Advanced Relational Practice

THE TALKING THERAPIES UK PRACTITIONER SERIES



Advanced Relational Practice

Relational depth, enactment, the wounded healer and the ethics of power in long relational work.

Advanced level · 14 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the Advanced Relational Practice course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 5. This printing was set on 10 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

Contents

How to use this manual 1

Part 1 Deep Relational Dynamics and Therapeutic Enactments . . . 3

1. Relational depth and its conditions 4
2. Enactment: when the relationship replays the problem 9

How to use this manual

There is a level of relational work that technique alone cannot reach: moments of relational depth that clients describe years later, enactments in which the relationship itself begins to replay the client's difficulty, and the sobering recognition that the therapist's own wounds are both instrument and hazard. This course works at that level, for experienced practitioners ready to examine their practice honestly.

The first module studies what the deepest therapeutic moments are made of and the conditions that make them possible, then turns to enactment: recognising when you have been recruited into the client's pattern, and how naming it from within becomes the most potent intervention available. The second module examines the practitioner as instrument: the wounded healer tradition and its double edge, the craft and ethics of endings, and the honest handling of the power that the therapeutic role confers whether acknowledged or not.

This is reflective, sometimes uncomfortable material, taught in four extended written lessons with key points and practice tasks that ask real questions of your own work, with a study tutor available for what they raise. Fourteen hours of CPD, around a year of access, a final assessment, and a personalised certificate on passing.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 14 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the

conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Practise relationally at depth, working with process as it unfolds moment to moment in the room
- Formulate clients' relational patterns and use the live relationship as the arena of change
- Work confidently with strong affect, hostility, idealisation and dependency without retaliating or withdrawing
- Integrate person-centred, relational and existential perspectives coherently rather than eclectically
- Maintain therapeutic presence under pressure, and repair your own empathic failures as they happen
- Evaluate the evidence on relationship factors and apply it to how you practise

PART 1

Deep Relational Dynamics and Therapeutic Enactments

Explores relational depth, enactments, ruptures, repairs, and the co-construction of meaning within the therapeutic field.

CHAPTER 1

Relational depth and its conditions

Mearns and Cooper first gave a name to something that seasoned practitioners had long sensed in the therapeutic encounter: relational depth. They described it as those moments of profound contact in which both therapist and client are mutually fully present, the client's experience is met at its very edge, and something in the relationship itself does work that no technique could ever replicate. The client's accounts, gathered in longitudinal qualitative studies, are strikingly consistent. When asked years after therapy what mattered most, clients rarely cite a specific intervention; instead they recall a moment when the therapist's eyes filled with genuine feeling, when a silence was shared without any intervening comment, or when a single sentence seemed to convey that they had been accompanied all the way to the brink of their pain. For many, those moments constitute the whole of the therapy.

Relational depth cannot be manufactured. Attempts to engineer profundity inevitably become performance, and clients, attuned to authenticity, detect the inauthenticity. The paradox, however, is that while depth itself is not a product that can be scheduled, the conditions that make it possible can be tended, cultivated, and rehearsed. Three interlocking conditions have emerged from the literature and from clinical observation. The first is the therapist's willingness to be genuinely affected. Depth is bidirectional; if the therapist erects a protective wall against feeling, the relational reach is capped. The second condition is the abandonment of technique as a shield. Skills that have been internalised over years must be available without being hidden behind a procedural veneer, because a therapist who reaches for the next intervention is, in that instant, not fully in the room. The third condition is responsiveness to the client's growing edge – the live, hesitant, unformed material that sits at the boundary of the client's awareness, rather than the rehearsed story that has been told many times. The rehearsed story deserves respect, but it is at the edge where contact happens.

Geller and Greenberg's research on therapeutic presence turned the pre-condition of relational depth into a trainable capacity. In their model, presence is composed of three phases: preparation, anchoring, and the

release of outcome. Preparation involves deliberate rituals before each session – clearing the previous hour, grounding in the body through breath or gentle movement, and setting an intention of openness. Anchoring refers to the sustained attention within the session, the ability to notice when the mind wanders, to return without self-attack, and to keep the therapist's own affective field in a state of receptivity. The release of outcome means letting go of the desire to make something happen, because a therapist who is busy trying to achieve a particular result is subtly absent from what is actually occurring. Geller and Greenberg demonstrated that the client's perception of the therapist's presence predicts both the therapeutic alliance and outcome, closing the loop with earlier evidence that presence is not decorative; it is the very vehicle of delivery.

The concept of the client's growing edge has its roots in the work of Rogers (1961) on the fully functioning person. It refers to the zone where the client's current narrative meets the as-yet-unarticulated feeling or belief that is poised to emerge. In practice, this edge is often signalled by a pause, a trembling voice, a sudden shift in posture, or a fleeting image that appears and disappears. The therapist's task is to stay with the moment, to hold the space without rushing to label, to mirror the affective tone, and to allow the client to move forward at their own pace. When the therapist does so, the relational field can deepen, and the client may experience a sense of being truly seen and heard, which in turn facilitates integration of the previously unprocessed material.

A concrete worked example illustrates how these conditions converge in a session. Marta, a 58-year-old woman who had been widowed for three years, presented with chronic grief and depressive symptoms measured by a PHQ-9 score of 16. She had narrated her husband's death many times in therapy, each account fluent and rehearsed. In a particular session, after saying, "and then I drove home," Marta fell silent. The therapist, having completed her preparation ritual – a brief grounding exercise, a mental clearing of the previous case, and an intention to be open – noticed the shift in Marta's breath and the slight tremor in her hand. Rather than offering a reflective summary or a probing question, she simply maintained eye contact, allowed her own affect to surface, and stayed present. After a minute of shared silence, Marta whispered, "I have never told anyone about the drive home." The therapist's response was not a technique but a holding of the moment; she nodded, her voice soft, and said, "I'm here with you."

Over the next few minutes, Marta explored the vivid memory of the road, the sudden feeling of loss that had been locked behind the routine narration, and the therapist's authentic affect mirrored her own. The session culminated in a profound sense of relief for Marta and a marked reduction in her anxiety, later reflected in a GAD-7 score that fell from 14 to 9. The depth experienced was not the result of a planned intervention but the product of the therapist's prepared presence, anchored attention, and willingness to release the outcome.

The evidence base for relational depth extends beyond anecdote. Safran and Muran (2000) place the therapist's capacity to stay present at the centre of repairing ruptures in the alliance, and a meta-analysis found rupture repair associated with better outcome (r = .29; Eubanks, Muran and Safran, 2018); therapist empathy, a core component of relational depth, also has a moderate association with outcome across modalities (Elliott et al., 2018). Moreover, social baseline theory proposes that the brain expects access to relationships that reduce risk and the effort needed to meet threats (Coan and Sbarra, 2015), which suggests one way in which relational experience is embodied.

Cultivating the conditions for relational depth therefore becomes a matter of disciplined practice. Preparation can be formalised into a two-minute pre-session ritual that includes a brief body scan, a mental clearing of the previous case, and the articulation of a single intention – for example, "I will be fully present to the client's emerging feeling." This ritual should be rehearsed for at least a month, with the therapist noting any resistance or distraction that arises. During the session, the therapist should engage in continuous self-observation, noting moments when the impulse to reach for a skill arises. When such moments are identified, the therapist can pause, take a breath, and return to the anchored attention on the client's affective field. After the session, a reflective note can be kept, documenting where the client's growing edge appeared, what the therapist's internal response was, and whether the therapist succeeded in releasing the outcome.

It is essential to recognise that relational depth is not a static achievement but a dynamic process. The therapist must remain vigilant to the shifting terrain of the therapeutic relationship, aware that depth can emerge, recede, and re-emerge as the client moves through different phases of change. The therapist's own self-care, supervision, and ongoing personal therapy are

integral to maintaining the capacity for presence. When the therapist's internal world is cluttered with unresolved affect, the ability to be fully present is compromised, and the relational field becomes thin.

In summary, relational depth is the mutual full presence at the client's growing edge, a phenomenon that cannot be manufactured but whose conditions can be tended. The three conditions – therapist willingness to be affected, suspension of technique as a shield, and responsiveness to the client's growing edge – are supported by a robust evidence base that links therapist presence to alliance, outcome, and even physiological synchrony. Geller and Greenberg's model of presence offers a practical framework: preparation, anchoring, and the release of outcome. By integrating a disciplined pre-session ritual, continuous self-observation, and post-session reflection, therapists can cultivate the fertile ground in which relational depth may arise. The depth itself remains a moment of lived experience, not a scheduled event, but the readiness to meet it can be cultivated, rehearsed, and refined, allowing the therapist to accompany clients into the most transformative parts of their journey.

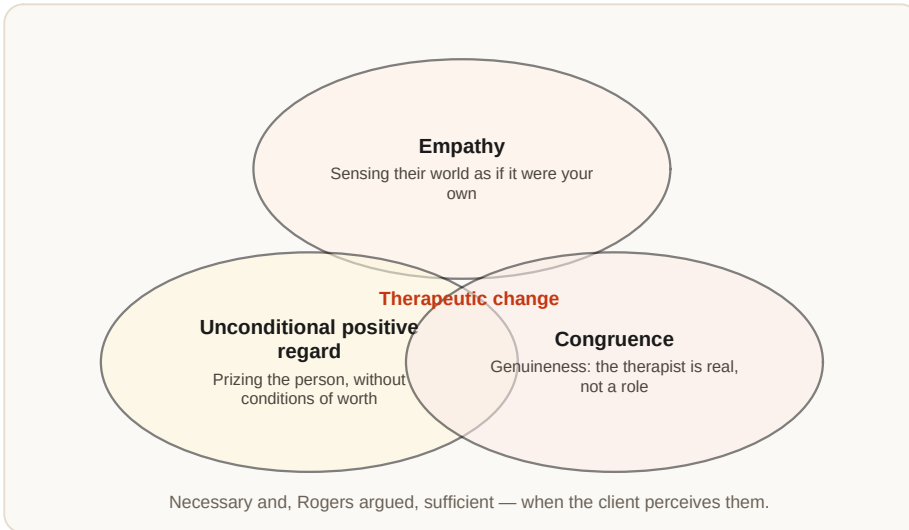


FIGURE 1.1 Rogers' core conditions

Person-centred therapy holds that when the therapist offers empathy, unconditional positive regard and congruence, and the client perceives them, the conditions for constructive personality change are present. They are ways of being, not techniques to perform.

Points worth keeping

- Relational depth: mutual full presence at the client's growing edge
- It cannot be manufactured; its conditions can be tended
- Presence is trainable: preparation, anchoring, releasing outcome

PRACTICE TASK

Recall your closest moment to relational depth in any role. What did you stop doing that made it possible?

CHAPTER 2

Enactment: when the relationship replays the problem

The relational work of an advanced practitioner is characterised by a paradox that becomes evident only after the therapist has remained with the client long enough for the client's central difficulty to move from the realm of description into the realm of lived experience. The client's core theme – whether it be abandonment, control, compliance, or any other organising pattern – ceases to be a story told about past events and begins to unfold in the therapeutic encounter itself. In that moment the relationship becomes a stage on which the client's problem is enacted, and the therapist, as a fellow participant, is drawn into the very pattern the client is trying to understand. This is not a sign of therapeutic failure; it is the point at which the material becomes most potent, provided the therapist can recognise and own their own contribution to the enactment.

The concept of enactment, as articulated by relational theorists such as Stephen Mitchell and Lewis Aron, refers to the moment when the client's unconscious relational script is played out in the here-and-now of the therapy session. Mitchell (1993) described enactments as the lived expression of unconscious relational patterns that emerge when the therapist, despite their best intentions, responds to the client's pull in a way that mirrors the client's historic expectations. Aron (1996) further clarified that an enactment is a duet: the client's relational pattern exerts a pull, and the therapist, being human, answers that pull before the pull is fully recognised. The therapist's response, whether it is an offer of rescue, a directive, or a collusive agreement, is the therapist's participation in the enactment. When this participation is noticed, named, and explored, the enactment becomes a laboratory for change; when it is missed, the therapy risks reproducing the client's original fate.

The first movement in working with an enactment is the therapist's noticing of the pull. This is a discipline of countertransference that is dressed in relational language. The therapist must attend to any unusual feeling that arises – a sudden dread, an unexpected delight, a sense of being drawn

towards a particular client, or a departure from one's usual practice norms. These feelings are data, not problems, and they signal the moment when the client's pattern is reaching across the therapeutic boundary. For example, a therapist who normally maintains a strict session schedule may feel an inexplicable urge to check a client's voicemail after a session has ended. That urge is the pull of a client whose life theme is abandonment, seeking reassurance that the therapist will not abandon them.

The second movement is the therapist's owning of their part, spoken aloud, without self-flagellation or blame. The therapist must articulate the observed pull in a way that invites the client into a joint inquiry. A formulation might be, "I have noticed that after our sessions I feel compelled to send you a quick message to see how you are doing, and I realise this is something I do rarely with other clients. I wonder whether this is part of the pattern we are both experiencing in our work together." By naming the therapist's own contribution first, the therapist creates a safe space for the client to reflect on their own role in the enactment, and the conversation remains survivable for the client.

The third movement is the collaborative wonder, where the therapist and client together explore what old pattern they have been rehearsing. This involves linking the in-room duet to the client's life outside therapy, identifying who else in the client's history has taken on the rescuing, directing, or colluding role, and examining the costs of those roles. The therapist may ask, "When we notice this urge to check in, what does it remind you of in your past relationships? Who else would have offered that kind of reassurance, and how did that feel for you?" This joint curiosity opens a space for the client to see the enactment as a demonstration rather than a report, and to consider alternative ways of relating.

When the enactment is handled in this three-step sequence, it becomes the most credible material the therapy will ever have, because it is not a narrative about the past but a live illustration of the pattern, observable by both participants. The therapist's honesty about their own participation models the possibility of breaking the pattern, and the client's awareness of the enactment provides a concrete target for change. Conversely, if the therapist fails to notice the pull, or if the pull is denied, defended, or allowed to run to its inevitable conclusion, the therapy reproduces the client's original fate, confirming the client's belief that the world is unchangeable.

To illustrate the process in concrete terms, consider the case of “Mia”, a 32-year-old woman who presents with a pervasive fear of abandonment. Mia’s history includes a series of relationships in which partners have left her, often after she expressed a need for closeness. In therapy, Mia describes herself as “always waiting for people to leave” and scores high on the PHQ-9, reflecting depressive symptoms linked to her abandonment fears. Over several months, the therapist, Dr. Patel, notices a subtle shift: after each session, Dr. Patel feels a strong impulse to send Mia a brief text checking in on her mood, a behaviour he has never exhibited with other clients. This impulse is accompanied by a feeling of anxiety that the therapeutic relationship might be at risk if he does not act.

Recognising the pull, Dr. Patel pauses before the next session and prepares to own his part. At the start of the session, he says, “Mia, I have become aware that after our sessions I have felt a strong urge to send you a quick message to see how you are feeling. I normally do not do that with other clients, and I realise this is something I am doing with you. I think this may be part of the pattern we are exploring together, and I would like us to look at it together.” By stating his observation without accusation, Dr. Patel invites Mia into a shared inquiry.

Mia’s response is initially hesitant, but as Dr. Patel continues, “When I feel that urge, I notice a sense of panic that something might go wrong if I do not reach out. Does this remind you of any experiences in your life?” Mia reflects, “It feels like the time when my mother would call me every night after I left the house. I always felt that if she didn’t call, something terrible had happened. I think I am expecting you to call me too, even though I know you have a professional boundary.” In this moment, the collaborative wonder unfolds: Dr. Patel and Mia link the therapist’s checking-in behaviour to Mia’s early relational script of needing constant reassurance. They explore the cost of this pattern – Mia’s anxiety and Dr. Patel’s boundary strain – and consider alternative ways of relating, such as establishing a clear plan for contact that respects both parties.

Through this worked example, the three movements become evident. The therapist’s noticing of the pull (the urge to text) provides the data; the therapist’s owning of his part (verbalising the urge) creates a safe container; the collaborative wonder (linking the urge to Mia’s early experiences) transforms the enactment into a learning moment. Over subsequent

sessions, Dr. Patel and Mia experiment with new relational behaviours, such as Mia expressing her needs directly within the session rather than waiting for an external check-in, and Dr. Patel refraining from unsolicited contact, thereby modelling a more secure attachment stance.

The broader clinical implication is that every therapist, regardless of theoretical orientation, must cultivate a heightened awareness of their own relational responses. The relational turn, as championed by scholars such as Jeremy Safran and Zvi Eisikovits, reframes the therapist's countertransference not as a hindrance but as a vital source of therapeutic data. When the therapist's participation is caught, the enactment becomes a laboratory for change; when it is missed, the enactment becomes a rehearsal of the client's original fate.

In practice, the therapist should maintain a reflective journal, noting moments of unexpected emotional response, physical sensations, or behavioural urges that deviate from their usual practice. These notes serve as a reservoir of potential pulls that can be examined in supervision. Supervision, in turn, should focus on the therapist's capacity to own their part, encouraging a stance of curiosity rather than self-criticism. The therapist's willingness to be vulnerable about their own participation models the authenticity that relational work demands.

It is also essential to recognise that enactments can take many forms beyond the obvious rescue or direction. A client whose pattern is compliance may present as overly agreeable, leading the therapist to experience a pleasant, conflict-free session that masks an underlying stagnation. In such cases, the therapist's enjoyment of the smooth interaction can be the pull, prompting a subtle shift towards a more challenging stance that invites the client to express disagreement. By naming this enjoyment, the therapist can prevent the collusive pattern from solidifying.

Finally, the therapist must remain vigilant that the enactment does not become a self-fulfilling prophecy. The moment the therapist recognises the pull, they have the opportunity to intervene, to pause the pattern, and to invite the client into a reflective dialogue. This intervention does not mean abandoning the relational authenticity of the enactment; rather, it means using the enactment as a springboard for insight and change. The therapist's ethical responsibility is to ensure that the enactment does not lead the client to the same dead-end that their past relationships have produced.

In sum, the phenomenon of enactment – the relationship replaying the client's problem – is a hallmark of advanced relational practice. It signals that the client's central difficulty has moved from abstract description to lived experience, offering a unique therapeutic opportunity. By following the sequence of noticing the pull, owning one's part, and wondering together, the therapist transforms the enactment from a potential failure into the most credible and transformative material available. This process demands humility, curiosity, and a willingness to be seen as a participant in the client's relational world, but the reward is a therapy that not only talks about change but demonstrates it in the very fabric of the therapeutic relationship.

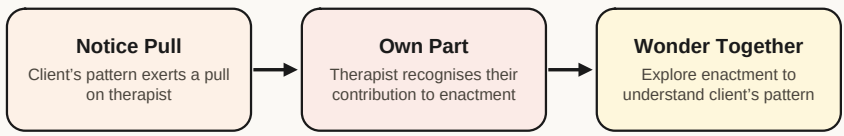


FIGURE 2.1 Enactment Process
The client's central difficulty is replayed in the therapeutic relationship, and the therapist must catch their own participation to make it workable. The sequence involves noticing the pull, owning one's part, and wondering together to explore the enactment.

Points worth keeping

- The client's central difficulty will eventually occur with you, not just be described
- Enactment becomes workable when the therapist catches their own participation
- Sequence: notice the pull, own your part, wonder together

PRACTICE TASK

Identify one characteristic pull you know clients evoke in you (to rescue, to withdraw, to impress) and write how you would own it aloud.