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Collaboration in Experiential Therapy

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Abstract

We offer a view of the nature and role of client-therapist collaboration in experiential psychotherapy, focusing on Gestalt and emotion-focused therapy (EFT). We distinguish between the necessary condition of mutual trust (the emotional bond between client and therapist) and effective collaboration (regarding the goals and tasks of therapy). Using a case study of experiential therapy for social anxiety, we illustrate how the development of collaboration can be both complex and pivotal for therapeutic success, and how it can involve client and therapist encountering one another by openly and nonjudgementally disclosing difficult experiences in order to enrich and advance the work.

Keywords: Emotion-focused therapy, Gestalt therapy, collaboration, therapeutic alliance

Collaboration in Experiential Therapy

Psychological therapies broadly referred to as experiential or humanistic (e.g., Elliott, Greenberg & Lietaer, 2004) include Person-Centered (e.g., Rogers, 1961), Gestalt (e.g., Perls, 1969), Emotion-Focused (e.g., Elliott, Watson, Goldman & Greenberg, 2004),approaches, among others. These psychotherapies share several features, including a focus on promoting client in-therapy emotional experiencing within the context of an empathic, compassionate, and authentic relationship. Commitment to a phenomenological approach follows from this interest in experiencing. People are viewed as meaning-creating, symbolizing agents, whose subjective experience is an essential aspect of their humanness. In addition, the experiential-humanistic view of functioning emphasizes the operation of an integrative, formative tendency, oriented toward survival, growth, and the creation of meaning. Moreover, all experientially oriented therapies are united by the understanding that people are wiser than their rational, cognitive processes and that tacit experiencing is fundamentally adaptive, and potentially available to awareness. A key aspect of these therapies is the offer of a deeply collaborative therapeutic relationship.

Gestalt psychotherapy is a complex psychological approach that aims to help clients develop self-awareness and personal responsibility. From early on Gestalt therapists have argued for the importance of dialogical aspects and, referring to the concept of 'I-thou' introduced by Buber (1958), Perls (1969) stated that Gestalt therapy should get beyond individualism and look at the "We" that consists of "I *and* You," the "ever-changing boundary where two people meet" (p.7). In recent years the dialogical aspects of the therapeutic process in Gestalt have become more and more explicit and relevant, with a stress on the importance of the contact and the co-creativity between therapist and client (Hycner & Jacobs, 1995).

A more recent development in humanistic-experiential therapy is the emergence of Emotion-Focused Therapy (EFT; Elliott, et al., 2004), which integrates Person-Centered and Gestalt therapy traditions, emphasizing both the therapeutic relationship and the process of reflection on aroused emotions to create new meaning. Although their general theories are distinctive, in contemporary practice, Gestalt (Hycner & Jacobs, 1995) and Emotion-Focused approaches show considerable commonality, and both strive to maintain a creative tension between the person-centered emphasis on creating a genuinely empathic and prizing therapeutic relationship, and a more active, task-focused process-facilitating style of engagement that promotes deeper experiencing and emotional transformation. In this article, we look at therapeutic collaboration from this overlapping Gestalt/EFT point of view on the practice of contemporary experiential psychotherapy.

Since Bordin (1979), it has become common to distinguish between bond, task agreement, and goal agreement aspects of the therapeutic relationship or alliance. The bond aspect is the emotional connection between client and therapist; while the task and goal agreement aspects are generally put under the general heading of therapeutic collaboration, the working together (*co-* + *laborare*) of client and therapist. Although a recent review by Norcross (2011) treats collaboration as separate from therapeutic alliance, we can see little justification for such a distinction. For us, client-therapist collaboration is a key aspect of alliance: There is no alliance without collaboration. Thus, even in highly relational psychotherapies such as person-centered therapy, Gestalt and EFT, an effective therapeutic relationship is seen as more than an emotional connection.

It also entails commitment and involvement on the part of both parties working together toward the global, shared goals of therapy (Bordin's Goal Agreement aspect of the alliance), by making use of specific agreed-to therapeutic activities carried out within the session (Bordin's Task Agreement aspect).

In this paper, we will look at how client and therapist in experiential therapy find a way to establish effective therapeutic collaboration, sometimes struggling in meantime. We will illustrate our points with a case study in which the struggle to achieve a productive, collaborative relationship appears to be a key element of the process of change in therapy. The first and second authors of this paper each represent a slightly different approach to experiential psychotherapy, respectively Gestalt and EFT.

Collaboration in Gestalt Therapy. In Gestalt, the relationship between the therapist and the client is the most important aspect of the therapy. The interaction between the two is based on a dialogical co-construction, in the here and now, of a relational process with the purpose of developing awareness, responsibility and self actualization in the client (Yontef, 1995; Hycner & Jacobs, 1995; Spagnuolo Lobb, 2009). In order to create a collaboration with the client, the therapist needs to be:

- 'Presence-centered', meaning fully aware of self and actively expressing self in the here and now
- Inclusive, trying to put themselves as much as possible in the client's experience
- Committed to staying in connection or contact with the client

In this approach the therapist is creatively active, both verbally and nonverbally, through any possible way that therapist and client, by experimenting, can create together (talking, singing, dancing, drawing, etc). These experiments indeed grow out of the immediate interaction between therapist and client; they are spontaneous and relevant to a particular moment and what is emerging through the client's report, for example, of a dream, a need, a fantasy, or a physical sensation. Experiments are done with the full participation and collaboration with clients; rather than achieving a particular outcome, experiments are aimed at developing client awareness and capacity to try out new ways of behaving (Polster & Polster, 1973).

In a recent article on therapeutic alliance, Quattrini (in press) describes the collaboration between therapist and client as a fragile and precarious process that develops through a series of passages, first of all through the building of trust, which really occurs only once the client realizes that the therapist is "on their side", so that they don't need to constantly monitor the therapist. The client at that point accepts what the therapist may suggest with an open attitude to explore what interesting experience can come out of it, even if the suggestion is not necessarily appealing at first. Quattrini uses several collaboration metaphors to describe the therapeutic alliance and its potential obstacles, one of which is the image of the therapist as a guide in the jungle, with whom the client needs to collaborate, rather than oppose, in order to stay safe in an unknown and dangerous area. Another metaphor is that of seeing therapist and client as a pair of mechanics who work on the same car: they need to collaborate, in order to avoid situations in which one is unscrewing something on one side while the other is unscrewing it on the other side. Finally, he presents the metaphor of a dance between two persons who need to co-ordinate movements in order to avoid stepping each other's feet (Quattrini, in press).

Collaboration in EFT. While agreeing in general with the creative and experimental approach of Gestalt therapy, EFT has attempted to specify in greater detail what the work of developing or repairing client-therapist collaboration looks like. In EFT, we assume that in addition to the therapeutic bond, the client must engage in different kinds of work on various therapeutic tasks. For example, in order to work on resolving an internal conflict, the client must engage in the activity of identifying, separating, expressing, exploring, and specifying different partial aspects of self; the client must also be able to create interaction between the different parts, etc. In order for the client to engage in this or other kinds of therapeutic work, she or he must (a) have the knowledge, skills, or resources to carry out the various forms of therapeutic activity ("task requirements"); and (b) agree to engage in these activities in the session ("task agreement"). If these conditions do not exist, the client will not be able or willing to work effectively at a particular therapeutic task.

As in Quattrini's (in press) formulation, the therapeutic bond comes first, enabling the client literally to take their eyes off the therapist. This sets the stage for the deepening development of the therapeutic relationship through the successive stages of agreement on therapeutic focus (general problem areas for therapy), goal agreement, and task agreement. The therapeutic bond goes a long way towards establishing the "safety conditions" (Daldrup, Beutler, Engle & Greenberg, 1988) needed by clients to be willing to attempt novel or unusual therapeutic activities. However, EFT specifies additional relationship principles as necessary for facilitating client change:

1. Offer a relationship of collaborativeness and mutual involvement. In addition to fostering client involvement in therapy through providing information and exploration, it is useful for the therapist to offer a mutual, collaborative relationship of equals. As the case example to follow illustrates, this attitude is communicated by the therapist (a) using both "I statements" and inclusive "we" messages; (b) being willing to consider alternatives, to admit error or misunderstanding, and to negotiate disagreements openly; and (c) avoiding of an overly definitive, expert manner.

2. Obtain client agreement and commitment on the general process goals and activities of therapy. EFT holds three general process goals as important for all clients: (a) helping the client use the optimal way of working with their experiences for a given kind of therapeutic work; (b) autonomy and acceptance of responsibility for own experiences and actions; and (c) completion of important kinds of therapeutic work. In other words, the therapist tries to help clients become more effective in making use their immediate experiences, exercising greater self-determination, and resolving the particular problems they bring to therapy. In addition, as Bordin (1979) noted, different therapies make different demands on clients. As with Gestalt therapy, EFT asks clients to engage in several kinds of activities (e.g., mindful attending of experiences, symbolizing and expressing experiences, opening up; Elliott et al., 2004). At the same time, they are asked to act as experts on their own experiences.

Because experiential therapy is based on these processes, the client must at least provisionally accept them in order for treatment to be effective. In fact, while they sound general enough to be agreeable to most clients, in actual practice for various reasons clients often find them difficult and sometimes even unacceptable, resulting in problems with initial alliance formation or later alliance ruptures.

In order to foster client agreement with these general process goals, it is a good idea to present them to the client at the beginning of or even prior therapy. For example, the client William, the client described later in this article, was told the following during his initial telephone screening:

> The therapy we are offering is person-centred and focused on your experiences. This therapy may be different from others that you are familiar with: In the person-centred/experiential approach, your therapist will not give you behavioural solutions for problems, and will not make interpretations about you. Instead, your therapist will work actively and respectfully with you to help you explore your emotions and other experiences, in order to help you find your own answers.

Providing this information to clients very early and without pressure allows them to consider and explore whether an experiential therapy is right for them, which in turn enhances their commitment and involvement in therapy, even though some will need to revisit their initial decision after they have experienced therapy first hand. In addition, it is important for the therapist to be willing to share information about the rationale or basis for specific therapeutic tasks or activities (e.g., talking to the "empty chair"), exploring and negotiating as needed.

3. Foster development of client task abilities. Many clients (especially those new to therapy) have difficulties with how they deal with their experiences, including expressing and exploring their feelings and other internal experiences. As in the case example below, at the beginning of therapy, many clients are distant, uninvolved, or out of touch with their own and others' emotions (termed “incongruence” in Person-Centered therapy, Rogers, 1957; or “deflection” in Gestalt therapy, Polster & Polster, 1973). This distancing from self and others manifests itself as intellectualization and emotional and interpersonal isolation.

As a result, it is possible that some clients beginning therapy will be unable to carry out some therapeutic activities. Even though they are willing to do so, they simply lack an understanding of how to do so. For example, some clients may not know that attending to inner experience can be facilitated by silence, looking at a neutral "focal point", imagining an internal space, and asking yourself open questions; or that inner conflicts can be usefully conceptualized not as “stuck places" but as internal arguments.

At times, then, it is very useful for the therapist to take on temporarily the role of process teacher, or "teacher of the method" (Mahrer, 1983), explaining the rationale or basis of a particular activity, and patiently coaching or modeling for the client activities that can help them move toward resolution. Thus, in both Gestalt and EFT approaches to experiential psychotherapy the therapist works actively in various ways with the client to help develop a mutual, collaborative relationship.

Research on Collaboration in Therapy

The research evidence provides some support for the specific claim that client-therapist collaboration as a specific effective ingredient in therapy. For example, in a small, recent meta-analysis of the general relationship between therapist collaboration and therapy outcome, Tryon and Winograd (2011) reported highly consistent, moderately strong relationship. However, the Norcross (2011) expert panel concluded that therapist collaboration is only “probably effective” (not “clearly effective”) in bringing about positive client outcomes. This is a confusing conclusion because, as noted earlier, collaboration is an essential aspect of therapeutic alliance, which does have unequivocal

research support and the full endorsement of the Norcross panel. (For example, two-thirds of the items on the Working Alliance Inventory [Horvath & Greenberg, 1989] refer to collaboration, i.e., agreement or goals and tasks.)

Unfortunately, little of the quantitative research evidence on collaboration or alliance involves experiential therapies such as Gestalt or EFT. Nevertheless, two lines of evidence point to the importance of collaboration in experiential therapies: First, working alliance (as measured by the Working Alliance Inventory) predicts outcome in experiential therapies (e.g., Paivio, Hall, Holowaty, Jellis & Tran, 2001). Second, in a meta-analysis of qualitative research on significant events in Timulak (2007) summarized results from studies of experiential therapies in which "client involvement" events played an important role.

Case Illustration

Therapist and Researchers

The case presented in this paper is part of an on-going study of experiential therapy for social anxiety at the University of Strathclyde. The therapist is the first author (LB), an experienced, 45-year-old Italian Gestalt psychotherapist, trained in both Person-Centred and Gestalt therapies and working within the EFT arm of the study. The principal investigator of the study is the second author (RE) and one of the developers of EFT; he finds that the therapist's practice fits easily within the framework of EFT. This article thus provides an opportunity for the first two authors to reflect on how Gestalt and EFT are similar and different in terms of theory and practice. The client's assigned researcher is the third author (JS), an MSc student in counselling working within the social anxiety research project.

Client Description and Presenting Problem

The client (whom we will refer to as "William") is a 20-year-old European male, who presented with generalized social anxiety focused on social interactions and being criticized by others. Although he fit the criteria for Social Anxiety, he did not meet any other DSM Axis I diagnostic categories. In addition, he met criteria for Schizoid and Narcissistic personality patterns on Axis II, reflecting his highly rational, intellectual and interpersonally detached style. He scored in the clinical range on all five of the outcome measures used in the research study, including the Personal Questionnaire (PQ, an individualized outcome measure consisting of seven problems the client wanted to work on in therapy, Wagner & Elliott, 2001), Social Phobia Inventory (SPIN; Connor, Davidson, Churchill, Sherwood, Foa & Weisler, 2000), CORE-Outcome Measure (a measure of general psychological distress, Barkham, Mellor-Clark, Connell & Cahill, 2006), Strathclyde Inventory (a person-centered outcome measure; Freire 2007), and Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureño & Villaseñor, 1988) (see Table 1 for his pre-therapy scores).

After informed consent, William was randomly assigned to receive up to 20 sessions in the EFT arm of the study. As of the writing of this article he is still in therapy, so we are using data from his first 17 sessions only. Following the ethics protocol of the study the client agreed to the use of his case for the present paper. His identifying details have been altered to prevent recognition. This specific case was been selected because the process of establishing collaboration between therapist and client was complex, and the therapist at first found it challenging to create a contact and collaboration with him.

William is a very intelligent and articulate young man with strong opinions and a wide variety of distinctive intellectual and artistic interests and hobbies, which he loves doing mostly on his own. He wanted to extend his network of social contacts and become more popular with his peers; however, he found it very difficult to enjoy the interests and activities engaged in by others (such as going to the pub or dancing). At the beginning of therapy he was very self-conscious in public or social contexts, and therefore tended to avoid them. In general he tended to develop physical symptoms (e.g., stomach aches) when anxious. He had come to therapy to work on enhancing his social skills and becoming relaxed enough to interact more effectively with other people; he hoped this would enable him to develop a wider network of long-term friendships.

First Session and Case Formulation

In the first session, William presented with many experiences common to clients suffering from social anxiety: social avoidance, anxiety, physical symptoms, self consciousness when with other people, worry about others seeing these vulnerable aspects, and strong self-criticism. Moreover, apart from his strong self-focus on his "nervousness" and anxiety, he functioned primarily on a cognitive level, even when talking about very difficult personal matters; he was thus not really in contact with his emotional experiences and body responses. In Gestalt, as in EFT, these elements are crucial for developing self-awareness and self-acceptance; therefore, during the first session the therapist suggested to William the possibility of working to help him develop greater and more immediate body and emotional awareness. The therapist also explained to the client her way of working: first, letting the client lead the sessions, and, then, based on the emerging needs and experiences, working with him to co-construct possible new and alternative experiences and behaviours. From the beginning, the client agreed to try this, but at the same time overtly expressed his doubts about the effectiveness of such an approach to therapy, given how long he had had some of these difficulties.

Thus, the therapist's first impression of William was very positive in terms of his original and sophisticated capacity for analysing and describing himself and his view of the world. On the other hand, she experienced him as interpersonally distant and carefully observing her responses and her presence.

Course of Psychotherapy

For the first 5 sessions William arrived very well prepared, with written notes about the things he wanted to discuss and resolve, as well as information about his current life, his interests, his family background and his relationship with each relative. These descriptions were expressed in an emotionless, rational and logical manner, with great attention to accuracy. In both Gestalt and EFT the mode of engagement or "how" that clients use to express themselves is at least as relevant as the content: It may function either as a bridge or as an interruption of the contact between different parts of the self, as well as between the client and the therapist, and thus quite often illustrates how the client carries themself around the world, interacting with people and responding to their own needs. In the formulation of this case, thus, mode of engagement was a key point for the therapist, and had a quite strong impact on the way she decided to work during the sessions, in terms of trying to reach a deeper emotional level of communication and contact within the therapeutic relationship and, through that, enhancing the client's self awareness, emotional contact, and potential capacity to make choices in his life based on a sense of responsible self-agency.

The therapist found that William's detailed and emotionally detached reports during the first stage of therapy made it difficult for her to feel connected with him. This lack of felt connection lasted for several sessions and at times made it difficult for her to be fully present, tuned into her client's needs, and creative in the therapeutic work. Whenever she asked him about his emotional awareness in the here and now, he responded that he felt "nothing special," or asked, "What do you mean?" When, at appropriate markers, she offered typical experiential therapy methods (e.g., empty chair work for unfinished business, or two chair work for internal conflicts, or arts materials for bringing out difficult-to-express feelings and emotions), he tried them briefly, then explained each time that this sort of thing was of no use for him, although he appreciated that it might be useful for other clients.

In session 5, William expressed a clear perplexity about the usefulness of therapy, saying that he felt that he was only providing the therapist with information, but wasn't getting anything useful or insightful for himself. This comment matched the therapist's experience of therapy to this point completely as well as her sense of frustration, which she had not yet disclosed to the client. Because of her sense of low psychological contact with the client, after this point she used several different sources of supervision to explore what was getting in the way of her allowing this contact. At the same time, she appreciated the client's honesty in communicating his frustration with the therapeutic process, taking it as a demonstration of his willingness to collaborate and engage with the process, and using it to work on opening herself up in her work with William.

In fact, William's observation of how therapy had been going perfectly fit her experience as well: Up to this point, therapy had been nothing more than a sequence of meetings in which he was reporting facts and providing information and where the therapist, although feeling empathic and warm towards him, had been unable either to "get" him empathically or to interact with him in a dialogical and constructive way. After the session 6, where the client mentioned a sense of depression and a very low mood, the therapist went to supervision with both her personal supervisor and the second author, where she was encouraged to express her difficulties directly to the client, consistent with EFT formulations of relationship work (Elliott et al., 2004).

In session 7, therefore, the therapist shared her feelings with William, explicitly validating his sense of a lack of progress in therapy, disclosing both her frustration at not being able to help him access his emotions during the sessions and at the same time sharing her difficulty in working effectively if the dialogue remained only at a cognitive level. The client was immediately very receptive and expressed his willingness to collaborate more from this point of view. In session 8, indeed, he presented a list of issues he was encountering at the time, naming for each of them also how he was feeling about them.

William's opening up in session 5 and the therapist's disclosure in session 7 thus seemed to have shifted something in the relationship, and from this point the collaboration became clearer and more overt. However, William continued to talk about his emotions rather than to express them, and he still reported a lack of capacity to put into daily life practice any meaningful or useful change in his attitudes or behaviours.

After session 8 the therapist had further supervision and, thanks to a comment of her personal supervisor, she had an insight and felt suddenly able to connect much more with her client's fear of opening up with other people (including, possibly, with herself).

Dialoguing about and what it was bringing up for her and her personal experiences, the supervisor commented, using a metaphor, "it is as if when you open yourself to others, you are at the same time allowing them to access to your internal 'stuff' and that they can even 'extirpate' it from you, as you don't necessarily have control of what they will do with it." This image had a strong emotional impact on the therapist and she thought that she could use it with her client.

In session 9, then, when the client mentioned his difficulty with taking risks and opening up with other people, the therapist shared this image with him, using her hands to spontaneously portray the act of taking "stuff" from him (an example of the experiential/Gestalt/EFT approach of creative expression in the here and now, rather than "talking about"):

> T1: I would like to know the impact that what I am going to tell you has on you. OK. You say that exposing yourself to others would create polarizations [*they may like me less or more than before*], and this is a way to see it, when you give something of yourself. What I am seeing, is that if you give something of yourself, the other "takes it" (the therapist moves suddenly towards the client pretending to grab something from the client's stomach).
>
> C1: Mhm...(He blushes and coughs, then there is silence.) Well, I don't know what do you mean by "taking it."
>
> T2: Well, they get something from you, and they have something of you. (C: mhm) And then they can decide what to do with it. (C: mhm [nods]) But a step before is that they have taken a piece of yourself, that is very intimate, if you see what I mean. (C: mhm) From the perspective I am watching it, the thing is that the more you give, the more the other takes. (C: Mhm) Takes of you, of your personal stuff…
>
> C2: But in saying that I would say that it would scare me, (swallows) because I don't know what they are doing with that.
>
> T3: Exactly! That's my point!
>
> C3: And that's where my need for security comes from…
>
> T: ... And they may like it or not, but they have taken a piece of me and *this is* scary!

The therapist's unexpected and sudden action had a huge impact on the client, who reacted by blushing and feeling afraid. At the same time he seemed to have realized something meaningful to him. It was then possible, for the first time, to really work on William's core, social-anxiety-related maladaptive fear (in EFT terms): it was in the room, in the here and now, and therefore open to transformation. This work began with acknowledging the fear, allowing space for it, identifying its object (offering other people access to very deep and personal aspects of him), and at the same time looking after this fear, through body awareness and a warm and acceptant attitude towards it.

Interestingly, on the Helpful Aspects of Therapy Form (HAT; Llewelyn, 1988) for session 9, the client wrote that the most helpful event was:

> Others Take a "Piece of You" theory. Outlining how being open and giving away information about oneself resonates in others – both positively and negatively. [What made it Helpful:] Going towards the core of the issues / deal with and putting fear in perspective. (Helpfulness Rating: 7 to 8: Moderately to greatly helpful.)

According to William's Personal Questionnaire (PQ) weekly outcome scores, this was the turning point of his therapy, where his PQ scores started to decrease, from being 5.14 at session 9, to 4.86 at session 10 and dropping gradually to 3.71 by session 17 (See Figure 1). (William himself notes that the approaching end of the academic year may also have affected his PQ scores.)

Outcome and Prognosis

In terms of collaboration, the relationship between therapist and client changed dramatically after session 9. The next sessions became much more collaborative and co-constructive in their process. William arrived looking physically more relaxed, more open, and usually without bringing prepared lists of what he wanted to talk about and more spontaneously present in the here and now. The therapist also felt much more present and in contact with him, and no longer struggled to work effectively with him.

After session 10 William began to talk about several improvements in his social life, based mainly of a feeling of "legitimation," a word he used many times in different sessions to refer to an internal process of evaluating possible actions for example, staying by himself if he wanted, or opening up to others only as much as he wanted and in different ways each time. As a four-month summer break in his therapy approached after 17 of his scheduled 20 sessions, he appeared to the therapist to be more relaxed and aware of what he needed or wanted, and in general he was more accepting and less critical of aspects of self that he previously thought needed to be changed. These changes were also highlighted by the client himself when the researcher (JS) interviewed him about his experiences of therapy after session 17. In this interview he noted that although some aspects of his social anxiety still remained, he was also aware of various other personally relevant changes that he attributed to the therapy. For him, the most important and unexpected of these was that through an internal "dialogue" (his words) of asking himself "how do I feel and what do I want" (as the therapist had done with him during the sessions) he had developed a much deeper awareness and consideration of his internal world, which was in turn helping him to feel calmer and more flexible in social situations.

The researcher also assessed William's outcome to date more formally during his break from therapy, as presented in Table 1. Of the five outcome measures, his PQ data show the strongest reliable change over the 17 sessions (pre-therapy: 5.86: after session 8: 5.18: after session 17: 3.71; $p<.05$). In addition, he showed reliable change on CORE Outcome Measure and Strathclyde Inventory, although he remained in the clinical range on four of the five measures (all for the CORE), pointing to the need for further therapy.

Clinical Practices and Summary

The case presented is interesting from the perspective of therapeutic collaboration in experiential therapy, as it shows that the development of a productive therapeutic collaboration is not necessarily a natural or spontaneous process, but can instead require a series of efforts, with both client and therapist having to take emotional and interpersonal risks by disclosing themselves to each other in an immediate and genuine manner. In Gestalt, this is understood as a process of experimentation with creative ways to establishing contact between therapist and client, and, through that, between different parts of the client's self. In EFT, this process is described as a specific kind of therapeutic work ("Relational Dialogue for Alliance Difficulties"), which here over the course of several sessions moved from a client complaint (session 5) through the stages of exploring the difficulty via mutual dialogue about the relationship (session 7) and

development of a shared understanding of the difficulty and its relation to core issues of the client (session 9), and deeper engagement in therapy (sessions 10 onward).

There were several pivotal points in the case example. First, in sessions 5 and 6, the client took the risk of sharing his sense of frustration about therapy and his depression, which was essential for setting up a therapeutic process in which both client and therapist could encounter one another by sharing their respective experiences and perceptions of what was going on. This seemed to have finally created an opportunity for them to use therapy actively and creatively in order to help the client reach a deeper level of emotional awareness, thus providing a basis for effective therapeutic collaboration based on trust and openness.

This case shows also how in experiential therapies the presence and the personal process of the therapist, as a real human being contributing to the relationship, can be either hindering or helpful for the development of the therapeutic process and for either interfering with or allowing effective collaboration. Because true therapeutic collaboration is an I-Thou relationship, the co-construction of the process is equally distributed between the two participants, requiring several passages or turning points, before the "dance" between client and therapist can flow fluently without stepping on each other's feet (Quattrini, in press). Looking at our case example from the related but distinctive perspectives Gestalt and Emotion-Focused therapies, we have tried to show how in experiential approaches collaboration is built on initial trust (Bordin's 1979 bond aspect of the alliance) and provides a basis for therapist and client to play with the varied possibilities of psychotherapy, giving life to the process by making it their own. Thus, even though common themes such as trust, risk, and collaboration weave most if not all successful psychotherapies, each course of psychotherapy is unique and allows space for creative experimentation, expression, and constant discovery of new paths from psychological pain and stuckness to healing and forward movement.

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Table 1. Client Outcome Data

Instruments	Cut-off	RCI Min*	Pre	Session 8	Session 17
Personal Questionnaire	<3.5	1.0 (↓)	**5.86**	**5.14**	**3.71****(+)
Social Phobia Inventory	<1.12	0.67 (↓)	**1.59**	--	**1.12**(=)
CORE-OM	<1.25	0.5 (↓)	**1.50**	--	0.97*(+)
Strathclyde Inventory	>2.45	.46 (↑)	**1.65**	--	**2.19***(+)
Inventory of Interpersonal Problems	<1.5	0.57 (↓)	**2.04**	--	**1.73(=)**

Notes. Value in bold fall within the clinical range; *p<.2; **p<.05; ↑ = increased score indicates positive change; ↓= decreased score indicates positive change; (+) = reliable positive change in relation to first available score; (=) = no change in relation to first available score; (-) = reliable negative change in relation to first available score.

Figure 1. Client Weekly Personal Questionnaire Scores Across Therapy