Welsh Psychotherapy Institute

9 Integrative Case Study Assessment Criteria & Marking Document

Trainee Name: John Dray

Marker: Rosy Wood-Bevan Date: 29.01.26.

	CRITERIA	MARK
1	**Overview of your Approach:** Introduction to your own style of Integration linked to existing theorists. This will include something about yourself and the context of your work. A good, clear summary of the context of your work, who you are and how you came to the work, consideration of your intersectionalities, good discussion of how you are managing boundaries, both within the LGBTQ and your small geographical communities. I would like to have seen a little more depth in the discussion of your reasons for choosing this piece of client work. You give a coherent summary of the theory that informs your work and offer an excellent discussion of your position on understanding and engaging with neurodiversity.	**7 /10**
2	**Problem Formulation:** Ability to formulate client's issues in terms of Integrative therapy; evidence of contract & provisionally agreed ways of working. You offer some rather terse empirical observations of the client which lead you to discuss some speculative psychiatric diagnoses. As the client has not been given these diagnoses, I was unclear about how this was important. I had the impression that you were seeking to be quasi-objective and scientific in response to this section and I would like to have heard more about your relational and psychological formulations, more about your experience of the client in the room, perhaps exploring developmental and attachment issues in relation to the client's ADHD (although it would have been helpful to say whether this was a formal diagnosis or a self-made one). You use the concept of Schizoid process or adaptation appropriately but I would like to have seen more of your understanding about this and how it helps you make sense of your client. You do show a good understanding of the implications for practice in terms of Ware's 'Doors to therapy' model of Persoanlity Adaptations.? Some more philosophical discussion of how you understand the relationship between diagnosis and formulation is also needed.	**6/10**
3	**Effectiveness:** Clarity, precision, timing and effectiveness of interventions. You describe thoughtful and reflective work which judging by the outcome, has clearly been effective. You discuss how you caught your anxiety about needing to fix things and therefore your tendency to work too quickly, and say that you adjusted your pace accordingly. You convey a sense of what went on between you when re-framing your client's experience with his partner. However, in general you tend to present your conclusions without showing the workings out, so I cannot judge the 'clarity, precision, timing, effectiveness of interventions'. What is needed is greater evidence of your interaction eg a sample of transcript to illustrate the key episode. This will be required in order to pass if you want to submit for the Level 6 award.	**6/10**
4	**Therapeutic Relationship:** Demonstration of its use in practice with reference to	**6/10**

	relevant theory. You show a good understanding of your relationship through the lens of various kinds of countertransference, both reactive and proactive and of TA. Your key episode indicates careful and thoughtful work from a well-considered 'developmentally needed' stance on your part and built on the foundations of a solid working alliance. Again, you tell the Reader about your work rather than show through examples of what went on between you. So, whilst I believe that you formed a valuable working relationship, I am left needing greater detail of the evidence. I would also like to have seen some overarching relational framework.	
5	**Creativity:** Range, flexibility and creativity of therapist's approach evidenced. You mention a range of kinds of intervention - psycho-education, re-framing, flexible clinical thinking around your mode of initial contact and preparedness to send reminders of the session in relation to the client's ADHD. You also evidence independent thinking around the theory and its applicability to your client. As in other sessions I would like more substance in terms of your actual interventions to demonstrate your creativity. In particular I would like to know more about your phenomenology and any exploration of the client's to gain a more alive sense of the work.	**6/10**
6	**Quality of Contact between Therapist & Client:** including awareness and availability of therapist's own process & reference to transference. You demonstrate valuable self-awareness of how your own process was implicated in the work and an understanding of both proactive and reactive countertransference. There is no overt discussion of the client's transference although you show that you took a developmentally needed stance, being supportive, nurturing and enabling the client to find his own solutions rather than rescuing (this last being well backed up by your theoretical understanding of the schizoid adaptation). Overall, I experience you as talking **about** your work, rather than **showing** much evidence of your interaction. This creates a feeling of the work being held at a distance and lacking in an alive sense of your therapeutic contact.	**6/10**
7	**Professionalism:** including awareness of ethical considerations, anti-oppressive practice, limits of own competence & use of supervision. You discuss your ethical framework and supervision arrangements clearly. You show that you are aware of areas of identification in terms of shared intersectionalities, although I wanted to hear more about how this impacted the work. You evidence ethical thinking in terms of the factors which led you to believe that the client was within your level of competence and also that you discussed this in supervision. It is clear that you regularly took a range of issues in this work to supervision and explored these fruitfully. Likewise, you show self-responsibilty in taking issues evoked to your own therapy.	**8/10**
8	**Anticipation and predictions of Integrative Process:** if therapy is continuing, or discussion of the ending process, as appropriate. Clarity around projective processes and a willingness to explore counter-transference. You communicate your genuine shock and sadness when the client decided to end abruptly and explain well how you would have preferred an ending to have been more gradual and negotiated. Nevertheless, you turn things around with your work around the transitional object and your agreement to check in after 2 months with a	**8/10**

	clear option of returning. You show good self-awareness in considering the possibility that he was responding to you pushing the pace. Again, a little more evidence of dialogue is needed and I am left wondering whether your openly discussed your surprise about his decision to end etc. Your final discussion of the issues involved in ending, with this specific client and in general, and your links to your own process, well explored in personal therapy, your account of your learning, both personally and professionally, demonstrate real depth and quality. I find this the most powerful part of your case study!	
9	**Integration of Theory into Practice:** demonstrating knowledge of significant aspects of Integrative therapy via clinical illustration. You give a good summary of the theory you are integrating, albeit I think you could discuss the connections more fully and there are some significant omissions eg attachment and developmental theory, Clarkson's 'Five types' as an overarching framework. Theory is appropriately peppered through the whole and related well to practice. Terms and concepts need to be explained however, eg the various forms of transference you correctly mention, 'schizoid' process and various TA terms. It is clear that you are using these in a relevant way but you do need to spell out your understanding.	**10/15**
10	**References & Quality of Writing:** Appropriate structure, referencing and written style throughout. Correctly referenced, although there are some theoretical terms which need referencing and explaining. Well written on the whole with a lovely clear structure. I find your discussion of diagnosis and formulation rather stilted and lacking in depth and wonder what was going on for you here? A full bibliography which you refer to in the case study. You have clearly read widely and valuably draw on understandings of neurodiversity and of the social construction of disability, from outside of psychotherapy per se.	**4/5**
	TOTAL MARK	67%
	GRADE	MERIT

Candidates must attain a 50% pass in every category in order to gain an overall pass to progress to year 4 or if this is a Final Submission piece to be eligible to apply for UKCP

Under 50% = Refer; 50% - 60% = PASS; 61% - 79% = Merit; 80% + = Distinction

General Comments
You have written carefully and thoughtfully about a constructive and ethically handled piece of work, which demonstrates valuable use of supervision. At the same time, I would like to have had a more alive and direct sense of how you and the client interacted and impacted one another. Whilst you talk **about** this, it is at one remove and majors in abstract understanding more than immediate phenomenology. You

also demonstrate, to my mind, an over reliance on using techniques eg drawing a diagram or recording a tape and I wonder whether this indicates a lack of confidence on your part to work with intersubjective processes. You bring in pertinent and accurate use of theory, although some terms need explaining. What is missing for me is an account of the attachment dynamics and I suspect this reflects an Avoidant tendency for both of you, the quality of which somewhat permeates the work, as indicated by comments above about a certain lack of immediacy. For Level 6 (if you decide to go for this) you will need to include greater evidence of your interaction to demonstrate the effectiveness of your work and bring your writing to life. You will also need a fuller relational formulation and a sense of how you understand the difference between diagnosis and formulation. Nevertheless, your work communicates competence and a genuine care for your client. The final sections demonstrate a real depth of reflection and understanding!

	Specific Comments
1	**Overview of your Approach:**
2	**Problem Formulation:**
3	**Effectiveness:**
4	**Therapeutic Relationship:**
5	**Creativity:**
6	**Quality of Contact between Therapist & Client:**
7	**Professionalism:**
8	**Anticipation and predictions of Gestalt Process:**
9	**Integration of Gestalt Theory into Practice:**
10	**References & Quality of Writing:**

Marker Signature:  Date:

FINAL SUBMISSION (Year 3)

Would you recommend this candidate for UKCP Registration at Postgraduate Level? YES / NO

If this candidate does not reach a pass in each category would you pass them at an Undergraduate Counselling Level?

YES / NO

All Final Submissions will be sent to the External Examiner

EXTERNAL EXAMINATION

The Grade must be agreed by two markers before this work goes to the External Examiner.

Final Grade Agreed:

Comments from Both Markers after Discussion

External Examiner - Do you agree with this Grade, please delete appropriately: Grade Agreed / Not agreed

External Examiner Comments

External Examiner Signature:
Date:

Introduction to Self

I am currently a fourth year student with the Welsh Psychotherapy Institute (WPI). I have been seeing clients through my placement with New Pathways since April 2024 and through my Affordable Therapy Placement (ATS) since September 2024. I have accumulated more than 340 hours of clinical practice. As a trainee member of the United Kingdom Council for Psychotherapy (UKCP), I adhere to the UKCP codes of ethics (*UKCP Code of Ethics and Professional Practice*, 2019). I use these ethical frameworks as a foundation for my private practice, from the content of written contracting and GDPR statements to safeguarding and keeping the therapeutic work in the best interest of my clients. I attend weekly therapy, with a UKCP-registered integrative psychotherapist, which provides me with space to take personal process work that arises from any area of my life. Additionally, I undertake individual supervision at a ratio of one hour for every six clinical hours with a UKCP-accredited supervisor. I work with long-term clients through my private practice and with short-term clients through my placement with New Pathways. In my placement I have additional supervision with a BACP registered supervisor, covering those clients.

I have come to psychotherapy relatively late in life, and I have had a varied career. I have studied both physics and theology at undergraduate degree level. The former underpinned a career in Information Technology, while the latter underpinned a vocation, working as a parish priest and a chaplain working with Deaf, deafblind and hard of hearing people within the Church of England. I left this latter profession when I realised that as a single man, with ever increasing workloads, and a fixed income, I would probably be crushed by the workload and retire into penury. Additionally, there was increasing pressure on LGBTQ people, particularly from the evangelical wing of the Church of England, to be vilified. It was known that if someone within the Rochester diocese ‘outed’ themselves then they would be immediately sacked by the bishop with loss of home, income and reputation. This was brought home to me when the bishop tried to sack a colleague and friend who had been divorced. As a lay person, she had employment rights. As an ordained person I had none.

Reflecting on this over the subsequent decades, I came to the conclusion that I never wanted to be pushed out of a profession through lack of money. This came to the fore during a two day course on the topic of money in the context of psychotherapy.

I wanted to be working in a profession where “who I am” is valued and part of the process, rather than something to be hidden and only a hollow shell projected into the work. I have experienced much shaming for being gay and, sadly, I have absorbed this deeply. This has much to offer the therapeutic relationship, however I have to be aware of potential counter-transference issues, which could potentially be Destructive Client Countertransference (Clarkson, 2013 ,159). Just because I feel shame does not mean that everyone who identifies as LGBTQ should! Good awareness

I have chosen this client as they are part of my work through the WPI Affordable Therapy Service (ATS). Can you say a little bit more (in addition to what you say below about intersectionality) about why you chose this client ie what the relational issues were, what you learned, how you developed personally and professionally, what skills and capacities the work called out of you. My advertising with the ATS stresses that I offer an LGBTQ affirming service. This client represents part of this community and so the therapeutic process brings up issues related to my own sexuality. I also self-identify as being neurodivergent, and I am on the waiting list for a formal diagnosis. A large proportion of my relatives has been formally diagnosed as being neurodivergent in various ways, adding weight to my hunch. This heritability is explored in Sandin et al. (2017). This client will also bring up issues of intersectionality (Crenshaw, 1991).

A significant ethical boundary issue is related to both the client and myself belonging to the LGBTQ community in rural West Wales. There are very limited opportunities for socialising within that community and it is not fair that either of us should be cut off from socialising. For this reason I talk through boundary issues based on the boundary work of Davies (2025). This goes beyond my normal boundary statement where I explain to client that if I see them out and about I will not acknowledge them, but they are free to come up to me - a way of

giving them control over whether they want other people to know that they see a therapist. With clients who identify as LGBTQ, I further explain that if we do meet at an LGBTQ event I will typically leave early on, unless that would draw attention to our therapeutic relationship and, thereby, break confidentiality. At our subsequent therapy session, this meeting would become a subject of the session - so that we could discuss how the boundaries and the meeting affected our therapeutic relationship. There can be a fear that such disclosure will 'contaminate the transference'. Reference needed for this opinion. However, withholding such information is also a wilful act that can affect the transference, see Stolorow, Brandchaft, & Atwood (1987, p. 42). The approach I have chosen is an attempt to hold defensible boundaries in the intersectionality of being a member of a small, rural community and within that community being part of a small minority group. I have also thoroughly discussed this with my supervisor. Very well handled and discussed.

The supervisor for this work is both a director and a tutor of WPI. I meet her on a monthly basis either for individual (1 hour) or group supervision (2 hours). Usually the supervision is face to face, but occasionally it is online, using Zoom.

As well as advertising through the ATS, I maintain an entry on the Psychology Today directory and a professional website. The client contacted me through my Psychology Today directory listing.

My Theoretical Basis

The main models I am using in this relationship are Transactional Analysis (TA) (Stewart & Joines, 1987) developed further in Joines & Stewart (2002), Polyvagal Theory (PVT) (D. A. Dana & Porges, 2018) as developed by D. Dana (2024) and a Trauma Informed (TI) approach (Rothschild, 2000), (Van der Kolk, 2015). I will also be relying on Erskine, Moursund, & Trautmann (1999) for an examination of the developing therapeutic relationship. As a student with WPI, my integrative approach is influenced by Gestalt Psychotherapy (GP) (Perls, Hefferline, & Goodman, 1972) as developed in (Fish & Lapworth, 2005). I also work from an intersubjective perspective, as put forth by Stolorow & Atwood (2014), where neither the client nor the therapist are objective, and their interactions form an intersubjective space between them. From my own therapy, I am influenced by Mindfulness Based Stress Reduction (MBSR) based on the work of Kabat-Zinn (2013). My therapist suggested this as a way of reconnecting to my own internal sense, after years of dissociation. My therapist is a registered teacher of MBSR and I have attended her eight-week course three times. I find MBSR complementary to the noticing of internal states in Polyvagal Theory. If I suspect that a client is unaware of their internal states, then Farb, Segal, & Anderson (2015) suggests that MBSR may be helpful in helping them reconnect. I will also be exploring intersectionality as developed by Crenshaw (1991, p. 1241).

This model of therapy is informed by my personal therapy, which is delivered by a UKATA registered therapist who introduces other models into my therapy, such as Gestalt Psychotherapy. As I have been in therapy with my current therapist for more than eight years, I have a great deal of experience of the use of TA by a *particular*, skilled practitioner, rather than a more general experience. I realise that much of what my clients get is what I have learned from my own therapy. In the last year, I am beginning to notice where the therapy I deliver differs from the therapy I receive—I am developing my own model. I am also working with issues that have not occurred in my own therapy, so I am beginning to develop my own approaches based on the theoretical bases outlined above. Good,

self- aware discussion with evidence of your own individuation as a therapist.

I have chosen this client as he is part of my work with the WPI Affordable Therapy Service (ATS). Can you say a little bit more than this…? Throughout this case study I will refer to him as **Jim**. For confidentiality, that is not his real name. My advertising with the ATS stresses that I offer an LGBTQ-affirming service. Jim represents the crossroads of many identities, producing an intersectionality which, as noted in Crenshaw (1991), gives rise to a different set of needs compared with each identity considered individually. Jim identifies as gay, trans (pronouns he/they), and as having Attention Deficit Hyperactivity Disorder (ADHD). Has he had a formal diagnosis? I share some of this intersectionality, specifically being gay and self-identifying as neurodivergent, and so the work brings up issues related to my own sense of identity. In my work, rather than medicalising the client as a list of symptoms or syndromes, I am drawn to a social understanding of the self, as discussed in Reeve (2002). Through this lens, my understanding is that Jim is whole, and it is society that attempts to diminish his personhood. There is even a growing sense of a 'neurodivergent community' [Kapp (2020)]. This is also in line with my earlier work with Deaf people, where a social view of disability could argue that Deaf individuals live successful and thriving lives within a rich culture, but that most of the world is set up around hearing people—among their own, Deaf people, deafness is not a disability. Excellent discussion.

Notably, Jim chose to pay for the initial introductory session so that we could meet in person rather than by video or audio call.

As he comes into the room, I notice that Jim is walking very stiffly. He is a young person in his early twenties. His hair parts in the centre and is gently wavy. He has a moustache and a small, thin beard. I notice that there is virtually no face movement—so little that it is striking—and I find myself wondering why. To my initial eye, this appears more rigid than shyness. I wonder whether there has been trauma, or whether this is an aspect of masking. Good question This is already an aspect of my Complementary Reactive Counter-transference (Clarkson, 2013, p. 156). Can you explain this term and amplify how you feel it is applicable

here? Although I have these initial hunches, I try to stay open to possibilities, aware that my prejudices may prevent me from truly seeing Jim, but also aware that they may offer insights into the processes to come. Good

Jim states that their ADHD makes it difficult to make initial contact by video call or phone call —an in-person meeting is much preferred. As well as being able to speak to me directly, I have a booking system that allows new clients to book a session without interacting with another person. Clients can choose phone, video call, or in-person for the initial 15 minutes. I make a small charge for in-person meetings as I have to pay for the room. Despite this, nearly 50% of my new clients book in-person. All of the clients who have booked this way have self-identified as having ADHD.

Jim explains that he finds it very difficult to cope with the unpredictability of a video or phone call. Meeting in person gives them more cues about what is happening in the interaction. In addition, I send out booking confirmations as well as reminders 24 hours before a session. This automation helps me manage tasks that I also struggle with—something I associate with my own neurodivergent behaviour. Some argue that automated reminders reduce client autonomy, a point made by another supervisor. I could see the validity of that if I were dealing primarily with people who are neurotypical. However, with people who self-diagnose as having ADHD, I believe reminders reduce anxiety around remembering appointments—many report time-blindness or difficulty keeping track of time as part of their symptoms. Similarly, I allow for many ways to pay so that the client does not worry about bringing the right form of payment to a session. I see this as part of making the service accessible, and many of these ways of working are suggested in Tuckman (2009). A well-argued position, considering other points of view and explaining why you choose to run your practice as you do.

Clients Presenting Issues

At the time of starting therapy, Jim is in a marriage with another trans man. His partner self-identifies as having Autistic Spectrum Disorder (ASD) and is the primary earner in the household.

Jim is unemployed. He names his issues as difficulties with scheduling, motivation, and anxiety. He also reports communication problems within the relationship. Jim and his partner have recently purchased a house together. He undertakes home-improvement projects and then has the work reviewed by his partner. They describe experiencing their partner's feedback as criticism. Jim's partner works from home. To put these in the context of a diagnosis framework, the client presents with something akin to "Generalised Anxiety Disorder" (*ICD-11 Reference Guide*, n.d., code: 6B00), ADHD (*ICD-11 Reference Guide*, n.d., code: 6A05.Z) and "Gender incongruence of adolescence or adulthood" (*ICD-11 Reference Guide*, n.d., code: HA60), although this latter classification has been deprecated. I say 'akin to' as I am not a diagnostician, so realise that these classifications may be inaccurate. They are also not relational–they do not speak of actual contact with the actual client. The latter 'diagnosis' also speaks of the social context in which the category was defined–our understanding of being trans has moved on, so that it is not longer seen as a pathology, which is why it has been deprecated. Further, this latter category is not part of the issues that the client is asking to be part of the contract. Some discussion of the value and purpose of diagnosis is called for here, and its relation to formulation. Given that you rightly say, you are not able to diagnose, I am left wondering why you major in discussing your client in terms of psychiatric diagnoses and what your relational formulation might be?

Jim's past employment includes working in a zoo as an animal technician. They have a love for animals, and their passions include concern for the environment. At this time, Jim does not feel able to work due to anxiety or something else? and is receiving benefits.

As a teenager, Jim had a significant curvature of the spine, which was corrected using implanted rods. This contributes to the somewhat rigid posture I noticed when he first arrived.

Jim has been in therapy before, primarily to work on anxiety. This was short-term and based on Cognitive Behavioural Therapy (CBT). He sought counselling with anxiety as the presenting issue; however, this was also the period during which he was beginning to wonder whether he might be trans. From Jim's account, the therapy appeared to be fairly scripted. A major part of his life at that time was the question of being trans, yet any mention of it was ignored by the counsellor. I find it interesting that in that episode of care anxiety was the presenting issue but being trans was figural for the client. In this episode, anxiety is the presenting issue and being trans is part of the field, but not figural. So what conclusions might you draw from this? Can you expand on your observations? As part of the assessment, I use the CORE-10 instrument (Barkham et al., 2013). This offers a score of 14, which, according to *CORE Measurement Tools (CORE-10)* (n.d.), suggests 'Mild psychological distress'. There is no suicidal ideation. I am aware that clients from my New Pathways placement typically have much higher scores than this, to the point that I am tempted to be dismissive of this 'low' level of anxiety. However, reading the website I do find that this level is clinically significant. From an assessment stance, this suggests that Jim will be within my level of competence. I am also taking into account that Jim is currently on Sertraline and that this may be lowering his score. This is useful and can you also give some more subjective evidence re how you experienced his anxiety in the room.

As Jim is currently unemployed, he feels he should be doing tasks around the house. He reports that if his partner walks in and sees him doing nothing, Jim feels "like a naughty child." I am wondering if this is an indicator of shame (DeYoung, 2015).

So, our contract consists of looking at Jim's anxiety, their interactions with their partner/others and aspects where their self-identified ADHD is impinging on their life (e.g. lack of motivation, task initiation, getting into employment).

Finally, there are no safeguarding issues, as outlined in *UKCP Safeguarding Guidelines* (2018) or *Safeguarding Wales* (n.d.).

I take this all to supervision and my supervisor is happy for me to work with this client.

First 6 sessions

Figural in the early sessions was Jim's communication with his partner. As Jim was unemployed, he was doing most of the home-improvement work on their joint home. His partner worked from home, and a common scenario arose in which Jim would spend the day completing improvements; his partner would finish work; the partner would ask why Jim had done something in a particular way; and Jim would feel criticised. On other days, when he "felt rubbish," Jim would not manage to do anything at all.

I wondered whether Jim was actually being criticised. When I heard his response to questioning, I began to consider whether he might have a schizoid process, as people with this process often experience questions as statements or criticisms. reference needed, or is this your experience? What do you think this feature is about for your client, or in general with a schizoid process? This would also be consistent with Greenberg (2016, p. 43) understanding of the schizoid process and links with Jim's preference for booking the initial session online for a face-to-face meeting, rather than having the first contact by phone or video call. Could you say something more substantial about the features and relational process of the Schizoid adaptation? Can you say how this last statement pointed towards schizoid functioning?

I was also curious about the communication style of both individuals within the relationship.

In relation to competence, Jim's father was retired from the building industry, and Jim was learning most of the home-improvement tasks by watching YouTube videos and asking his father for guidance. When exploring this dynamic, Jim often felt criticised by his father. This seemed to sit within Jim's **Controlling Parent (CP)** ego state. Further, in terms of his *life position* (Stewart & Joines, 1987), Jim appeared to be operating from a **You're OK, I'm not OK (U+I-)** stance. I wondered what it might be like to explore this directly with him. Can you explain these theoretical terms a little more, either here or in the introduction to your theoretical stance above.

I introduced some psycho-education around the Parent/Adult/Child ego states and the life positions, drawing on Stewart & Joines (1987) and my own experience of therapy. I checked with Jim to see whether this conceptualisation felt accurate. He stated that he always completed the home improvements to the best of his ability but that it never felt good enough. This sounded like an indicator of shame (DeYoung, 2015). Can you say whether and how you might have explored this? Jim further described differences between his family's communication style and that of his partner's family. His own family communicated quietly, politely, and with one person speaking at a time. In contrast, his partner's family dynamics felt, to Jim, like listening to an argument. Even talking about this, I noticed that Jim's face blanched—it appeared that visiting his partner's family was quite challenging. I checked this with him, and Jim confirmed that he found it overwhelming. Good evidence of your observations and interaction.

I took this to supervision. Given that so much material was emerging in the first session, my supervisor reminded me that it is important to pace the work. I noticed my own tendency to want to fix things quickly. I also became aware of feelings of inadequacy, and I wondered whether I was picking up on Jim's own experience. I recognised my need to be "good enough"—in other words, working with my own shame around competence. Good awareness of the parallel process. I wonder whether you could have explored this theoretically in greater depth ie looking at how Projective Identification (experiencing the client's possibly disavowed feelings) may have dovetailed with your own Proactive countertransference.I have taken this "need to fix" to supervision many times. I was also noticing the difference in tempo between my New Pathways clients, whose work is bounded by fixed-term contracts, and my ATS clients, whose work is generally open-ended. This has become an important part of understanding what I am doing in the room. My supervisor has often reminded me of this different tempo and that in the ATS work the working relationship has much longer to establish and grow. Good awareness and evidence of exploring in

supervision. In terms of Erskine's relational needs (Erskine et al., 1999) we are building security, valuing, acceptance and self-definition. Good link.

As there was a considerable amount of self-criticism directed towards Jim, my immediate thought was to engage in some re-framing. Within the context of integrative psychotherapy, this would more accurately be termed **"revising meaning"**, as explored by Erskine (2025) and Stolorow, Atwood, & Orange (2002). I wondered whether, if Jim were able to be kinder towards himself, that might help him shift his narrative. Good clinical thinking, well linked to theory.

Jim was open to this, so we explored his communication with his partner. As we worked through the interactions, it sounded less as though the partner was genuinely criticising Jim and more that he was curious about why Jim had approached tasks in a particular way. Together, we developed a form of words that might help when Jim felt criticised. Instead of immediately apologising, Jim might say, *"thank you for noticing."* My thinking was that, rather than shutting down in shame, this phrase came from an **"I'm OK, You're OK" (U+I+)** position and allowed room for continued dialogue from the Adult ego state. Sounds useful with good link to theory. Did Jim arrive at this form of words himself? At this point, Jim shared that he had previous experience working with Special Educational Needs and Disabilities (SEND) children and had used similar communication approaches with them. I felt this was highly positive—it showed he had internal resources to draw upon and had already seen such techniques work. My only concern was whether Jim, an intelligent and competent person, might feel infantilised by using strategies he previously used with SEND children. Good question. Did you/could you have asked?

Over the next few sessions, we continued this work, and Jim appeared to be gaining confidence in communicating with his partner. We discussed the possibility of volunteering as a route back into working life—to build his CV, regain routine, and begin networking. Jim began searching for volunteering roles within the conservation sector and found a position that involved meeting other conservationists and ringing birds. My understanding of the

benefits of volunteering, including benefits to mental health, is based on works such as Fegan & Cook (2014), Nichol, Michel, Lewis, & Goodwin (2024) and Pérez-Corrales, Fernández, Jiménez, & Párraga-Martínez (2019). Good recognition of the need for him to develop his ‘field’.

As the weeks progressed, we explored how this role was affecting Jim’s confidence. The role involved meeting many people whom Jim identified as neurodivergent. I felt excited by Jim’s new-found confidence and his emerging ability to socialise more freely. I shared this enthusiasm with him, and he beamed back at me. At this stage, my counter-transference was that of a proud parent—eager to celebrate his next success and ready to offer comfort and support should he encounter a setback. This felt like complementary reactive countertransference (Clarkson, 2013, p. 155).Yes I agree and again, it would be more powerful as a comment if you had previously explained what this means.

Fear of Dentist

My chosen *key episode* relates to Jim's fear of the dentist. It unfolded over the course of several sessions.

During his sixth session, Jim raised the issue of needing dental treatment. He had a deep fear of dental work and described how, as a child, he had undergone orthodontic treatment to straighten his teeth. He now feared dental procedures so intensely that his teeth had since crowded together, leaving one of his front teeth twisted. Do you mean because of his fear or that his fear was great because his teeth had twisted? Jim was sure that extensive work was needed, but he did not want to go to the dentist.

Hearing this and reflecting on it, I sensed several different processes at play.

There was the clear anxiety about going to the dentist. Previous dental visits had been difficult, even traumatic. As a child, Jim had not been granted any agency. There was also the potential for shame around his appearance, particularly as his parents had tried to safeguard and straighten his teeth. I wondered whether, as a trans man, looks held particular significance, given our previous discussions about "passing" as a man. I was also aware of my own projection, where my parents had often had things 'done to' me for my benefit, without considering what I had wanted. This feels like what Clarkson (2013, p. 157) might call "Concordant Pro-Active Countertransference". Jim's partner was supportive of him seeking dental care, but as his partner would be funding the treatment—Jim not being in paid employment—there was the possibility of complex emotional responses: perhaps guilt about financial dependence. Being in a relationship with someone is one thing; depending on them is quite another. I imagined how vulnerable this level of reliance might feel for someone for whom safety was such a vital quality.

At the same time, the lack of dental care risked significantly affecting Jim's health. He needed at least one filling, possibly more. Jim recognised this, but his childhood experience of orthodontic treatment—carried out by a dentist who had not been sensitive to his needs—

had left him unwilling to seek further help. Here, Jim's **Adult** ego state was being overwhelmed by the fears held in his **Child** ego state. In my counter-transference, I felt a pull to reassure him. This felt like what Clarkson (2013, p. 158) might call "Complementary Client Countertransference". At the same time, I recognised that I could not do this *for* him. This form of counter-transference may reflect an activation of Jim's earliest relational needs for safety and security (Erskine et al., 1999).

Excellent unpacking of the intertwined issues involved here, including the relevance of your own process. Good links to theory.

This presented a decision point for me: should I rescue Jim by supporting him toward a quick "solution," or should I prioritise providing a safe and secure environment in which he could uncover his own internal resources? With hindsight, the answer feels obvious, but at the time I took this dilemma to supervision. Providing a safe environment would allow Jim to mobilise his own internal resources. Good evidence of your reflection and use of supervision.

Jim presented with strong cognitive abilities. He clearly understood the importance of dental treatment and had the capacity to research alternatives to a typical dental practice. Against this sat a rebellious inner child who refused to go—and could not be forced. Given his history of being made to attend dental appointments as a child, my expectation was that he was now trying to *force* himself to go as an adult. Cognitively, he was firing on all cylinders, but what I felt he needed was compassion for his Child ego state. Yes, good. Over the coming sessions, we explored the agency Jim now had as an adult—agency he did not have as a child. This aligned with the **re-decision** process described in Goulding & Goulding (1997) and further developed in Joines (1986). The latter paper reframes the harsh and clinical-sounding "schizoid" as the softer "creative daydreamer," and emphasises the importance of "making contact from a firm Controlling Parent ego state that communicates clear expectations that they be active." (Joines, 1986, p. 155). To my ears, this sounded more robust than Jim could tolerate—evoking images of strong directives about what he "should" do. Instead, the more resonant approach felt like one of **compassionate curiosity**, which

supports and invites the problem-solving aspects of a creative daydreamer. Reflecting on this, I realised that compassionate curiosity is analogous to the Controlling Parent contact—one that guides rather than pushes but that is actually employing the ‘here and now’–the Adult ego state. You demonstrate careful independent clinical thinking here, considering a theoretical position but also how you might adapt this to better attune to your client.

In this way, Jim might move toward making an appointment—provided that his Child ego state agreed.

In the seventh session, Jim raised the dental issue again. This time, we were able to explore options for “nervous patients.” Jim had discovered two tiers of support. One group of dentists was assigned longer appointment times, allowing practitioners more opportunity to explain procedures and reassure patients. A second tier offered similar support but could also provide general anaesthetic. In talking through this, Jim decided he should opt for the highest tier. With curiosity, I asked how he had discovered these options. It felt important to praise and show genuine enthusiasm—and to avoid the **negative Controlling Parent (CP-)** voice that might question his need for such support, a voice that could carry shame, guilt, and ultimately poor dental health.

My curiosity was sincere; I genuinely had not known these services existed. Jim’s response to the invitation to problem-solve had been thoughtful and resourceful. I felt relieved—rather than rescuing him, I had acted as a sounding board and as someone who could celebrate his progress. This felt fulfilling of more of Erskine’s relational needs (Erskine et al., 1999): safety and security; validation of personal experience; acceptance and mutuality.

By working through this over several sessions, Jim was able to fully mobilise and take action to get his needs met. He was also able to ask for support from me, from his partner, and from the specialist dental service. All of these steps are challenging for someone with a strong need for safety, yet Jim achieved them.

This all sounds like valuable work which is well thought through and linked to theory. However, what is missing is a sample of your dialogue to demonstrate your interventions which you talk about in general terms but do not directly evidence. This will be needed if you want to submit the work for a Level 6 qualification.

It was not until our thirteenth session—approximately four months after Jim first raised the issue—that he had finally received the dental treatment. Some of this delay reflected the length of waiting lists; another part reflected the time required to work through a childhood fear. Such work must unfold at the pace of the frightened child—one who is likely distrustful and requires time for trust to build. In my Complementary Client Countertransference felt very proud of Jim. I felt that through compassion, Jim had been able to support his frightened child and make meaningful progress.

This episode was key because, in the following months, Jim began applying for positions he genuinely wanted. He also applied for jobs that would bring in an income, even if he was less enthusiastic about them. Jim found himself increasingly able to tolerate anxiety related to meeting new people and entering new situations. In doing so, he was able to address many of the issues that had brought him to therapy.

It would be worth making a point in your reflections here about the parallel between going to the dentist and coming to therapy. Cite ‘listening from an interactional viewpoint’ Patrick Casement. I think you were the patient, informative dentist in this narrative.

Sessions 7 to 13

In parallel with the work around going to the dentist, at the eighth session Jim told me that his father's brother had died. Jim did not appear particularly upset; he had not been close to his uncle. However, he found himself needing to support his father, who lived a significant distance away. Two main issues emerged from this.

First, Jim began exploring what he would want for his own funeral arrangements. We explored this in an existential sense—what his life would have meant, what he would want to communicate through the way his remains were handled, and what values he wanted reflected in that final act. Congruent with his environmental concerns, Jim felt strongly that he would want an environmentally responsible funeral. Perhaps not surprisingly, this reminded me of the many funeral visits I had done as a parish priest–where time was spent working out funeral arrangements. This process seems very similar to that described by Clarkson (2013, p. 154) as Concordant Reactive Countertransference. In a similar way to Clarkson's description, I wonder if the client is somehow expecting me to experience his emotions on his behalf. Can you evidence what happened between you that led you to wonder this? What were your emotions or other phenomenology at this point? This process, which we could also call 'Projective Identification' would be at an unconscious level, so I am not sure the word 'expecting' quite fits. Again, it would have been useful earlier to explain what is meant by Concordant CT. This does seem to fit in with Jim's apparent difficulty with processing emotions–it fits in with DeYoung (2015) and her understanding of the role of the therapist to provide the right-brain/emotional processing and attunement that were not available to the client as a child, it also reflect's the understanding of D. Dana (2024) that in the therapy room the nervous system of the client is communicating with the nervous system of the therapist.Yes, all good links to theory, but rather abstract. Can you say what was going on for you that led you to believe you were processing something for the client?

Second, Jim found it disconcerting to be supporting his father rather than being supported by him. This was particularly poignant because, when Jim came out to his father as trans, his

father had been immediately accepting. Jim now found himself in a role reversal, providing emotional support rather than receiving it. I wondered whether these newly developing relational skills—offering care, emotional steadiness, and containment—were also contributing to his growing ability to support himself in facing the dental work. I also wondered whether this experience helped him realise that asking for help and receiving help is not shameful. This was something I hoped I had been quietly modelling in my therapeutic relationship with him. Yes,good links here. I think you could say something more about your part in this.

At this stage, I explored with Jim how well he felt he fitted into the walking group and the bird-ringing group. Both had significantly enhanced his confidence in meeting new people. Through the bird-ringing work, Jim had found out about a job that seemed ideally suited to what he wanted to do. Although he lacked confidence around the interview, we explored what that lack of confidence was about. Using the PAC (Parent–Adult–Child) diagrams from Transactional Analysis, we explored where those doubts were coming from. We then looked at the situation from the **Adult** perspective, based on the here-and-now facts as Jim understood them. I am aware that this type of analysis can feel cognitive, rather than relational. However, this fits in well with Jim's creative-daydreamer process and his reliance on thought. Good point. Can you give a reference to back this up. My hope is that this will build skills in the processing of emotion.

Through this process Jim was able to identify which fears were based in the present moment and which stemmed from **scripts** (TA) or **introjects** (Gestalt). This exploration helped him ground himself, differentiate past from present, and recognise the resources he had available as an adult—resources that had not been available to him as a child.

Sessions 14-20

Jim came to his fourteenth session with the news that he had been offered a new job. It seemed a perfect fit for what he hoped to be doing. Even though this was excellent news, it was only after I expressed my excitement that he allowed himself a smile. It felt like it was not safe for Jim to express this emotion unless it had been 'allowed'. This felt like the description of projective identification found in Ogden (1979, pp. 357–358), where Jim projected their part that felt happiness onto me, as it did not feel safe to express it himself. This parallels the concept of *neuroception* as described by D. A. Dana & Porges (2018).Yes, good observation, well linked to theory. This kind of evidence of interaction gives a more 'alive' feel to the work.

Around this time, we had begun working with various mindfulness practices, drawing on Kabat-Zinn (2013). My intention in introducing this was to help Jim reconnect bodily sensation with emotional awareness. Over the following session, I guided Jim through a body scan and a mindful movement exercise. When we reviewed these practices, Jim noticed pervasive tension—he described himself as being tense "everywhere"—yet he also found that when he noticed sensations, they began to shift. I felt hopeful about this. When I asked about accompanying emotions, Jim often said he could not find any, and I felt frustrated. But I also knew this was like knocking on the trapdoor: from my own therapy I understood that reconnecting with emotion takes time—a lot of time. I think there is a bit of muddling of models here. You need first to reference 'trap door' to Paul Ware and also to clarify that you are now using the Personality adaptations model from TA rather than Greenberg's model.

Even though I tried not to, I suspect that I projected a negative Controlling Parent (CP-) stance towards Jim when he was unable to identify emotions. Reviewing this now, with a more developed sense of polyvagal theory, I notice tension in my own body. I worry that I may have transmitted this tension in the room and that Jim's *neuroception* (D. A. Dana & Porges, 2018) may have picked up on it. Good awareness and reflection.

At this stage, Jim also shifted his sessions to a fortnightly rhythm. He felt more able to cope, which was positive, but I felt a pang of frustration that just as Jim was gaining more capacity to engage with his anxiety, the frequency reduced. I wondered whether this was something it would be helpful to name explicitly in future sessions. How was this negotiated? You write about this change impersonally rather than as a result of a decision by one or both parties. I can see that you do discuss this later. Can you just reference that you do so here…

As the work continued, we explored how mindfulness was developing Jim's capacity to notice bodily states. He reported intermittent practice with body scans, which helped him identify sensations, although making meaning from those sensations still took time. Alongside this, we celebrated successes: improvements in communication with his partner—such as being able to say he needed time to think before responding—along with his reduced dose of sertraline, his progress toward employment, and his growing confidence in networking. Jim also brought his reactions to the recent Supreme Court decision on trans rights. He expressed sadness and anger, but also a growing wish to focus on what he *could* influence rather than what he could not change.

During this period, Jim also found himself looking after his husband during a walk when his husband became anxious. Jim noticed that his husband's anxiety brought out his own. We explored how Jim soothed himself, and the discomfort he felt when even subtle self-soothing was noticed by others. We also looked at communication patterns within the relationship, and I led Jim through a walking meditation, which he found grounding. I later recorded a version of this for him to use between sessions.

Jim also brought material about his anxiety when staying at his parents' home, which seemed linked to childhood experiences of tension and a felt sense of being required to stay present rather than retreating to his room. We explored strategies for coping with this. Such as ? I would like a greater sense of what happened in the room, rather than a description of what is going on for the client outside. Other themes during these weeks included

procrastination, difficulty prioritising tasks, and anxiety when he felt unable to plan a conversation—such as when he believed a neighbour might have taken in his bin.

By the eighteenth session, Jim had been on holiday to Sussex and had attended a trans weekend in Pembrokeshire. He said he felt tired. He also shared that he had restarted sertraline. He explained that when he had been off the medication, criticism would trigger a spiral that often resulted in him expressing anger towards the person who had criticised him. I explained that combining medication with talking therapy could be particularly helpful for this kind of work. reference needed for this opinion or is it your own, based in experience? If so, you need to own it as yours.We explored whether there were formative experiences that shaped his need for perfection or his sensitivity to criticism. Such as?Jim stated that growing up he “just got things right.”

By the nineteenth session, Jim had experienced another setback: a job offer had fallen through due to funding being cut. We explored anger—its presence, its inhibition, and its expression. Jim described how sertraline created more space before he moved into a spiral, giving him time to regulate. In the following session, we explored a “fire-fighter” part that suppressed anger. You are now using the language of Internal Family Systems which needs referencing, explaining and including in your theoretical overview at the beginning. Jim linked this part to an early experience: he had argued with a friend, been angry, and by the next day the conflict had passed and the friendship was intact. Together, we identified two parts —the anger part and the part that suppressed it—and we explored how the suppressing part believed it was protecting him. Can you also explore this in terms of theory addressed during the training eg you could name and discuss Avoidant attachment which involves avoiding emotion and contact with the self as well as with other people.

This work opened up further possibilities for exploring anger, self-protection, and the developmental roots of his fear of conflict.

Next Steps

As mentioned earlier, when we had reached twenty sessions when Jim, quite suddenly, stated that he wanted to move to fortnightly appointments. I feel this needs further exploration as it matches the pausing of therapy. This change to fortnightly was not a discussion but a simple statement delivered right at the end of a session. I felt frustrated. I believed there was still a great deal of therapeutic work to be done. The prescribed medication for anxiety and depression seemed to be working well enough that Jim was no longer overwhelmed by anxiety, and this appeared to give him a sense of being "OK." I felt deeply conflicted: from my perspective this felt like the perfect time to begin working more directly with emotion.Yes, I agree and I like that you bring your feelings in here. So can you say what you said to him about this and how the conversation developed?

At the same time, I was aware of the "trapdoor" quality that emotional work often holds for individuals with a schizoid process (Joines & Stewart, 2002). Yes, good and accurate. Jim felt "well enough" to reduce the frequency of our contact—meaning that he felt confident enough to step back. Another interpretation might be that I had begun to lose attunement, focusing too much on emotional exploration at a pace that felt overwhelming for him. Good catch as a possibility. It was entirely possible that Jim needed things to slow down and that fortnightly sessions were his way of creating that space for himself. I did take this to supervision at the time. My felt sense had been that we were at the perfect point to push deeper into emotional material; on reflection, I wonder whether that pace was more reflective of *my* readiness rather than his. Good question. I think your analysis here is very valid and I would just like a bit about how you explored it together.

Pausing therapy

At the twenty-seventh session, Jim again surprised me when he said he had nothing more to bring and that he would like to pause therapy. This came just as suddenly as his move to fortnightly sessions. Unprompted, Jim began to talk about what he felt he had achieved:

improved communication with his partner; greater ease in networking and meeting people; increasing awareness of his own feelings; and the sense of being “heard” rather than being taken through a scripted model. Much of his earlier therapy had been NHS-provided Cognitive Behavioural Therapy, during which he had felt that his therapist ignored all mentions of his trans experience—despite this being the dominant theme in his life at the time.

In terms of emotional contact, I was quietly delighted to hear that Jim **hated** his new job at the local supermarket strongly enough to quit. I found the moment oddly joyful: it was evidence that he could feel emotion and take action on it, even if that action was to walk away from something that felt wrong for him. Paradoxically, I had taken my perception of Jim’s lack of progress in getting in touch with his emotions to my supervisor and she had pointed out this exact moment where he clearly *was* in touch with his emotions.

Jim and I discussed the situation and agreed that this would be our last session for now. We also agreed to review things in two months. Jim made it clear that if he needed support before then, he could simply book a session. He also asked me to send an email after two months, and I readily agreed. This was an example of the ‘having the other initiate’ in the therapeutic relationship (Erskine, Moursund, & Trautmann, 2022, p. 143). Good

I explained that I would usually prepare more intentionally for endings. For long-term clients, I often bring a selection of seashells—a symbolic object that serves as a memento of their therapeutic achievement. I had some stress balls with me and asked whether Jim would like to choose one. He selected a green one. I saw this object as a transitional object as well as a reminder of what he had achieved. For clients who identify as neurodivergent, I make a point of saying that stimming in sessions is welcome—helpful for concentration, and a physical expression of unmasking. I hoped that the stress ball might continue to support Jim to “be himself.” Nice symbolic gesture, combining an offer from you and a choice by him and perhaps encapsulating the agreed hope that he would return.

We discussed what he would be taking forward from our work together. I told Jim that I had enjoyed working with him. When working with transitional objects (Winnicott, 1953), I also discuss what happens if the object is lost or damaged. My years as a parish priest taught me how distressing it can be when a cherished memento of a loved one is lost. In some ways, I may be trying to protect clients from that kind of anguish. Another part of me suspects this may also contain a hint of grandiosity: perhaps an unconscious desire for therapy—and therefore my role within it—to "matter." I feel the need to remain mindful of this, so as not to slip into rescuing or elevating the work beyond what is useful. Very good self-awareness

Jim's announcement caught me off guard. I experienced it as an ending. Even knowing he could return, I felt a wave of grief—after the session, I noticed tears welling in my eyes. In supervision, we examined whether I had agreed too quickly to pause the work. At the same time, working with Jim had involved supporting him to recognise and voice his own needs. Perhaps a particularly important moment of therapy was to hear him state those needs and to honour them—to let his inner child know that his wants, needs, feelings, and desires *matter*. Good consideration of both sides of the coin. Could you have discussed these issues overtly with him?

I also wondered whether I had worked too directly with emotion. In the later sessions Jim seemed more withdrawn. I questioned whether this was related to his SSRI medication, or whether I had spoken too frequently about emotions—directly approaching the "trapdoor" of emotions experienced by people with a creative-daydreamer process—it might have been more helpful to engage his problem-solving abilities. My hope is that, if Jim chooses to return, I will hold these reflections with greater gentleness and adjust the pace accordingly. Again, this is something that I have brought to supervision–which has helped me reflect on my shame process at 'not being good enough'. Could you have asked the client too – often we cannot simply know how a client experiences us or the work without checking in with them.

My learning from the client

In doing this work, I found myself repeatedly referring to my own process in therapy.

After Jim paused our work, I felt sad and cried. I had lost three long-term clients in a month, and although each ending had made sense, something about the cumulative effect struck me. Losing this client in particular touched something deeper. I took this to my own therapy that same day. It became an opportunity to look honestly at what I had lost. I was very clear that none of these clients were my friends—although I do have a tendency to become “pally” with some clients, this was not the case with Jim. Even so, the feeling of loss was real.

In the following week’s therapy session, I brought the depth of my reaction into the room. I had been unexpectedly impacted by a session with a new client who took the same time slot Jim had vacated. This new client was bringing grief, and the resonance with my own experience was powerful. Through this work with my therapist, I discovered that I have an early, largely unacknowledged childhood process around grief and endings. My experience of endings varies dramatically depending on their quality. My earliest significant loss was the death of my grandfather when I was about nine. I had not been allowed to see him before he died, nor to attend the funeral. That experience had a very different emotional tone to the later loss of my grandmother, whom I was able to hug goodbye, and my husband, whose sudden death I discovered without warning. The grief of losing a client sits in complex interplay with these earlier losses. Very good exploration of your process

My therapist and I explored what my sense of loss might be about. Was it that I had lost “people who needed me”? Had I lost the objects of my rescuing? While these questions were important, they did not feel true. In later reflection, I remembered my time as a parish priest. Early in my ministry, I had attempted to “convert” people—a strategy which invariably pushed them away. I reflect on that now as very ‘I-it’ (Buber, 2018). Later I discovered that simply living authentically, offering good experiences of contact, and being present as myself was far more powerful—paralleling Erskine et al. (1999). Perhaps another layer in this present ending with Jim was the feeling that he had not progressed as far as he “should”

have. In short-term work at New Pathways, endings happened on schedule, imposed by external constraints. I could be angry at the funders or the organisation; I could howl at the moon. But in longer-term work, endings are chosen. A client might run out of money, or find things too difficult, or decide that they have done enough for now. In this case, Jim decided he had reached a sufficient point in his journey. There was no target for my frustration. Jim felt he had done enough, and I—as the "all-knowing clinician"—felt he "needed" more. Rationally, I knew that this represented the client's autonomy, competence, and growth. The Adult part of me insisted that this was a healthy step. Another part kept reminding me that a good ending is important. I wondered whether it would have been in Jim's best interest to challenge him to stay longer, or whether it was more therapeutic to trust that he would return if and when it felt right. That same week, I also had the opportunity to take this process to supervision. My supervisor helped me examine this situation, to contact my feelings about it, and look at 'what was going on.' To have such a sudden ending raised in me a sense of failure. We were able to examine and confront that. At a further supervision we also looked at the possibility that Jim's schizoid process had down-played the impact that their leaving would have on me. They had completed their gestalt and were now slipping back into the shadows without being aware of the impact that might have on me.

Another part of me wondered whether this was Jim's way of ending without naming it—an indirect ending rather than a direct one. This brought up big questions for me: to what extent do I trust the client's Adult? What is it like when a client takes hold of their own process and makes an adult decision from an adult place? Was my unspoken wish for Jim to continue also a wish for them to remain in a more childlike position? I was reminded of returning home from university and hearing my mother say she could only remember me as a five-year-old. I remember how unseen I felt in that moment. I am determined not to perpetrate this "en-child-ment" onto my clients. The intricacies of these issues are very well discussed with a very good dose of self-awareness explored in both supervision and therapy.

It is my hope—and there is evidence for this—that Jim now carries an internalised experience of therapy in which they felt heard, seen, and met. At this moment of (possibly temporary) ending, I was reminded of the profound privilege of being invited to sit in a room with someone and explore the depth of their being—their fears, their shame, their triumphs—and to hold this with confidentiality. To write about it now feels exposing: it reaches into my own anxieties about competence, timing, attunement. The nagging thought that I did not get it quite right, or that I got it wrong, or that I missed something important. At the same time, Jim spoke clearly about the changes they had made. Hearing that is hard. Allowing myself to imagine that I may have been part of those changes feels humbling.

Writing about the ending now, I notice tears again. I wonder whether this is about a failure to be perfect, or the mourning of the death of my own “Be Perfect” driver (Stewart & Joines, 1987), which shapes my being so powerfully. Or perhaps it is about the loss of someone I cared about. Alongside that, I am aware that I also have a deep-rooted fear of success. For now, I will sit with these feelings and see what develops. This relationship with Jim has shaped me, just as I have shaped him. In many ways, this work appears to have fulfilled the eight relational needs described by Erskine et al. (1999).

What I have learnt from my own therapy is that, even when I feel “missed,” the conversation can still stimulate reflection and growth. Perhaps one of the hardest—and most important—lessons I learned from Jim is that the responsibility for change never lies with me as therapist; it belongs entirely to the client. Another learning is that, should Jim return, he will not be the person he was at the end of session twenty-seven. He will have changed, and so will I. There will be familiar elements, but also an opportunity for new and different contact.

An excellent discussion of the issues involved in ending, both in general and for this particular client and for you as a person and as a therapist

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