How to make therapy experiential when the client is far from the experiential level[1]

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Summary

A client is far from the experiential level when he is only describing happenings in the outside world, for example, or only keeps asking reassurance from the therapist, or wants the therapist in the position of leader. The client brings his[3] personality difficulties into the relationship with the therapist. We must get to know as good as possible the different non-experiential ways of being and speaking (blockages, stoppages, structure-bound experiencing) in therapy. In this presentation I want to examine the blockages at the relationship level. The main characteristic of these blockages is that the client is not reflective. And focusing requires first of all the ability to be reflective. We must get to know how to make the process experiential. The solution is not simply to offer focusing sessions, but to try to bring the client gradually closer to the reflective attitude, and from there to the experientially reflective attitude: the focusing attitude.

Also in this paper the idea is developed and demonstrated of how the therapist can bring in focusing in therapy not as one skill but as numerous subskills.

Introduction

Practice and research have shown **[2**[4]**]** that therapy is only effective when the experiential body is involved, this means when the body-as-it-feels-and-creates-meaning is involved (Gendlin, Beebe, Cassens, Klein & Oberlander, 1968; Hendricks, 2002). ***Therapy must be made experiential***[5]. If not, the client remains the same (Gendlin, 1978) or progresses only half a step on the experiencing scale (Klein, Mathieu, Gendlin and Kiesler, 1969). The client must be helped to come to and to work on his experiential level, on the higher stages of

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[3] 'His' can everywhere be substituted for 'her', 'he' for 'she', and 'him' for 'her'.

[4] See the powerpoint.

[5] One may say that a client is always on *an* experiential level. Also when he is at a low level of the experiencing scale; this is a level not high enough to be therapeutic; the client is in a structurebound experiencing mode. For the ease of the discussion here I call the therapeutic fruitful level experiential, and the low levels non-experiential.

the experiencing scale. But we will see that much finer distinctions may be made in the levels of low or high experiential functioning than those made by the experiencing scale.

Therapy needs the experiential body to 'come into therapy' (for an elaboration of this point, see Depestele, 2013), not the physiological body but the body-as-it-feels-and-creates-meaning[6]. The access road for the body to come into therapy is focusing. Focusing or the experiential reflective attitude is the attitude that invites the body to come into therapy. It is tuning oneself in to the bodily knowing of a problem and to the implied bodily knowing of the solution.

The deeper bodily knowing needs the reflecting I, the inner attention, so that this knowing becomes involved in the feeling process, in the experiencing. And it needs symbolization to progress[7]. The body is the first subject, the I is the second subject.

Usually one looks at focusing from the perspective of the inner attention and the symbolization, but we can look at focusing in another way, namely what is it that we want to bring in? We want to bring in the experiential body into the feeling process. So there are two things that meet each other; from 'above' the inner attention and symbolization, and from 'below' the body, i.e. the body-as-it-feels-and-creates-meaning.

Involving the experiential body doesn't come automatically, as research has shown (see a.o. Gendlin, Beebe, Cassens, Klein & Oberlander, 1968). ***The client must get help for that***. The client must get help to come and to work at the experiential level, he must get help to come to the higher stages of the experiencing scale. The usual client-centered therapy brings the client only half a step higher on this scale (Gendlin et al., 1968, pp. 225-226)[8].

[3] ***How can the therapist help the client with this***? How can the therapist help the client to involve 'this body' – i.e. the body-as-it-feels-and-creates-meaning – into his[9] therapy?

[redacted]

[6] A helpful distinction here is that made by Merleau-Ponty between the body-subject and the body-object (Depestele, 2013).

[7] Although direct reference is already a symbolization: the first formation (see Gendlin, 1962).

[8] The basic research that led to the discovery of focusing and the discovering of the necessity to integrate focusing into therapy is ignored in the client-centered community and literature. The research published by Gendlin, Beebe, Cassens, Klein & Oberlander (1968) is not included in the big research review of Greenberg, Elliott & Lietaer (1994). Also the research published by Rogers (Ed.) (1967) is not included in it. I had pointed out this omission in a letter when they prepared the 2004 edition of this work but again in the new edition (Elliott, Greenberg & Lietaer, 2004) they didn't include the 1968 article and they only mentioned the 1967 book.

Greenberg, L., R. Elliott & G. Lietaer (1994). Research on experiential psychotherapies. In A.E. Bergin & S.L. Garfield (eds.), Handbook of psychotherapy and behavior change. Fourth edition (pp. 509-539). New York: Wiley.

Elliott, R., L.S. Greenberg & G. Lietaer (2004). Research on experiential psychotherapies. In M.J. Lambert (Ed.), Bergin and Garfield's handbook of psychotherapy and behavior change. Fifth edition (pp. 439-539). New York: Wiley.

[9] 'His' can everywhere be substituted for 'her', 'he' for 'she', and 'him' for 'her'.

Helping the client to come to and to work on his experiential level means bringing focusing into therapy. But bringing focusing into therapy does not mean doing therapy with now and then a sequence of the six steps (Gendlin, 1977; 1996; 1997a). It means bringing in focusing as the numerous small 'actions toward one's inner life'. Focusing as many different small bits of this specific reflective act. An example of such a small bit is saying to the client 'wait here for some moments', 'feel this' (see excerpts from session below). It means making therapy experiential in nearly all, even the smallest reflections and suggestions.

If you can do the six steps in a therapy session or if you can do clearing a space in a therapy session, that is okay of course. But in doing that we try to cross big packs: the therapy pack with the focusing pack. And integrating big packs is much more difficult than bringing together small bits of the one (focusing) with small bits of the other (therapy[10]). So our point is: How to integrate small bits of focusing with small bits of therapy. We try to bring in focusing not as one big pack, not an one big skill, but as a whole cluster of many, many small subskills.

Therapy events occur on a very very small scale: a saying of the client, a response of the therapist, a sentence, a few words, one word, a handle, a silence, etc. Therapy is a matter of small things, of a few seconds even, a nuance. The experiencing asks for very precise, fine responses. Also therefore the importance of ***sub***skills: finely tuned suggestions.

Subskills

[4] We may define focusing as ***one thing***: spending some time with the unclear bodily sense of a situation. So defined focusing can be seen as one skill. Or we may see it as ***two things***: first letting form an unclear sense in the inner attention, and second letting it carry forward by symbolizing it. So focusing can be seen as two skills[11]. Or we may consider focusing as the numerous aspects of it: In fact the big access road by which we can invite the body to come in, is constituted by ***many small avenues***, each with a distinct character. In the focusing skill many subskills may be distinguished.

The following excerpts come from a session with a client who came in therapy because of chronic depressivity, started after he finished his PhD one year ago, and intensified after the birth of his son half a year ago. He came to Belgium six years ago for his PhD, and here he met his partner. In the previous sessions it became clear that he had difficulty to make the transition from his life in his native country to life in Belgium, and from the life as a student to the life of an autonomous person who is responsible for everything. At the end of

[redacted]

[10] See below: Finely differentiating the being non-experiential of the client.

[11] Of course they are not separate, they go together. But they can be distinguished: In *A Process Model* Gendlin (1997b) describes and analyzes in VIII-A.1 the process of *how to let form a felt sense* (with the famous Duncan example), and in VIII-A.2 the process of *how to help a felt sense open itself*.

the previous session he had said that his father died when he was 12 years, and he had added: "If he [his father] had lived a couple of years longer, then he could have taught me to make this transition [the transition from child to adult]; my father considered me still as a child". The sessions were fruitful. In this session he says that he has come to realize that he must make a transition, even with a transition ceremony: He will marry his partner within a couple of months.

In these excerpts I want to show some small bits of focusing, some small subskills that I bring in.

For example,

T **[5]** How do you see this transition?

C I must leave something: What is done, is done. And I don't look back. My student life is finished. The adventurous trip, which I have made to Belgium to make a dissertation, is finished. A month ago I still was between the two.

T *Try to **stay with that** image, with that sentence*, the sentence 'the adventurous trip is finished'.

The suggestion 'try to stay with' is a small focusing suggestion. It is not the whole focusing, it is only one element of the whole bunch of numerous possible different suggestions which together constitute the whole focusing set. It is that element which is the most useful here. But the suggestion comes up spontaneously in the therapist.

Example of a different aspect (session continues)

C **[6]** As a student much is done for you, predetermined by the university, by the promotor, and so on. This is different now. Now *I* have to decide about everything. There is no longer a promotor.

T There is no father any more.

C (…) [C is telling some things but I want him to feel it]

T ***How does it feel when** I say this*?

Example of still another kind of focusing suggestion (session continues)

C **[7]** It is the same as saying: My student life is finished. I decide on myself. Now I decide myself in my life, without looking if somewhere there will be a father.

T *Stay with this sentence, slowly, **don't go too fast**, take some time.*

Some more aspects (session continues)

C **[8]** I always search for confirmation. I also did it with the promotor. Now there is nobody there. *I* have to decide[12].

[12] I underline the sentences that seem to be experientially loaded.

T *Try to **pause** and **give this sentence a moment thought***[13] [This may seem an interruption but it tries to *be with* the client in a deeper way, and to help the client to *be with* himself in a deeper way. A subskill can be brought in seamless, in response to what the deeper process needs].

C **[9]** That is something I have to learn. It is standing on an unstable, trembling ground. But there is no other way. The other way I had [in his depressive episode] was: Closing off myself, because after all there is nobody. There is nobody and you have to accept it.

T (This again is a sentence that carries much experiential load, and therefore I invite him again:) ***stay** with the sentence, and **feel it** for a moment. **Wait** for **what may come inside**, be **patient*** [these are five different facets of 'going inside': stay with, feel it, wait, for what may come, patient: five different things, in fact five subskills].

C **[10]** (Silence). Scary … jumping into deep water is the only way to learn to swim. It is not scary … but more 'I don't know what will be there. A big unknown'.

All these **[11]** suggestions are attempts to make connection with the body, to bring the body into the process; otherwise the client may be merely talking, or the talking may be merely cognitive, for example; and this does not result in change. To bring the body into the process is to make the body a close companion of the client's talking and expressing. 'The body' means (as we have already said): this specific body, the knowing body, the process body (i.e. there is a forward tendency in it), the body-subject, the body-as-it-feels-and-creates-meaning.

In these excerpts you see how the therapist can make focusing suggestions[14] – which are small bits of focusing - in a regular therapy session.

Before I say more about these subskills, first let us look at a difference in the kind of interventions in experiential therapy **[12]**. The therapist can give a content reflection (this is well known): Content reflections help to *express* the experiential datum[15]. And he can give a focusing suggestion[16]. Focusing suggestions help the client to *form* an experiential datum or help the client's inner attention to *symbolize* an experiential datum[17].

Example of a content reflection **[13]**.

[13] (1) It is not just pausing (interrupting just for a moment) but also giving this sentence a moment thought.

(2) Another suggestion could be to repeat this sentence slowly. But it may seem a bit weird to do this in a therapy session. We can do this when we teach focusing, but not so easily in therapy.

[14] See below: Difference between *content reflection* and *focusing suggestion*.

[15] Although, strictly speaking, expressing an experiential datum is a further forming of it. Also in other words we can say: Forming an experiential datum is an implicit symbolization (direct referent: Gendlin, 1962; 1997b, Ch. VIII). Expressing an experiential datum is an explicit symbolization.

[16] This is a correction of the concept 'forming reflection' developed in Depestele (2012).

[17] This is not the same as a content reflection, where the therapist himself - and not the client's inner attention - symbolizes or tries to symbolize the content.

C "He lets me wait such a long time for what must come from him. It must come from him. For him it must be: I determine. I may not make a proposal myself, I may not ask for it. And when I don't react anymore and think 'I've had enough', then he comes with it".

T "As if first you have to surrender"

C "Ha! Constantly that power game". The word 'surrender' clearly fits for the client. She becomes silent. It's visible from her bodily reaction that she gets a shift and an insight. At the end of the session she comes back to that word - 'surrender' - and describes it as a clear shift. And she says: "I had experienced it that way, but I did not have that word yet".

This example shows the mere wording of an experiential content. Here the therapist's words 'come in' and express the experiencing of the client. If, on the other hand, the therapist gives a suggestion that invites and helps the client's inner attention *to let form an experiential datum* or *to symbolize it*, than we can call this a focusing suggestion.

So, the being oriented of the therapist can be specified. The therapist is oriented to the client's content and reflects it (mere work with client's content). Or the therapist mainly is oriented to the client's connecting with his experiential level, which means that he *helps the client's inner attention* to let form an experiential datum and to symbolize it (work with client's connecting and with client's content).

In the focusing skill many subskills may be distinguished

Now let us come back to the subskills. As is said above, the inner act of focusing – the big avenue by which the body can come to create the experiential process – can be seen as constituted by many small avenues, each with a distinct character. The inner act of focusing consists of numerous inner subacts. In other terms: In the focusing skill many subskills may be distinguished, which each of them can be brought in in therapy. How many subskills can we differentiate? ***The more we can, the more finely the focusing 'instrument' may be 'used'***.

In the presentation of the following survey we start with a distinction into three, at a deeper level we find some subdivisions, at one more level deeper we see that each of these subdivisions appear to contain several deeper subdivisions, and at the final level the whole arrangement shows numerous subskills.

At the most general level the focusing skill may be divided in:

1. Bringing oneself to focusing
2. Your body as it feels a situation: How to help a felt sense to form itself?
3. Your body as it wants to take a step: How to help a felt sense to open itself?

You see: three subskills: How to let form a felt sense? How to let open a felt sense? And a preparation phase.

At one level deeper we see that these three subskills appear to be three *groups* of skills:

1. Bringing oneself to focusing
   1.1. Learning to make for oneself the opportunity for coming to focusing
   1.2. Creating a good 'environment'
2. Your body as it feels a situation: How to help a felt sense to form itself?
   2.1. The crucial pause, the crucial breaking
   2.2. We can always start focusing in two ways: starting from the body or from the situation
   2.3. 'Choosing' the focal point
   2.4. Inviting attention: The specific bodily way to be with the situation with my attention
   2.5. The specific inner attention must be sufficiently long
   2.6 Finding the right distance
   2.7. Presencing attention (the pure being-with; presence)
   2.8. Central characteristics of a felt sense
3. Your body as it wants to take a step: How to help a felt sense to open itself?
   3.1 If you stay with 'it', then it will possibly take a step from itself
   3.2 Try to get deeper, try to get at how the situation effects something in you
   3.3. Handle: Asking for the core
   3.4 Resonate
   3.5. Deepening questions
   3.6. Receive and protect

At one more level deeper what can we find? Let us take the skill '2.4. Inviting attention: The specific bodily way to be with the situation with my attention'. This appears to contain more subaspects:

   2.4.1. The quickest way: "Does I feel totally okay with this situation?"
   2.4.2. Inner focusing attention is friendly, receptive, and without comment
   2.4.3. The trainee learns to avoid the non-focusing way of going inside
   2.4.4. Learning to distinguish a felt sense from what is not a felt sense
   2.4.5. What to do when the usual manner to let form a felt sense doesn't succeed?

And, in this, when we look closer at 2.4.2 and ask *what we can see more in* 'Inner focusing attention is friendly, receptive, and without comment', then we get a list of more specified subskills:

- You[18] let it happen that something affects you. ***You let come the being-affected*** **(SS 36)** (SS = subskill). You must feel 'it': 'Something' is there. You feel that you don't feel bodily okay when you think of the situation: There is something, you feel it physically and you don't have words for it at all. And if there are immediate words you let them go by. ***Not analyzing 'it', not describing, not judging, not doing anything with 'it'*** **(SS 37)**, just staying with the bodily-not-okay-feeling[19].
- Letting come the being affected, may be difficult. And the result of it may be that one does not begin to focus (see the problems with solofocusing: 1.1.3.).
- Because at first the being affected may be vague, one easily passes by it. One thing to learn is ***that 'it' may be inconspicuous or may begin inconspicuously; you can barely see it, it is something at the periphery of your experiencing*** **(SS 38)**. It is important to learn to be aware of this and to go back to it when something seemingly insignificant had just surfaced for a moment, also when you think at first that it isn't important.
- Self-in-presence is a quality of the I, a quality of *being-with*, which is such (1) that a felt sense may form itself, (2) that later (see 2.7.2.) the focuser can be with the felt sense purely, without words, in silence, and (3) that still later the focuser can be with the felt sense with questions and reflections (see 3.5.2.). Here it is a being-with in such a way that an 'it' may form itself:
  - your body knows how it can create this 'environment';
  - it is ***a being-with without compelling expectancy, without agenda, without that it must come, without that it has to be such and such*** **(SS 39**; SS 39 differs from SS 37 in that it specifies more the right attitude); the felt sense may want something, but the I not;
  - not only this step but the whole focusing 'route' asks for patience; trying out all these things asks for patience;
  - self-in-presence language: For example, ***instead of 'I am so shocked'*** **→ I** ***feel/notice/am aware of/am sensing …*** **something** ***in me that is so shocked*** **(SS 40)**. In this formulation I don't coincide with it, I dis-identify from it, *I* can have a relationship with this *something*, inside me I enter into a relationship with it (see also 2.6.1.).
  - ***in this way the 'I' can be a stable pole*** **(SS 41)**.
    * the 'I' won't be blown away by what comes;
    * this is the holding side (the 'I' keeps the space open), and the deliberate side;

[18] A subskill may be offered in the form of a suggestion.

[19] These subskills (distilled from the skill '2.4.2') may be brought in at some subtle moment in the session. So, for example, the therapist may say, when the wording of the client implies it specifically: "Let come the being affected"; or: "Don't analyze it".

* the ‘I’ finds for itself the inner space that does not take side between contradictory tendencies;
* the ‘I’ sets boundaries: When the inner critic arises, its influence over the ‘it’ is kept off but also the critic is not sent away. The ‘I’ can say: “I am here, speak to me”. Saying ‘I am here, speak to me’ may also be a relief and may be accompanied by a feeling of standing up firmly and not budging for the violence of the inner critic.

At this level of differentiation we see different subskills. One of them is SS 38: One thing to learn is that ‘it’ may be inconspicuous or may begin inconspicuously, you can barely see it, it is something at the periphery of your experiencing (SS 38)**.** It is important for the client to have experienced that ‘it’ may be inconspicuous. It is a skill to know experientially. It is something the therapist may bring in, at a point in the session where he feels it applies. It is something the client can learn at this point of his process-development in the session, and can take with him as a new general learning that he can use later, also outside the sessions and outside the therapy situation.

In this arrangement of the subskills we try to understand and to put them in a systematic order: Not only differentiating them but also seeing them in their coherence. And you see when you go deeper and deeper more and more skills come into view, are specified. More and more experiential knowings, very very small skills that as a therapist you may bring in – in the way I did in the session I have shown you. Very small skills that you may bring in *as a being-with* the sayings of the client, at the level of the real meaningful exchanges (see my example). As I said therapy occurs in very very small events, exchanges.

You see the big access road by which we can invite the body to come in, is constituted by *many small avenues,* ***each with a distinct character***. In focusing we have a powerful tool to help the client to acquire and to use many small subtle inner acts to bring the body into therapy, to be with the body, and to let the body develop its implicit meanings.

So far this long introduction (1) about the necessity to make therapy experiential, and (2) about the preparation of the general focusing skill into subskills in order to make it available on a micro-scale for integration in therapy sessions.

Let’s go back to the excerpts one more time **[14]**. When we look at these excerpts and the small focusing suggestions of the therapist, what do we see? Using focusing subskills in therapy does not mean using small techniques[20]. ***When the therapist suggests, for example,***

[20] Compare Gendlin (1996): “Skills for relating are not artificial” (pp. 8-9 from unpublished manuscript ‘Fitting in, pouring out, and relating’. Available at http://www.focusingresources.com/_private_/reading_pdf/Fitting-In2.pdf (originally this text is part of a booklet ‘Focusing partnerships’: chapter 5). This may help to understand that using these subskills in therapy does not mean using small techniques. These small bits of focusing are so well known by the

'try to pause' or 'wait for' then - in suggesting this subskill - the therapist is together with the client oriented towards an experiential referent or to what may become an experiential referent within the client's inner attention. So in our experiential therapy the therapist is not only with the content and the development of the content the client is exploring (empathy), but he is also with the manner in which the client tries to cope with his feeling life and he offers help to ameliorate this coping process. And also *this* is a being-with, in fact more being-with than just being with the client's content. It is a being with how the client can be with himself. So that after the therapy the client may continue this coping in an autonomous way, independent of the therapîst.

Clients differ in the degree that access to the body is possible

[15] With the client of the excerpt making the session experiential is relatively easy, because this client has a relatively easy or free access to his experiencing and is not impeded. Also in this group (group I: see below) is the client who has the ability to be experiential reflective, but who does not do it for some reason. The client is relatively close to his being experiential but he needs help to be and to work fully experiential.

Another client may have more difficulty: He is reflective, he tries to work inside and to search for wordings for his experiencing, but this pure, free contact with his experiencing is impeded or opposed. He says for example: "I must be able to accept that". Or he succeeds to access his experiencing and to say something from there but very quickly this experiential expressing is opposed by the inner critic. He has brief moments of experiential contact with himself but cannot hold it because of an inner urge – the inner critic, in this case - coming up (Depestele, 2009).

And with still another client this reflective work is not or not yet possible, at least temporarily (see further).

We must get to know as good as possible the different ways of non-experiential being and speaking - blockages, stoppages, structure-bound experiencing (Gendlin, 1964) - in therapy, and the different degrees of being non-experiential.

It is necessary to *differentiate further and very finely the big packs of being non-experiential* of the client. Kinds of being non-experiential are, for example, the client who suppresses what he is experiencing, or who is interrupted by the inner critic. Or the client who is somatizing, giving descriptions, searching for causes, rationalizing, etc. Or the client who keeps asking reassurance from the therapist. In all these cases the blockage is not one single

therapist that they are implicitly functioning and come spontaneously in the therapist's interacting with the client.

thing; it consists of several small blockages, which each will ask a different intervening of the therapist (Depestele, 2005).

Three groups [16]

So, from practice I think we can distinguish three groups of problems when we try to make therapy experiential (see also Depestele, 2012; with many examples).

(1) Some clients, or some sessions, or some parts of sessions occur close to the experiential level. This means that some clients may have a relatively easy access to the body (S2b in the scheme of therapeutic spaces: Depestele, 2004).
(2) There are clients for whom 'the body' is accessible with difficulty (S2a).
(3) And there are clients for whom the level of experiential reflecting – another word for being in the focusing attitude during the session – or the level of feeling meaning in a bodily way, is not accessible, at least temporarily (S1).

How can the therapist help the client in these three kinds of situations? Each needs specific help:

(1) The first group: see the excerpts above for examples of help. These clients can be brought ***in*** the experiential level.
(2) The second group: these clients try to be reflective but have no free access to their experiencing. First they need help ***to free*** the experiential level.
(3) The third group will be of helping clients who are far from the experiential level to come bit by bit closer ***in the direction of*** the experiential level.

Group I

[17] The main characteristic of the client in group I is that he is ***more or less freely reflective but he is not inclined really to come close to the body***. The client has the ability to be experiential reflective, but does not do it for some reason.

The client is relatively close to his being experiential but he needs help to be and to work fully experiential. The example above is from a client who can be brought easily to the experiential level.

For many other examples of this group, see Depestele (2012)[21].

[21] Group I in this paper corresponds with the 'third group of examples' in my 2012 paper. Group II corresponds with the 'second group of examples', and group III with the 'first group of examples' in the 2012 paper.

Group II

[18] The main characteristic of the second group is that the client ***heads himself off on his way to the experiential level***. I am tempted to write: When the client comes into the reflective mode he spontaneously wants to go to the free experiential feeling and speaking, but an urge interferes. For example, a client says: "I must be able to accept that". It is as if he feels 'that' for a split second but immediately forces something on it. The client is no longer freely reflective (in contrast with the client from group I). He becomes occupied by the urge. Here it is an urge to demand oneself for something. It may also be an inner critic or an urge to reassure oneself[22], and so on (Depestele, 2009).

So this client can come to the experiential level, but some inner urge pulls him away from it. He tries to be reflective but has no free access to his experiencing. The client from group II is not like the client of group III (see below): He is not oriented to the therapist for a solution but to himself, and he has brief moments of experiential contact with himself but cannot hold it because of an inner urge coming up.

Let us now discuss (a) the example where the client demands himself for something and (b) the example where the inner critic interferes[23].

(a) For example the client says: "*I must* be able to accept that". She tries to manipulate aspects of her experiencing, or we can say: An occupying urge forces her to manipulate her experiencing. The sentence is a prototypical example of what happens in these moments of a therapy: Unfree reflecting (Depestele, 2004; 2005).

The sentence comes in the following context **[19]**: "The client's daughter leaves for Paris for three months, and the daughter had not been willing to spend her last evening with the client. This was so painful for the client that she took pills, drank, and then went for a drive in her car. Nevertheless, in the session, she demands of herself: "I must be able to accept that" — and she does not attend to the other side of her experiencing, where she would feel the pain of that. Somehow she blocks herself" (Depestele, 2009, p. 96).

Let us look at the sentence **[20]**. In all this work I have learned to appreciate the value of single sentences. What is happening there? When somebody says such a sentence what is happening to/in this person? This is the very first question. It is a sentence that occurs while the client is in the reflective mode. The sentence occurs in the first place in relating to oneself not in relating to the therapist.

We must look at sentences and study them, make an analysis of them, not a linguistic analysis but an experiential analysis. What does the sentence say about the coping of the

[illegible]

[22] For example finding reassurance by thinking things over and over again (obsessive thoughts) or by compulsions.

[23] Also see examples in Depestele (2009: the examples in that article are also examples of group II) and in Depestele (2012).

client with herself? What is *the experientiality* of the sentence? These questions are not just theory. Really hearing and listening to the sentence is a moment of contact with the client; it is a wanting to understand the client as precise as possible. The wanting to connect to 'the person in there' is a continuously going on; it is implicit background throughout the sessions. Hearing and listening to the sentence occurs in a specific contact with the client and with the client's feeling, in an intensive contact looking for carrying forward this feeling moment of the client.

The next question is: How can we intervene in experientializing way? How can the therapist meet the client deeper, and chiefly how can the therapist help the client to meet herself deeper, continuing from a sentence like 'I must be able to accept *that*'?

Because in saying this the client leaves herself in the lurch, leaves herself alone, takes distance from herself. By the way we also see this in the sentence structure. The sentence has three possible *experiential parts*: 'I must', 'able to accept', and '*that*' (below: I, II, and III). The last one, *that*, contains the core experiential load. Before coming to *that* there are hindrances.

It requires specific activities from the therapist **[21]** to help the client to work through these inner hindrances. The following are *possible* reflections or interventions. They may come in an order following the progress of the client's process. But of course they are left when the responses of the client take another direction. So we follow the three parts of the sentence. To the first part (I) the therapist may respond:

I (1) "Okay, you feel <u>you must</u> be able to accept *that*".

Then a possible passage to II:

(2) "Other than this demand what all does *that* evoke in you? What more does *that* effect in you?"

II (3) "Next to that part, you might make a space inside yourself for the fact that it is <u>difficult to accept</u> *that.* Can you make a space for these feelings?"[24]

Possible passage to III: **[22]**

(4) "Now that it seems less difficult, can you try to look *in the direction of* the other side, in the direction of *that*, where the most pain is?"

(III) (5) "If possible can you make a space inside yourself for <u>the whole painful *that*</u>?"

(6) "Can you ask inside: What does it really mean to me that my daughter has not been willing to spend that last evening with me? In which various ways did it affect me?

(7) "Can you stay with the *that*, and ask the question 'what all is in the *that*, in that pain?"

You see what becomes possible when we can develop focusing oriented questions that gradually unfold the different experiential layers stored away in the original sentence. We

[24] "By doing so the usual self becomes free somewhat, makes a free space for the other self, and the other self can speak" (Depestele, 2009, p. 97).

help the client to make a space for the subelements of the avoided experiencing, and this occurs in the order that they become available.

This is a possible route for an unfolding of the whole experiencing which the sentence points to. We see also that the route has layers, just like we outlined for the psychosomatic client (see below). But when we compare, the layers under the psychosomatic experience seem to be at a macro level, while the layers under the sentence experience are at a micro level!

(b) Now let us look at other examples where the client tries to cope with his experiencing but is not (yet) able to do that in a free way. This speaking is thwarted, for example, by the inner critic/critical voice[25]. A woman in a certain passage of the session suppresses nearly every sentence that comes from the experiential level with a *critical judgment*. The client is reflective, she tries to work inside and to search for wordings for her experiencing, but this pure, free contact with her experiencing is impeded or opposed[26].

How can the therapist be helpful? With a client **[23]** who struggles in the session with the comments of the inner critic, often I propose to take a piece of paper, and to divide it in two parts. The right half is entitled 'CV' (*c*ritical *v*oice), and the left half (the nearest one for a right-handed client) is entitled 'E' (*e*xperiential aspect; *e*go: I). First I invite the client to write down on the right half the comments of the inner critic. This is making a *space for the inner critic*. Then we go to the left half. I invite the client to ask inside: "Apart from what the critical voice thinks and says about the situation, what do I myself feel about the situation? Let the comments of the critic aside, push them back there if necessary, keep them outside, and make a free space for yourself, here at this left half, to feel free about the situation, and to allow your personal meanings about the situation to come. Write them down. Try to stay in this half as long as possible, and to let come as much aspects and meanings as possible". This is making a *free space for 'e'*, a free space for the own experiential aspects.

Group III

Introduction to group III

Let us look at the third group which is known least of all, namely the group with the client who is far from his experiential functioning. I know this group well because I try to

[illegible]

[25] Therapy also is feeling as exactly as possible how we (client and therapist) for the moment cannot get to the client's experiential level, how you as therapist cannot bring in a subskill at a certain passage. Feeling this is a work of the therapist alone. The therapist immediately feels when the client interrupts himself, even before the client is aware of it.

[26] A client may bring his personality difficulties into the relationship with the therapist (see also Gendlin, 1968, p. 209), but he may also bring his personality difficulties in the relationship with himself.

offer therapy to every client who is referred to me by the family doctor, also the client who is not familiar with psychotherapy. I offer individual psychotherapy, as a psychiatrist, with outpatients. I see each client in sessions of 45 minutes. When they start therapy many of them are functioning far from their experiencing. Some of these clients expect a purely medical approach to their complaints. Sometimes they need much help to find the avenue to experiential functioning.

Let us look at the kind of obstacles these clients find themselves involved in when they come in a psychotherapeutic setting, the setting that highlights[27] their obstacles (Depestele, 2005).

You will see: these are all different ways of structureboundness (also group II; and group I also in some sense: further study is necessary here).

Main characteristic of group III **[24]**

Knowing what to do to make therapy experiential is the aim. Getting a better knowledge about non-experiential ways of being and functioning is part of the work to achieve this aim.

It is necessary to *differentiate very finely the being non-experiential* of the clients in this group. As is already said above kinds of being non-experiential here are, for example, somatizing, giving descriptions, searching for causes, rationalizing, etc.; or the client who keeps asking reassurance from the therapist.

The main characteristic of this kind of being non-experiential is: ***The client doesn't become reflective, let alone experientially reflective***. The client remains in the relationship space[28] (S1) and doesn't come to reflection. He doesn't attain the reflection space (S2) (Depestele, 2004).

For example, the client wants reassurance from the therapist on some point, and he insists. He cannot step back and look at his pattern. He is not able to reflect on it, in contrast with the client from group II. The client is so occupied by the urge to get reassurance that he *becomes* and *is* the urge; he *is* his personality difficulty. It is a being, not a being-with (Depestele, 2009, p. 102). He is not free. He is not able to 'look at' his patterns (see also below: Therapy for transference urges). He is not able to stop asking the therapist and to feel deeper into the being not-reassured.

[27] If the therapist gives in to the clients structurebound tendency to ask for a medical approach, then the possibility that the setting may highlight the (different layers of the) obstacle is lost, and a possible entrance to psychotherapeutic work is lost.

[28] We situate the origin of a symptom at the level of the reflective space (see Depestele, 2009, p. 97) but because the client doesn't find a solution there, he backs away to the relationship space where he tries to get a solution from the outside world (see below).

You see this group of being non-experiential will show its difficulties in the relationship between client and therapist, in the relationship space. While the client from group II will show his difficulties in the relationship with himself, the reflection space.

By the way, the fine differentiating of ways of being non-experiential helps therapists to learn to be attentive to them, in order to be able to know and to feel and to understand exactly and to be empathic for where the client *is* now, for the exact spot/point of the client's current being non-experiential (or experientially blocked). It is also a tool that can be used in the training of therapists.

A) Manners of being non-experiential in the relationship space (S1)

What follows are some general descriptions of manners of not being experiential in the relationship space[29] (S1).

As a provisional survey in the relationship space we distinguish four groups of being non-experiential in therapeutic sessions (but they can be distinguished further and more finely).

Overview **[25]**:

1 the client has difficulty to start speaking or to continue speaking

2 the client is only talking about happenings in the outside world

3 the client is describing

- describing complaints (over and over)
- talking about

4 the client does something with the relationship with the therapist (transference)

First I want to describe the difficulties briefly, and thereafter I will show what the therapist can do.

1 The client has **difficulty to *start* speaking or to *continue* speaking**

1.1 A client may remain silent at the start of a therapy. The first thing therapy needs if it wants to become experiential, is that *the client speaks of his own accord* (see also the notion self-movement – 'zelfbeweging' - Depestele, 2000). Often, when a first sentence is said the next one may follow more easily. When we invite the client to say something we help him to make a first step *in the direction of* the experiential level, even when he is still far from it.

[29] Also in the reflection space (S2) some clients may have problems to remain being experiential: see group II.

1.2 A client may speak for a while, and then become silent (again). A silence may last a long time. It seems to be difficult to start speaking again from the silence. Also he doesn't seem to be with something inwardly.

1.3 Another example of a client who doesn't 'enter the therapy' (immediately) is someone who says after two or three sessions: "*I have already told everything*. What can I say more here? I think that next time I will say the same thing".

2 If the client has started speaking (see 1.1), there are many other ways for him to *not come to an own, genuine speaking* and thus to avoid the reflective attitude in another way. So this client is not silent. He is speaking but he is **only talking about *happenings in the outside world***, not about the own person (see below: scheme psychosomatic client).

3 The client is merely describing

3.1 The client is describing his complaints

[26] For example, a client with somatizations may talk about the somatic complaints repeatedly (see also below: The first stages in the scheme of the psychosomatic client). He is not even speaking about himself, let alone from himself.

Some clients begin the session in this way but after some time and with some help of the therapist[30] they come to a reflective speaking (own person, involved in situations, etc).

But with some clients these descriptions have the characteristics of findings or conclusions ('vaststellingen'). In Dutch 'iets vaststellen' literally means 'to fix something'. This is the opposite of change.

3.2 Talking about

What we are showing here are examples of a general problem in therapy (in S1), namely the client is ***talking about*** instead of speaking. He is talking *about* his state or his condition or about himself; the client is discussing, considering the matter; he is not speaking (real speaking is genuinely saying things from oneself). In Dutch we can indicate it succinctly as the distinction between 'spreken' and 'be-spreken' (speak and speak about; the prefix be- is linked with 'about'), in German between 'sprechen' and 'be-sprechen', in Spanish between 'hablar' and 'hablar de'.

These clients are ***objectiving*** their problems, while for therapy we need subjectifying (see above: The distinction between body-object and body-subject).

[30] Exceptionally a client may start the session in this way and after some time come *on his own* to a reflective speaking.

Sometimes a client even wants to debate the matter with 'the doctor'. He wants to make the psychiatrist to a purely medical doctor, a neurologist. It may be associated with transference (see further): Putting the therapist in a certain position, e.g. the position of 'he who will take away the problem'.

In all this the complaint is objectified and considered as an entity: The client speaks about his difficulties[31] as an entity, an illness, an ailment (for example, fatigue; shakes). For example, the client says: "Doctor, I have borderline"; you see how far such a client is withdrawn from his own person (the problem is put outside his person, outside his self), and how far he is from the experiential level.

These clients are oriented to their body-as-object. They are far from their body-as-subject, their body-as-knowing-subject, their body-subject-as-it-feels-and-creates-meaning.

3.3 Asking for an external solution

They **[27]** want 'their problem' - that 'object' - to be removed, to get rid of it. Thus they are **asking** the doctor to remove it, to *give* the solution (advice) or to *be* the solution (transference). So, another way of avoiding reflective speaking is *asking questions* of the therapist[32]. These clients are oriented to the external world for a solution, and not to their inner world. They are not reflective, not engaging their person, and not 'asking' their own bodily knowing to develop its own resolving steps. They are asking externally, not internally.

The client wants that a solution comes from the outside. Another client asks an explanation about 'his problem', his 'disorder'. Sometimes he only wants an advice. Or he wants to be said what he must do. Or he wants a pill that takes away the shakes (and thereby skipping the 'entrance' and the road to the experiential level that can 'resolve' the shakes in a good manner).

Another way of asking is the client who stops speaking and *looks at the therapist* for the continuation. The client stops talking and keeps looking at the therapist, with the message 'do you want to take over?' So looking as an indirect asking. The client desires that the therapist takes over because it's difficult for him to come to an own speaking.

So there is a whole attitude of being far from the experiential level. This whole attitude needs to be changed for a psychotherapy being effective; this may require many subsequent interventions from the therapist (see below: Example psychosomatic client).

4 The client does something with the relationship with the therapist (transference)

Asking may be asking for reassurance; and the client may keep doing it. Sometimes a client explicitly says that he *expects guidance from the therapist*, in the sense that the therapist

[31] Indirect addressing (Depestele, 2006, p. 60). All the examples of group III belong to S1 (space 1) of the scheme of spaces (Depestele, 2004).
[32] Direct addressing (Depestele, 2006, p. 60).

says what the client should do or should not do to become better; he wants to get the therapist in the position of a leader. These are simple examples of transference. For a long time a client can try to make the therapist into the leader, but also the client can try to make the therapist into many *other kinds of transference figures*.

This means the client wants to find a solution in the relationship space (S1) instead of the reflection space (S2) (Depestele, 2004).

B) How to deal with these difficulties therapeutically?

These are different ways of non-experiential being and speaking (blockages, stoppages, structure-bound experiencing) in the relationship space. ***How can the therapist help*** these client to move gradually – with small steps - in the direction of the experiential level?

There is a difference with helping group I and with helping group II.

In group I we have seen examples of intervening when the client is in the neighbourhood of the experiential level but does not find the way to it. This client is ***close*** to the experiential level, and can relatively easily be brought to it.

In group II we have seen examples where the client is closer to the experiential level than the client of group III: The client tries to be reflective but has no free access to his experiencing; this client is not oriented to the therapist for a solution but to himself and he has ***brief moments of experiential contact*** with himself but cannot hold it because of an inner urge coming up. This client can come to the experiential level, but some inner blockage pulls him away from it. The therapist helps to dismantle these inner blockages.

The client in group III ***does not know*** the experiential-reflective avenue to his inner life; he is far from the experiential level; we will need to help him to come bit by bit closer *in the direction of* it.

B1) The scheme of the psychosomatic client

A client in a therapy session may be close to the experiential level, or he may be far from it. Let us look at the example of a psychosomatic client **[28]**. Let us look at the different possible kinds of hindrances that may be met subsequently in therapy sessions with this client. At the same time one can read them as subsequent steps that may be taken if we want to come to fruitful therapy sessions.

"At the start of the therapy such a client typically speaks about his ***uncomfortable body sensations***. It is a 'speaking about'; it is not even about feelings, let alone from feelings. The client doesn't involve his person and his situations in what he says.

This client makes a little progress when he talks not only about his body but also

about the ***outside world***. It is still an 'about', but the client's scope is broader: He involves the world in it. Later on, he will talk about ***his*** outside world. This means that the client is now able to talk about his situation, and that he already involves his person in his talking, but it is still a speaking about and an externalizing.

The next step might be that this client begins to speak about his ***position*** in his situations. Here he is already reflecting; he realizes that a situation affects him, and that he can have an effect on a situation. The client's attention goes in the direction of his being affected.

It is a big step further - and closer to himself - when the client no longer speaks about his position but ***from*** it: He is able to speak from what he feels about his situation (S2b). Very likely the client will first bring ***emotions*** here, for example being angry; he can feel and express his anger. But after that the client may be able to make contact with personal meanings; he can catch more precisely ***that about which*** he feels angry, the precise nuances of the situation which makes him angry, and feel them in a bodily meaningful way. The client can put some of this into words, but for other aspects he has to wait because they are unclear. He has to wait and to let a ***felt sense*** form, and to let this unclearness exist, this unease, this whole set of implicitly felt nuances (S3). Now the client is focusing, attending to a felt sense, which is a cluster of felt meanings. After some more inner work, he can ***symbolize*** these implicit meanings (S4)" (according Depestele, 2005, p. 49).

Schematically:

1 C typically speaks about his ***uncomfortable body sensations*** (S1[33])

↓

2 " also about ***the outside world*** (scope broader; involves the world)

↓

3 " about ***his*** outside world (his situation, and his person)

↓

4 " **about *his position*** in his situations (S2a)

↓

5 C no longer speaks about but ***from*** his position (S2b)

↓

6 C may first bring ***emotions***, e.g. anger

↓

7 C reflects on and speaks from ***that about which*** he feels e.g. angry

↓

8 C can wait and let form a ***felt sense***, and let exist it (S3)

↓

9 C can ***symbolize*** the implied meanings (S4)

[33] See the scheme of therapeutic spaces (Depestele, 2004).

What a big difference between level 1 and level 9 where the client speaks from a felt sense! And you see, there are many levels between these two. At all these transitions the therapist can make specific interventions to help the client from one level to the next level.

Such a scheme could be made not only for the psychosomatic client but also for other kinds of problems. In the scheme you see **[29]** that at the highest levels (5-9) the client is functioning experientially, this means that the client somehow is attending inwardly, is with his experiencing (somehow this seems to be introduced between level 4 and level 5). The lowest levels (1-4) are several *layers of non-experiential functioning*.

When the client is far from the experiential level then the therapist cannot use the usual focusing suggestions (he can use some of them but not to focus: see below). At the non-experiential levels we must help the client, gradually and with respect for his pace, to come step by step closer *in the direction of the experiential levels*. We cannot bring the client with one single intervention or reflection to the experiential level. Often there are many steps between where the client is on the one hand and his experiencing (his experiential levels, his experiential body) on the other hand.

So there are many steps between the non-experiential functioning and the experiential functioning. And *each step has its own value*. In the scheme above, for example, step three has the following specific importance: The person himself begins to come into play. This is necessary: It is a first preparation of step seven where the experiential speaking will come from the person himself.

B2) Now, let us look at the four kinds of blockages we described in group III, and put some examples of therapeutic interventions next to them.

1 The client has **difficulty to *start* speaking or to *continue* speaking**

1.1 A client may remain silent at the start of a therapy/session.

Example. **[30]** The client has a dejected look on her face, puts on an aggrieved expression; she is stuck with something but she doesn't tend to say anything about it. The danger is that she remains in this unproductive silence (the silence as blockage). I don't wait passively, I invite her to tell something anyhow. The invitation is helpful. She starts reluctantly and eventually she brings the story.

So this client needs an inviting/encouraging therapist to *start* speaking[34].

1.2 **[31]** A client may speak for a while, and then become silent (again). In this situation sometimes I ask:

[34] This is different from being purely non-directive.

To what is your attention directed now?
What draws your attention now?
What needs your attention now?
What's on your mind now?
What are you thinking about?
Where are your thoughts now?
What is in your thoughts now?
What did your thoughts come to?

These are questions that invite the client to say something more. Here these questions don't invite the client to focus but simply to say something.

So this client needs an inviting/encouraging therapist to *continue* speaking.

In the scheme of the psychosomatic client the non-experiential functioning can be seen as different obstacles to the experiential levels. And this was already more differentiated than the stages of the experiencing scale.

But here, in these examples, we see that the obstacles can be differentiated still much finer than in the scheme of the psychosomatic client. Much finer: i.e. on a more basic level, the level of single human actions: start to speak, continue to speak, ask a question (see below), etc. The therapist can look and listen much more carefully to the client's functioning in the session, moment-per-moment. When the therapist knows these possible fine obstacles, he can intervene much more precisely.

1.3 With the client who says: "I have already told everything. What can I say more here? I think that next time I will say the same thing", often the therapist must try different ways to get the therapeutic speaking started. For example, he may ask: if you don't repeat the same thing, what else comes to your mind?

1.4 That a client cannot speak can have many causes. A client may have been so traumatized that mere being in a therapy room may be hardly tolerable. Body-oriented psychotherapeutic work may be necessary first (e.g. Ogden, Minton & Pain, 2006). Gendlin (1967) describes very concretely his work with clients who are silent and unresponsive, with clients who are silent but responsive, and with clients who are verbal but externalized.

2 The client is speaking but he is only **talking about happenings in *the outside world*** (not about the own person; see scheme psychosomatic client). The therapist can help the client to make the transition. When the client speaks about *the* outside world, the therapist may ask for *his* outside world (*his* situations) and – further step - *how* he is involved in it. From there a further step is to ask how it *affects* him; and how he would express that, speak *from* that.

3 The client is merely describing

3.1 The client is describing his complaints (over and over)

Example **[32]**

A client repeatedly brought the complaint of tiredness. She could describe the complaint and speak about it, without making any reference to her experiencing but with the implicit request to the therapist: Take this complaint away from me (e.g. by medication). This is a form of not-experiential functioning: The solution must come from the outside.

Repeatedly I have shown her the way to the reflective-experiential level: *Looking behind the tiredness, which situations are difficult in your life currently? Which current situations do you feel the tiredness could be connected to? Which situations, what all in your life tires you currently? What in all about your life right now, tires you?* This is a 'what … about' question, not a 'why' question (see below). I often use this question to invite the client to move up from a mere objectifying description to an experiencing. But this transition doesn't always succeed immediately.

Later in this therapy, in a particular session this client starts to speak again about her tiredness but spontaneously she makes on her own the transition: "I have to work on another point. Who do I want to be? Who am I? What do I still want to do? But in order to do that I first have to resolve something else, that is: I need to free myself from the established patterns which I live in, because my wanting to do everything perfectly pulls me down completely (this seems to be one source of her tiredness)". So here she herself could move from the non-experiential to the experiential.

3.2 The client is talking about

As we said, the complaint is objectified. The client speaks about his difficulties as an entity. Often a question that may help is: what is this fatigue (this …) *about*? The 'about' question.

It will be necessary that the therapist repeats this suggestion several times, shows the right way repeatedly. And it is important to keep in mind that the client may make a step forward but may fall back into his old pattern again. By the way these examples also show that getting a therapy started may be more complex than just make contact with 'the I in there'.

Exceptionally the client quickly comes from a talking about to experiential work.

***Example* [33]**

This is an example of a client with somatizations; a somatization is a bodily complaint without medical explanation. In the first interview she has a note with a list of twelve somatizations. For each one she has a medicine. At the end of the session I suggest her – somehow I felt I could do that - the following homework: "Each time you feel something somatic, try to ask yourself 'With which situation may this complaint have to do, and with which personal difficulty in that situation may it have to do?' and write it down briefly".

In the second session, to my surprise she has been working very fruitfully with this suggestion. She is enthusiastic and says: it was a golden clue to ask for the situation with each complaint. *Because until now with any painful event I tended to push it away instead of feeling it.*

Now she did the opposite. For example, her sister is visitng her with her family for dinner. During the aperitif she becomes dizzy. But she succeeds to reflect on her situation. She asks herself: "What is upsetting me now? I am sitting here alone, across a family, sitting there opposite to me. Being single, without a family, is a failing. I don't comply with the expectations of the prevailing standard".

She did this reflecting work in different situations. Each time she writes it down briefly. She says: "At the moment I can name it, the tension diminishes and after one hour the somatic complaint has disappeared completely, or it has strongly diminished, or it becomes totally unimportant".

In the sessions she showed me several small notes where she has written down these new experiences. And so she continued to do a lot of therapeutic work on her own in each period of three weeks between the sessions[35].

At the end of the twelfth session she says: "My life has changed very much in positive sense in a few months, and that is not self-evident".

***Example* [34]**

The client is spending the whole first part of the session talking about her complaints. She needs the therapist making an opening in order to be able to start speaking *about personal issues* (later *from* personal issues). These are things she feels guilty about. Later she says that she doesn't get so easily to speak spontaneously. Both issues come from her education, from what her mother forced upon her.

So in the first part we see a non-experiential speaking, a resistance for a long time. The resistance comes from the fact that in her education, because of her mother, she was not

[35] This is also an application of therapeutic writing, and of the fact that the client can do much therapeutic work on his own, between the sessions, without the direct help and interventions and presence of the therapist.

allowed to feel what she felt and she was not allowed to speak about what she really felt: Her mother was not interested in it.

3.3 Asking for an external solution [35]

One way of avoiding reflective speaking is *asking questions* of the therapist. How can the therapist handle this? When it happens in the first sessions of the therapy the therapist can explain to the client that asking questions doesn't help him (and why), that it is better to try to come to a speaking of one's own accord, and that it is important to speak from the issues which actually are in the foreground of his or her feeling life (cognitive approach[36]). When it happens later in the therapy the therapist lets it pass, and he may ask: "What do you want to say with this question (experiential approach)?"

One way of asking is that the client stops speaking and *looks at the therapist* for the continuation. The therapist may ask: "What makes you look at me?" The client may answer that a question from the therapist could help him. A variant of the question may be the suggestion: "Maybe you look at me for the continuation, but you might want to try to look into yourself and not at me for the continuation". Or the therapist may reflect: "Something makes you look at me". So, the therapist tries to go back to the client's intention.

Hopefully the 'what' in the questions 'what do you want to say with this question?' and 'what makes you look at me?' or the 'something' in the therapist's reflection 'something makes you look at me', may bring the client inside himself in a reflective way.

4 The client does something with the relationship with the therapist (transference)

[36] Working at the reflective level means that the client is oriented toward himself, looking inside for further issues to explore experientially. But the client may remain at the relationship level (for a while; sometimes briefly at the beginning of the session).

When a client explicitly says, for example, that he *expects guidance from the therapist* in the sense that the therapist says what the client should do or not do to become better, the therapist may explain how therapy works, and how the client can work fruitfully in the sessions. When it happens later in the therapy the therapist may ask: "You want me to take the position of the leader?" "You want to get me there?". These are attempts to bring the client in a reflective attitude.

Later on the question may become: "*What* in you is it that wants to get me in the position, for example, of the leader?" Or it may be a reflection: "*Something* in you wants to get me in the position of the leader". This is a next possible move that may make the client experientially reflective.

[redacted]

[36] Giving information about what therapy is and how it works.

Via a reflection of the client's *impulse* which is *directed to the therapist*, the therapist tries to bring the client in a reflective attitude, inviting him to look inside and thus to make a small experiential opening. Instead of the client *being* the impulse (or acting out the impulse), *the impulse is made into something which the client may start to think about, to 'feel about', to question, to reflect on it.* This originates a difference between the client and the impulse (dis-identification). The client no longer *is* totally the impulse (being it). Now he can '*look at*' it (being *with* it; and later asking it questions in a focusing way).

Example. The client **[37]** is a man who behaves docile. In the session he wants that I take the lead and give him advice. He tells that his wife presses him to stop working and to close his garage, but he tries to oppose this: "Always being with her, never being able to go out, I don't like the look of it". I take this point to show him that not I, the therapist, can give him good advice, but *that exactly now he feels inside* what he really wants, what he really feels as right for him, and *so that his best advisor is in there*. In this way I try to show him the way inwards and to bring him to an experiential moment.

As we said, for a long time a client can try to change me, the therapist, for example, into the leader, but also into many *other kinds of transference figures*. Often the therapist may not be aware of it at first; it works implicitly for a while before the therapist becomes aware of it. When he becomes aware of it, he may ask: "Which effect do you want to have on me?"[37]

It is possible that we cannot bring the client immediately to the experientially reflective position, and that the client needs some time to stay in the transference attitude. But with a few clients – when it comes to a repetition which is not fruitful - we need to make clear our own position at a certain moment: "You want to make me into this (and I show 'this' with my right hand on half a meter beside me) but I am 'here'". This is a variant of the implicit message 'I don't want to be that figure', for example, the leader.

In a psychoanalytically oriented therapy it is likely that the therapist will not say this, and that one will work for a long time with the transference. But we want to bring the client as soon as possible - and in respect for the pace of the client's process - to the experiential level where he can explicate *that from which* he tries to make the therapist into that figure. On the one hand it is important to acknowledge the structureboundness the client is experiencing and (the power of) how it occupies him. And on the other hand helping the client is to bring him beyond his unfruitful repetitions, to bring him to the reflective level, to acknowledge and to facilitate the implicit forward moving which is in the structurebound pattern[38]. Sometimes this needs a 'stop' from the therapist; such a stop or boundary is in the service of bringing the client to a deeper level.

[redacted]

[37] In these questions the therapist points to the client's desire: '*you* want (…)', '(…) do *you* want (…)'?. This is different from creating 'an us' as Lynn Preston does.

[38] We can see an 'entity' as: What wants to proceed is frozen fast in it.

Sometimes there is a client who causes *serious relational difficulties* with the therapist, for example by blaming and verbally and nonverbally attacking and rejecting the therapist, and denying the therapist and the boundaries of the therapy (Depestele, 2008a; 2008b). Also here much *relational work will be needed before* the client can work reflectively on the experiential level. The therapist will try to help to work through meaningfully this tense situation. On a rare occasion this will require some struggle to overcome the relational impasse.

All this work and occasionally this struggle is needed because therapy is something that occurs within certain limits, within a certain frame: Certain things are only possible when other things (for example getting answers to certain questions, getting reassurance, etc) don't occur (any more).

Conclusion [38]

In the process of experientializing therapy we can distinguish three phases. It is a gradual process. When a client is far from his experiential level (group III) we try to move him in the direction of it, we try to help him to come ***to*** his experiential level. When the client is in group II we try to bring him ***near*** his experiential level. And the client in group I may need help to come ***in*** his experiential level.

Experientializing interventions may occur in the different phases. When the therapist says, for example: "So, what I said isn't right", then he shows to the client of group III that his feeling inside is right and not how the therapist reflects it. Hearing this may be new for this client, a new experiential skill he is learning.

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