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From Gestalt Therapy to Family Systems: How Theoretical Frameworks Inform Clinical Applications

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Working with a client, the author transitioned from a Gestalt psychotherapy framework informed by attachment theory and developmental theories to Bowen family systems theory. Using a Gestalt framework, the development of self was seen as embedded at times in the interconnectedness of all things and at times in the mother/child dyad with the clinical priority working within the therapeutic relationship. From a Bowen family systems theory framework, the author viewed self as an evolutionary biological process that developed through the family system and worked outside the therapeutic relationship. Working within the therapeutic relationship, there was evidence of a decrease in anxiety, an increase in self-regulation and a more positive self-perception. Working outside the therapeutic relationship, the client demonstrated an increased ability to self-soothe in the midst of challenging interactions with significant others and less dependence on the therapist for self-regulation. Whilst the therapeutic relationship was effective in achieving self-regulation in non-challenging relationships, working outside the therapeutic relationship was effective in achieving self-regulation within challenging relationships.

Keywords: Bowen family systems theory, gestalt therapy, therapeutic relationship, theoretical framework, systems, relational

Key Points

1. Therapists may be aided by clarifying and sharpening their theoretical framework and its application, whether it is eclectic, integrative or transitioning between theories.
2. The application of different theoretical frameworks may result in divergent clinical outcomes, which may lead to a client's increased resilience in his/her significant relationships.
3. Working outside the therapeutic relationship, as with Bowen family systems theory, assists clients to work through their issues in their real life circumstances *between* sessions, rather than the work occurring within sessions and within the therapeutic relationship.
4. The efficacy of a therapeutic framework is substantiated both through clinical outcomes *and* through the therapist's personal application of the framework in their life and work.

This article contains a description of the author's transition from a Gestalt psychotherapy framework (Perls, Hefferline & Goodman, 1951/1995) informed by attachment theory (Bowlby, 1988) and developmental theories (Stern, 1985), to a Bowen family systems theory framework (Bowen, 1978). These frameworks are different in their therapeutic focus, clinical application and potential divergence in clinical outcome. In Gestalt therapy, the therapeutic relationship is used as a tool for the advancement of therapy. In Bowen theory, the work is with the family regardless of how many clients are in the room. Further, clinical work is redirected to the real life circumstances of the client's significant relationships and is not core to the therapist–client relationship.

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The following case study is a description of the author's transition between frameworks both from a personal/experiential perspective, as in the author's own therapeutic process, and from a theoretical and clinical perspective in the work with clients. It includes reflections on the clinical effectiveness of working in the real life situation of the family system in contrast to working within the therapeutic relationship.

My Perspective on the Therapeutic Relationship

My knowledge of Gestalt therapy emerges from my training and substantial reading about Gestalt theory and its application. Gestalt therapy training introduced me to, and integrated in its thinking and application, developmental psychology, attachment theory and an understanding of psychological pathology as specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013).

Part of the requirement of my Gestalt training was to undertake therapy with a Gestalt clinician. I spent several years in Gestalt therapy with therapists who, in turn, integrated theories and ideas such as psychodynamic approaches, attachment theory, developmental theories and trauma therapies, hence who worked within the therapeutic relationship. This personal therapeutic experience helped me understand my problems not as inherently mine, but as emerging from how I had been parented. Through this developmental platform, I became aware that I had continued to behave in ways that did not serve me. I found the therapeutic process one in which I felt safe, validated and cared for. The process supported insight into how I related to my environment. It also helped me learn to regulate underdeveloped parts of myself whilst in the presence of my therapists. However, in the long term, I found it difficult to sufficiently manage difficult emotional states in my real life interactions with significant others outside the empathic contact with my therapists. While my therapists' validation helped me understand how others had affected me, it did not help me understand how I equally contributed to or could solve my own relationship problems.

It could be argued that my successful transition from Gestalt to Bowen theory (Bowen, 1978; Kerr & Bowen, 1988) was influenced by an earlier positive transferential experience or that my therapeutic work with my therapist was stuck in the transference/countertransference. However, I believe multiple factors contributed to my decision to move frames. It appeared that the more my Gestalt therapists validated my experience, the more my relationship with both my partner and my mother escalated in conflict. In contrast, I appeared more able to regulate myself in the midst of conflict with my partner and mother whilst working with a Bowen therapist who disinvited alignment with me and prompted me to address issues with important others directly. The successful change I made in myself in relationship to significant others was what ultimately convinced me of the efficacy of Bowen theory.

Additionally, Bowen theory's proposal that humans are inherently more sensitive/reactive to family members and significant others than they are to people of less importance to them, made sense to me (Bowen, 1978). It accounted for the work of self-development being more effective and long-lasting when worked through with family members rather than in the client–therapist relationship.

Gestalt Therapy and Theory

Gestalt therapy was developed by Frederick (Fritz) and Laura Perls in the 1940s. Fritz and Laura Perls had both trained in psychoanalysis as well as Gestalt psychology and reconsidered Freudian theory in their first publication of *Ego, Hunger and Aggression* (1946), subtitled *A Revision of Freud's Theory and Method* (Bowman, 2005). This gave rise to Gestalt therapy in a zeitgeist of humanistic psychotherapy and existential philosophy.

The term Gestalt therapy was first used in a book written by Fritz Perls, Ralph Hefferline and Paul Goodman: *Gestalt Therapy: Excitement and Growth in the Human Personality* (Perls et al., 1951/1995). Influenced by Gestalt psychology (Koffka, 1935; Köhler, 1947; Wertheimer, 1945), existential phenomenology, field theory (Lewin, 1951), holism (Smuts, 1927), Zen Buddhism, and psychodrama (Moreno, 1946), Perls, along with his co-authors Hefferline and Goodman (PHG), developed a model of self-process that was revolutionary against the individual psychoanalytic backdrop of the time.

PHG emphasised that the nature of 'being' is fundamentally relational and that self is made up of the contact (experience) of organism and environment (Perls et al., 1951/1995). Self, according to PHG, did not exist within the individual or within the mind of the individual but 'in the system of contacts at the boundary between "me" and "not me", between organism and environment. The experience of self . . . is constituted in the experience of the continually shifting configurations and reconfigurations of the organism/environment field' (Stawman, 2009, p. 13).

PHG significantly contributed to a move away from an interpretive transferential model to an approach focused on the exploration of the boundary between individual and environment (and at times between individual and individual). This shift from psychoanalysis with the therapist as scientific analyst to a field theoretical framework, based on the interconnectedness of all things (Parlett, 1991) in which everything is connected to everything else in a mutually affective process, gave a way for the Gestalt therapist to engage in the therapeutic relationship.

Whilst PHG proposed their newly developed relational theory of self, their theorizing also included a depiction of a separate self, that is, a single organism interacting with the environment (Parlett, 2005). This incongruence may have reflected the different paradigms Fritz Perls and Paul Goodman inhabited. Perls' view and application of theory was more individualistic, the organism either sought its survival requirements from the environment or did not. Perls' individual Gestalt paradigm, though very progressive for the time, was not entirely relational. The therapist was still somewhat separate from the client.

Goodman's view on the other hand was more relational, the boundary between self and other was not a rigid distinction but rather, 'the function of self centrally involved the construction of a cohesive sense of experience of self and other' (Lee & Wheeler, 2013, pp. 40–41). Goodman's constructivist and intersubjectivist view was that by default, one's own experience of self (or of 'me') includes the other (or 'you').

In the 1980s, relational Gestalt therapy emerged as a new wave distinguishing itself from the early Gestalt therapy framework (Jacobs & Hycner, 1995; Yontef, 1999). As Gestalt theory advanced, it reconsidered its *application* from a field or relational point of view (Lee & Wheeler, 2013). Though relational Gestalt was embedded in PHG's original work, it integrated Buber's philosophy of dialogue (Buber, 1970)

and aspects of contemporary psychoanalysis to align its thinking and application to a more congruent relational framework (Hycner & Jacobs, 2009).

Just as Gestalt therapy was evolving, so was the overall field of psychoanalysis. Relational Gestalt therapists Yontef (1999) and Jacobs and Hycner (1995) began integrating some of the work of psychoanalytic theorists Kohut (1976) and Stolorow, Atwood and Branchaft (1994), which resonated with Gestalt's dialogic stance. What Yontef and Hycner and Jacobs highlighted was the perspective that the therapist and client mutually influence and organise each other's experience and reality in the moment of contact (Parlett, 2005).

Bowen Family Systems Theory

Murray Bowen was a researcher, clinician and theorist. He originally trained as a psychiatrist and practised within the psychoanalytic model. Early in his career Bowen wondered why a psychiatry that was primarily based on psychoanalytic theory was not a real science and much of his research was driven by wanting to move Freudian theory to an accepted science (Kerr & Bowen, 1988).

From the 1940s to 1950s Bowen developed his theory based on his research, first at the Menninger Clinic where he involved mothers of patients with schizophrenia and then at the National Institute of Mental Health where his research broadened to include whole families. Bowen's theory was influenced by his wide reading of the natural sciences, with a focus on evolutionary biology. His aim was to describe human behaviour scientifically. His research and reading eventually led him 'to the notion of the human as a phylogenetic development from the lower forms of life' (Bowen,1982, p. 16). He believed that human beings were closer to all life forms, not unique and different from them. As Bowen's focus shifted from the individual to the family he began to view the family's behaviour as a *natural system*.

Ultimately Bowen fashioned a natural systems theory from his research designed to fit within the principles of evolution and the human as an evolutionary being. Bowen theory proposed that 'human behaviour, along with that of many other social species, is not only self-regulated by individuals, but co-regulated in the highly interdependent systems in which individuals are embedded' (Noone & Papero, 2015, p. 10). His effort went to 'view the human phenomenon the way Darwin had viewed the subhuman world' (Bowen, 1980, p. 183), which led him to anchor his theory on the assumption that the human and the human family are driven and guided by processes (systems) that are 'written in nature' (Kerr & Bowen, 1988, p. 26).

A Gestalt Lens – The Author's Experience

Due to the fact that Gestalt theory has changed throughout history and its application varies from more individual to more relational perspectives, it is difficult to define a global Gestalt therapy framework. It is therefore necessary to define *which* Gestalt theory one is referring to when one refers to Gestalt therapy.

How I applied Gestalt theory

In the last two years of my training I focused on the dialogic relationship, a particular form of therapeutic relationship proposed by Gestalt therapy (Joyce & Sills, 2014). This was a veering away from a more individual Gestalt paradigm toward a relational

Gestalt paradigm. The therapist was not viewed as separate from the client, therefore the disruptions to self-development were not explored within the *individual self* of the client but rather within the *co-created selves* of the client/therapist. From this perspective the client's whole life experience, present and past, combined and came together according to their relational context.

After some time, I was introduced to a supervisor who was influenced by the work of Jacobs and Hycner (1995). Through this introduction and supervision I attempted to apply this particular relational lens. The backdrop to my thinking was further influenced by developmental and attachment theorists such as Bowlby and Stern and Wallin (2007), whose focus had been to research the interconnection between mother and child, and who saw the individual's developmental process, whether towards health or dysfunction, as shaped by the relationship with the primary carer. The therapist–client relationship was thought to be central to adult treatment in providing the missed developmental experience, through the internalisation of an ongoing regulatory process between client and therapist (Wallin, 2007, p. 193). Whilst field theoretical Gestalt (Lee & Wheeler, 2013) equally takes into consideration 'everything' that influences the client, both past and present, without considering one thing (phenomenon) to be more important than another, with my attachment theory influence I gave more weight to the developmental history of the client.

Transitioning to Bowen Theory

It was through a personal issue that I came to a Bowen therapist and to an interest in Bowen theory. Moving from an amalgam of existential humanitarian and developmental theories to a scientific theory based on systems thinking was a challenging transition. The transition between frameworks occurred slowly, both at a theoretical and personal level. Theory and practice reinforced each other, and the more I applied Bowen theory to my personal life the more it came alive. The complexity of Bowen theory broadened my perception of human behaviour to *systems thinking*. Whilst Gestalt's field theory is equally complex, Bowen theory's notion that people are more reactive to family members/significant others, than they are to people of less importance to them, or to 'things', made more sense to me.

As a Bowen theory trainee much of my work was redirected to my own family: nuclear/family of origin/multigenerational. I engaged in family of origin research by way of interviewing family members. I gathered facts, retraced triangles, considered symptoms, and multigenerational patterns (Kerr & Bowen, 1988). I practised defining myself and self-regulating in situ, with my partner, my children and family members. The work occurred outside the therapy room, focused back in the family, where it had originated, not with a therapist or supervisor. Sessions with a Bowen therapist focused on reporting what I had observed of myself in family interactions. Discussions centred around setbacks and steps of progress, on my own differentiating effort and observations made both of myself and of other's responses to me.

This was a change in mind-set, from viewing the therapeutic relationship as the central therapeutic process, to viewing the therapeutic process as occurring outside the transference of the therapist–client relationship and within the original relationships which contained the disturbance: 'The goal was to leave intense emotional relationships between the family members where they had developed and to remain outside the emotional conglomerate of the family' (Bowen, 1980, p. 184).

Bowen's perspective on the therapeutic relationship

Bowen maintained that psychoanalytic theory contained numerous elements of subjectivity derived from literature: ideas that could not be proven by science (Bowen, 1978). Nevertheless, he incorporated parts of psychoanalytic theory he believed to be factual (Noone & Papero, 2015). During his research he started to understand the function of the therapeutic relationship through the phenomenon of the *family emotional system*, the idea that the family functioned as a whole, a unit or system (Kerr & Bowen, 1988). The term refers to two elements. The first is the internal process occurring within an individual, how a person's innumerable biochemical and neurobiological interactions to external responses might guide him/her to behave. The second element refers to interpersonal exchanges of emotional reactivity and how these give way to relationship patterns (Noone & Papero, 2015).

Bowen noted that 'the successful introduction of a significant other person into an anxious or disturbed relationship system has the capacity to modify relationships within the system' (Bowen, 1978, p. 342). Further, he observed that a therapist who formed a relationship with a member of the family could become a 'significant other' just as a minister, a teacher or a friend could. Bowen noticed that an important relationship could decrease symptoms just as a substance or behaviour could. If the relationship with the therapist became important enough to the client without becoming disturbed, the client's symptoms would subside yet the relationship with the family would either remain the same or deteriorate. Bowen theory ultimately maintains that the work of differentiating a self is more effective when done in situ within the family of origin rather than the therapeutic relationship (Bowen, 1978).

Case Study – Shifting Theories in a Clinical Case[1]

Background

The following case study will illustrate how different theoretical frameworks were applied in the clinical work with an individual client. In the first phase of therapy lasting 4 years, Gestalt therapy with an attachment and developmental theory influence was used to guide my thinking. In the second phase of therapy also lasting 4 years I applied a Bowen theory lens. The transition between theories will be discussed as well as the respective clinical applications and outcomes.

Ms C was referred through a relapse prevention program that offered therapeutic support to people in recovery from addictions. She was seen weekly and then fortnightly over 8 years. At 65 years old, Ms C had been divorced for 25 years. She had a son and a daughter from a former marriage who were now both adults. She lived on her own, worked full time and belonged to a spiritual community. When she left her marriage and family home to recover from what she called a 'nervous breakdown', Ms C distanced from her daughter, age ten and her son, age eight. Ms C had been through rehabilitation and had been sober 17 years.

As Ms C's story unfolded her challenges in her life made more sense. She was the middle daughter between an older sister and younger brother. Her childhood was characterised by what she described as 'abandonment' by a mother who was often depressed and a father whose anxiety of upsetting his wife led him to disciplining Ms C. Ms C's behaviour at school was unsettled and later, in high school, she acted out with boys. When her mother complained to her father about Ms C's school

behaviour, the father often hit Ms C and verbally demeaned her in an attempt to both contain her behaviour and his wife's upset. The more pressure she experienced from her parents to behave at school, the more Ms C rebelled, resulting in a polarised and distant relationship with them. An event that often resurfaced in our conversations was that of Ms C, age 14, being made a ward of the state and being sent to a girls' home by her parents after having been sexually assaulted by an adolescent male. Her parents blamed her for the encounter, perceived it as another act of disobedience and believed she needed disciplining. When she returned home after 2 years in a neglectful environment, Ms C was emotionally distant from her parents and had internalised the belief of being 'worthless'.

Ms C grew up as a child who was pivotal to her family of origin in embodying what was perceived as 'wrong', that is, as having a personality and associated behaviour that was perceived as abject. As tension grew to reflect increasing conflict between Ms C and her father, less tension was absorbed or reflected in the relationship between Ms C's mother and older sister, as this relationship remained relatively harmonious. It appeared that Ms C's mother and sister unintentionally maintained their interpersonal equanimity and functioning at the expense of Ms C. Ms C was perceived to be 'bad', and acted accordingly, often referring to herself as the 'scapegoat'. The more her parents viewed her as dysfunctional the more she identified in some way as 'sick'. She followed that tangent into adulthood – married young, had children, felt overwhelmed by motherhood and marriage, had extra-marital affairs and started drinking alcohol. This alleviated her internal and marital anxiety, yet she continued to feel 'defiled, wrong, worthless'. In an attempt to regulate her overwhelm, Ms C increased her alcohol consumption until drinking became a problem of its own.

When she left her marriage and children and admitted herself into a rehabilitation program, Ms C still believed, as did the rest of her family and mental health professionals, that she was fundamentally flawed. During her withdrawal from her nuclear family, including a 3 year period where she stopped speaking to her parents, Ms C regained functioning in some areas of her life, worked full time, stayed sober, and self-cared. On one hand she felt guilty for leaving her children, on the other she felt she could only function away from them. This was also true in subsequent intimate relationships Ms C had with men following her divorce, where her functioning decreased as her emotional dependence on the relationship increased.

When Ms C came to see me she was experiencing panic attacks and felt like she was 'falling apart'. She was avoidant of her children, emotionally distant from her parents and siblings and had some difficult collegial relationships. In contrast, she was very connected to her spiritual community and felt a sense of support which she had not felt in her own family.

Therapy

At the time Ms C began therapy with me I was working within a relational Gestalt framework with a focus on the therapeutic relationship and developmental theories. My perspective was that the therapist–client relationship was at the core of treatment. I viewed therapy as a developmental process – at different stages of the process I attempted to be present in different ways depending on Ms C's relational/developmental needs. My clinical aim was to provide Ms C with the opportunity of self-development through

sustained empathic enquiry, attuned responsiveness and presence (Hycner & Jacobs, 2009).

A major focus at the beginning was Ms C's fear of 'falling apart', her panic attacks, and stressful past events such as being made ward of the state and being sexually abused. I predominantly listened empathically, yet there was tentativeness – Ms C would inform me that she thought I perceived her as *dysfunctional* and that she was not sure if therapy was helping her. I would affirm her ability to be direct whilst reassuring her that I did not judge her. The further we built trust the more Ms C leaned into our encounters, finding solace in her ability to express herself whilst being heard. I acknowledged what Ms C and I both labelled the *traumatic events* in her life. We spoke about her experience of abandonment by her parents as her core pain, a recurring experience when she sensed someone was leaving her. Ms C reported feeling relieved when I acknowledged her childhood pain. I invited Ms C to seek my support between sessions and she accepted the offer.

Later, when we had established a stronger alliance I challenged some of Ms C's self-beliefs about 'not ever being able to change' and 'being damaged'. I encouraged her to have a voice where she did not. I became more aware of my automatic responses to her and shared what I was thinking and feeling in order to differentiate my response from her assumptions of me. At times my reactions toward her were outside of my awareness, such as when the reciprocity of her vigilance of me and my need to be *more* for her was activated and I automatically over-functioned to meet her needs.

As the work progressed I attended to the process of 'rupture and repair' (Badenoch, 2008) when, for example, Ms C's sense of being 'wrong' would emerge between us. My efforts went to resolve our breaches by acknowledging her experience, and stating that I was not frustrated or bored as she feared, on the contrary I thought her pain made sense given her history of parental abandonment. When we were able to work through interactions of disruption and repair Ms C's sense of worthlessness decreased. When I validated her subjective experience as real for her she stated that her distress diminished. When Ms C disclosed her experience in the girls' home as a 14 year old girl to her siblings and friends, I replied: 'You really needed witnesses back then'. Ms C indicated that she more and more saw me as someone who 'understood' and with whom she could talk about her disconnection with others.

However, with all my careful empathic attunement (Badenoch, 2008) and sustained efforts at presence, her relationships with significant others in her real life circumstances did not reflect her increasing experience of validation. Although her self-regulatory capacity had increased, it was only sustained within the confines of our relationship and within stable, less anxious relationships with significant others, such as with people from her spiritual community. When Ms C experienced discord and anxiety with people, like her children, parents and siblings, she automatically distanced to regulate. She could not tolerate the discomfort of a relationship with an avoidant boyfriend and separated from him to regain her functioning.

Transition

Four years into therapy, when I transitioned to Bowen theory, I began inviting Ms C to slowly do less work within the context of our relationship and redirected the therapeutic focus outside our sessions in the real circumstances of her important relationships:

> Bowen's guiding premise was to stay outside the transference by keeping a research attitude, staying out of invitations to triangle, and by keeping the work between the family member and his/her family. Bowen called the process of staying out of the transference detriangling
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> (Brown, 1999, p. 94).

I gradually made less interventions geared to reassure and attend to Ms C's relational needs. In Bowen theory I was introduced to the idea of 'lending a self', which describes the ways in which a person (therapist) can take up the functions of the self of the other (client), by taking the stance of helper or healer and thereby diminishing the client's ability to develop his/her own self (Kerr & Bowen, 1988). I stopped making our relationship more important than her relationships with significant others by decreasing the affirmation of her suffering and instead inquiring into how she was managing her reactivity in those relationships. My effort went to explore how her presenting complaint with a family member directly related to the underlying relationship processes between him/her. I worked hard to stay neutral toward all family members and important others by not taking sides; whether it was friends, family or colleagues. When Ms C complained about her sister 'bossing her around', for example, instead of replying with affirmative statements such as 'that's tough', I would ask how she had gone about resolving this difficulty and how it was working for her. My intention was to guide Ms C to function more from and for herself within the original relationship disturbance as opposed to seeking regulation and resolution with me in regards to the relationship disturbance.

In response to Ms C's painful memories of her father's treatment of her in childhood, I began inquiring about the previous generations by inviting her to explore the patterns of reactivity her father had been caught in himself. Ms C gathered information from her father to understand her paternal family's history. This broadened Ms C's perspective on what her father brought into their interactions that was unresolved with his own parents. She learned that when her father was 6 years old, her paternal grandfather gave her father up to her paternal aunt and uncle as they could not have children. Ms C's grandmother could not tolerate her husband's decision and emotionally withdrew from him. When Ms C's grandfather died, her grandmother quickly remarried leaving Ms C's father with his uncle and aunt. Ms C's grandmother physically distanced in a bid to regulate herself and Ms C's father never saw his mother and sister again. The generational repetition of distance between parents and children as a way to regulate anxiety became evident, depersonalising some of Ms C's 'wrongness' and decreasing her blame toward her father, replacing it with 'distancing is a way my family automatically responds to a disturbance in a relationship when faced with differences and stressful events'.

In regard to her emotional and physical distance from her children, when Ms C brought up her sense of guilt or her resistance in contacting them or how angry she felt when they did not respond to her, I again attempted to stay outside the triangles by asking: 'How do you decide to respond to your son's silence?' or 'What efforts have you made to clarify your position with your daughter?'

Observations about different theory approaches

Working within a Gestalt framework. During this phase, Ms C became increasingly aware of how her internal beliefs limited her functioning and was slowly better able

to self-regulate. After we had established a more robust rapport, Ms C's sense of self grew in awareness and she was more able to share her internal processes with me or others she felt close to. On the one hand, she shared more of her authentic self in contexts where it was easy to remain calm; on the other, she did not share her thoughts and feelings in contexts where she was unable to self-regulate. During times when she did get anxious, her tendency was to distance. Despite the relationship with me and her spiritual community growing in importance, her relationship with family members and intimate relationships with men became more distant and closed. Whilst this stabilised her, it also limited her ability to have more open relationships with those who challenged her.

I saw a decrease in symptoms in Ms C in regards to her anxiety, her negative self-talk and her sharing more of herself congruently. I believe that Ms C's increase in self functioning and emotional resilience, and her decrease in anxiety (she no longer experienced panic attacks) was dependent on the affirmation and validation of the accepting and attuned 'other'. The decrease of symptoms did not seem to equate with her self-development as it relied on the other being consistently non-threatening. When this did not happen, as it often did with family members, her self-regulatory capacity and ability to define herself regressed into habituated reactivity, such as distancing in order to self-soothe. Ms C was not able at this stage to self-regulate whilst maintaining contact with family members with whom she had challenging interactions.

Working within a Bowen theory framework. 'The clinician worked with the family to assist their analysing their own relationship processes in situ rather than the process between clinician and individual' (Noone & Papero, 2015, p. 27).

This phase of Ms C's therapy coincided with my transition to Bowen theory. As my understanding of Bowen theory increased and I engaged in personal work with my family of origin more, my thinking about the nature of emotional issues changed, and as a result so did my clinical application. From a Bowen theory perspective, the role of the therapist is one of taking a neutral position (Fleck & Bowen, 1961, p. 49). The more neutral and objective about family members the therapist is the more successful the therapy will be. The therapist works toward staying in equal relationship to all family members, checking when there's a pull toward the emotional field of the family through identification with a particular family member (Fleck & Bowen, 1961, p. 49).

When Ms C spoke about issues she was experiencing with colleagues, friends or family, in contrast to the previous validating approach, I asked about how she had responded to each person, how she had managed her feelings, how this impacted her. My questions indicated it was her problem to resolve within the context of her family or a relationship, my tone was neutral and curious, not accusatory (Kerr & Bowen, 1988). I did not think soothing Ms C's stress-responses in the clinical encounter was ultimately beneficial to her in the long term as it would deprive her of the opportunity to grow those functions in herself. Instead, I inquired about how she soothed herself in her real life circumstances – who she spoke to, how she managed her difficult feelings, what she expected of others, how she wanted to respond to a family member's reaction, what realistically she could expect of herself or others, what was a first step toward differentiating herself in relationships. My effort went to asking questions to stimulate Ms C's thinking about herself as separate from her automatic emotional reactions (Noone & Papero, 2015).

Clinical Outcomes and Discussion

Since I began working outside the therapeutic relationship and within a Bowen theoretical framework, Ms C made progress in how she managed herself in important relationships with her tendency toward distancing decreasing in intensity. In the relationship with each parent she worked on defining and regulating herself whilst maintaining connection. In exploring her reactivity toward her mother, Ms C began observing herself in their interactions and noticed that when she felt overwhelmed she withdrew from connection. As she became more able to distinguish reactions from thoughtful responses, she became more able to calm herself and respond mindfully. For example, if her mother wanted Ms C to take her for a walk 'immediately' and asked in a complaining tone, Ms C would still internally react by wanting to distance but she would catch the reaction, pause, and respond by defining what she would do. In time, she began defining what she was willing and not willing to do whilst maintaining connection. As a result, Ms C's relationship with her mother became closer and more stable.

Ms C worked on detriangling (Kerr & Bowen, 1988) from invitations by her siblings to take sides about other family members. When her sister complained about her mother for example, rather than joining in, Ms C would suggest her sister speak directly to her mother about the problem. Ms C also made a consistent effort to maintain a more thoughtful position within various collegial relationships and close friendships by taking responsibility for how she contributed to the disturbance in the interactions, trying out different behaviours and taking care of herself (not through the relationship having to be a certain way but through her self regulatory capacity).

Ms C is still single and this too is a more thought-out decision. Ms C continues to find her relationships with her children challenging though she continues to make progress through her effort to engage with them more thoughtfully. She has made consistent attempts to move closer to them by maintaining regular one-to-one involvement. Ms C still struggles to regulate herself when her children do not respond positively, especially when they reject her. However, she is exploring her part in the reciprocity and is taking increasingly more responsibility for how she affects the pattern of inter-reactivity. To do this she has had to become a keen observer of herself in the midst of interactions with them. Ms C still experiences difficult feelings, yet now she can self-regulate in the context of challenging relationships rather than away from them.

It is impossible to know how therapy might have evolved had I continued to work within a relational Gestalt framework and how that might have affected Ms C differently (or not). It is interesting to note that in having given Ms C this article to read before publishing it, she fed back to me that it may have been too difficult for her to self-regulate within her challenging relationships had we not initially worked within the therapeutic relationship. What I do know is I transitioned from one way of thinking to another, I applied that thinking to my encounters with Ms C and these had the effect they did. There would be multiple variables to consider in researching the clinical outcomes of these two theoretical applications.

In summary, when working from a Gestalt therapy framework there was a decrease in Ms C's negative self-perception and she was more able to self-soothe in supportive relationships. When working from a Bowen theory framework, Ms C was more able to self-soothe in the midst of challenging interactions with family members and significant others and less dependent on me, the therapist, for self-regulation and defining a self in relationship.

Conclusion

My personal therapeutic experience of working both within and outside the therapeutic relationship, first with Gestalt therapists and then a Bowen theory therapist, supported my theoretical transition and clinical application. From an experiential perspective I was convinced of the efficacy of working outside the therapeutic relationship in how I was better able to deal with issues that existed with family members outside the therapy room.

In transitioning theoretically from a Gestalt therapy lens, influenced by attachment and developmental theories, to Bowen theory, I also transitioned from a framework that implemented the therapeutic relationship to working within a framework that aimed to stay outside the therapeutic relationship. In the former approach, the lens was both 'holistic' and dyadic, at times maintaining that the development of self was steeped in the interconnectedness of all things, and at times in the parent–child relationship (Bowlby, 1988). In the latter approach, the development of self was viewed as intrinsic to the family system as viewed from a *natural systems* perspective.

Clinically, when working within the therapeutic relationship and then outside the therapeutic relationship, Ms C reported different clinical outcomes. When working within the therapeutic relationship, Ms C reported a decrease in anxiety, an increase in self-regulation and a more positive perception of self. Her changes were possible in a relationship context she did not find too difficult to manage along with her distancing/cutting off from relationships which she did find difficult to manage. When I aimed to work outside the therapeutic relationship guiding Ms C back to manage herself in those relationships she found challenging, the work occurred *between* our sessions, not *within* our sessions. Ms C reported being able to slowly calm her stress-response down in challenging relationships by defining herself more clearly, staying in connection, and decreasing the use of distance to achieve this.

My hope is that this case study serves to highlight the importance of clarifying and defining a therapist's therapeutic lens and its application whether that framework is eclectic or aligns with a comprehensive theory. It illustrates how the differences between working within a Bowen family systems theory paradigm, versus a relational Gestalt paradigm with attachment and developmental influences, results in divergent clinical applications and potentially differing outcomes for an individual client. Additionally, the case conveys how in aiming to work outside the therapeutic relationship, the client's work of self-development is guided back to the original relationship disturbances rather than the interactions between client and therapist. Based on the outlined clinical case, the efficacy of working in situ as opposed to within the therapeutic relationship may be due to lending a hand to the client in achieving self maturation in their significant relationships.

Endnote

[1] The following case study is constructed from clinical practice with all biographical details changed to protect privacy

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