How Is Contextual Therapy Applied Today? An analysis of the Practice of Current Contextual Therapists.

Jaap van der Meiden MCH
Christian University of Applied Sciences Ede,

Martine Noordegraaf, Ph.D, Professor of Youth and Family,
Christian University of Applied Sciences Ede,

Hans van Ewijk, Prof. em. Ph.D
University of Humanistic Studies

Abstract

Contextual therapy focusses on restoring and enhancing relationships, based on its paradigm of relational ethics, presuming a human tendency for reciprocal care. It is precisely in a time of stressed relationships that this focus on strengthening humanity is of great importance. This article presents the first study on the application of this paradigm into concrete interventions of twelve current contextual therapists, answering the question: How do contextual therapists apply the contextual theory and therapy into concrete interventions? Using the Thematic Analysis, fourteen therapy sessions were analyzed, revealing a typical working-method and eight characteristic categories of interventions. The findings of this qualitative research reveal a consistent working-method and several recognizable contextual elements. These may contribute to further integrating the paradigm of relational ethics in family therapy and developing a contemporary contextual guideline for therapy. It also provides a conditional step for investigating the efficacy of contextual therapy, for evidence-based research, and for further development of the methodology of contextual therapy.

1. Introduction

In a time of increasing complexity and stressed, sometimes overburdened social relations, the contextual theory of Ivan Boszormenyi-Nagy and his associates (henceforth Nagy) with its specific view on the deeper structuring forces of meaningful relationships (Boszormenyi-Nagy & Spark, 1984, p. xxi), seems to be more relevant than ever. It offers a unique paradigm for relational and family therapy. This normative approach is consistent with a growing interest in the reassessment of mutual care and solidarity, in response to ‘an increasing dominance of a narrow pragmatic attitude, an increasing moral indifference towards the other ones, resignation and decline of respect’ (Meulink-Korf & Noorlander, 2012, p. 160). Contextual therapy assumes that within family relationships, important resources are available and originate from an innate tendency to care about other people (Boszormenyi-Nagy & Krasner, 1986, p. 78). This so-called relational ethical dimension, with a focus on mutual respect and fairness, is, according to the contextual theory, the common denominator for all personal, familial and social dynamics. A quantitative study on relational ethics in couples already confirmed the importance of fairness in

relationships (Gangamma, Bartle-Haring, & Glebova, 2012). Also others researched and tested (elements of) the contextual theory (Canevaro, 1990; Delsing, Aken, Oud, Bruyn, & Scholte, 2005; Delsing, Oud, & De Bruyn, 2005; Earley, Cushway, & Cassidy, 2007; Grames, Miller, Robinson, & Higgins, 2008; Hekken, 1990; Knudson-Martin, 1992; Kuperminc, Jurkovic, & Casey, 2009; Leibig & Green, 1999; Stein, 1992; Ziter, 1990). Furthermore, several authors elaborated on the rather complicated and conceptual contextual theory, contributing to its accessibility and transferability (Goldenthal, 1993, 1996b; Hargrave & Pfitzer, 2003; Krasner & Joyce, 1998; Michielsen, Mulligen, & Hermkens, 1998; Onderwaater, 2015; Rhijn & Meulink-Korf, 1997), where others researched the applicability of the contextual therapy to different target groups or problem areas (Gangamma et al., 2012; Gangamma, Bartle-Haring, Holowacz, Hartwell, & Glebova, 2015; Grames et al., 2008; Schmidt, Green, & Prouty, 2016; Wilson, Glebova, Davis, & Seshadri, 2017).

However, there has been hardly any publication about empirical research on the practice or outcome of contextual therapy. In the opinion of the authors, however, more knowledge about the application of the contextual theory and therapy is essential for the training of (upcoming) therapists and the further development of this approach. Hence, this article presents the first qualitative research on best practices of twelve contextual therapists, and answers the following question: How do current contextual therapists apply the contextual theory and therapy into concrete interventions? Identifying elements of the contextual theory and therapy in current therapy practices gives insight into its contemporary working method. In conjunction with an earlier research on the practice of Nagy (van der Meiden, Noordegraaf, & van Ewijk, 2017), this research may offer stepping stones for the development of a more verifiable working-method, which would be useful for the training of therapists. Such a working method is a prerequisite for investigating its efficacy and for conducting evidence-based research into contextual therapy.

This article continues with a concise description of the contextual theory and the research method used. Thereafter, the findings will be presented in categories, illustrated by example-fragments from the sessions and subsequently examined from the perspective of the contextual theory. This article ends with some concluding remarks and some recommendations for further research.

2. Contextual therapy

Contextual therapy is founded on a theory that postulates that every individual ‘has an innate sense of justice and a natural tendency to see justice served in interpersonal relationships’ (Adkins, 2010, p. 23). According to Nagy, justice is the underlying structure of these collective normative expectations and forms the context of relationships (Boszormenyi-Nagy & Spark, 1984, p. 111). Focusing on this innate tendency to care unlocks mutual care balances in interpersonal relationships (Boszormenyi-Nagy & Krasner, 1986, p. 78). This balance influences the development of trustworthiness between closely related people, especially family members. Next to the dynamics of justice and trustworthiness, the best known dynamic of this theory concerning relational ethics is loyalty: ‘a preferential attachment to relational partners who are entitled to a priority of “bonding”’ (Boszormenyi-Nagy & Krasner, 1986, p. 418). These three dynamics, justice, trustworthiness and loyalty, are the core of the contextual theory and relational ethics (Boszormenyi-Nagy & Krasner, 1986, p. xii).

Another characteristic element of the contextual therapy is its ‘framework for integrating concepts and techniques from diverse models of individual and family development, functioning, and therapy’

(Goldenthal, 1996a, p. 6). This integrative framework consists of four dimensions or determinants of relationships (Boszormenyi-Nagy, 1997) that must be considered in therapy: The dimension of the facts, the psychology, the transactions, and the dimension of relational ethics, the cornerstone of contextual therapy (Boszormenyi-Nagy, Grunebaum, & Ulrich, 1991, p. 204).

Nagy describes how this balance between giving and receiving care can be disrupted and can jeopardize relationships. Such disturbances carry for instance the risk of behavioral, emotional and developmental problems in children. Consequently, Nagy states that this leads to a revolving slate towards the future (Boszormenyi-Nagy & Spark, 1984, p. 67) when 'unfaced and unresolved, unbalanced intergenerational unfairness functions as an intrusive, mystifying element in later relationships' (Boszormenyi-Nagy & Krasner, 1987, p. 271). Therefore, contextual therapy is both an intergenerational and a preventive therapy; it is aware of how the impact of injustice in previous generations influences the next. Therefore, one of the main goals of contextual therapy is care for future generations.

Contextual therapists aim at 'stabilizing trust and positive initiatives between family members, especially as far as consequences for posterity are concerned' (Boszormenyi-Nagy, Carney, & Fedoroff, 1988, 1:44:12-1:44:24). Therefore, it focuses not so much on pathology but tries to elicit the always present but sometimes latent innate tendency to take care of the other. The basic strategy is 'rejunction', encompassing re-engagement of the family members through reinstate a fair balance of give and receive. This renews the capacity of reciprocal acknowledgement, and restores fairness and responsibility towards the more vulnerable family members and other close relationships (Boszormenyi-Nagy & Krasner, 1987, pp. 260–262).

The chief method in contextual therapy is multidirected partiality. It encompasses sequential siding with every family member, providing the opportunity for each of them to be open about both the missed care, as well as how the person concerned has tried to give care. This, so called, direct address is 'the cornerstone of dialogic possibilities' (Krasner & Joyce, 1995, p. xxi). The structure of distributing turns, namely, requires the non-speaking family members to listen. This may evoke understanding and acknowledgement for the speaking family member, if need be initiated by the therapist. It is an opportunity to develop individual autonomy, since inducing the dialogue between the family members enhances the process of self-delineation and self-validation. Next to this methodic element of multidirected partiality, it is also reflected in the contextual therapist's attitude: accountability to those who are potentially affected by the therapy, which is 'linked to the determination to discover the humanity of every participant, even the family's "monster member"' (Boszormenyi-Nagy & Krasner, 1986, p. 418).

Sometimes, family members are severely damaged by victimization in their own childhood. They gain special consideration from the contextual therapist, who may lead them into a process of exoneration: 'lifting the load of culpability of the shoulders of a given person whom heretofore has been blamed'. An important part of this process is an adult reassessment by which the grown-up child is helped to replace a framework of blame for understanding and appreciation for the parents and their situation back then (Boszormenyi-Nagy & Krasner, 1986, p. 416). This process is often accompanied by a transgenerational maneuver: working on the parents (bad) behavior towards the child, the therapist shifts the focus towards the suffering in the time the parent was a child himself. This parallel between the two generations may evoke insight and compassion with the suffering of the parent's own child (Boszormenyi-Nagy & Krasner, 1986, p. 321). 'Clinical improvement often coincides with the renewed capacity of parents to exonerate their own seemingly failing parents' (Boszormenyi-Nagy & Krasner, 1986, p. 416).

3. Method

This study provides an answer to the following research question: How do contextual therapists apply the contextual theory and therapy into concrete interventions? Interventions in this study are defined as all utterances of the therapist.

3.1. Participants

The data used come from Dutch contextual therapists. In 1967, the Netherlands was the first country outside the USA in which Nagy introduced his contextual therapy (Boszormenyi-Nagy & Krasner, 1986; Clemens Schröner, van Heusden, Fransen, & Blankenstein, 1967; Savenije, Lawick, & Reijmers, 2010). It appeared to catch on well, and in the last decades even a growing interest in this approach is observable.

All Dutch therapists who met the therapy-criteria of the Dutch professional organization for Contextual Workers (VCW) received an invitation to participate in this research. This group of therapists has the most extensive training in contextual therapy in the Netherlands, encompassing a four years training of psychotherapeutic theories and skills with a specialization in contextual therapy, combined with an extensive amount of supervision, learning therapy and experience. Thus, they may be expected to be the most capable of implementing the contextual theory in therapy. At the time that the invitations for participation in this research project were sent, this group consisted of 57 registered contextual therapists (Vereniging Contextueel Werkers, 2017). They were asked to participate by submitting one or more therapy sessions with Dutch clients without severe psychiatric problems or a mental handicap. Since this is an explorative study, no further limitations were given in order to make a cross section of contextual therapy practices.

Twelve therapists were willing to participate in this study, a response of more than 20%. This is a remarkable high percentage, considering the threshold for both offering behind-the-therapy-scenes impressions and obtaining permission from the clients involved. All twelve therapists, six male and six female, are between 45 and 65 years old, and have at least ten years of experience in conducting contextual therapy. Some therapists are also trained in a different modality, such as EFT, experiential interpersonal therapy, or system therapy.

All participating clients and therapists signed a consent form providing permission to use the recordings for this study. Since the participating therapists are part of a small group, this article does not provide any more specific information that can lead to recognition. In consideration of privacy, names stated in the recorded fragments were changed and city names are indicated by a capital letter.

3.2. Data

Ten of the twelve participating therapists recorded one session, and two of them recorded two sessions, a total of fourteen sessions: eleven video-recordings and three audio recordings. One of the sessions was a consultation session, recorded during a training day for upcoming contextual therapists. Two sessions were opening sessions with clients who were already familiar to the therapist because of a former therapy process. The other eleven sessions were taken out of an ongoing therapy process. Furthermore, eight of the sessions were conducted from the private practice of the therapist, and four of them come from an institution for ambulant family therapy.

3.3. Researchers

The data are first analyzed by the first author. Since the aim of this explorative study is to extract and analyze concrete interventions from the practices of current contextual therapist, it is an advantage that the researcher is a seasoned contextual therapist himself. The researcher is aware of his bias, knowing that reaching objectivity in such an exploring research is impossible. In an explorative qualitative research as this , 'the researcher is part of what he studies' (Charmaz, 2006, p. 178), which means that 'the subjectivity of the observer provides a *way* of viewing' (Charmaz, 2006, p. 139). The hereafter explained process of data collection, coding and categorizing 'serves as a genuinely explicit control over the researcher's biases' (Strauss, 1987, p. 11). To further monitor the researchers' subjectivity (Kumar, 2012, pp. 5–6; Maso & Smaling, 1998, p. 79), five of the twelve sessions were also analyzed by another senior contextual therapist. The findings of this colleague are discussed and helped to refine the analysis. The second and third author functioned as auditors, serving as 'an outside perspective to help the main researchers to correct their interpretations and present more trustworthy results' (Mörtl & Gelo, 2015, p. 421). They critically followed the different phases of all observations and analysis. Their remarks were regularly discussed and aligned with the first author, which presented 'windows of opportunity' for the clarification of emergent ideas and opportunities to gain new insights about the data (Saldaña, 2009, p. 28). These actions helped improve a methodological objectivity 'consisting of a reflecting, intelligent, positive application of the subjectivity of the researcher' (Maso & Smaling, 1998, p. 67). At the end of the analysis process, the codes, the categories as well as the relation with the contextual theory were also discussed with two of the participating therapists, which led to some refinements and adjustments. Finally, by adding some of the transcripts to this article, the reader can follow the interpretations, argumentations and analysis.

3.4. Analysis

The data are analyzed by using the Thematic Analysis (Braun & Clarke, 2006; Greg Guest, MacQueen, & Namey, 2012). The authors consider this method appropriate for this research, because of its clear structure combining an inductive and deductive analysis of the data and with the aim to recognize and compare the data with a theoretical framework (Alhojailan, 2012), in this research the contextual theory.

Hereafter the different waves are described:

- This qualitative research started with a process of familiarizing with the data. The recorded sessions are transcribed, using Jefferson's transcription conventions (Jefferson, 2004). This permitted the transcription of the spoken language as well as all other utterances such as laughing, weeping and silences. The data are not translated, except for the fragments that are used in this article. Both the recordings and the transcripts were loaded into Atlas.ti, a computer program for qualitative data analysis supporting coding and categorizing of the codes (Friese, 2012).
- The next step was carefully re-reading the transcripts and observing the recordings, now with the aim of identifying potential meaningful utterances of the therapists (interventions), and allocating a possible meaning, as for instance is advocated in grounded theory (Glaser & Strauss, 1967; McMillan & McLeod, 2006, p. 281). During the first, inductive analysis 'patterns emerged progressively without using a code table or preformulated sensitizing concepts (Baarda, Goede, & Teunissen, 2009; Braun & Clarke, 2006, p. 12; Miles, Huberman, & Saldaña, 2014, p. 81). In this way, all interventions were carefully examined and, where applicable, provided with a provisional code. Also a second wave of

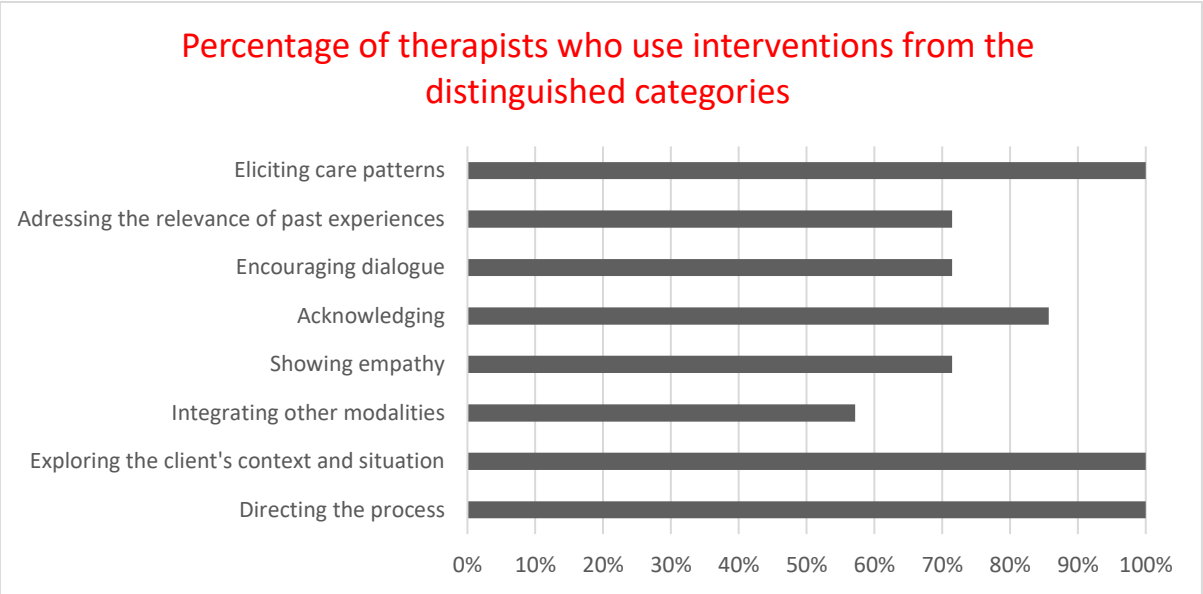
open coding followed, after which codes were compared, merged, renamed, deleted and new codes were added. This resulted in a collection of unsorted codes.

- Subsequently, a third and fourth wave were performed, using the contextual framework as reference. During these theoretical waves, whereby the analysis was more driven by the researcher's theoretical and analytic interests (Braun & Clarke, 2006, p. 12), new codes were added, renamed, merged, and removed.
- The next step was to search for themes and structures in the defined codes, and accordingly assign equivalent codes to the categories defined therein. Each category was then provided with a name, reflecting the structure, characteristics and patterns of the assigned codes. Since the analysis was focused on therapeutic interventions that could be recognized as part of, or related to the contextual theory and as such reveal elements of the contextual theory and therapy, the categories are named accordingly.
- Then, several new deductive waves were executed, comparing (parts of) the data with the currently developed code-list and categories, as well as with the contextual theory. This again led to a refinement of the codes, the assignment to categories, as well as re-naming the categories.
- Eventually, a last analysis of the data was executed to 'refine the specifics of each theme (…), and 'generating clear definitions for each theme' (Braun & Clarke, 2006). This wave verified the categories and the assigned interventions.

During the process, memos were designed to capture emerging insights and impressions (Baarda et al., 2013, p. 245; Friese, 2012, p. 141; Miles et al., 2014, p. 95). These memos where helpful in the analysis process and ultimately in formulating the findings.

4. Findings

As expected, in the interventions of the twelve well-trained and experienced contextual therapists, elements of the contextual theory and therapy are observed. The analysis resulted in 665 coded fragments (phrases of the therapists), and 124 codes, combined in eight categories of interventions. These eight categories present an equal number of characteristic elements, giving insight onto the way current contextual therapist apply contextual therapy in concrete interventions. The figure below shows how many of the respondents exhibited interventions in their session(s) from the distinguished categories. Three of the categories are used by all therapists: Eliciting care patterns, Exploring the client's situation and directing the process, where integrating other modalities is the category used by the smallest number of therapists, 57%.



Hereafter, the findings on this study are described per category, illustrated by examples of interventions and provided with a reflection from the perspective of the contextual theory. As such, not all of these categories are specific for contextual therapy. Obviously, there are similarities between the modalities in family therapy, not in the least also because of the importance of the common factors (Sprenkle, Davis, & Lebow, 2009). This concerns the categories acknowledging, showing empathy and integrating other modalities. But every modality has its own way of embedding and shaping these interventions in the therapy process. In contextual therapy, these more or less non-specific interventions gain their value by permeating them with a focus on relational ethics, which makes them indispensable building blocks for a contextual therapy process. Hereafter is described how contextual therapists do so. The most characteristic interventions belong to the categories: eliciting care patterns, encouraging dialogue, addressing the relevance of past experiences, exploring the client's context and situation, and directing the process.

4.1. Eliciting care patterns

All participating therapists and 12% of the encoded fragments are focused on eliciting care patterns, which is an expression of the central postulate of the contextual theory regarding the inter-subjectivity of human beings. According to Nagy, relational ethics in particular are reflected in reciprocal care, in the contextual theory formulated as the balance of mutual giving and receiving (Boszormenyi-Nagy & Krasner, 1986; Ulrich, 1983). This balance is one of the most well-known elements of contextual therapy and reflects something of the reciprocity and trustworthiness of the relationship. According to the contextual theory, encouraging family members to actively start giving, and to open up for receiving the giving of the other, is the most helpful intervention (Grunebaum, 1987, 1990; Krasner, 1986).

> Fragment 1:
> Therapist: yes, and and and now, now you are moving too fast. Because if I ask: what does it do to you (1) because you outline the situation for me and you start telling: yes, actually there was a moment of (1.5) how would you call that…
> Client: that moment would, that's how it should go (.) between father and son Therapist: yes, it

was a father–son moment at that point
Therapist: yes (P13:437-440)

Fragment 2:
Therapist: you're a bit you think it's scary, like children can find something scary and also a bit anxious maybe and actually does not know (.) it looks like something new (2) and how am I gonna do that now (7) who would be a person to you, to help you with this
Client: I do not know anything, I just need the Lord to help, I know nothing at all, I am scared to death, I'm afraid, I find it hard (6) (P19:181-182)

The contextual therapists are convinced of the importance of this relational dynamic. Fragment 1 shows how the therapist reflects on an encounter between the client and his father after a lengthy period without any contact. The therapist helps the client, the adult son, to receive his father's attempt to repair the relationship. In doing so, the therapist induces the balance of giving and receiving (Boszormenyi-Nagy & Krasner, 1986, p. 111).

Fragment 2 stimulates the client to think about the possibility of asking and receiving care, which would be a major step in overcoming the anxiety of this client about being vulnerable. She would gain entitlement and shape the possibility of entering a dialogue. This fragment also highlights how the focus on giving and receiving simultaneously elicits relational resources: 'factual and fundamental means, options and opportunities in people and their relationships by which they can improve and help themselves and others' (Boszormenyi-Nagy & Krasner, 1986, p. 420). A resource means a relationship with options for mutual beneficial action, implying that reciprocal receiving and giving are valued and thus provide opportunities for earning entitlement by a process of self-validation that is linked to due consideration of significant others. However, the explicit search for resources as illustrated in fragment 2, is only scarcely observed.

4.2. Addressing the relevance of past experiences

A recurring theme in eleven of the fourteen sessions and 7% of the encoded fragments is the relevance of past experiences for the here and now and for present relationships.

The contextual theory assumes that unjust and painful experiences, specifically during childhood, can become a revolving slate towards present and future generations and jeopardize the innate tendency to care for others (Boszormenyi-Nagy & Spark, 1984, p. 102). Especially within families and because of the invisible loyalty of the child towards the parents, it is, according to the contextual theory, the chief factor in family and marital dysfunction (Boszormenyi-Nagy et al., 1991, p. 212). Therefore, exploring such intergenerational patterns as repetitions of relational strategies learned in the family of origin is of great importance (Bernal, Rodríguez, & Diamond, 1990, p. 59). The following fragments show some examples of how the contextual therapists induce such an exploration.

Fragment 3:
Therapist: Rationally, I hear you telling that you know it all very well and are able to give words to it, but it seems something has touched you, something vulnerable, which is older than this event, do you recognize?
Client: Ehm (2) yes I think it is the same feeling of rejection, I also know ehm that I am doing

quite a lot of effort to go to birthdays and now I have come up with something I need to get somewhat looser in it (P23:61-62)

Fragment 4:
Therapist: Yes yes (.) And eh (1.0) you said of, I start to get somewhat more troubled by it.
Client: yes
Therapist: Can you tell something about that?
Client: in respect to eh making choices for instance
Therapist: hmhm
Client: then ehm (.) For example, then my father has the one point of view and my mother has the other. And they are then (r) really against each other
Therapist: Yes
Therapist: As a child you may see that perhaps, but then you are not so much aware of it.
Client: no
Therapist: but now as a grown-up woman, you can look back on how it was then (P16:59-69)

Fragment 5:
Therapist: and if you look at the quarrel last two weeks, two weeks ago, eh, and it's still about taking place
Client: (nods)
Therapist: (…) You you could ask yourself if not the same things happen here
Client: yes
Therapist: that you fight for it and that perhaps that is where- that that is what is going on
Client: yes, yes there is a parallel (P12:475-480)

In fragment 3, the therapist suggests that the source of the vulnerability of the client may lie in past experiences. Such interventions are aimed at evoking a willingness to explore these earlier events. Fragment 4 is an example of a next step, namely, how the therapist leads the client into adult reassessment, a process in which, according to the contextual theory, the client is helped to replace a framework of blame towards the failing parents 'with mature appreciation of a given person's (or situation's) past options, efforts and limits' (Boszormenyi-Nagy & Krasner, 1986, p. 416). In fragment 5, the therapist is speaking with a client who talks about unfairness in his own childhood but appears to be blind to his unfairness towards his own children. Then, the therapist connects the client's experiences as a parent with the victimization of the client's own childhood (Boszormenyi-Nagy, 1987b, p. 49), opening the parent's eyes. This is what Nagy calls a transgenerational maneuver: helping the parent as a parent, facing the parent as the child (debriefing P2). Nagy holds that this is specifically important in situations where severe destructive entitlement hinders the client's remorse about his or her own unjust behavior. However, looking at his or her unjust parenting through the eyes of the own victimization as a child evokes care.

4.3. Encouraging dialogue

Eleven of the twelve participating therapists actively encouraged the client to interact with family members (11% of the encoded fragments). This is observed in the sessions with one client as well as in sessions with two clients. Nagy states that evoking a dialogue between the family members is one of the main goals of contextual therapy.

Fragment 6:
Therapist: (2) What was it like at home, formerly
Client: Actually, we never talked about those things (…)
Therapist: (2) Could you ask for it?
Client: (2) Yes I think I now dare to. (P14:395-400)

Fragment 7:
Client: I'm not going to raise my voice soon
Therapist: You hear - you say something but you actually should=
Client: =that is what I mean that as hard as Kirsten screams loudly
Therapist: [Yes, exactly]
Client: [Yes] only [with me does not register] that it is heavy (.) and if she screams, it will be much heavier on me
Therapist: yes
Client: Yes indeed even heavier, because for me that is yes that is more how I do, as I do it then it is just my thing of: well I do not agree
Therapist: Because how do you ensure that your- if you say that you don't like this, how do you ensure that it is sufficiently clear to her and that she will take you into account (P21:612-620)

The above fragments show some examples of how the contextual therapists put this into practice, especially by siding with the individual client and enhancing the client's openness about his or her own needs and desires, leading to self-delineation and a capacity for direct address: 'a willingness to know one's own truth and to risk it in the service of building fairness and trust' (Krasner & Joyce, 1995, p. 217). This is consistent with what Nagy calls the individual goal of the dialogue, resulting in gain through earned entitlement, but intertwined with the relational goal of consideration of the partner (Boszormenyi-Nagy, 1996).

In this respect, it is important that the therapist is sequentially partial to every present family member, to avoid giving the impression of alliances against others, which is an essential element of multidirected partiality. In the analyzed sessions, this element of multidirected partiality becomes visible as turn-distribution. The fragments above are examples of how the therapist gives the turn to another family member:

Fragment 8:
Therapist: (4) What about you? There have been some things said about you… (P14:308)

Fragment 9:
Therapist: [What what] is your version so to say… (P21:240)

The contextual therapists appear to focus mainly on reinforcing the self-delineation of the client as an important prerequisite for engaging in dialogue. They rarely encourage clients to actively start a dialogue *during* the session. This occurred only in one session, probably mainly because only four of the fourteen sessions was with more than one client present.

4.4. Acknowledging

All participating therapists give recognition to their clients (11% of the encoded fragments). Nagy describes acknowledgment or crediting as 'recognition of the merit that has accrued to a person from his

or her offers of care and consideration, i.e., contributions that have earned the donor entitlement' (Boszormenyi-Nagy & Krasner, 1986, p. 413). In the contextual theory, entitlement means an ethical 'guarantee' of being cared for, earned through actions that merit trust (Boszormenyi-Nagy & Krasner, 1986; Gangamma et al., 2015).

> Fragment 10:
> Therapist: Yes, I think I think that you've helped your parents eh quite often
> Client: yes
> Therapist: to make it as as easy as possible for them hm?
> Client: that's right (P16:89-92)

> Fragment 11:
> Client: (…) Yes then that really has eh eh given a really big blow. The fact that I was not well supported and too much work to do and I just literally became overworked, I think. Looking back (2). Yes, that really was a low point.
> Therapist: yes (1) I can imagine that it (.) hit you, and that it made you somewhat depressed
> Client: yes
> Therapist: and you have fought yourself out (P14:2017-218)

In fragment 10, the therapist gives credit to a fourteen-year-old boy for him giving care to his parents. Emphasizing the giving of this client is, according to the contextual therapy, important to enhance the client's self-reward and trust. Acknowledging or crediting by the therapist is a therapeutic goal 'to guide family members towards self-rewarding avenues of autonomy and trust building. It is this self-reinforcing process rather than therapeutic acknowledgment *per se* that ultimately functions as a healing source' (Boszormenyi-Nagy & Krasner, 1986, pp. 113–114).

In fragment 11, the therapist gives a husband, in the presence of his wife, acknowledgement for a painful experience. This highlights another didactic function. By acknowledging each person's rights and past injuries, the therapist hopes to induce a process of mutual acknowledging between the family members, which enhances accountability and contributes to a fair and trustworthy relationship. Acknowledgement is also part of multidirected partiality.

4.5. Showing empathy

Ten of the twelve contextual therapists show empathy in their sessions (10% of the encoded fragments). In contextual therapy, it represents a way of taking care of the client and helping him or her to be open about sometimes long buried experiences and emotions. This way of empathic siding and showing the capacity to hear and sense the affective tone of the relational process is, according to Nagy, one of the first requirements of the trustability of the contextual therapist (Boszormenyi-Nagy & Krasner, 1986, p. 398). Hence, it is an aspect of multidirected partiality, and as such, it goes hand in hand with acknowledgment, as can be seen in fragment 12.

> Fragment 12:
> Therapist: You have a lot of fear in your life, right?
> Client: °Yes° (5)
> Therapist: Unsafe (P18:304-306)

Eight of the therapists also explicitly give attention to the emotions of the client, as illustrated in the following examples where the clients tell something about how they struggled themselves through a difficult period:

> Fragment 13:
> Therapist: you're not afraid of- and what I (.) what I see in you, you get a little emotional too huh?
> Client: [yes]
> Therapist: Well, that's all right. (P17:992-994)

> Fragment 14:
> Therapists: I can see that it touches you, if give words to it
> Client: Yes, it does indeed
> Therapist: Can you try to give words to what touches you in this? (P23:63-65)

In contextual therapy, this way of helping the client to surface his possibly long covered emotions is an important intervention, but it is more of a method than a goal. Emotions should be interpreted as an 'indicator of relational configurations, actions and plans' (Boszormenyi-Nagy & Krasner, 1986, p. 397), which possibly provides an entry into deeper motivations of the client's behavior. In that respect, Nagy cautions that 'the therapist's own natural feelings and reactions towards particular family members should be reined in by his own efforts to be partial' (Boszormenyi-Nagy & Krasner, 1986, p. 302).

Acknowledgement and showing empathy are elements of the therapeutic alliance, and as such, belong to the common therapy factors (Cooper, 2010; Reiter, 2014, p. 14; Sprenkle & Blow, 2004). But within contextual therapy, they are considered to be significant parts of multidirected partiality, and as such, important methodological interventions towards reciprocity and dialogue. Showing empathy and giving credit should make it 'more bearable to be held accountable and to extend empathy and acknowledgment to others' (Grunebaum, 1987, p. 648). According to the contextual therapy, it enhances the self-generating process of trust building and supports each person's courage to risk reengagement in relationships (Grunebaum, 1987, p. 649).

4.6. Integrating other modalities

Some of the contextual therapists make use of interventions that reflect, next to contextual therapy, another specific psychological or transactional framework (5% of the encoded fragments). Nagy himself was convinced of the added value of integrating other methods into a contextual therapy process (Boszormenyi-Nagy, 1987a, pp. 58, 121, 191; Boszormenyi-Nagy & Spark, 1984, p. xxi). The most notable are the observed interventions that show an influence of experiential interpersonal therapy (Bouwkamp, 1999) and interventions apparently coming from Emotionally Focused Therapy (Johnson, 2004).

> Fragment 15:
> Client: Uhm (5.5) yes then it happened, then I'm in a kind of vacuum or something, as I feel it where I [just]
> Therapist: [ok]
> Client: nothing is possible.
> Therapist: No, that is the question whether you can do nothing, (1.5) let's look at that. (1.5)
> Client: (lowers the head and sighs)

T: What does that sigh mean?
Client: (2.5) °That it is not easy°
Therapist: Yeah, but I like you to simply say that aloud to me. (0.5) Because now I get a sort of a sigh and then you look away and then I think oh my, I said something wrong or something or uh (P18:354-361)

Fragment 16:
Therapist: Yes, but I can - what I'm actually asking for is, we have talked about how you can extend the 'thank you' to your employees, for example, or to your mother or friend. How did that work through.
Husband: Not yet
Therapist: No? Because?
Husband: Honestly, eh haven't thought about it yet and didn't take the time to eh to think about it
Wife: It did not linger
Husband: No. It is still not there yet
Therapist: it's still too far away, is not it?
Husband: Yes. And I do know that it there, but it does not come out yet.
Therapist: And how does that feel now, if you stop and reflect on it, what do you feel about it
Husband: Well, just like I said to her last night, I get such a weird feeling in my gut that - and I get that more and more often with actions that I do (P25:90-99)

Fragment 15 is an example of how the therapist constructively shares his personal reactions and experiences as feedback to the client. The experiential interpersonal therapy assumes that the client's problems also appear in the relationship with the therapist. Both self-disclosure and personal feedback characterize the experiential interpersonal therapist (Bouwkamp, 1999, p. 469). Fragment 16, session with a husband and wife, is an example of an intervention that would fit in an emotionally focused therapy process. This approach holds that emotions are the most important factor in intrapsychic and interpersonal change (Johnson, 2004, p. 51).

Nagy himself did not extensively describe or demonstrate how such an integration should take place, except that relational ethics should always be the core guideline of a contextual therapy process (Boszormenyi-Nagy, 1987a, p. xiv, 121). This aligns with an assimilative integration: the incorporation of attitudes, perspectives, or techniques from an auxiliary therapy into a therapist's primary grounding approach, which, in contextual therapy, is the paradigm of relational ethics (Messer, 2001, p. 1,2).

4.7. Exploring the client's context and situation

All contextual therapists devote a significant part of their interventions to exploring the context and situation of the client(s) (31% of the encoded fragments). These interventions are mostly aimed at inviting, stimulating, and evoking the clients to be more open or to give concrete examples of their narratives or experiences (see fragments 17, 18, 19 and 20, respectively). Other interventions consist of questions to obtain more information and to encourage or help clients unveil possible covered or hidden elements of their past or other relevant matters.

Fragment 17:
Therapist: Tell me. (P17:505)

Fragment 18:
Therapist: Yes, and what happens next? (P21:124)

Fragment 19:
Therapist: Because what strikes me is that you too, you go in the defense isn't it? You're going to tell him that it is not true what he says… (P25:316)

Fragment 20:
Therapist: Mhm. Do give me an example (P18:228)

According to Nagy, 'information-gathering in contextual therapy is tantamount to exploring past and current balances of fairness and unfairness' (Boszormenyi-Nagy & Krasner, 1986, p. 140), basically encompassing the relational ethical context. A portion of the interventions assigned to this category are not immediately recognizable as exploring relational ethical issues, since they have an introductory or exploratory nature. But another part of the interventions clearly is related to exploring relational ethical issues, as can be seen in the example below in which the therapist examines whether there is a danger of split loyalty:

Fragment 21:
Therapist: Well that you, yeah, that you have to choose so much that you feel that you it going through yourself a bit
Client: Well that was a bit with that mobile. Because my father was really like: he needs that new subscription because his old mobile does not work anymore.
Therapist: Yes
Client: and my mother was so: well we can have it repaired and then he can really continue with his old subscription
Therapist: yes
Client: and then it is very difficult because they were both really steadfast and (1) that's it!
Therapist: yes
Client: so (1) that was quite difficult
Therapist: yes, yes, yes. And do they also have tensions about that together?
Client: (1.0) ehm (.) I do not know exactly if there really is tension [between them]
Therapist: No, no
Client: Since I do not try to involve myself so much [because]
Therapist: [no]
Client: if it is a bit of a kind of (.) a small quarrel between each other.
Therapist: Yes Yes. Because do you notice that you sometimes- that your parents uh have uh hassle to you? (P16:226-241)

In summary, the interventions of this category appear to play a significant role in uncovering themes and issues that are important for a contextual therapy process.

4.8. Directing the process

The participating therapists direct the process mainly with an attitude of approachability and amity towards the client (14% of the encoded fragments). Such an attitude aligns with the emphasis of

contextual therapy on the therapist as a trustworthy, reliable person and a fellow human being (Boszormenyi-Nagy & Krasner, 1986, p. 395), as for example in fragment 22 by self-disclosure:

> Fragment 22:
> Therapist: [Yes, of course], that that's- I have that too, hey and uh, that I cannot handle it, the moment that when I (.) people are critical where I don't agree, uhm, if you say failure and criticism from others, I think: where is ehm ehm where is the root of that, that you always have the idea, another is is is, who is, that you let it come in so strongly, what the other says, thinks, and maybe thinks (…) (P12:351)

This attitude contributes to a non-directive working-method, observed in most of the sessions of the contextual therapists. They follow the narratives of the clients and encourage them by questions or other interventions focused on the contextual paradigm of relational ethics. They wait for passages in the narrative that offer an entry into relational ethical issues. As soon as such a possible entry shows up, however, they show a more directive and sometimes persuading attitude. They also occasionally suggest or softly push the client in a rather directive way, freely interpret what the client says, or explicitly assert their opinion on these issues. These types of interventions seem to be designed to start or accelerate a certain process, or as Nagy explains: 'elicit therapeutic action' (Boszormenyi-Nagy & Krasner, 1986, p. 277). The following fragments are interventions that follows a story, told by the client, and where the therapists now highlight an element by which a possible entry into the realm of relational ethics can be found:

> Fragment 23:
> Therapist: it seems like the other is more important than yourself (P17:325)

> Fragment 24:
> Therapist: (1) Because she (the mother of the client) will have done her best
> Client: Yes, I know of course, sure (P14:379-380).

> Fragment 25:
> Therapist: Yes (1) And look what happens when walking outside. I think, yes, that is what you would like with your father. But you have no confidence in it yet, because you are just, just for the first time together, speaking with each other again. And I think that is hopeful (…) (P13:541)

The three above fragments illustrate such therapeutic actions towards self-delineation, adult reassessment and exoneration, respectively. According the contextual therapy, this is a way of 'planting seeds' through eliciting, catalyzing and influencing people and their motives (Boszormenyi-Nagy & Krasner, 1986, pp. 277–278).

5. Concluding remarks

This study started with the question: How do contextual therapists apply the contextual theory and therapy into concrete interventions? The findings provide empirical evidence for eight categories of therapeutic interventions, characterizing the practice of current contextual therapists. Combined with the explanation and illustration of how these characteristics play a role in applying the contextual paradigm in therapy, this research contributes insights into how the core elements of contextual therapy are nowadays applied into therapy.

Though the authors do not argue that the findings may be generalized for all contextual therapists, and that a similar research with other participants and characteristics would deliver identical findings, this study does present a convincing picture of implemented contextual elements in the practice of the respondents. Throughout the analysis, also a certain working-method for conducting a therapy session became visible. With an attitude of approachability towards the client, the therapist waits for opportunities to emphasize relational ethical issues, taking a more directive and sometimes persuading attitude. In subsequent studies, a comparison of the working-method of current contextual therapists with Nagy's practice could contribute to further deepening and clarification of contextual therapy.

This research presents good practices of contextual therapy and gives insight into how contextual therapy nowadays is conducted. The observed working method, combined with the described categories may be useful for developing and refining training programs and guidelines for upcoming contextual therapists. It provides also an opportunity for contextual therapists to use it as a mirror for their own practice, and to reflect on it in peer-to-peer coaching, in intervision or supervision. The findings of this research may be a starting point for composing a contextual taxonomy, as well as for the further development of a practice-based contemporary contextual approach or method. Ultimately, this research is a conditional step in investigating the efficacy of contextual therapy as well as the development of future efficacy studies.

As far as the authors know, this is the first study using the methodology of close observing and analyzing ‘real world’ data, encompassing recordings of therapy-sessions conducted by current contextual therapists. It provides practice-based insights into how therapeutic interventions are conducted and is thus helpful in refining and enhancing the application of the contextual theory in therapy and is recommendable for research on other models and modalities.

The aim of this study was not so much to gain insight into the sequential phases and steps of a complete therapy process, for which a research on one or more complete therapy processes would be necessary. Because this study aimed at recognizing the application of characteristic contextual interventions, the authors needed data from a number of single sessions of different therapists instead of researching only a small amount of complete therapy processes. This research was also not focused on determining which interventions are used most at which place in the process. Based on this research, no conclusions can be drawn about this, because the collection of the data has not been focused on a controlled dissemination of the recorded sessions on the therapy process.

The observations give rise to further investigation on the number of clients involved in therapy sessions conducted by contemporary contextual therapists, since only four of the fourteen sessions are with more than one client, where the other sessions in this research are with only one client. It may be related to obtaining permission from clients or other issues concerning the research setting. However, Jansen and van Waaij (Jansen & van Waaij, 2016) already found in their inventory among the caseloads of 57 contextual workers that nearly 60% of the cases were with only one client. Though contextual therapy does not prescribe who, and how many should attend the sessions, ‘optimal resource potential means bringing together as many people as can really work with one another toward mutual benefit’ (Boszormenyi-Nagy et al., 1991, p. 217). This is hardly reflected in the practice of the therapists, for which no conclusive explanation could be found. Possibly, it is part of a conscious methodological choice of the current contextual therapists, which would be important to know, relating to further development of a contextual working method.

Acknowledgements We would like to acknowledge the Dutch National Scientific Foundation (NWO), for funding this project (project number 023.004.047). Furthermore, we are grateful for the cooperation of the participating therapists and clients by giving permission to use recordings of their therapy sessions, by which they have made this research possible.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest

References

Adkins, K. (2010). *A Contextual Family Therapy Theory Explanation for Intimate Partner Violence*. The Ohio State University.

Alhojailan, M. I. (2012). Thematic Analysis: A Critical Review of Its Process and Evaluation. *West East Journal of Social Sciences*, *1*(1), 39–47.

Baarda, D. B., Bakker, E., Fischer, T., Julsing, M., Goede, M. de, Peters, V., & Velden, T. van der. (2013). *Basisboek Kwalitatief Onderzoek*. Groningen/Houten: Noordhoff Uitgevers.

Baarda, D. B., Goede, M. P. M. de, & Teunissen, J. (2009). *Basisboek Kwalitatief Onderzoek*. Groningen/Houten: Noordhoff Uitgevers.

Bernal, G., Rodríguez, C., & Diamond, G. (1990). Contextual Therapy: Brief Treatment of an Addict and Spouse. *Family Process*, *29*(1), 59–71. https://doi.org/10.1111/j.1545-5300.1990.00059.x

Boszormenyi-Nagy, I. (1987a). *Foundations of contextual therapy: Collected papers of Ivan Boszormenyi-Nagy, M.D.* New York: Brunner/Mazel.

Boszormenyi-Nagy, I. (1987b). The Context of Consequences and the Limits of Therapeutic Responsibility. In H. Stierlin, F. B. Simon, & G. Schmidt (Eds.), *Familiar realities: The Heidelberg conference* (pp. 41–52). New York.

Boszormenyi-Nagy, I. (1996). Relational Ethics in Contextual Therapy. In M. Friedman (Ed.), *Martin Buber and the Human Sciences* (pp. 371–382). Albany: State University of New York Press.

Boszormenyi-Nagy, I. (1997). Response to are trustworthyness and fairness enough. *Journal of Marital and Family Therapy*, *23*(2), 171–173. https://doi.org/10.1111/j.1752-0606.1997.tb00241.x

Boszormenyi-Nagy, I., Carney, D., & Fedoroff, K. (1988). *I would like to call you mother*. [Motion picture on VHS]. USA: AAMFT.

Boszormenyi-Nagy, I., Grunebaum, J., & Ulrich, D. (1991). Contextual Therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of Family Therapy, Vol. II* (pp. 200–238). New York: Brunner/Mazel.

Boszormenyi-Nagy, I., & Krasner, B. R. (1986). *Between Give and Take: A Clinical Guide to Contextual Therapy*. New York: Brunner/Mazel.

Boszormenyi-Nagy, I., & Krasner, B. R. (1987). The Contextual Approach to Psychotherapy: Premises and lmplications. In I. Boszormenyi-Nagy (Ed.), *Foundations of Contextual Therapy. Collected Papers of Ivan Boszormenyi-Nagy, M.D.* (pp. 251–285). New York: Brunner/Mazel.

Boszormenyi-Nagy, I., & Spark, G. M. (1984). *Invisible Loyalties: Reciprocity in Intergenerational Family Therapy*. New York: Brunner/Mazel.

Bouwkamp, R. (1999). *Helen door delen. Experientiële interpersoonlijke therapie*. Maarssen: Elsevier/De

Tijdstroom.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Canevaro, Al. A. (1990). Marital Crisis and the Trigenerational Context: A Model Of Short - Term Therapy. *Contemporary Family Therapy*, *12*(2), 115–127. https://doi.org/10.1007/BF00892490

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage Publications.

Clemens Schröner, B. L. F., Heusden, A. A. van, Fransen, W. A., & Blankenstein, J. H. (1967). Training van gezinstherapeuten. Leiden: Werkgroep Gezinsbenadering.

Cooper, M. (2010). The challenge of counselling and psychotherapy research. *Counselling and Psychotherapy Research*, *10*(3), 183–191. https://doi.org/10.1080/14733140903518420

Delsing, M. J. M. H., Aken, M. A. G. van, Oud, J. H. L., Bruyn, E. E. J. de, & Scholte, R. H. J. (2005). Family Loyalty and Adolescent Problem Behavior: The Validity of the Family Group Effect. *Journal of Research on Adolescence*, *15*(2), 127–150. https://doi.org/10.1111/j.1532-7795.2005.00089.x

Delsing, M. J. M. H., Oud, J. H. L., & De Bruyn, E. E. J. (2005). Assessment of Bidirectional Influences Between Family Relationships and Adolescent Problem Behavior. *European Journal of Psychological Assessment*, *21*(4), 226–231. https://doi.org/10.1027/1015-5759.21.4.226

Earley, L., Cushway, D., & Cassidy, T. (2007). Children's perceptions and experiences of care giving: A focus group study. *Counselling Psychology Quarterly*, *20*(1), 69–80. https://doi.org/10.1080/09515070701217830

Friese, S. (2012). *Qualitative Data Analysis with Atlas.ti*. Los Angeles: Sage.

Gangamma, R., Bartle-Haring, S., & Glebova, T. (2012). A Study of Contextual Therapy Theory's Relational Ethics in Couples in Therapy. *Family Relations*, *61*(5), 825–835. https://doi.org/10.1111/j.1741-3729.2012.00732.x

Gangamma, R., Bartle-Haring, S., Holowacz, E., Hartwell, E. E., & Glebova, T. (2015). Relational Ethics, Depressive Symptoms, and Relationship Satisfaction in Couples in Therapy. *Journal of Marital and Family Therapy*, *41*(3), 354–366. https://doi.org/10.1111/jmft.12070

Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Vol. 1). New Brunswick/London: AldineTransaction. https://doi.org/10.2307/2575405

Goldenthal, P. (1993). Contextual Therapy. Concepts and Treatment Strategies. In *Innovations in Clinical Practice: A Source Book (Vol. 9)* (pp. 131–143).

Goldenthal, P. (1996a). *Doing Contextual Therapy. An Integrated Model For Working with Individual, Couples, and Families* (1st ed.). New York/London: W.W.Norton & Company.

Goldenthal, P. (1996b). *Doing Contextual Therapy*. New York: W.W.Norton & Company.

Grames, H. A., Miller, R. B., Robinson, W. D., & Higgins, D. J. (2008). A Test of Contextual Theory: The Relationship Among Relational Ethics, Marital Satisfaction, Health Problems, and Depression. *Contemporary Family Therapy*, *30*(4). https://doi.org/10.1007/s10591-008-9073-3

Greg Guest, K. M., MacQueen, & Namey, E. E. (2012). *Applied Thematic Analysis*. Thousand Oaks: Sage Publications. https://doi.org/http://dx.doi.org.ru.idm.oclc.org/10.4135/9781483384436

Grunebaum, J. (1987). Multidirected Partiality and the "Parental Imperative." *Psychotherapy*, *24*(3), 646–656. https://doi.org/10.1037/h0085763

Grunebaum, J. (1990). *From symptom to dialogue Part Two: Marital Dialogue*. [Motion picture on VHS].

USA: G-N Productions.

Hargrave, T. D., & Pfitzer, F. (2003). *The New Contextual Therapy: Guiding the Power of Give and Take*. New York: Brunner-Routledge.

Hekken, S. M. J. van. (1990). Parent and Child Perceptions of Boszormenyi-Nagy's Ethical Dimensions of the Parent-Child Relationship. *Contemporary Family Therapy*, *12*(6), 529–543. https://doi.org/10.1007/BF00901040

Jansen, M., & Waaij, E. van. (2016). *Zien is weten*. Ede (niet gepubliceerd).

Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G.H. Lerner (Ed.), *Conversation Analysis: Studies from the First Generation* (pp. 13–31). Amsterdam: John Benjamins.

Johnson, S. M. (2004). *The Practice of Emotionally Focussed Couple Therapy* (2nd ed.). New York: Brunner-Routledge.

Knudson-Martin, C. (1992). Balancing the Ledger: An Application of Nagy's Theories to the Study of Continuity and Change Among Generations. *Contemporary Family Therapy*, *14*(3), 241–258. https://doi.org/10.1007/BF00901507

Krasner, B. R. (1986). Trustworthiness: The Primal Family Resource. In M. A. Karpel (Ed.), *Family Resources* (pp. 116–148). New York: The Guilford Press.

Krasner, B. R., & Joyce, A. (1998). Elementen van toegewijde verbintenis. In M. Michielsen, W. van Mulligen, & L. Hermkens (Eds.), *Leren over leven in loyaliteit. Over contextuele benadering* (pp. 51–80). Leuven: Acco.

Krasner, B. R., & Joyce, A. J. (1995). *Truth, Trust and Relationships. Healing Interventions in Contextual Therapy*. New York: Brunner/Mazel.

Kumar, R. (2012). *Research Methodology. A step by step guide for beginners*. London/Thousand Oaks/New Delhi/Singapore: Sage.

Kuperminc, G. P., Jurkovic, G. J., & Casey, S. (2009). Relation of Filial Responsibility to the Personal and Social Adjustment of Latino Adolescents From Immigrant Families. *Journal of Family Psychology*, *23*(1), 14–22. https://doi.org/10.1037/a0014064

Leibig, A. L., & Green, K. (1999). The Development of Family Loyalty and Relational Ethics in Children. *Contemporary Family Therapy*, *21*(1), 89–112. https://doi.org/10.1023/A:102196670

Maso, I., & Smaling, A. (1998). *Kwalitatief onderzoek : praktijk en theorie*. Amsterdam: Boom.

McMillan, M., & McLeod, J. (2006). Letting Go: The client's experience of relational depth. *Person-Centered & Experiential Psychotherapies*, *5*(4), 277–292. https://doi.org/10.1080/14779757.2006.9688419

Meiden, J. H. van der, Noordegraaf, M., & van Ewijk, H. J. P. (2017). Applying the Paradigm of Relational Ethics into Contextual therapy. Analyzing the practice of Ivan Boszormenyi-Nagy. *Journal of Marital and Family Therapy*. https://doi.org/10.1111/jmft.12262

Messer, S. B. (2001). Introduction to the Special Issue on Assimilative Integration. *Journal of Psychotherapy Integration*, *11*(1), 1–4. https://doi.org/10.1023/A:1026619423048

Meulink-Korf, H., & Noorlander, W. (2012). Resourcing Trust in a Fragmenting World. The Social-Economic Dimension and Relational Ethics in the Track of Boszormenyi-Nagy. *European Journal of Mental Health*, *7*, 157–183. https://doi.org/10.5708/EJMH.7.2012.2.1

Michielsen, M., Mulligen, W. van, & Hermkens, L. (1998). *Leren over leven in loyaliteit. Over Contextuele Hulpverlening*. Leuven/Amersfoort: Acco.

Miles, M. B., Huberman, A. M., & Saldaña, J. (2014). *Qualitative Data Analysis. A Methods Sourcebook*. Los Angeles: Sage.

Mörtl, K., & Gelo, O. C. G. (2015). Qualitative Methods in Psychotherapy Process Research. In O. C. G. Gelo, B. Rieken, & A. Pritz (Eds.), *Psychotherapy Research. Foundations, Process, and Outcome* (pp. 381–429). Vienna: Springer.

Onderwaater, A. (2015). *De onverbrekelijke band. Inleidingen & ontwikkelingen in de contextuele therapie van Nagy*. Amsterdam: Pearson.

Reiter, M. D. (2014). *Case Conceptualisation in Family Therapy*. New Jersey: Pearson Education.

Rhijn, A. van, & Meulink-Korf, H. (1997). *De Context en de Ander: Nagy herlezen in het spoor van Levinas met het oog op pastoraat*. Zoetermeer: Boekencentrum.

Saldaña, J. (2009). *The Coding Manual for Qualitative Researchers*. London/Thousand Oaks/New Delhi/Singapore: Sage.

Savenije, A., Lawick, M. J. van, & Reijmers, E. T. M. (2010). *Handboek Systeemtherapie*. Utrecht: De Tijdstroom.

Schmidt, A. E., Green, M. S., & Prouty, A. M. (2016). Effects of parental infidelity and interparental conflict on relational ethics between adult children and parents: a contextual perspective. *Journal of Family Therapy*, *38*(3), 386–408. https://doi.org/10.1111/1467-6427.12091

Sprenkle, D. H., & Blow, J. (2004). Common Factors and Our Sacred Models. *Journal of Marital and Family Therapy*, *30*(2), 113–129. https://doi.org/10.1111/j.1752-0606.2004.tb01228.x

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common Factors in Couple and Family Therapy*. New York: Guilford.

Stein, C. H. (1992). Ties that Bind: Three Studies of Obligation in Adult Relationships with Family. *Journal of Social and Personal Relationships*, *9*(4), 525–547. https://doi.org/10.1177/0265407592094004

Strauss, A. L. (1987). *Qualitative analysis for social scientists*. Cambridge: Cambridge University Press.

Ulrich, D. (1983). Contextual Family and Marital Therapy. In B. B. Wolman & G. Stricker (Eds.), *Handbook of Family Therapy* (pp. 187–213). New York: Plenum Press.

Vereniging Contextueel Werkers. (2017). Register Contextueel Therapeuten VCW reg. Retrieved May 2, 2017, from http://www.contextueelwerkers.nl/register-nl-therapeuten/

Wilson, K. L., Glebova, T., Davis, S., & Seshadri, G. (2017). Adolescent Mothers in Foster Care: Relational Ethics, Depressive Symptoms and Health Problems Through a Contextual Therapy Lens. *Contemporary Family Therapy*, *39*(3), 150–161. https://doi.org/10.1007/s10591-017-9417-y

Ziter, M. L. P. (1990). Family-Therapy and a Good Society - Fit or Misfit. *Contemporary Family Therapy*, *12*(6), 515–527. https://doi.org/10.1007/Bf00901039