Sometimes I just get so sick and tired of all the hassle.

THERAPIST: You sound weary and fed up.

CLIENT: I just can't stand work at present…I wonder if I can carry on…it's just awful!

In the first example above, when the therapist fails to pick up the verbal cue, the client goes on to give an external account of the problem. In the second example, by picking up the verbal cue, the client is encouraged to describe how he/she feels.

Vocal cues

These cues refer to the tonal inflection used by the client when he/she speaks. The client could make a relatively innocuous statement but the tone of his/her voice might, for example, sound angry. There may be more subtle changes in rhythm and intonation that stress particular aspects.

It is not possible to give examples of this kind of cue in written text, but when the therapist responds to it, he/she should acknowledge the evidence on which it is based. Instead of just saying, 'you're angry' the therapist should say '…what you said just now – there was a real sting in your voice, I wonder if you sometimes feel quite angry inside'. This will make more sense to the client and will also make the client feel that the therapist is listening to him/her and trying to understand.

Non-verbal cues

Non-verbal cues include all other kinds of behaviour that the client may exhibit during the therapy. They include the client's facial expression and demeanour, eye contact, body language, clothing, personal items and behaviour outside the therapy room. They can be fairly straightforward, for example the client looking sad, or they can be much more complex, for example the client avoiding eye contact whenever referring to himself or the therapist.

When the therapist comments on a non-verbal cue, it is important to gauge how receptive the client is to such an observation. For some clients it can feel very intrusive, for others it can be an enormous relief. Observations should be couched in a tentative manner, particularly if the cue is rather complex and subtle and also if the cue refers to the client–therapist relationship. If the client appears receptive, then the therapist can go on to suggest possible feelings that may underlie the client's actions, but expressed in a tentative way. Or, the client may spontaneously develop the theme.

Box 4.4 Responses to non-verbal cues

THERAPIST: You look really sad today.

THERAPIST: I can see that you're screwing up your fists…you seem…very angry.

THERAPIST: When I confirmed just now we'll be finishing meeting in six weeks' time, you looked…umh…you looked to me quite stunned…[pause to see if client accepts this]…as if it was a surprise…

THERAPIST: I'm not sure, but when you said you were going to miss me during the break…you turned your head away and looked down…as if…well…you didn't want to or couldn't look at me…[pause to see if this is denied or accepted and to see if client responds]…

THERAPIST: This may be quite difficult for you, but I've been aware that since we've been meeting for these last four weeks, you've never really been able to look at me…you know…look me in the eye…[pause again to see whether client can tolerate this observation]…

Cues in the therapist

The ways that the therapist behaves or feels can, on some occasions, provide clues as to how the client is feeling in the therapy session. This idea is based upon the psychodynamic theories of counter transference. These theories suggest that the therapist can sometimes act as either a resonating board and pick up the same feeling as the client is actually feeling in the session, or act as a depository so that the therapist experiences a feeling but the client has no sense of experiencing it.

This is a highly complex area and supervision is important in disentangling the different elements – even for very experienced therapists. The therapist has to be able to distinguish his/her own personal feelings from feelings that are more closely related to the client. This is difficult as there is usually a great deal of overlap between the two, and the client's feelings may well resonate with some of the therapist's own emotionally vulnerable areas.

For example, the therapist may begin to feel irritated with the client for no obvious reason. This may not be related directly to the therapy and could be related to the therapist's own personal issues which have intruded into the session. It is important, however, that the therapist reflects upon the unusual feeling and asks himself/herself whether it could be intimating something important about the interpersonal situation with the client too. It is possible that, in this example, the therapist may be picking up that the client is actually very angry with him/her, but, is not expressing this directly. The therapist is picking up the theme of anger, although this was initially experienced as related to personal issues, but it may have several sources that are not mutually exclusive.

1.3 Negotiation

The 'how' of the therapist's talk is crucial: the therapist should not imply that he or she is right. The therapist is really trying to say to the client, 'This is how I see things now, but I might not be right; I may have misunderstood; I'd like you to help me see things clearer'. This attitude produces an atmosphere of collaboration between the client and therapist where deeper understanding is reached through a series of gradual adjustments of meaning which get closer and

closer to the client's experience. It is also a way of pacing the therapy so that the client does not feel either overwhelmed, or intruded upon, by the therapist.

The client should feel able to reject any suggestion from the therapist, even if the therapist thinks that he/she is right. In some circumstances, the therapist's statement may be accurate but unacceptable to the client in the form in which it has been presented. Accuracy is not always therapeutic.

Box 4.5 Illustrating negotiation

Example 1: Non-negotiating

CLIENT: I think if people are in professional jobs they should be trustworthy, if they say they're going to turn up [talking about a nurse not turning up for a home visit], they should!

THERAPIST: I think that you feel angry because I was late today.

CLIENT: You what?…no I'm not angry with you.

Example 2: Negotiating

CLIENT: I think if people are in professional jobs they should be trustworthy, if they say they're going to turn up [talking about nurse not turning up for a home visit], they should!

THERAPIST: You seem very upset about this…I wonder if your upset is also partly about something similar to what you describe…in that I turned up quite late today…I'm not sure.

CLIENT: I was annoyed with you.

THERAPIST: I thought that you were, but I wasn't sure…it's quite a big thing for you.

CLIENT: Yes, when I was little my mother was always, always late…I cannot stand it, I really cannot stand it.

In the first example above, the therapist's statement is too direct. The client cannot deal with it and blocks. In the second example the therapist first of all acknowledges the client's distress and then tentatively suggests a possible link. The statement is phrased in such a way that the client could easily reject the suggestion if it still seemed too intrusive. The use of phrases like 'I'm not sure', 'I wonder', 'This may not be quite right', etc. invite the client to subtly provide corrections and refinements to the important details that are being discussed.

The first example could be salvaged if the therapist was able to acknowledge that he/she had made a mistake.

Box 4.6 Acknowledging mistakes

CLIENT: I think if people in professional jobs should be trustworthy, if they say they're going to turn up [talking about nurse not turning up for a home visit], they should!

THERAPIST: You feel angry because I was late today.

CLIENT: You what?…no I'm not angry with you.

THERAPIST: I've not got that right…it seemed as if it was a very important thing for you, people not turning up or letting you down…

CLIENT: It is…

THERAPIST: …Something really gets to you inside.

CLIENT: Yes, when I was little my mum always, always turned up late…it was a family joke…but…I can't bear it.

THERAPIST: I thought it was really important for you…which is why I wondered whether me being late this morning had an effect on you.

CLIENT: Well I was slightly annoyed by it…but I know you're very busy… it's not like with my mother…she's got all the time in the world.

THERAPIST: Well, let's see, there's something similar between how you felt this morning about me when I was late and how you feel about your mum,…but also something that makes that feeling feel different.

By initially retracting the first statement, the therapist has now enabled the client to explore the link between her anger towards the therapist and her own mother. The client can go on to explore with the therapist her view that the therapist is very busy and therefore cannot be blamed for being late. This will be a rich and complex area for discovery and mutual understanding.

Negotiating is particularly helpful when it is used to explore issues involving the relationship between the client and the therapist. The following example illustrates this. It is quite long as it attempts to convey the process of negotiation.

Box 4.7 The process of negotiation

CLIENT: You're bound to be judging me, no matter what you say, you can't sit there and not have an opinion.

THERAPIST: …Umh…well…I do have some impressions of you, but…you said judging you…it implies possibly that you may think…or fear that I'm…judging you in a bad light?…

(Continued)

(Continued)

CLIENT:	…yeah…
THERAPIST:	umh…criticising.
CLIENT:	Yeah,…I think you must be sitting there thinking how dull and boring I am.
THERAPIST:	I'd like to understand this a bit more…it sounds…very painful.
CLIENT:	Yeah, it's really hard…
THERAPIST:	You feel on edge with me,…not comfortable…at all.
CLIENT:	I just feel you must think I'm pathetic.
THERAPIST	…umh……..weak?
CLIENT:	Yeah, weak and pathetic and useless…
THERAPIST:	Well, you want to know what I think of you…yet you fear what I think of you…you feel criticised… you feel this weakness inside…it feels sort of exposing?…
CLIENT:	Yeah…
THERAPIST:	Yes…and…I…wonder…this situation now…you and me…makes you feel a bit cross?
CLIENT:	Cross with myself…angry with myself for being so pathetic…
THERAPIST:	Well… [hesitantly]
CLIENT:	I know I don't have to be here…no one's forcing me to come here and see you, but I couldn't not just turn up…I should be able to…just not let it bother me…just tell people to get lost.
THERAPIST:	…and here, with me, suppose you felt you wanted to say…'why don't you shut up and stop asking these questions…stop looking at me…I'm not putting myself through this any more'…
CLIENT:	No…no…[smiling]…no I couldn't do that.
THERAPIST:	Well perhaps could we look at that…I wonder what the feeling would be…

1.4 Understanding hypotheses

Hypotheses in the PI therapy are ways of promoting exploration and understanding of the client's feelings, especially in interpersonal relationships. There are some similarities between hypotheses and interpretations – which are also exploratory statements – as used in other kinds of interpersonal and

dynamic therapies. Hypotheses, however, are offered with much less certainty and conviction than interpretations commonly are, and they are usually couched in more subtle language than interpretations, which are usually more direct and unambiguous.

The aim of a hypothesis is to engage the client in a dialogue concerning its accuracy. It is always better expressed in a tentative manner so it can be accepted, rejected or modified by the client. Of importance is the communication of a desire to understand, not necessarily to get it right.

These are statements made by the therapist that refer to how he/she imagines the client is feeling. They are usually based upon subtle non-verbal cues or are responses to verbal cues from the client. They are not mere reflections of the client's feelings but an attempt on the part of the therapist to take the exploration of the client's feelings a little further.

Box 4.8 Understanding hypotheses

Example 1

CLIENT: I'm edgy, I can't settle…

THERAPIST: I'd like to hear a bit more about that…seems you feel sort of wound-up.

Example 2

CLIENT: I feel dead inside.

THERAPIST: …it's hard to feel anything at all…empty…

Example 3

THERAPIST: I wonder if you're feeling a bit stuck right now.

Although the use of filling words like 'sort of' or 'a bit' may appear rather unnecessary in the examples above, they reduce the harshness and starkness of the statements, making them more acceptable for the client.

Summary

The four Stage 1 competencies of PI therapy have been described above. They are: using statements; picking up cues; negotiating style; and understanding hypotheses. They are relatively easy to learn and can be picked up quickly by health professionals who have good interpersonal skills, and they

can be used together in a coherent form (Guthrie et al., 2004b). Cue response is an area that can always be improved, as even the most experienced therapists miss or fail to recognise important cues.

These basic skills lay the foundation for the development of a strong working relationship with a client. They encourage people to share how they are feeling with the therapist, rather than talk about problems in a detached or abstract way. They promote a feeling of being listened to and understood. The next chapter will describe the four Stage 2 competencies.

5

Intermediate Psychodynamic-Interpersonal Skills

Introduction

This chapter describes the second stage competencies of PI therapy. They are slightly more challenging to learn than the Stage 1 competencies but their use leads to a deepening of the relationship between therapist and client. When used collectively, they promote the development of a *feeling language* and sharing of experience.

Stage 2 competencies

2.1 Focusing on feelings ('here and now')

This technique involves focusing on what the client is experiencing during the session. Instead of talking about feelings in the abstract or as if they belong only to the past, an attempt is made to re-create them or facilitate the actual expression of them in the immediacy of the therapeutic environment. The client experiences the feeling and is able to share it with the therapist.

Box 5.1 Here and now

Example 1: Not using 'here' and 'now'

CLIENT: When my grandmother died, I didn't say goodnight to her before she went to bed, when I woke up the next morning, my mum came in and told me she had died in the night…I know it seems a small thing…I know she knew that I loved her…but it really used to upset me…that I hadn't said goodnight…and…that was the last time I saw her.

THERAPIST: You must have been very upset.

CLIENT: Yes I was, it seems such a long time ago though.

Example 2: Using the 'here and now'

CLIENT: When my grandmother died, I didn't say goodnight to her before she went to bed, when I woke up the next morning, my mum came in and told me she had died in the night..I know it seems a small thing…I know she knew that I loved her…but it really used to upset me…that I hadn't said goodnight…and…that was the last time I saw her.

THERAPIST: And there's something of that upset and sadness now…you feel it now…here…with me.

CLIENT: Uh yes…

THERAPIST: Can we stay with that feeling.

CLIENT: [cries]

In the first example above, although the therapist acknowledges that the client must have been very distressed, because the therapist uses the past tense the actual feelings remain in the past and inaccessible. In the second example, because the therapist focuses upon the present, the client is able to get in touch with these feelings that previously have been buried.

This technique should only be used if the therapist senses that the client is actually experiencing the feeling, even if it is only mild, although he/she finds it difficult to acknowledge directly. If the client appears completely detached and unemotional, such a response from the therapist would be inappropriate. In these circumstances, it would be better for the therapist to contrast the distress described by the client, with the *lack* of feeling he/she is actually experiencing, although this needs tact as the client may not yet be aware of the discrepancy.

Another way of helping people get in touch with feelings is to ask them to relive experiences as if they were happening 'now'. The therapist asks the client to use the present tense to describe something from the past, as if it were happening 'now'. The event has already been identified as a significant one that the client has remembered as having some specific meaning or importance for them.

Box 5.2 Here and now (continued)

THERAPIST: I suppose…could you tell me…just let it come to mind…any time when you were small…we when you were really wanting your mum to be close to you.

CLIENT: Er…

THERAPIST: And were upset about it.

CLIENT: Er…I was eight. My mother had another child. When I came home, she went into hospital. I knew she was going into hospital to have a baby. That night she did go in. I can still remember it…five or seven days…I'm not sure how long it was. It was when she did come home – when she did come home, my mother was angry…and from that point onwards I don't think she treated me any different…because I was always as my mother would say a sickly child, I would get a lot of things, my other sisters felt sorry for me, but I didn't know this at the time. I'm not sure if I felt jealousy for my youngest sister. I was eight then…

THERAPIST: But your mother was angry.

CLIENT: Yes I don't know why…because she was always very kind. It took a lot to get her angry. And I did walk in and she did have a lot of visitors there that day, and I don't know if I said anything but she appeared to be very angry and that affected me for some reason and I've never forgotten that.

THERAPIST: Yes…I wonder if we could go through that bit, almost as if it's happening now. Conjure up a picture.

CLIENT: Yes I can still picture it.

THERAPIST: Right well now can you talk about it as if it's happening now.

CLIENT: Right.

THERAPIST: Where are you? Can you say 'I am' not 'I was'?

CLIENT: Well there were a few people.

THERAPIST: I am [indicates with hand]…There are…

CLIENT: Oh…I am…I walked into the room…

THERAPIST: You are walking…

CLIENT: I'm walking to the door…my mother and a few other ladies were speaking…

THERAPIST: are…[gestures with hand]…there they are…

CLIENT: I'd say I'm in…In the lounge by this stage…and I must have said something to my mother…I'm not sure…

(Continued)

(Continued)

THERAPIST:	You see how hard you are finding it…to say as if it's happening now… it isn't easy…to say it as if it's happening now…I must have said something…I don't know what it is…but my mom…
CLIENT:	She snapped.
THERAPIST:	Snapped…as if she's doing it now.
CLIENT:	Yes…she snapped at me and that affected me…maybe because she'd never snapped at me before the baby was born…so therefore I took it very hard…that's the only way I can describe that.
THERAPIST:	Well when you say you took it very hard…let's imagine what that feeling was like.
CLIENT:	A hurt feeling.
THERAPIST:	Feels like I'm really hurt.
CLIENT:	Very hurt…very hurt.
THERAPIST:	Deep down inside.
CLIENT:	Very hurt and I thought, she wasn't like that before she had the baby.
THERAPIST:	Well…stay with it now…stay with the feeling.
CLIENT:	Yes very hurt…I feel that…… just comes over me…from here [points to tummy] upwards. [Points to head]
[Therapist mirrors action]	
CLIENT:	This horrible hurt feeling, why did she snap at me?
THERAPIST:	Aaaand…maybe she doesn't love me anymore.
CLIENT:	Right… [long pause]…yes I suppose that is the feeling.

In the example in Box 5.2 the therapist and client explore an important memory from the client's childhood. The therapist encourages the client to try to re-experience the memory, as if it is happening 'now'. This approach is only used for memories that are likely to have significant emotional meaning, and where the client finds it difficult to get back in touch with feelings.

Note how, in the first part of the example, the client is gradually remembering some facts about what happened, but seems hazy about what was experienced. The client knows something important happened between her and her mother that has stuck with her. The therapist pushes quite hard to help the client relive the associated feelings.

There are two main reasons for trying to focus on feelings within the PI model. First, some feelings may be difficult to acknowledge and share. For example, someone who feels angry following the death of a loved one, may not

be able to acknowledge this feeling, as it may seem unacceptable. Other feelings may be warded off because they are too frightening to acknowledge or embarrassing. Beginning to experience a warded off feeling in the presence of a supportive other can be therapeutic and cathartic, and lead to change (Box 5.3).

Box 5.3 Getting in touch with a warded off feeling

A young mother developed feelings of intense anxiety about her baby daughter and was unable to leave her in the company of others (even her own mother) without developing panic attacks. Brief cognitive behavioural treatment had not been successful as she was too anxious to carry out the homework or tolerate any separation from her baby.

Initially in the sessions, which she attended with her baby, she described herself as having anxiety all the time. This started around the time her baby was born. She said the birth had been difficult but she had got over it, and didn't think it was connected to her current problem. The therapist noticed that she used the word 'anxiety' to describe how she felt and never elaborated upon this: 'It's my anxiety, it just stops me from doing anything.'

THERAPIST: Your anxiety…I'd like to try and understand more…get a feeling of what it feels like for you…what you actually experience…

CLIENT: Anxiety…it's my anxiety.

THERAPIST: A feeling inside?

CLIENT: Anxiety. [Client responds several times to gentle probes by the therapist, each time responding with the word 'anxiety'.]

THERAPIST: A feeling in your body…perhaps…a tenseness?

CLIENT: Yes…a shakiness…[Makes a fluttering gesture with her hands.]

THERAPIST: It's there a bit now?…this shakiness [makes similar fluttering gesture]

CLIENT: Yes…[client noticeably becomes more anxious]

THERAPIST: …with the tenseness and the shakiness…there's a fear…

CLIENT: Yes…[breathing more heavily]…that she's going to die…Hayley's going to die…

THERAPIST: Like it's really going to happen…or you thought she had?

CLIENT: Like when she were born, I was out of it, it was forceps and she was taken to the special care unit. But I didn't know, so when I woke up, she weren't there, she weren't there…and I thought she died…and I just began wailing…until one of the midwives came in…but I couldn't

(Continued)

(Continued)

	stop shaking until they took me up to the unit to see her…it's like I didn't believe them…
THERAPIST:	You thought she'd died.
CLIENT:	Yes…it were terrible…terrible. We'd been trying for ages…I'd kept miscarrying and I thought…all through the pregnancy…I thought I was going to lose her. Like all the other babies…I just knew it.
THERAPIST:	You've had a really terrible time…so many lost babies…it's really difficult to cope with all that loss.
CLIENT:	I blame myself…[Client is connected and talking closely with the therapist.]

In this example, the therapist is able to help the client get in touch with feelings that lie behind her 'anxiety'; the terrible fear that her baby had died and that in some way she may be responsible for this.

The second reason for focusing on feelings in this model is to encourage the connection between feelings and symbolic thought processes. The feelings have to be present and experienced by the client for this process to happen, otherwise it becomes an intellectual exercise. The notion of 'forms of feelings' has already been discussed in the first chapter in this book and in the introduction to the manual (Chapter 4). It implies a complex system of connected feelings and images, which arise from and are woven into the fabric of interpersonal relating. As the person experiences and stays in touch with a feeling, certain thoughts, images or ideas 'come into mind'.

2.2 Metaphor and living symbols

Use of metaphor in literature refers to the fusing of two or more images and/or ideas to bring a new experience and a new order and meaning. Metaphor is not exclusive to PI therapy, but it is used commonly by PI therapists to bring vividness to an idea, to expand understanding of an experience or concept, and to deepen the level of emotional exchange between the client and the therapist. The therapist should be alert to the language that the client uses to describe his/her experience.

It is often by 'staying with' immediate experience (focus on feelings) that nascent images, symbols and ideas emerge. In this model, the emphasis is not on what a symbol might mean, or why a particular metaphor has been used. The interest is in where they might lead the conversation. The therapist aims to convey and promote a *symbolical attitude*.

> This means endowing words, gestures, experiences, and dreams with value; regarding them not only as communications of formulated messages but also as living symbols. They are intimations of, and means of apprehending, what is as yet unknown. (Hobson, 1985: 199)

Box 5.4 Using metaphors

Example 1

CLIENT: I feel on edge all the time…I just can't settle.

THERAPIST: Sounds as if you feel…sort of wound up.

CLIENT: I feel myself getting tighter and tighter inside…everything's rigid…

THERAPIST: Feels a bit like you feel like a spring…that's all coiled up…being turned tighter and tighter.

CLIENT: Yeah, I think sometimes people do things deliberately to wind me up…I'm sure I'm going to just snap.

Example 2

CLIENT: I feel trapped…there's no way out…nothing to look forward to…nothing's going to change.

THERAPIST: It all feels quite hopeless…

CLIENT: Yeah.

THERAPIST: …as if you can't move…stuck.

CLIENT: I can't…I can't do anything.

THERAPIST: It's a bit like…you feel like almost caught in some kind of trap…like perhaps an animal caught in a trap.

CLIENT: I always feel sorry for animals…like that…I hate hunting…it's so cruel…it's so unfair, the animal hasn't done anything wrong…it's an awful death…so painful and frightening…

THERAPIST: Hmm.

CLIENT: It's so unfair…what have I done to deserve this.

In both of the examples in Box 5.4, the therapist picks up and extends the metaphor initially voiced by the client. There is a movement, a carrying forward. In the first example, the extension of the metaphor leads to a deepening of the feeling language, and to a new insight. That is, that the experience of being 'on edge' is linked to an interpersonal dynamic (a feeling that people are deliberately trying to upset the client).

In the second example, the feeling of being trapped is elaborated, and there is movement from 'stuckness' to the client's 'here and now' experience of being an 'innocent creature' who is hunted and persecuted. Note at the beginning the therapist is active in developing the metaphor, but later leaves space with just a small encouragement for the client to stay with the exploration.

In *Forms of Feeling*, Bob Hobson describes seeing a client called 'Joe Smith' (Hobson, 1985: 33). Joe finds it difficult to describe how he feels and to put his feelings into words. Hobson encourages him to stay with the difficulty of being in touch with himself and Joe blurts out that there isn't anything inside, there is 'no me'. After a longish pause, Joe says, 'I feel queer'. Hobson asks Joe to stay with the feeling, but Joe becomes very tense and begins to feel scared. He loses touch with the feeling and then noticeably relaxes. Something, however, has been shared. A few weeks later the feeling emerges again and this time he is able to stay with it. Joe describes a 'wobbly feeling' and from this, he and the therapist get to a feeling of 'being wobbly like a child trying to walk'. A symbolic transformation has occurred. The original experience of 'feeling queer' has been transformed into a shared personal feeling between the therapist and client, involving fears about being little and vulnerable, and fears about 'leaving mum'. This process only occurred because the therapist adopted an attitude of expectant waiting, what Hobson called a 'symbolic attitude' and encouraged Joe to stay with the feeling of 'queer' (see Chapter 6 for further discussion of a 'symbolic attitude').

This example demonstrates that an important metaphor can hold together an important theme across sessions. When looking in more detail at assimilation in psychotherapy we found that this ongoing shared reference to a key idea was highly characteristic of PI therapy and often the theme could be brought back in a subsequent session just by either the client or the therapist mentioning the key phrase as a shared reference point (Stiles et al., 1990).

2.3 Language of mutuality ('I and we')

The therapist explicitly refers to the relationship between therapist and client in terms of first-person words 'I' and 'we'. This indicates an active and mutual involvement in exploration. It also facilitates a deepening of the relationship between the therapist and the client, and accentuates a directness of communication. Some examples are given in Box 5.5.

Box 5.5 Examples of using a language of mutuality

- I'd like you to stay with that feeling if you can?
- I can imagine how difficult that was for you.
- I think that you're feeling that a bit now, that feeling of upset…here with me.
- I'd like to try and get a better understanding of how you are feeling.
- Maybe it's something that you and I can work together on?

This component of the model sounds simple and straightforward but it can have a surprisingly powerful effect when used, and usually results in a deepening of the conversation and a focus on what is happening between the client and the therapist at that moment in therapy (see Box 5.6).

Box 5.6 Example of deepening the conversation using 'I and we'

Not using 'I' and 'we'

THERAPIST: It seems like an effort to come here.

Using 'I' and 'we'

THERAPIST: I wonder if you feel it's an effort to come here and see me.

The shift in language is subtle, but the accumulated effect is significant as it models personal language and avoids abstractions like 'It's'. The example also shows the therapist being tentative at the same time, which is easier to achieve when using personal language. It also focuses the therapy on the relationship between the therapist and client, and on the 'problem', which is alive in the session between the two people.

If the therapist starts to use passive or abstract language when referring to the client–therapist relationship, it may be a sign in this model that the therapist and client are not connected. It can even imply on occasions that the therapist is avoiding uncomfortable or difficult feelings that he/she feels the client holds towards him or her.

2.4 Linking hypotheses

Linking hypotheses are statements that link feelings that have emerged in the therapy sessions to other feelings both inside and outside the therapy. They are a way of drawing links between the client–therapist relationship and other important relationships in the client's life, past or present. In this respect, they may refer to the transference relationship between the client and therapist, although this is not always the case.

Box 5.7 Examples of linking hypotheses

THERAPIST: Maybe some of the feelings you've had here of worrying whether I would take you seriously are a bit like feelings you've had at work worrying whether people would believe you.

THERAPIST : I wonder if the way you feel now…a bit unsure of me…a bit worried whether you can trust me…is a bit like…a little bit like…like you were saying earlier…finding it difficult to trust your dad because you didn't know whether he'd hug you or beat you…

These examples show the link being made between the relationship between therapist and client, to other relationships. The first example is to a current outside relationship at work, and the second to a past experience with a relationship with the client's father. At this point the therapist is simply establishing the link but not drawing any general conclusions from it. That step could occur later once the link has been established.

Linking hypotheses are used by the therapist to create a pattern of interlinking relationships or themes, which gradually build as the therapy progresses. The links can be vertical (i.e. referring to past or childhood relationships) or horizontal (referring to current relationships outside therapy) or both. A more coherent picture begins to emerge as the links that are made resonate with the present and the current difficulties or problems facing the client.

Summary

The four Stage 2 competencies that have been described in this chapter are powerful therapeutic tools, and care and experience are required to use them appropriately and wisely. They enable the therapy to 'come alive' and for experiences to be shared rather than talked about. In the next chapter, the Stage 3 competencies will be described that deal with the ways in which the session can be used to help the client to structure their experiences into a coherent shape and then begin to address their difficulties.