Steen Halling, Marie McNabb, and Jan O. Rowe

Seattle University and the Psychotherapy Cooperative

Existential-Phenomenological Psychotherapy in the Trenches: A Collaborative Approach to Serving the Underserved

ABSTRACT

This article describes the origin and the work of a volunteer run nonprofit agency designed to provide low cost psychotherapy. The agency was developed by psychotherapists connected with the Seattle University graduate program guided by the vision of psychotherapy as a healing relationship and in response to a growing crisis in the mental health system. We address the benefits and the challenges of this collaborative effort, and especially the difficulty involved in successfully running an agency while staying true to a particular vision of therapy, collaboration, and community.

Introduction

In the current climate of cost cutting and emphasis on efficiency, the practice of psychotherapy faces many challenges: agencies are burdened by bureaucracy and proscriptions, psychotherapists in the public sector are challenged to make time and place to practice therapy and not just do case management, and psychologically distressed people are left navigating an increasingly complex, dehumanizing, and often expensive web of treatment options. This article

Journal of Phenomenological Psychology, 37:2
© Koninklijke Brill NV, Leiden, The Netherlands, 2006

documents the formation and work of the Psychotherapy Cooperative, run by a group of therapists who wanted to address this situation and form a community in which to practice. As members of the Cooperative, we wish to reflect back on its ten-year history and the challenges and benefits of our collaborative endeavor—some that are shared with other nonprofits and some that seem unique to the practice of psychotherapy. We reviewed minutes and documents from over the years, interviewed current and former members, and spent many months in dialogue. In addition to providing a history and a discussion of the practical experience of running our nonprofit clinic, we outline our vision of Existential-Phenomenological psychotherapy, the orientation that undergirds both our clinical practice and the organization of the clinic itself. Finally, we consider what we have learned about the nature of collaboration in a community committed to phenomenological practice.

Background

The Psychotherapy Cooperative, a small nonprofit agency, run entirely by volunteers, was started in 1996 by a group of Seattle University graduate psychology program alumni and professors in response to a growing crisis in the field of mental health services in Seattle and the surrounding area. This crisis was a reflection of changes in both the public and private sectors of the mental health system across the United States. Psychotherapy was becoming less affordable while the advent of managed care, emphasis on "prescribed treatments," and the growth of bureaucracy threatened the very existence of psychotherapy understood as a healing relationship rather than one where the psychotherapist is primarily diagnostician or technician.

Already in 1989 the Seattle Times had run an in-depth report on how the local mental health system was "Facing a breakdown" because of inadequate resources, poor coordination among agencies, legal restrictions, and lack of support for the staff providing treatment (Simon, 1989). The advent of "managed care," an attempt to control the escalating cost of health care by reducing the services provided to clients, typically made things worse. Although outpatient psychotherapy was not a contributor to this rising cost (Pipal, 1995), insurance companies moved to limit the number of sessions that they would cover and to increase the amount of documentation they required for treatment

to continue. Ivan Miller (1996) has argued that the efforts of managed care companies to substitute brief therapy for longer term treatment, even when this is counter-indicated, really amounts to rationing treatment. Further, the demand from third parties, such as insurance companies, for more information about the client threatens the confidentiality of psychotherapy, and a form of triangulation occurs as this third party becomes increasingly present in the psychotherapy office (Pipal, 1995, 1996). In the public sector, where the less-well-off seek care, various restrictions were likewise imposed on length of treatment and the types of problems that were covered. Although some authors (e.g., Minkoff, 1994) have argued that managed care does not necessarily pose a threat to community mental health, this is less than self-evident. For example, in their extensive study of over five hundred mental health agencies in New York State, Cypres, Landsberg, and Spellman (1997) found overall a decrease in long term therapy and an increase in brief therapy over a four year period. Most of those who seek treatment from mental health agencies have significant psychiatric problems and it is implausible that they could be adequate addressed through brief therapy.

During this period of crisis in the mental health system, the faculty of Seattle University's graduate program received ongoing descriptions from the students they supervised of how changes in requirements were affecting clients as well as staff. Seattle University's graduate program is closely connected to the local mental health community: second-year students do internships in community agencies, typically for twenty hours a week, over a nine to twelve month period. Increasingly, students reported that mental health agencies were run by people with graduate degrees in business administration, who had little understanding or appreciation of clinical issues. The subsequent preoccupation with the "bottom line" resulted in decisions that often adversely affected the well-being of clients and the morale of clinicians. In addition, these decisions were often presented as being based on clinical consideration when in fact they were at odds with traditional standards of care.

Awareness of these changes at the local and national level led to preliminary discussions among several faculty and a handful of alumni as to how we might help to address these mounting problems in the community. Gradually, we made outreach to two local Catholic Churches with the goal of starting to provide services for the less affluent among their parishioners. We also

hoped that they might be able to provide a space for psychotherapy services. In our initial deliberations during 1996 and 1997 we considered naming the fledging agency something like Parish Counseling Services, but we realized that this would lead prospective clients to think that we were a religious agency. Eventually we settled upon the name the "Psychotherapy Cooperative" to reflect both the nature of the service that we would be providing and the collaborative nature of our effort. We also ended up finding our own office, initially subleasing from a graduate of our program who was also a founder of the Cooperative, then leasing our own office in 1998, and eventually taking on the lease for a second office in 2000.

While we were aware of the tremendous need in the community for psychological services, we were also aware of our own limitations in providing services. At the time, the population that we seemed most able to serve were those unable to afford private practice and who were not disturbed enough to be eligible for state services. As clinical services were being developed, we realized that we needed a more structured and strategic approach toward the responsibilities of running the Cooperative. We formed a board of directors in 1998 when we registered with the State of Washington as a nonprofit organization. We developed formal bylaws as a matter of necessity when we applied for nonprofit status (501(c)(3)) with the federal government two years later. Once the federal government granted us nonprofit status, donations to the Cooperative became tax deductible.

According to the mission statement developed in the first two years, the goal of the Psychotherapy Cooperative is "to provide affordable counseling services to those who are not able to afford these services from therapists in private practice or from counseling and community mental health agencies. We also want to provide services where the length of counseling is determined by the needs of the client rather than by limits imposed by insurance companies or other funding sources."

Overview of the Cooperative

Currently, we have sixteen members, eleven of whom see clients, and six of whom provide supervision. Eight of our members also constitute the board of directors. This is a working model board which runs the day-to-day operations

of the agency (Gill, 2005). On average twenty to twenty-two clients are seen on a weekly basis.

We do not have a receptionist so prospective clients call our number and leave a message, and then we return their call. The stories clients tell about their experiences of seeking services and ultimately coming to the Cooperative reveal something about the current situation in mental health. When we ask people, as part of the intake, how they heard of us, the typical answer is "I couldn't tell you exactly, I have called so many places that are full and been referred to so many possibilities, that I have lost track." The Cooperative does no formal advertising, but we do contact mental health agencies and the local crisis phone line to let them know the range of services that we provide. A fair number are referrals from current or past clients or from psychotherapists who have some connection with the Seattle University graduate program.

From a practical standpoint, two members of the Cooperative have responsibility for the intake process, with a third person acting as supervisor. One has responsibility for returning messages left on the Cooperative's voice mail box. Approximately half of the callers are screened out. These are individuals whom the intake member determines should have services beyond what we can provide, such as 24-hour call, hospitalization or medication management, if they are facing legal problems, have serious characterological issues, or are actively suicidal. In the last year, we have seen an increase in calls from seriously or chronically mentally ill people as services in the community have decreased.

For those people who are screened as appropriate for the Cooperative, a brief history is taken by a second member of the intake team. There is generally a wait of a number or weeks or months before a therapist becomes available. Whenever people are put on the wait list or are declined services, we do make referrals to other agencies and therapist locator services, and we contact clients on the wait list once a month to stay connected with them and to see if they have found other services. When a therapist has an opening, the intake person, a supervisor, and the therapist discuss and decide which person on the wait list appears to be a good match for the available therapist. Once therapy begins, its structure is similar to that of a private practice. While we do not track this specifically, it seems that about half of our clients stay for

some months and the other half are "long term," meaning they are seen for several years.

For those on the intake team, the work is emotionally challenging. They are on the front line of the collapse in the mental health system and hear the more personal stories of what people have gone through to get to us. Accordingly, we have recently decided that those involved in the intake should present briefly at each clinical meeting in order to share the burden of doing this work as well as to keep everyone abreast about the calls we are receiving.

The psychotherapists in the Cooperative receive regular supervision either from the faculty members in the agency or from the more experienced alumni. Two alumni supervisors have teamed up and meet with two relatively new psychotherapists on a regular basis. This innovative approach to supervision has been effective and satisfying for the four clinicians involved. From the very beginning it has been clear to everyone that supervision provides essential support, opportunities for personal and professional growth, and a source of guidance and direction.

Having described the background that led to the spawning of the Cooperative as well as providing an overview of what this agency is like, we would like to offer a brief outline of our understanding of psychotherapy in order to describe more fully our clinical practices within the Cooperative.

The Psychotherapeutic Relationship

Our understanding of the nature of human experience has its roots in the existential-phenomenological tradition with its emphasis on experience-as-lived and the centrality of the meaning people give that experience (e.g., Boss, 1957/1963; May, 1961, 1981; Yalom, 1980); the humanistic tradition, with its focus on the desire for and movement towards the realization of one's potential (e.g., Rogers, 1961; Maslow, 1971; Bugental, 1978); and the neo-analytic tradition with its concern for the early interpersonal development of the individual, and the impact of this on later relationships and one's experience of self (e.g., Sullivan, 1953; Kohut, 1971; Stolorow & Atwood, 1992).

While these traditions provide useful "maps" for understanding human behavior, and we value greatly the insight they provide, we believe the essence of the

healing that occurs in psychotherapy to be grounded in the humanness of the therapeutic relationship, a relationship that ultimately transcends theory. When van Kaam (1966) writes of existential psychotherapy he is not referring to another school of psychology, but instead writes that it "embraces an attitude, an orientation of attention, which I find, to some degree, present in all schools of psychotherapy and psychiatry" (p. 11). It is this attitude we work toward. We see this relationship as the collaborative venture between one who is identified as the psychotherapist or helper and another who is identified as the client. The therapist is concerned with providing a psychological as well as physical space where a relationship can develop that allows for the exploration of the difficulties the client is experiencing so that new, more satisfying ways of living may emerge. To this end we make a number of assumptions about the work we do as psychotherapists and the people we see:

1. Whatever distress or troubles people are experiencing, they make sense in light of their history and/or current life circumstances. They have direction or intent and need to be taken seriously, even if the "sense" does not seem clear and seems illogical or even pathological (e.g., being afraid to go out in a crowd has some point, even if it is not obvious). It is by honoring the importance of the other's upsetness in his/her living that the therapist gives the client permission to be with his or her own experience as opposed to insisting on a "quick fix." As one client with a long history of physical and emotional abuse said, "It was okay for me to be wherever I was even when it wasn't okay with me" (Rowe, 2001).
2. The agency of the client is always assumed, respected, and acknowledged. The very act of making an appointment with a therapist, when one feels helpless and hopeless, is a decisive act that indicates that there is at least a glimmer of hope that things can be different. Havens (1989), describes working with a young woman who had displayed self-destructive behavior that was particularly disturbing to her over-protective mother: "I did not tell her when to come, how often, whether to sit or lie down . . . I had confidence in her and wished her freedom. She did not abuse my trust, and when she was ready, she left. She did not need me anymore, nor me to tell her so" (p. 3).

3. The primary "tool" the therapist has is his/her person and all this entails: history, professional training, personal psychotherapy, and current life situation. The therapeutic venture will be more satisfying insofar as the therapist is willing to enter into this relationship, to make the relationship with the client his or her primary concern during the time they are together, and to be open to being touched and surprised by the encounter. As Warkentin and Valerius (1976) contend, "The therapist's entire being is committed in the service of the patient's effort. Our whole character is present and to some degree perceptible to the patient" (p. 155). It is this commitment that communicates without words the willingness of the therapist to authentically engage with the client.
4. The therapist's primary skill is the capacity to hear the request for help from the one seeking treatment. This is a skill that is developed through many avenues, (e.g., consultation) but most importantly it is honed as the therapist experiences his/her own struggles with being human. This allows him/her to see in the client a fellow human being rather than something less. Writing of their co-therapy with a very disturbed hospitalized patient who early on in the treatment wanted to leave the interview and the hospital so she could "lead a normal life," Whitaker and Malone (1953) write, "She was not a patient until the therapists not only theoretically knew, but more important subjectively felt, she was asking for help [from her schizophrenic isolation]. With the concurrence of her need felt in both herself and the therapist, she became a patient" (p. 69).
5. The notion of "sitting with," being with, and "witnessing" what the client is experiencing in the moment, rather than leaping ahead to correct, communicates a fundamental and radical acceptance of and respect for the person of the client. This in and of itself calls into question the client's relationship to him or herself and at the same time helps him or her to bear the pain so it is experienced as less formidable, dangerous, and/or toxic. Basically, this means being in a relationship in a way that is new for the client. Havens (1989) remarks about a patient who was full of self loathing and allowed others to take advantage of him, "He had to be able to hate me even as he looked to me for affirmation and acceptance" (p. 46).
6. It is important to note that every therapeutic relationship is different because each client and therapist is a unique twosome. For the therapist

the question is, "How can I be of most use to this particular person at this point in his/her life?" Warkentin (unpublished paper, 1975) suggests, "A young woman, who habitually stimulated competitive arguments with men, repeatedly left our own interviews with a sense of peaceful confusion; I just offered my presence without combat. If another patient comes in with intellectual questions I will begin to offer whatever intellectual answers I have available. If a patient comes with confusion, I will participate in outlining the confused areas of his life. If he comes with emotional torment, I make every effort to feel this with him . . . Thus, I am prepared for a great variety of interviews including silently sitting together" (p. 3).

7. Finally, we strive to be open and receptive to the newness of every session with a client. In a profound way we embrace a stance of "not knowing" (Lawner, 1981) so that ideally we are in a space free of expectations and assumptions where we can see more clearly what presents itself. Thus, we can never predict where the relationship will take us nor can we ever know what is best for our clients. We can, however, participate as fully as possible in their life's movement and be engaged in reflection on that movement. According to Karasu (1992) the fundamental axiom of psychotherapy speaks to this: "Indeed, the phenomenon [healing] arrives irrespective of out best expertise, most scrupulous planning, or even profoundest portents—and it applies to every patient, every session and every nuance, as the clinician must continually experience the ongoing process anew" (p. 286).

This way of working professionally not only reflects us as psychotherapists but as persons. While not conducting ourselves in our everyday living with the discipline we bring to the office, we tend to approach life and others, particularly those whom we trust (such as our fellow co-op members), with an open, non-judgmental, and appreciative stance.

The Cooperative has provided a place where we can indeed hold these principles as primary because the most obvious constraints of money and government or insurance company regulation have been removed. But this does not mean therapist and client sit easily in this place. The brief therapy model (and medicated quick fix) creeps into the therapy room. We say to our clients "Relax, you have all the time you need" but our clients often respond, "I've

been coming six weeks, why am I not better?" or, when they are further into therapy, "I'm not always sure what we're doing."

Also, since our practice runs counter to the prevailing culture, we have our own doubts to address. The philosophy outlined above, perhaps because it is short on specifics, requires a certain amount of self-reassurance. We are outside the norm, both in seeing clients for an open-ended period and also in continually reexamining ourselves in relationship with our clients. Therapists can achieve some grace and authority in the realm of abstractions and theories, but when it comes to working with clients we are confronted with the messiness and uncertainty of this type of endeavor.

The additional level of "messiness" is that the therapeutic tradition of which we are a part acknowledges that therapists develop their own style or way of doing therapy (within broad parameters) as a function of who they are as persons. Thus to discuss with others how one is working with clients involves being vulnerable and taking a leap of faith; there are few clear-cut criteria against which one can assess whether one's approach is "correct." Even more so than in most professions, to talk specifically about one's work is to bare one's soul. This means that the building of an atmosphere of trust is a critical responsibility for the board as well as every member of this nonprofit.

Ultimately, however, the Cooperative has given people with limited income a choice about the length of their treatment and we are pleased that many have chosen to continue in long term therapy. It has also given us, as psychotherapists, a place where we can practice in accordance with our deepest values and aspirations.

The Meaning and Nature of Collaboration

Words like collaboration and cooperation are used rather liberally; it is assumed that these are good things, that they are principles and practices that one should emulate. The implementation of these principles is, however, neither straightforward nor without difficulty. "Nonprofit" and "volunteer" are also words with a positive connotation, but perhaps they are a little easier to define. However, as Pearce (1993) points out in her book, *Volunteers: The Organized Behavior of Unpaid Workers*, little is understood as to what motivates volunteers

to continue to serve in the absence of pay. Of course, there is a distinction between nonprofit organizations with paid staff and those staffed exclusively by volunteers, like the Cooperative, certainly in terms of size and structure, and probably in terms of what members seek through their participation.

Because of this distinction, much of the nonprofit literature we reviewed required some honing before it applied to the Cooperative. Issues of maintaining culture in the face of bureaucracy, the impact of turnover of executive directors and boards, and fluctuations in funding are much grander in scale in most other nonprofits than what we face as a small organization. On the other hand, accounts of some nonprofits resonated with our experience in surprising ways. For example, a description (Clifford, 1998) of the Aspen Mountain Rescue Team—a team of volunteer mountaineers who face pressures to define a "standard of care" (p. 115) in the face of diverse, at times, trauma-inducing situations—reminded us of our own rational for volunteering and the strength of the bond that forms among those who share such a commitment. "I would just about guarantee that everybody on Mountain Rescue is partially on Mountain Rescue because they see themselves on the other end of the line," (Clifford, 1998, p. 35) just as most therapists have awareness of, if not personal experience with, the depth and distress of human experience and have been called to accompany others through difficult times.

In what follows we will discuss the nature of the collaborative process in the Psychotherapy Cooperative, what we have learned about the reasons our volunteers participate in this endeavor, and reflect on the bond formed among these therapists.

Approach

The authors met approximately monthly for about a year to review documents and notes from the years of the Psychotherapy Cooperative's formation, to talk about impressions of the Cooperative in action, to discuss relevant literature on psychotherapy and nonprofit ventures, and (gradually) to form an intention about what we wanted to say in this article. We also distributed a draft of the paper at two different points to all past and present members of the Cooperative and set aside time at two of our monthly clinical meetings to discuss the paper and to reflect on the history of the Cooperative.

In order to gather more impressions of the volunteers' relationship to the Psychotherapy Cooperative, one of the authors conducted semi-structured interviews with current and former members of the Cooperative. We are in agreement with Pearce (1993) that in-depth interviews are the best way to arrive at a meaningful understanding of the attitudes of volunteers.

The non-faculty author (Marie McNabb) conducted the interviews in hopes that the interviewees would be more candid with her. We selected the interviewees randomly after separating the members by current versus former status. Four names were selected and all four members agreed to be interviewed. The interviews were transcribed and then edited by the interviewer to remove identifying details. The topics explored included the experience of joining the Cooperative, thoughts on their relationship to the faculty members, impressions of the balance between process and action, and the ability to speak freely at meetings of the Cooperative. We asked two questions of a hypothetical nature: what would you tell a friend considering joining the Cooperative? and what advice would you have for others thinking of forming such a therapeutic group? Quotes from the four interviews are included below and coded A-D.

Overview of Results

Our research and dialogue led us to several areas of reflection about the challenges and benefits of forming and joining our cooperative, similar in many respects to other nonprofit endeavors. The dissimilarities that we uncovered led us to further reflection about the ways that a cooperative of therapists is unique, with the particular experience of collaboration in this context appearing as a central and relevant theme.

That is, what is the nature of our working together to run a clinic and support each other in our therapeutic practice and to remain in ongoing dialogue with each other, not just around clinical issues but also with regard to issues that have to do with creating viable structures, protocols, and doing strategic planning.

Challenges

The formation and maintenance of the Cooperative has certainly presented challenges, some of them unexpected. These include keeping the agency financially stable and compliant with regulations, resolving differences among members as to the direction of the Cooperative, and fostering development of volunteers. Our basic therapeutic stance is highly process-oriented and flexible and, as indicated above, we have always been very mindful of what we did not want to become. However, this working-board model emphasizing process does not necessarily work so well when running a business and when planning ahead in financial terms. As an example, it was in the midst of a fundraising event seven years after organizing that we realized that we needed a city business license and suddenly had to pay fees covering those seven years. Although we have become more structured in the running of the Cooperative, it is still fair to say that we are a long way from becoming encumbered by what Max Weber called “the hazards of routinization.” Kelley, Lune and Murphy (2005) have argued that this concept applies to voluntary service organizations that are originally organized around a strong vision and strong leaders and then over time tend to become much more bureaucratic.

The lack of bureaucracy may create a more level field among members, but it also has an effect on our group dynamics. The interviewees noted a tendency to “process, process, process” (B) and spoke to the weariness that comes with adopting consensus as a decision making model “It seems like we revisit and revisit and revisit. I think a lot of that is out of deference for other people’s feelings and . . . not wanting to step on anybody’s toes, but it also gets to the point where ‘if we could just make a decision’ and ‘I thought we had decided on this’” (A). “I mean, who’s going to make a decision for God’s sake? Nobody’s going to make a decision, there are so many possibilities, we’re just endlessly deliberating, you know? Which is our greatest strength as well” (D). As this last member noted, we can appreciate that the time is well spent, even if it is sometimes exhausting.

The Cooperative’s progress toward financial stability has similarities to the balancing of administrative structure and flexibility. When we started the Cooperative, there was discussion about how much, if anything, to charge the people we would be seeing as clients. This has been an on-going discussion over the years and has raised many issues we have with money:

some personal, some clinical. But the reality is that unless we have a certain average monthly income, these issues are moot. We will cease to exist. We also realized that if client fees do not cover costs, then fundraising becomes a greater requirement. So the question becomes: how do we run a business in the most efficient way without losing the spirit or the mission? If we lose sight of that—while we may be solvent—what brought us together and keeps us together will be lost. This is a tension that we have been coming to grips with as a group. So far our basic solution has been to negotiate fees with clients based on their available income.

Relying entirely on volunteers placed significant demands on every member of the board both in terms of time and expertise. We have had several discussions regarding hiring someone to facilitate intakes and maintain contact with people on the waiting list. However, the cost of hiring someone, even on a part-time basis, has been well beyond our means. By training, the members are therapists and professors of psychology, but by necessity we have become treasurers, interior decorators, marketers, and fundraisers. In addition, engagement in the business and organizational side of the agency was at best reluctant, and in that specific dimension the agency was run by relatively inexperienced leaders, which can be risky in terms of the survival of a nonprofit (Chambre & Fatt, 2002). However, over time we have become somewhat more efficient and strategic in order to get done what needs to be done and have either developed or found enough expertise to move forward.

In the interviews, members said that the commitment of time and energy was something they didn't understand fully as they joined but became an issue later. "I think I kind of jumped the gun on that, I just was so excited to just participate . . . It took a little bit of adjusting to that" (B). "Just be mindful this is a commitment you make and don't make it lightly because you've got people counting on you, so be very clear and sure that that's how you want to spend your energy" (A). The interviewees who had left the Cooperative cited demands on their time and the financial value of their time as the primary reasons for leaving.

Such pressures of time and resulting lack of opportunities to meet as a group have made it difficult to develop a clear sense of community and develop some of the protocols that (in the long run) would make the operation of the Cooperative easier. For example, the intake process has taken a more defined

and workable shape only after many incarnations. At other times, members have complained that a preoccupation with procedural matters seemed to supercede clinical focus: the mission of the Cooperative and what most engaged us. On the other hand, we find that therapist attendance at our monthly clinical meetings, which is deliberately voluntary, is sometimes sporadic. This is perplexing and also hinders community building.

This pattern of attendance highlights, perhaps, the fact that people have a variety of motives for participating in the Cooperative. A number of alumni of the program saw this primarily as a method for moving toward licensing by getting supervised hours of practice. For this and other reasons, there has been a good deal of turnover in the Cooperative as people have moved away, retired, or gone on to different undertakings.

This change in membership has made it a challenge to maintain a sense of continuity. An interviewee termed it "one hit after the other of letting go of important relationships . . . and that complicated, for me, being fully present to somebody new coming in" (C). There is currently a sense that the Cooperative needs to plan for these inevitable membership changes or perhaps be more concrete in terms of the level of commitment expected when new therapists join. However, it is probably inevitable that those who remain will feel a loss for the group-that-was no matter how nice the newly-formed group may be. It is clear that the members of our group have grieved as long-standing volunteers have left.

In principle, the founders had a shared vision of what this endeavor would look like, but (as always) once we started to make decisions differences emerged, both those that were previously evident (e.g., should this clinic become a placement for graduate students or not) and those that were not evident (e.g., different notions as to how new volunteers should be brought into the Cooperative). Addressing these differences has been complicated by the fact that most members are related outside the Cooperative through the university, and we suspect that most of us, frankly, prefer to avoid conflict. Upon reflection, we see several examples of decision-making, such as the process for inviting people to become members, which might have led to a fuller debate. Our sense is that over time, disagreements have been voiced more readily, and that as a result we have fuller discussions leading up to decisions.

Initially all members of the Psychotherapy Cooperative were either alumni or faculty from the same program; the faculty-student dynamic that already existed tended to continue, even if with some modifications, into this new enterprise. Yet in terms of our work as board members those definitions of who was a leader and who was a follower came to be something of an obstacle. Furthermore, for the most part, the alumni members have been seeing clients while the faculty provided supervision, thus reinforcing the existing dynamics. Over time several alumni became supervisors of new members of the Cooperative thus increasing their level of responsibility, although still in consultation with faculty. It seems, looking forward, that the Cooperative's biggest challenge may be finding ways to evolve beyond this dynamic.

Benefits

With all the challenges described above, one wonders how this effort could continue on and be able to draw in new members and provide services. The answer is that there are clearly benefits involved in this collaborative effort. For example, there is the satisfaction of participating in the movement of their clients' lives, being part of a community with regular in-depth discussions about psychotherapy, learning from colleagues with diverse backgrounds, having the opportunity to develop one's own therapeutic style, and enjoying the companionship of people with similar values. As several studies of volunteers point out (e.g., Pearce, 1993; Chambre & Fatt, 2002; Kelley, Lune & Murphy, 2005) the emotional connections among them is crucial to keeping them involved.

The challenges related to the faculty-student dynamic just discussed are balanced by many benefits, especially leveraging this dynamic for group cohesiveness. It is also clear from the interviews that the faculty members carry significant weight. Especially when discussing the time of joining the Cooperative, the interviewees referred to faculty as "The wise ones" (D) "god-like" (A) and noted "their knowledge so much surpasses mine" (B). Each interviewee referred to the emergence over time of a peer or friend or collegial feeling with the faculty members, "just being able to rub shoulders with them a little bit and you see that they question the same things that you do and . . . some of the same things I was dealing with, they were as well"(A).

The faculty are also recognized in the interviews as structurally important, "a built-in board" (B), and as supervisors: "To have supervision with faculty after graduation through certification and beyond"(C). The faculty carried administrative and program experience from Seattle University into the Cooperative which has doubtless made things easier over the years. In all of these respects the faculty members probably have much in common with charismatic founders of any nonprofit: leadership abilities, expertise in the stated mission, and respect within a given community (Pearce, 1993).

The Cooperative emerged from the Seattle University clinical program and it is clear that some members have joined to maintain an existing connection, not only to the faculty, but also to the program's philosophy and to like-minded therapists. In other words, continuing as members of a larger community has been important. Although the Cooperative now has two members who graduated from other programs, and we are likely to add others in the future, it is still mostly made up of Seattle University graduates. We believe that these pre-existing relationships and commonality of study and outlook have contributed to the direction and success of the Cooperative. Although we would by no means claim that such a shared background is necessary for the development of this kind of organization, we do believe that it has been helpful, especially in the beginning years.

Having a place where there can be a meaningful clinical discussion within a therapeutic community—a part of our work that we felt did not get enough time—is also rewarding even if it has been happening on less of a scale than most wished for. There is the enjoyment of being together as a community and feeling supported in terms of shared values in a world that at times seems quite inimical to a genuine valuing of the personal and the relational aspects of life, and of the therapeutic vision that the graduate program embodies. Several of our members are acutely aware that they can do case management outside of the Cooperative, but that there are very few opportunities for doing psychotherapy in the public sector.

For new therapists, the Cooperative has become a site where they can develop their own therapeutic style in the context of a setting that provides supervision and support but where much of the decision-making is left to the therapist. There is an overall philosophy, but not a lot of definitive guidelines beyond the obvious. One interviewee summed it up: "I was kind of wet

behind the ears and wanting to really see clients and be able to integrate the learnings and have an opportunity to do that with such close supervision and community around me" (D).

The Cooperative provides opportunities for the more experienced therapist members as well. Several therapists have become supervisors, again in a well-supported atmosphere and with supervisors who know their strengths and styles. And all of us have taken on responsibilities that are at least somewhat different than have been the case previously (facilitating board meetings, speaking for a position on which some do not agree, finding ways to do intakes that are effective, etc). We have seen members' hidden talents emerge in response to particular challenges which both helped the Cooperative and aided the members' personal and professional development.

Above all our primary mission is to provide psychotherapy. The Cooperative supports people in the larger community and also has a growing reputation in the community as a place where one can affordably participate in long term therapy (thereby enhancing the psychology department's distinction in training very good therapists). Therapists and supervisors reap the rewards that go with long term work—seeing at least some people "come into their own" and make significant progress in their lives, and do this in a way that is unhurried and "organic." Endings with clients can also happen in a more relaxed manner, providing what is becoming an increasingly rare opportunity for therapists to examine their own attachment to clients at a deep level.

Finally, given what was and is happening in the larger mental health community, being part of the solution (even if in a very modest way) helps us to feel less demoralized and more hopeful. Each interviewee referred to the Cooperative as a buffer against managed care and one put it well, saying, "In this odd country where mental health [care] is just laid to waste, that's one of the draws, . . . [audible sigh] back to being with, sitting with, experiencing with, a patient" (A).

Reflection on Collaboration and the Cooperative

We recognize that the challenges and the benefits we have described are likely to be common to other nonprofits or any large collaborative group. Like the

Cooperative, this type of organization typically lacks a clear leader, disdains a lot of structure, varies in rank and file commitment over time, and usually has a noble mission to which members are indeed committed—but each in his or her own way (Gill, 2005). Even subtle shifts in leadership, attendance, and other group dynamics can bring about unexpected changes in the members' experience of the organization. Such shifts can leave members feeling ungrounded by change or loss, struggling with commitment if the mission seems out of focus, or simply worn down by the demands of running the organization. In this respect the Cooperative is not unique, even though its history and mission is distinctive.

Likewise the benefits are similar to those of other nonprofits in giving members a space somehow closer to the heart of the identified mission. Each interviewee referred to the opportunity to give back and to meet an important need. To work without pay carries a different sense in Western society and volunteers make a statement in doing so. Earlier we included the fact that members take on a variety of roles as a challenge, and yet it may be that nonprofits provide people with lower risk opportunities to do a little something different, or to lay some of the groundwork that is often taken for granted in larger organizations.

However, it seems reasonable to assume that the mission of, or the practice inherent in, any co-operative group impacts the process of that group. The illegal, back-alley nature of the early syringe exchange programs combating the spread of HIV/AIDS (Kelley et al., 2005) can be seen as a primary motivator for the first volunteers: "Volunteers were conspiring together under conditions of risk to address a problem that no one else would touch. As credibility grew and additional sources of support became available, individual commitment was less essential. Some volunteers lost interest" (p. 381). The proximity to danger and death of members of Aspen Mountain Rescue (Clifford, 1998) probably exerts power outside of the actual rescue. "What forges this bond is the shared fear and shared horror of what Mountain Rescue members do . . . they work in a world that is largely their own, and they depend on one another not only to survive it, but to understand it" (p. 154). What seems distinctive to the practice of psychotherapy, beyond a similar, if usually more subtle, closeness to life and death, is the way therapy, of whatever orientation, draws on the style of the individual therapists.

This personal involvement is even more of an issue for therapists encouraged to practice within a phenomenological or interpersonal stance. With clients, the therapist must speak to the space they share with the client rather than follow a technique. With peers or supervisor, the therapist must face again the real and therefore at times inelegant way they did or did not manage to connect. And within the broader therapeutic community, the Existential-Phenomenological therapist must try to explain his or her model to a society holding an increasingly formulaic way of seeing and addressing psychological distress. To attempt to form a community in the midst of these pressures may present unique challenges for the group attempting to support such a project.

Every therapist ultimately weathers the reality of this demand in his/her own way, with differing needs for support, for independence, to be free from—or surrounded by—counsel at crucial times with clients. But at least one of the missions of the Cooperative is to attempt to support its members as they do this work. What are the tricky parts of supporting each other?

Especially in a modality that demands one be genuinely oneself with clients, it is still hard (and maybe harder) to be an individual in a group. The relatively brief answers to the interview question "Can you be straightforward in your opinion when you are meeting with the other members of the Cooperative?" generated two almost identical answers, paraphrased as "I am always straightforward. But actually, I often hold back and don't speak within the Cooperative." This hesitancy to speak may be read as an acknowledgment about how careful one must be with comments or advice, and this hesitation is entirely appropriate when one is discussing clinical issues. But we also see it as evidence of the vulnerability that is felt as a therapist considers whether or not to share details of their work. In reflection, it may be that discussing a case, especially a "messy" one, has much more in common with revealing a work of art or poetry than describing a medical course of treatment. Again, the issue of trust is central.

As we discussed above, the two interviewees who had left the Cooperative referred to the practical demands of time and money as being the main reasons that they withdrew. In addition, one referred to a vague sense of wanting something more, referring to a sense of "stuck-ness" and the other referred to emotional demands and the complexity of her particular position within

the Cooperative. Both referred to the personal nature of the decision: "It was pretty—, personally, I needed a change for myself" and "I also became very aware of how my time was being spent and I just needed to make some choices about that." The particular and personal nature of the reasons brings to mind the importance of acknowledging the full range of one's needs—including those of an everyday sort. Ironically, therapists may be more comfortable discussing the "big" existential issues that arise around our work, but perhaps not so much the "little" ones involving our children, our bankbooks, and our commute, which ultimately may drive our decisions to just as great a degree. In addition to that, therapists may be reluctant to acknowledge the need for help or support.

In gathering these various reflections into a statement of how we see the Cooperative's mission impacting the collaboration within our particular group we arrive at the notion of change. That is, to make a commitment to provide relationship-aware therapy to those disadvantaged economically—and to make this commitment for the long term—means walking into unknown territory. We are going to be involved in long term change, just like our clients. Change is both exciting and stressful, and it is core and constant to the practice of therapy. It is after all what we seek with our clients. However, the longevity of the group, health of the community and the quality of therapy we practice depends on our ability to keep remembering that change is hard and that constant change can wear us out. We should care for each other, and accept this care, just as we care for our clients. Happily, the same principles of psychotherapy outlined above can be applied within our collaborative group, namely that our chaos makes sense, that openness is a necessity and that ultimately it is our relationships that sustain us.

Recommendations and Conclusion

Running the Cooperative takes time and energy. In the midst of our work with this agency we occasionally pause and remind ourselves of what is core to this effort, that is, the relationship between psychotherapist and client. At a recent meeting when the members of the Cooperative discussed this paper, one therapist reflected on how for her psychotherapy is a vocation, and how in mental health settings where she had worked previously there was little

room for her to follow her vocation. This is what the Psychotherapy Cooperative was about for her, and, we believe, for all of us.

One of our clients also made an interesting observation about our orientation. This client is a graduate student in psychology and is quite familiar with different therapeutic modalities. In one of her classes they considered the theory and practice of various modalities, including the existential-phenomenological and got more of an experiential feeling for each one through role plays. After one of these classes, she commented that doing existential therapy requires "a whole lot of trust in your clients." Although for the client it was an off-hand remark, it was, nonetheless, an apt summary of a fundamental principle of our work, namely that the therapist is often the primary holder of faith in the process.

These two words—vocation and trust—are foundational to our practice and the Cooperative as a whole. The realties to which they point are difficult to achieve. To be true to our vocation and to develop trust requires a lot of each of us and indeed, sometimes seems beyond us. They both call us but seem continually out of reach. Yet it is our commitment to these values that in the end sustains us in doing psychotherapy and in working together as part of this larger project in attempting to make psychotherapy available to the underserved.

When we started to write this paper, our main goal was to describe the formation and work of the Psychotherapy Cooperative as accurately as possible so that other psychotherapists could learn from our experience. We have tried to be as faithful as possible to the realities of this project, with its ups and downs. But as we discussed the paper, at various stages of development, with current and past members of the Psychotherapy Cooperative, it started to have a second purpose. It became a vehicle for all of us to reflect on what we were doing together, identifying what was working well, and what issues needed to be addressed. Over time, the board has become more strategic in its decisions. It has become more mindful of the specific qualities and skills that we need in new board members, and more aware of the fact that while reliance on the faculty members who helped to get this volunteer-run organization started was inescapable, in the long-run, the responsibility has to become more evenly distributed. In the last year or so, the Cooperative has

in fact moved in this direction. At the same time, all of the members of the Cooperative want to protect and enhance the values, and the sense of community and solidarity that holds us together. For this reason, it is likely and prudent for the Cooperative to be relatively cautious when it comes to making decisions that might bring about changes (such as increasing in size) in its basic structure and way of operating. At the same time, there are changes underway, such as increasing the diversity of the Cooperative in terms both of its members and the clients that it serves, that if done thoughtfully will enhance the mission of the Cooperative.

As we reflect back on the first decade of this small volunteer run clinic, we are grateful for the work we have been able to carry out, for the companionship of our fellow volunteers, and for the fact that the Cooperative is solvent and has become better organized. When one starts out—as a parent, a business owner, or as member of a nonprofit—one really doesn't quite know what one is doing. The volunteers who started the Cooperative had a vision and an enthusiasm that has endured, and now we also have a better understanding born of some years of experience. We are hopeful that this experience will serve the Cooperative well during its next ten years.

Acknowledgements: We wish to thank the present and past members of the Psychotherapy Cooperative who provided feedback on earlier versions of this paper, and who helped to make it as much their statement as ours. We also appreciate the insights of the four members of the Cooperative who so willingly agreed to be interviewed about their experiences with and views of our clinic.

We are grateful to Professor Yvonne Harrison, of the Seattle University Center for Nonprofit and Social Enterprise Management. Yvonne gave generously of her time and expertise, helping us to find relevant literature from the nonprofit field, and providing us detailed comments on an earlier version of the manuscript.

We want to thank Karen Lutz, the very literate Administrative Assistant in the Department of Psychology at Seattle University, whose careful proofreading of the manuscript has been invaluable. Finally, we appreciate Jennifer Schulz' generous donation of time and expertise in a final reading and editing of the manuscript.

This paper is based, in part, on a presentation given at the International Human Science Research Conference, University of Bournemouth, UK, August 2006. We are grateful to our colleagues at that conference for their encouragement and suggestions.

Appendix: Current and Former Members of the Psychotherapy Cooperative

KEY: italics = former member; P = psychotherapist; I = intake; S = supervisor; B = board member; O = officer of the Board.

Wes Anderson	P; B.
Karl Brown	P.
Kim Buehlman	P; B.
Shannon Cornwall	P.
Susan Fenner	P; B; I; S.
Lane A. Gerber	B; O; S.
Steen Halling	P; B; O; S.
Cheryl Hamack	P; B.
Karen Halsey	P; S; B.
David Hostetler	P; S; B.
Tim Kneedler	P; S; B; O.
Don Kuch	B; I.
Dalis LaGrotta	P.
Tim Leahy	P; B.
Marie McNabb	P; B.
Joan Murphy	P; I.
Josephine L. Rosner	P; S; B.
Jan O. Rowe	S; B; O.
Claire Steele	P; S; B; I.
Jen Stoakes	P; I.
David Van Rask	P.
Vicki Sween	P; I.

References

Boss, M. (1963). *Psychoanalysis and Daseinanalysis*. New York: Basic Books. (Originally published 1957.)

Bugental, J.F. (1978). *Psychotherapy and process.* Reading, MA: Addison-Wesley.

Chambrẽ, S.M., & Fatt, N. (2002). Beyond the liability of newness: Nonprofit organizations in an emerging policy domain. *Nonprofit and Voluntary Sector Quarterly, 31*, 502-524.

Clifford, H. (1998). *The Falling Season: Inside the life and death drama of Aspen's Mountain Rescue team*. Seattle: The Mountaineers.

Cypres, A., Landsberg, G., & Spellman, M. (1997). The impact of managed care on community mental health outpatient services in New York State. *Administration & Policy in Mental Health, 24*, 509-521.

Gill, M.D. (2005). *Governing for results: A Director's guide to good governance*. Victoria, BC: Trafford.

Havens, L. (1989). *A safe place: Laying the groundwork of psychotherapy*. Cambridge: Harvard University Press.

Havens, L. (2000). Forming effective relationships. In Sabo, A.N., & Havens, L. (Eds.), *The real world guide to psychotherapy practice* (pp. 17-33). Cambridge: Harvard University Press.

Karasu, T.B. (1992). *Wisdom in the practice of psychotherapy*. New York: Basic Books.

Kelley, M.S., Lune, H., & Murphy, S. (2005). Doing syringe exchange: Organizational transformation and volunteer commitment. *Nonprofit and Voluntary Sector Quarterly, 34*, 362-386.

Kohut, H. (1971). *The analysis of self*. New York: International Universities Press.

Lawner, P. (1981). Reflections on the "unknown" in psychotherapy. *Psychotherapy: Theory, Research and Practice, 18*, 306-312.

Maslow, A.H. (1971). *The farther reaches of human nature*. New York: The Viking Press.

May, R. (1961). *Existential psychology*. New York: Random House.

May, R. (1981). *Freedom and destiny*. New York: Norton.

Miller, I.V. (1996). Ethical and liability issues concerning invisible rationing. *Professional Psychology: Research and Practice, 27*, 583-587.

Minkoff, K. (1994). Community mental health in the nineties: Public sector managed care. Comm*unity Mental Health Journal, 30*, 317-321.

Pearce, J.L. (1993). Volunteers; The organized behavior of unpaid workers. New York: Routledge.

Pipal, J.E. (1995). Managed care: It is the corpse in the living room? An exposé. *Psychotherapy, 32*, 323-332.

Pipal, J.E. (1996). Without apology or fear: Reflections on Hoyt and Budman (1996) and managed mental health care. *Psychotherapy, 33*, 124-128.

Rogers, C. (1961). *On becoming a person*. Boston: Houghton Mifflin.

Rowe, J. (2001, January). *Who changed the rules: Reclaiming intimacy in psychotherapy* Paper presented at the Alumni Dinner, Seattle University, Seattle, WA.

Simon, J. (1989). At the breaking point: A mental health system in crisis. *The Seattle Times* (January 8-12).

Stolorow, R., & Atwood, G. (1992). *Contexts of being: The intersubjective foundations of psychological life.* Hillsdale, NJ: Analytic Press.

Sullivan, H.S. (1958). *The interpersonal theory of psychiatry*. New York: Norton.

van Kaam, A. (1966). *The art of existential counseling: A new perspective in psychotherapy*. Rockaway, NJ: Dimension Books, Inc.

Warkentin, J. (1975). *Experiential psychotherapy: A contrast to rational emotive psychotherapy.* Unpublished manuscript.

Warkentin, J., & Valerius, E. (1976). Seasons in the Affairs of men. In A. Burton (Ed.), *What makes behavior change possible?* (pp. 152-176). New York: Brunner Mazel Inc.

Whitaker, C.A., & Malone, T.P. (1953). *The roots of psychotherapy*. New York: The Blakiston Company.

Yalom, I. (1980). *Existential psychotherapy*. New York: Basic Books.

Copyright of Journal of Phenomenological Psychology is the property of Brill Academic Publishers and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.