Chapter 1

Five Facets of the Therapeutic Relationship

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> There is a kind of food
> not taken in through the mouth:
>
> Bits of knowing that nourish love.
> The body and the human personality form a cup.
> Every time you meet someone, something is poured in.
>
> (Rumi 1991: 50)

> Epistemologically, the things we see (people, objects, etc.) exist only in relationship and, when analysed microscopically, they too are best viewed as relationships. It is no secret in physics (Capra 1975; 1978) that the closer we analyse some 'thing' the less it appears as a thing and the more it appears as a dynamic process (things in relationship). Consequently, relationships become a primary source of our knowledge of the world. This can be taken to the ontological extreme by stating that things do not exist ... that, in fact, things ultimately are relationships. (Cottone 1988: 360)

Introduction

Relationship, or the interconnectedness between two people, has been significant in all healing since the time of Hippocrates and Galen. It seems to be one of the principal features in any major change, or '*metanoia*' (Clarkson 1989b), in people's lives, whether this happens as a result of falling in love, being in crisis, educational development, religious conversion or effective psychotherapy (see also Field 1996).

A current definition of psychotherapy reads as follows: 'The . . . systematic use of a *relationship* between therapist and patient – as opposed to pharmacological or social methods – to produce changes in cognition, feelings and behaviour' (Holmes and Lindley 1989: 3; emphasis added). (It is interesting to note that these integrative dimensions of *affect*, *behaviour* and *cognition* were identified by Beutler in 1971.)

Relationship can be defined as 'the state of being related; a condition or character based upon this; kinship' (Onions 1973: 1786). Wilkinson (1994) expressed it as 'A sustained pattern of communication and response involving two or more people'. Relationship is the first condition of being human. It circumscribes two or more individuals and creates a bond in the space between them, which is more than the sum of the parts. It is so obvious that it is frequently taken for granted and so mysterious that many of the world's greatest psychologists, novelists and philosophers have made it a focal point of a lifetime's passion. According to the received wisdom of the late twentieth century, of all the forces of nature it is our familial relationships that often cause the most damage. Statistically, you are more likely to be killed by a relative than by a stranger.

This chapter is concerned with an elucidation of relationship, the *between-ness*, of people. It is common knowledge that ordinary human relationships can have psychotherapeutic value. The old structures of religion, accepted moral order and extended family networks used to provide supportive relationships and healing matrices for many people. These appeared to crumble in the twentieth century. Indeed, it is possible that psychotherapy as an institutionalised profession became necessary as a consequence of such a decline in society and of the availability of healing relationships which had been available in earlier centuries.

It is the intention of this chapter to make explicit what is often implicit in the psychotherapy literature regarding the variety and nature of psychotherapeutic relationships. It may remind experienced clinicians of what has been forgotten, and novice psychotherapists of what they may still need to learn. It provides perspectives from different approaches and schools and attempts to reach across and between them. This may begin to clarify confusion in the literature and contribute towards precision and purpose in clinical practice. This section also provides a brief overview of the field, which will be covered in far greater depth in the rest of the book.

The relationship in psychotherapy

More and more research studies (Bergin and Lambert 1978; Luborsky et al. 1983; O'Malley, Suh and Strupp 1983; Hill 1989) demonstrate that it is the relationship between the client and psychotherapist, more than any other factor, that determines the effectiveness of psychotherapy. That is, success in psychotherapy can best be predicted by the properties of the patient, psychotherapist and their particular relationship (Norcross and Goldfried 1992). Yet few books deal directly with the relationship. Those that do tend to focus on the working alliance or the transference/countertransference relationship to the exclusion of others.

A growing body of research pays attention to the match between client and psychotherapist, considering the influence of such factors as compatibility in terms of background, class, education and values (Garfield and Bergin 1986). For Goldfried (1980) and Padesky (2000) the relationship is the cornerstone of all psychotherapy. Research has also shown that one of the most influential factors in the outcome of psychotherapy is the relationship between psychotherapist and client (Frank 1979; Hynan 1981).

Since the first edition of this book was published, overwhelming research evidence has confirmed this (see Clarkson 1998c; and Hubble, Duncan and Miller 1999 for references to research). The relationship is consistently being shown in research investigations as more significant than theoretical orientation. Therefore, it made sense to investigate this factor which appears to be of such overarching importance in statistical comparison of outcome studies, subjective reports, qualitative research and empirical clinical evaluation approaches.

> We are born of relationship, nurtured in relationship, and educated in relationship. We represent every biological and social relationship of our forebears, as we interact and exist in a consensual domain called 'society'. (Cottone 1988: 363)

It is for this reason that the client (or patient) in systemic integrative psychotherapy is thought of as *always* in relationship, whether this be conceived of in object-relations terms or in subject-relations terms, as in existential approaches to psychotherapy (Clarkson 1991e).

One way of conceptualising or imagining the healthy psychotherapeutic relationship is to conceive of it as involving the psychotherapist voluntarily entering into a kinship relationship with the patient. This, in some views, recapitulates the early familial maladaptions (if they have occurred). In many perspectives this replication is construed as providing the arena for understanding, reparation or healing. Fundamentally, if a psychotherapist can establish a relationship with someone who has lost the capacity for relationship, such as an individual in psychosis, they have been retrieved in their relatedness with others. Thus they can begin to rejoin the family of humankind. Most forms of psychotherapy use this state of voluntary kinship or relationship more or less consciously. The Jungian Andrew Samuels states: 'the psychology of the soul turns out to be about people in relationship' (1985: 21).

If, indeed, the psychotherapeutic relationship is one of the most, if not the most, important factor in successful psychotherapy, one would expect that much of the training in psychotherapy or counselling psychology would be in the *intentional* use of relationship. Some psychotherapies claim that psychotherapy requires use of only one kind of relationship, or at most two –

for example, the working alliance and the transference relationship. Some specifically exclude the use of certain kinds of relationship. The Gestaltists Polster and Polster (1973) and the existentialist May (1969b) focus on the existential nature of the psychotherapeutic relationship.

Some psychotherapeutic approaches pay little theoretical attention to the nature of the relationship and may attempt to be entirely free of content. In some approaches to hypnotherapy or neuro-linguistic programming, for example, psychotherapeutic changes are claimed to be made by the patient without the practitioner necessarily knowing what these changes are. In most approaches, stated policy and actual practice often diverge. As we shall see, even Freud's actions (speaking perhaps louder than his words) often belied the assumed orthodoxy of psychoanalytic practice. A more recent psychoanalyst comments:

> The most neglected feature of the psychoanalytic relationship still seems to me to be that it is a relationship: a very peculiar relationship, but a definite one. Patient and analyst need one another. The patient comes to the analyst because of internal conflicts that prevent him from enjoying life, and he begins to use the analyst not only to resolve them, but increasingly as a receptacle for his pent-up feelings. But the analyst also needs the patient in order to crystallize and communicate his own thoughts, including some of his inmost thoughts on intimate human problems, which can only grow organically in the context of this relationship. (Klauber 1986: 200–1)

The psychotherapeutic relationship is characterised by the facts that:

- it is usually paid for according to some contractual agreement;
- one of the parties in the relationship has been specifically trained to take part in it;
- the stated goal is usually the amelioration of psychological problems or the improvement of mental health of the paying partner in the work; and finally
- the psychotherapist is willing to commit him/herself to the welfare of another human being in this way.

An integrative psychotherapy framework: five relationship modalities

I have identified an integrative psychotherapeutic framework containing five possible modalities of the client–psychotherapist relationship (Clarkson 1990a) as being present in any effective psychotherapy. It forms the spinal structure for all the individual, group or organisational consultancy trainings I have originated since the 1970s. It has also been used explicitly or

implicitly in many other contexts for the training and supervision of counsellors and psychotherapists, and validated by many accrediting bodies and several universities. The research on which it is based itself has been validated by the award of a PhD by Surrey University. It has certainly stood the test of time.

By the 1990s North American researchers had independently found that that *different kinds of relationship* are required for different kinds of patients and this is more important than diagnosis in predicting psychotherapeutic effectiveness (Norcross 1997). As Bachelor and Horvath report:

> clients have been found to vary widely in their experience of the core conditions that distinguish good therapeutic relationships . . .[this] demands a higher measure of flexibility on the part of the therapist and a willingness to change one's relational stance to fit with the client's perceptions of what is most helpful. Some clients, for instance, will prefer a formal or professional manner over a casual or warmer one. Others might prefer more self-disclosure from their therapist, greater directiveness, a focus on their symptoms or a focus on the possible meanings beneath them, and a faster or perhaps a more laid back pace for therapeutic work. (in Hubble, Duncan and Miller 1999: 417–18)

The five-relational Clarkson framework provides an integrative principle, which focuses on similarities and differences between different approaches to psychotherapy and differentiates which relationships each approach tends to favour. It is designed to facilitate this recommended flexibility and range in every psychotherapist – whatever their training.

A consistent and coherent integrative approach to psychotherapy has also been developed using this framework. It is one means of intellectually and experientially engaging with the systemic complexity of the relationship matrix in *all* psychotherapies, forms of psychoanalysis or approaches to psychological counselling. It also provides a conceptual principle for integration between different orientations to psychotherapy, notwithstanding the apparently irreconcilable schisms between schools or theories.

The following section distinguishes theoretically, and demonstrates by means of a small number of representative clinical examples, how to respond to a question, dreams and kinship metaphors by the five different kinds of psychotherapeutic relationship. They are all potentially available for constructive use in psychotherapy. These are:

- the working alliance;
- the transferential/countertransferential relationship;
- the reparative/developmentally needed relationship;
- the person-to-person relationship; and
- the transpersonal relationship.

From a systemic integrative perspective these five relationships in psychotherapy are all valid. Their intentional and informed use will, of course, depend on differences between individual patients and different phases in the psychotherapy over time. At any one moment in psychotherapy one of these relationships may predominate. For example, the development of the transference neurosis may appear to be antithetical to the furthering of the working alliance (Stone 1961; Greenson 1965, 1967) or reparative intentions. It is unlikely that two or more 'can be operative at the same moment. Which one is allowed to become figure, or focus, must depend on the nature of the psychotherapeutic task at a particular time with a particular patient. Other modes of therapeutic relationship may also be present but may be more in the background at a particular time' (Clarkson 1990a: 150). These themes will be expanded in later chapters.

The working alliance

In order for 'help' to be of any use, a *working alliance* needs to be established. This involves cooperation between patient and therapist, which underpins all effective helping. Greenson (1967) in psychoanalysis, Berne (1975) in transactional analysis and Bordin (1979) among many others, have addressed the nature and use of the working alliance. In psychoanalysis it is

> the relatively non-neurotic, rational, and realistic attitudes of the patient toward the analyst . . . It is this part of the patient-analyst relationship that enables the patient to identify with the analyst's point of view and to work with the analyst despite the neurotic transference reactions. (Greenson 1967: 29)

For many psychotherapists, the working alliance is the crucial and sometimes only relationship necessary for effective therapy (Dryden 1984). It certainly is the necessary cooperation that even the general practitioner requires in order to work effectively with patients, be it at the level of the patient taking the medication as prescribed. Yet anecdotal evidence and research have shown that the working alliance is frequently missing in general practice (Griffith 1990), and a surprisingly large number of patients do not take their medication as prescribed and do not follow doctors' regimes or suggestions.

Definition: **The working alliance is the part of client–psychotherapist relationship that enables the client and therapist to work together even when either or both of them do not want to.**

'The therapeutic alliance is the powerful joining of forces which energizes and supports the long, difficult, and frequently painful work of life-changing psychotherapy' (Bugental 1987: 49). In personal construct therapy, the

relationship is also central; it 'involves client and therapist working together as co-experimenters' (Winter 1992: 316). (Some authors, e.g. Lapworth, Sills and Fish 2001, refer to this working alliance aspect as 'the professional relationship'. I do not find this acceptable as an alternative since it may suggest that the other dimensions are not professional. The five aspects my research has identified – see Chapter 9 – are all aspects of *one professional therapeutic relationship*.)

Bordin (1979) differentiated *goals*, *bonds* and *tasks* – three aspects of the working alliance that seem to be required for any form of therapy to be successful. In other words, the goals must be agreed first, then there must be agreement on the necessary tasks, and there should be a personal bond, that is, a therapeutic relationship. Several studies emphasise the importance of further common factors. These include the significance of the early stages of therapy work (Luborsky 1976) and the patient's ability to form a meaningful relationship with the therapist (Strupp and Hadley 1979). Sloane et al. (1975) found that patients listed the significant factors for successful therapy as first, the therapist's personality, grasp of problems, encouragement and help towards understanding themselves.

> Among the common factors most frequently studied have been those identified by the client-centred school as 'necessary and sufficient conditions' for patient personality change: accurate empathy, positive regard, non-possessive warmth, and congruence or genuineness. Virtually all schools of psychotherapy accept the notion that these or related therapist relationship variables are important for significant progress in psychotherapy and in fact, *fundamental in the formation of a working alliance*. (Lambert 1986: 444–5; emphasis in the original)

In response to the client asking '*How are you?*' the psychotherapist in working alliance mode is likely to make any reply that will enhance optimum conditions to accomplish the stated psychotherapeutic task. For example, the psychotherapist may say, 'Fine, and how have you been?' or 'As you can hear from my husky voice, I have a bit of a cold, but I am quite well enough to work with you today'.

The following dream *example* contrasts symbolically a patient's therapeutic alliance with her psychotherapist and a previous relationship with her mother. The dream illustrates how one type of relationship becomes the focus whilst the other recedes, as well as the choices patients make moment-to-moment whilst working in therapy.

> I was with you and we were working – or engaged in something serious but having an enjoyable time. My mother was coming at three o'clock and I had an arrangement to meet her. You didn't know that and you said, 'I am available at three o'clock – why don't we carry on then?' I thought, 'Oh God, If I stay with you [the

> therapist], then I won't be there for my mother; if I go, I may lose the connection with you'. I might break this thing that felt so good. It wouldn't actually be disastrous, since we would continue working again the next day, but it would be like breaking the energy. It is so pleasurable, the work is so good, we're both getting something from it. My mother is more of a shadowy figure than you are. I then decided to do neither and went off for a walk on my own. In this way I wouldn't be choosing one person or the other. I would be choosing myself. You would agree with that. If I went with my mother you would say, 'You needed to do that, but it would be less wise'. But you would absolutely appreciate me for doing my own thing.

In *kinship* terms, the relationship of working together can be likened to that between cousins. According to Kidd (1988), in *Debrett's* the word 'cousin' loosely indicates uncle/aunt/niece/nephew relationships as well as cousin relationships. The notion is meant to convey a metaphoric distance from the family of origin (different parents) but kindred loyalties to each other's welfare, so that it is possible to have a blend of subjective altruism and an objective capacity which may make that relationship constructive.

The transferential/countertransferential relationship

This mode of psychotherapeutic relationship is the one most extensively written about, for it is extremely well developed, articulated and effectively used within the theoretically rich psychoanalytic tradition, as well as other approaches (Heimann 1950; Langs 1976; Racker 1982; Cashdan 1988; Clarkson 1992c). It is important to remember that Freud did not intend psychoanalysis to be a cure, but rather a search for understanding, and he frowned upon psychoanalysts who wished to change patients rather than analyse them. More generally, however, the transference relationship is considered an essential part of the analytic process since the analysis consists in inviting the transference and gradually dissolving it by means of interpretation (Greenson 1967).

Laplanche and Pontalis define transference as follows:

> For psycho-analysis, a process of actualization of unconscious wishes. Transference uses specific objects and operates in the framework of a specific relationship established with these objects. Its context *par excellence* is the analytic situation.
>
> In the transference, infantile prototypes re-emerge and are experienced with a strong sensation of immediacy. As a rule what psycho-analysts mean by the unqualified use of the term 'transference' is *transference during treatment*.
>
> Classically, the transference is acknowledged to be the terrain on which all the basic problems of a given analysis play themselves out: the establishment, modalities, interpretation and resolution of the transference are in fact what define the cure. (1988: 455)

Freud (1912b) went so far as to suggest that the analyst model himself on the surgeon, put aside his human sympathy and adopt an attitude of emotional coldness. 'This means that the analyst must have the ability to restrain his psychotherapeutic intentions, must control his urge for closeness and must "blanket" his usual personality' (Stone, in Greenson 1967: 389). Freud advocated that the analyst should refrain from intruding his personality into the treatment, and introduced the simile of the analyst being a 'mirror' for the analysand (Freud 1912b: 118). In a paper also written in 1912, Freud stated:

> Thus the solution of the puzzle is that transference to the doctor is suitable for resistance to the treatment only in so far as it is a negative transference or a positive transference of repressed erotic impulses. If we 'remove' the transference by making it conscious, we are detaching only these two components of the emotional act from the person of the doctor; the other component, which is admissible to consciousness and unobjectionable, persists and is the vehicle of success in psycho-analysis exactly as it is in other methods of treatment. (1912a: 105)

This may not be an accurate picture of what Freud had in mind. Perhaps he emphasised certain 'unnatural' aspects of psychoanalytic technique because they were so foreign and artificial to the usual doctor–patient relationship and the customary psychotherapy of his day. I consider that his work on transference is his major contribution to our field. Alexander and French expressed the psychoanalytic principle as follows:

> The old pattern was an attempt at adaptation on the part of the child to parental behavior . . . the analyst's objective and understanding attitudes allow the patient . . . to make a new settlement of the old problem . . . While the patient continues to act according to outdated patterns, the analyst's reaction conforms strictly to the actual therapeutic situation. (1946: 66–7)

Definition: **The transference/countertransference relationship is the experience of 'distortion' (Freud's word) of the working alliance by wishes and fears and experiences from the past transferred (carried over) onto or into the therapeutic partnership.**

When I work with people or organisations who are not familiar with these words I use others such as 'the anticipated or incomplete relationship' or 'the expected relationship' or 'unfinished business from the past interfering with our here-and-now relationship'.

It has also been referred to in the existentialist vocabulary as client or therapist *bias* (Van Deurzen-Smith 1988), although many other existentialists, such as Binswanger (1968), use the term 'transference' accurately and explicitly. Lapworth, Sills and Fish (2001) refer to this as 'the projective

relationship'. This is an acceptable alternative. Williams (in press, in Clarkson and Nuttall's *Companion to the Therapeutic Relationship*) conducted a literature review and phenomenological research study, which showed that the cognitive-behavioural therapy notion of 'schema' is identical to the concept of transference.

In the transference/countertransference relationship the patient's question '*How are you*?' may be met with analytic silence. Alternatively, the therapist may reply: 'I wonder what prompts your concern for me? It may be that you are anxious again, like you were with your mother, that I will not be able to withstand your envy towards me.'

The transferential psychotherapeutic relationship can be compared in terms of *kinship* to that of stepparent or godparent. Negative transference connects with the former (the witch of many traditional fairy tales – for example, Hansel and Gretel). Idealising positive transference resonates with the godparent or fairy godmother relationship in that a putative family connection exists, but lacks the immediacy of a real parent. Whether or not the psychotherapist identifies with such projections or archetypal images, and how he or she handles them, may destroy or facilitate the psychotherapy. Clearly, the nature and vicissitudes of the clinician's own feelings, thoughts and images (the countertransference) are inextricably interwoven with the management of the transference relationship, and efficacy of the psychotherapy may well be determined by it.

For example, a narcissistic, apparently generous, but dynamically retentive patient, whose mother overfed him while never responding to his feelings of isolation, abandonment and rage, reported the following dream: 'I am at a sumptuous banquet which is presided over by you [the psychotherapist]. I take the food from the table, but I don't eat it. I put it in a plastic bag so that you won't see and I throw it in a wastepaper basket. I want to continue to be invited, but not to have to eat the food.'

> The great importance of the transference has often led to the mistaken idea that it is absolutely indispensable for a cure, that it must be demanded from the patient, so to speak. But a thing like that can no more be demanded than faith, which is only valuable when it is spontaneous. Enforced faith is nothing but spiritual cramp. Anyone who thinks that he must 'demand' a transference is forgetting that this is only one of the therapeutic factors . . . (Jung 1946: 172)

The reparative/developmentally needed relationship

The reparative/developmentally needed relationship is another relationship mode that can occasionally be differentiated from the others. I distinguish for clinical analytical purposes between whether the relational focus is more on repair of previous damage or reinstating healthy developmental processes.

Definition: **The reparative/developmentally needed relationship is the intentional provision by the psychotherapist of a corrective, reparative, or replenishing relationship or action where the original parenting (or previous experience) was deficient, abusive or overprotective. (Sometimes this is what is meant by phrases such as 'corrective emotional experience' or 'maturational responses'.)**

The following dream shows a client separating out a developmentally needed relationship (for the client's future) from the transferential relationship (based on the client's past).

He dreams about two psychotherapists, both with the same name as his psychotherapist. One psychotherapist says to him, 'How could you make such mistakes? This is terrible! You ought to be punished.' The other psychotherapist says, 'Look, I myself received a D in this subject. I was not very interested in it and you can see that you do not have to be perfect in all things.' The first psychotherapist responds with anger and accusations of unethical conduct, saying, 'How could you say such things, you are just encouraging him to make mistakes and setting a very bad example!'. The client himself then steps in to arbitrate and explains to the first psychotherapist: 'Actually, she is right. You have to understand what she is saying *in the right spirit*.' This is what the client needed to hear.

Dreams often act as communication about the progress of the psychotherapy from the unconscious of the client. In this dream the client is clearly telling the psychotherapist what he needs developmentally – what was absent in the original relationship, where he veered between being the saintly, clean little boy who has to play without getting dirty and the disgusting child who causes embarrassment and shame to his family if he gets his hands dirty. (In his adult life he veers between saintly self-sacrifice and secret addictions.) The client is also communicating a most significant fact – not only has he internalised the psychotherapist and distinguishes the two personifications of the person of the same name, but happily he is siding with the psychotherapist who has his best interests at heart and least resembles the transferential parent who would 'write him off' for the smallest misdemeanour, or shame him for not getting the best marks in every subject regardless of his true interests. (Even the D is still a pass mark!)

The developmentally needed relationship as indicated in the dream refers to those aspects of relationship which may have been absent or traumatic for the client at particular periods of his or her childhood and which are supplied or repaired by the psychotherapist, usually in a contracted form (on request by or with agreement from the patient) during the psychotherapy.

Sandor Ferenczi (1926/1980), one of Freud's early followers, attempted this early in the history of psychoanalysis. He departed from neutrality and

impassivity in favour of giving nursery care, friendly hugs or management of regression to very sick patients, including one whom he saw at any time, day or night, and took with him on his holidays. Ferenczi held that there needed to be a contrast between the original trauma in infancy and the analytic situation, so that remembering can be facilitative rather than a renewed trauma for the patient.

Freud prescribed a mirror-like impassivity on the part of the analyst, who should him- or herself be analysed, who should not reciprocate the patient's confidences and should not try to educate, morally influence or 'improve' the patient, and who should be tolerant of the patient's weakness. In practice, however, Freud 'conducted therapy as no classical Freudian analyst would conduct it today' (Malcolm 1981), shouting at the patient, praising him, arguing with him, accepting flowers from him on his birthday, lending him money, visiting him at home and even gossiping with him about other patients!

The psychoanalyst Sechehaye (1951) was able to break through the unreal wall that boxed in her patient Renée and bring her into some contact with life. In order to do so, Sechehaye not only took her on holiday, as Ferenczi had done with one of his patients, but also took Renée into her home for extended periods and allowed her to regress to the point where she felt she was re-entering her mother's body. Thus Sechehaye became one of the first psychotherapists to undertake to 'reparent' schizophrenic clients. She allowed her to lean on her bosom and pretended to give milk from her breasts to the doll with whom Renée identified.

> That Sechehaye was far more involved personally than even the most humanistic of therapists usually are we can infer from the accounts of how she gave instructions for her meals, saw to her baths, and in general played for Renée the nourishing mother that she had been denied as an infant. That this took an emotional toll far beyond the ordinary is evident from Renée's own account that 'Mama was extremely upset' or that she regained consciousness and found Mama weeping over her. (Friedman 1985: 188)

Miller's advocacy relationship (1983a and b; 1985) can be seen to be the provision of the developmentally needed force in a child's life which should have been provided by a parent or other significant caretaker, but which the psychotherapist ultimately has to provide. Winnicott's (1958) holding environment is another example of such provision, as are so-called 'reparenting' techniques (e.g. Schiff et al. 1975) and certain hypnotherapy techniques (e.g. Shapiro 1988). Person-centred responses of empathic reflection are in essence reparative. Few adults have had this experience in their lives before.

The psychotherapist's reply to a client who asks 'How are you?' in such a relationship will be determined by the client's specific needs which were not

responded to appropriately by their caretakers in childhood. In response to the adult who, as a child, was never allowed to show her care or love for the parent, the psychotherapist may reply: 'I'm fine thank you and I appreciate your caring.' Alternatively, in response to the adult who as a child was burdened with parental intimacies, a psychotherapist may reply: 'You don't need to worry about me right now. I am here to take care of you, and I am ready to do that.'

In the developmentally needed relationship, the metaphoric kinship relationship being established is clearly closer to a real parent and child relationship than any of the other forms of bonding in psychotherapy. In Schiff's words:

> I am as much part of the symbiosis and as vulnerable as any parent. While my attachments don't occur at the same kind of depth with each youngster, they have not been selective in favor of those kids who were successful, and several times I have experienced tremendous loss and grief. (1977: 63)

In view of the sometimes regressive nature of this kind of work and the likely length of time involved, the professional and ethical responsibilities of the psychotherapists are also concomitantly greater and perhaps so awesome that many psychotherapists try to avoid it. The work of Grof (1985), Reich (1945), Lake (1966) and other controversial figures outside mainstream psychotherapies, as well as some from the centre, belong in this category. It is true that this depth of long-standing psychotherapeutic relationship as the primary psychotherapeutic relationship modality is reported more frequently between psychotherapists and their more severely damaged patients.

The person-to-person relationship

Definition: **The person-to-person relationship is the dialogic relationship or core relationship. It concerns the authentic humanness shared by client and therapist. It has also been referred to as the 'real' dimension of the therapeutic relationship.**

Experientially, for the people concerned, no one aspect of any relationship is any less 'real' subjectively or phenomenologically than any other.

Particularly (but not exclusively) within the humanistic/existential tradition, there is an appreciation of the *person-to-person relationship*. This psychotherapeutic relationship modality also shows continuity with the healing relationships of ordinary life. Buber (1970) called this the I-Thou or I-You relationship, in contrast to the I-It relationship. The I-You relationship is referred to elsewhere in psychotherapeutic literature as 'the real relationship' or the core relationship (Barr 1987).

It is very likely that those ordinary relationships which human beings have experienced as particularly healing over the ages have been characterised by the qualities of the I–You relationship (Buber 1970). This has been retrieved and valued for its transformative potential in the psychotherapeutic arena if it is used skilfully and ethically (Rogers 1961; Laing 1965; Polster and Polster 1973). There has always been, and still is, recognition within psychoanalytic practice that the real relationship between analyst and analysand – following Freud's own example – is a deeply significant, unavoidable and potentially profound healing force within the psychoanalytic paradigm (Archambeau 1979; Malcolm 1981; Klauber 1986).

With Freud's discovery of the importance of the transference relationship came deep clinical suspicion of the real relationship – the psychotherapeutic relationship most similar to ordinary human relationships. For some decades, psychoanalysts' emotional reactions to their patients were usually understood to be a manifestation of the analysts' unresolved conflicts. It is only comparatively recently that analysts' feelings or countertransference reactions have been seen as valid and important sources of information to be used effectively in the psychotherapy (Heimann 1950). Even so, the analyst as a real person with real feelings, which are *not* necessarily countertransferences, is still rarely publicly acknowledged.

Object relations theorists have offered psychotherapy profoundly useful concepts and theoretical understandings, but the I–You psychotherapeutic relationship is the opposite of an object relationship. For Buber, the other is a person, not an object or part-object:

> Whoever says You does not have something for his object. For wherever there is something there is also another something; every It borders on other Its; It is only by virtue of bordering on others. But where You is said, there is no something. You has no borders. Whoever says You does not have something; he has nothing. But he stands in relation. (1970: 55)

Emotional involvement in the relationship between psychotherapist and patient is that between *person and person* in the existential dilemma where both stand in mutuality to each other. Indeed, as Friedman (1985) points out, it is a kind of mutuality because the psychotherapist is also *in* a role. For Rogers (1951), too, congruence is not wilful and arbitrary 'self-disclosure' that the mutuality is almost complete and the Self of the psychotherapist becomes the instrument through which the healing evolves.

For example, an intuitive, introverted patient sadly remembers difficulty with right or left, physical discomfort in the real world and incomprehension when required to learn kinaesthetically. The psychotherapist bends down to show a scar on her leg, which she used as a little girl to help her decide which side was left. The moment is unforgettable, the bonding person-to-

person. Yet it is enacted by a professional person who, at that very moment, has taken responsibility for that self-disclosure in the psychotherapy, judging it appropriate and timely to trust or delight the patient with a sense of shared personhood. The two then become siblings in incomprehension, siblings in discovery and siblings in the quest for wholeness.

Such self-disclosure needs extreme care, of course, and in its worst, abusive form has been an excuse for inauthentic acting out of the psychotherapist's need for display, hostility or seductiveness. Genuine, well-judged use of the I-You relationship is probably one of the most difficult forms of psychotherapeutic relating. Doubtless this was the very good reason behind the early analysts regarding it with extreme suspicion. Also, it is in the name of I-You relationship that many personal relationships have been destructive. It probably requires the most skill, the most self-knowledge and the greatest care because its potential for careless or destructive use is so great. Its influence is unavoidable. Yet there are only a few trainings that specifically address this experientially and theoretically. Sometimes lip-service is paid to the I-You, person-to-person concept as if we know what it is about, or it is 'outlawed' - as if this were possible. 'There can be no psychoanalysis without an existential bond between the analyst and the analysand' (Boss 1963). 'The analyst can deny but cannot avoid having an emotional relationship with the analysand: even the objectifying attitude of indifference is a mode of emotional relating' (Friedman 1985: 79–80).

The I-You relationship is characterised by the *here-and-now existential encounter* between two people. It involves mutual participation in the process and recognition that each is changed by the other. Its field is not object relations, but *subject relations*. The real person of the psychotherapist can never be totally excluded from an interactional matrix of therapy. Existential psychotherapy (Boss 1963; Binswanger 1968; May 1969a, 1969b) specifically includes the I-You genuine encounter as a major psychotherapeutic modality, but analysts are also addressing the issue.

> It is good for analyst and patient to have to admit some of the analyst's weaknesses as they are revealed in the interchange in the consulting room. The admission of deficiencies may help patient and analyst to let go of one another more easily when they have had enough. In other words, the somewhat freer admission of realities - but not too free - facilitates the process of mourning which enables an analysis to end satisfactorily. The end of analysis is in this way prepared from the beginning. (Klauber 1986: 213)

According to Fromm-Reichmann (1950/1974), Sullivan's (1940) concept of the psychotherapist as 'participant observer' includes spontaneous and genuine responses on the part of the psychotherapist and even, in some cases, reassuring touch and gestures of affection. It does *not* include trans-

forming the professional relationship into a social one, or seeking extraneous personal gratification from dialogue with the patient. But it does include confirmation of patients as worthy of respect and meeting on the basis of mutual human equality.

Guntrip (1961) also rejected the traditional restriction of the functions of the psychotherapist to the duality of a screen upon which the patient projects his fantasies and a colourless instrument of interpretative technique. Instead, he saw the real, personal relationship between patient and analyst as the truly psychotherapeutic factor on which all others depend. For him, psychotherapy only happens when the psychotherapist and patient find the person behind each other's defences.

Deep insight, as Fairbairn (1952) points out, develops only inside a good psychotherapeutic relationship. What is therapeutic, when it is achieved, is '*the moment of real meeting*'. This experience is transforming for both psychotherapist and patient because it is not what happened before (that is transference), but what has never happened before – a genuine experience of relationship centred in the here-and-now.

What Freud calls 'transference' Boss (1979) describes as 'always a genuine relationship between the analysand and the analyst'. Despite the difference in their positions, the partners disclose themselves to each other as human beings. It seems that Freud and Boss are both describing psychotherapeutic relationship modalities which are intrinsically different in intent, in execution and in effect; not merely a semantic blurring.

Of course, the existential and humanistically oriented psychotherapies (such as Gestalt, which emphasises here-and-now *contact* as a valid form of psychotherapeutic relating) have greatly amplified the value and use of the person-to-person encounter in psychotherapy.

> The details of technique vary, but the strategy is always to keep a steady, gentle pressure toward the direct and responsible I–Thou orientation, keeping the focus of awareness on the difficulties the patients experience in doing this, and helping them find their own ways through these difficulties. (Fagan and Shepherd 1971: 116)

For Rogers and Stevens (1967) too, the establishment of a relationship of genuineness or respectful congruence becomes a cornerstone condition for facilitating human growth and development.

Historically, in psychoanalysis, even Anna Freud called for recognition that in analysis two real people of equal adult status stand in a real personal relationship to each other. 'There are differences in the ways in which we receive and send off patients, and in the degree to which we permit a real relationship to the patient to coexist with the transferred, fantasied one' (A. Freud 1968: 360). It is the neglect of this side of the relationship, and not just

'transference', that may cause the hostile reactions of patients to their analysts (Stone 1961). Stone expressed concern lest the analyst's unrelentingly analytic behaviour subvert the process by shaking the patient's faith in the analyst's benign intent. He declared that failure to show reasonable human response at a critical juncture can invalidate years of patient, skilful work.

According to Malcolm (1981), honesty and spontaneity can correct the patient's transference misperceptions, making the psychotherapist's responses unpredictable and therefore less likely to be manipulated by the patient. The patient's distrust may be relieved when the psychotherapist provides a model of authentic being with which he can identify. Such authenticity on the psychotherapist's part may mean that the psychotherapeutic relationship changes the psychotherapist as much as the patient. Jourard (1971) and Jung (1946) both held this as a central truth in all healing endeavour. Searles (1975) also believed that the patient has a powerful, innate striving to heal the analyst (as he or she may have desired to heal the parents), which can and does contribute to greater individuation and growth for the psychotherapist, as they are ***both*** transformed in the psychotherapeutic dialogue.

'What is confirmed most of all is the personal "realness" of the therapist that has arisen from and been brought into the therapeutic relationship' (Archambeau 1979: 141–58). 'A certain amount of compassion, friendliness, warmth, and respect for the patient's rights is indispensable. The analyst's office is a treatment room and not a research laboratory' (Greenson 1967: 391).

Greenacre (1959) and Stone (1961) are clear that the analyst must be able to become emotionally involved with and committed to the patient. He must like the patient; prolonged dislike or disinterest as well as too strong a love will interfere with therapy. He must have a wish to help and cure the patient, and he must be concerned with the patient's welfare, without losing sight of long-range goals.

The ***kinship*** quality of the person-to-person relationship is analogous to that of siblings – a shared empathic understanding from a similar frame of reference. Although they are different, they are of more or less equal standing and share the ambiguous and ambivalent legacy of existence.

In answer to the patient's question: '*How are you?*' the psychotherapist may well reply: 'Physically I'm fine, but lately I have been wondering about the helpless feeling I sometimes experience when you talk about the death of your baby. I guess it reminds me of losing my husband, and the fact that we are both grieving for loved ones in the same year.' Or the reply may be much shorter, for example: 'Great – how about you?'

In all cases the person-to-person relationship will be honoured by truthfulness or authenticity – not at the expense of the client, but in the spirit of

mutuality. According to Buber, the genuine psychotherapist can accomplish the true task of regenerating the stunted growth of a personal centre only by entering as 'a partner into a person-to-person relationship, but never through the observation and investigation of an object' (1970: 179). Significantly, though, this does not mean injudicious honesty.

Buber further acknowledges the limited nature of the psychotherapeutic person-to-person relationship: 'Every I–You relationship in a situation defined by the attempt of one partner to act on the other one so as to accomplish some goal depends on a mutuality that is condemned never to become complete' (ibid.). The real relationship is one of a set of five in clinical practice.

The transpersonal relationship

> Contact is the means by which we feed ourselves, by which we understand, orient, and meet our needs, but cast in the light of I–Thou, contact also stands at the ontic center of the psychological and spiritual development unique to our human existence. (Jacobs 1989: 34)

Definition: **The transpersonal relationship as the timeless facet of the psychotherapeutic relationship, which is impossible to describe, but refers to the spiritual, mysterious or currently inexplicable dimension of the healing relationship.**

It is essential to remember that for two-thirds of the world a living relationship with the transpersonal is in the daily manifestation of a person's life. The notion that 'the transpersonal' or even 'the religious' dimension of a person's life should be excluded from therapy (as in many Eurocentric approaches) is a violation of the most important principle of an individual's and community's vital meaning. Unfortunately, many so-called 'transpersonal' approaches again privilege one narrative – that of Buddhism or psychosynthesis, for example – to the exclusion of others.

Within the Jungian tradition (Jung 1940), and also within the humanistic/existential perspective (Rowan 1993), there is acknowledgement of the influence of the qualities which presently transcend the limits of our understanding. ('There are more things in heaven and earth, Horatio, than are dreamt of in your philosophy' [*Hamlet*, I.v.166]). However defined, some implicit or explicit recognition of the possibility, if not the existence, of a *transpersonal relationship* between healer and healed as it unfolds within the psychotherapeutic *vas* (container) is gradually beginning to gain more acceptance (Clarkson 1990a).

'If the analyst has been moved by his patient, then the patient is more aware of the analyst as a healing presence' (Samuels 1985: 189). The transper-

sonal relationship in psychotherapy is characterised by its timelessness and, in Jungian thought, is conceived of as the relationship between the unconscious of the analyst and the unconscious of the patient not mediated by consciousness (Guggenbühl-Craig 1971).

> The psychotherapist and the client find themselves in a relationship built on mutual unconsciousness. The psychotherapist is led to a direct confrontation of the unreconciled part of himself. The activated unconsciousness of both the client and the therapist causes both to become involved in a transformation of the 'third'. Hence, the relationship itself becomes transformed in the process. (Archambeau 1979: 162)

There is not a great deal of documentation about the transpersonal relationship in psychotherapy, except for Rowan's (1992) important contribution to surveying and expanding the field. Peck (1978) mentions the concept of 'grace', as Buber did, as the ultimate factor which operates in the healing encounter and which may make the difference between whether a patient gets better or not. Berne, too, was aware of it when he quoted: 'Je le pensay, et Dieu le guarit . . . we treat them, but it is God who cures them' (Agnew, in Berne 1966: 63).

The nature of this transpersonal dimension is therefore quite difficult to express, because it is both rare and not readily accessible to the kind of descriptions that can easily be used in discussing other forms of psychotherapeutic relationships. 'The *numinosum* is either a quality belonging to a visible object or the influence of an invisible presence that causes a peculiar alternation of consciousness' (Jung 1940: 7). It is also possible that psychotherapists may be embarrassed who have to admit that, after all the years of training and personal analysis and supervision, ultimately we still don't know what it is that we are doing or whether it makes any difference at all. A statement like this can be understood only by experienced psychotherapists who have been faced repeatedly with incomprehensible and unpredictable outcomes - the person of whom you despaired, suddenly and sometimes apparently inexplicably gets well, thrives and actualises themselves beyond all expectation. At the other extreme, the client for whom the analyst had made an optimistic prognosis reaches a plateau from which they never move on, and the analysis is abandoned with a lingering sense of potential glimpsed but never reached.

The ***kinship*** relationship, which is characterised by the creation of space as well as fruitful substance between the psychotherapeutic partners, is analogous to that of the marital pair. Indeed, in Jung's (1966) work, the archetypal sexual relationship is used to represent the alchemical process of transformation. Of course, the conjunction was to be symbolic, not consummated in an unethical, incestuous way.

The transpersonal relationship is paradoxically also characterised by a kind of intimacy and simultaneously by an 'emptying of the ego'. It is as if the ego of even the personal unconscious of the psychotherapist is 'emptied out' of the psychotherapeutic space, leaving room for something numinous to be created in the 'between' of the relationship. This space can then become the '*temenos*' or the '*vas bene clausum* inside which transmutation takes place' (Adler 1979: 21). This dimension in the psychotherapeutic relationship cannot be proved and can hardly be described. Buber concludes: 'Nothing remains to me in the end but an appeal to the testimony of your own mysteries . . .' (1970: 174).

Implied is a letting go of skills, of knowledge, of experience, of preconceptions, even of the desire to heal, to be present. It is essentially allowing 'passivity' and receptiveness, for which preparation is always inadequate. But, paradoxically, you have to be full in order to be empty. It cannot be made to happen; it can only be encouraged in the same way that the inspirational muse cannot be forced, but needs to have the ground prepared or seized in the serendipitous moment of readiness. What can be prepared are the conditions conducive to the spontaneous or spiritual act.

For example, a trainee reports: 'When I first started learning psychotherapy it was like trying to learn a new language, say French, but when I saw a very experienced psychotherapist working it appeared to me that she was speaking an entirely different language such as Chinese. The more I have learnt the more I have come to realise that she does indeed speak French, she just speaks it very well. And sometimes she speaks Chinese.' The context from which this comment arose is that of how he has perceived the supervisor at times intuitively to know facts, feelings or intentions of patients without there being any prior evidence to lead to the conclusions. It is these intuitive illuminations which seem to flourish the more the psychotherapist dissolves the individual ego from the psychotherapeutic container, allowing wisdom and insight and transformation to emerge as a process.

The transpersonal relationship refers to the metaphorical Chinese in the psychotherapy. In response to the client's question 'How are you?', the psychotherapist's reply may be nothing or any of the earlier examples. The essence of the communication is in the heart of the shared silence of being together in a dimension which is impossible to articulate, too delicate to analyse and yet too pervasively present to deny.

Another trainee in supervision brought as an ethical problem the fact that he had seen a particular client for several years, who was seriously disturbed and showed no sign of improvement. He had utilised all the major interpretations and intervention strategies for such cases to no avail. Indeed, she refused to form any working alliance in the shape of an agreed goal for her psychotherapy. It was uncertain what benefit there could be for her, yet

she continued coming because (we speculated) this was the only human relationship that was alive for her in a physically and emotionally impoverished life.

The psychotherapist responsibly questioned whether she should be referred to another treatment facility. Yet he feared that she would experience this as abandonment. In our supervision we explored the possibility that he should let go of expectations that she should be different from the way she was. The psychotherapist was even willing and able to let go of the healer archetype, allowing himself to become an empty vessel, a container wherein healing could have space to manifest, or beingness could be validated without any expectation even of the acceptance. This needs to be done in good faith and not based on the trickery of paradoxical interventions where expectations are removed *in order for* the patient to change. The atmosphere is more suspension of ego-consciousness - a trance-like meditation. The quality is conveyed by the being-with of highly evolved psychotherapists such as Gendlin (1967) working with patients in acute psychosis.

It is possible that psychotherapists may delude themselves in ways that are dangerous to them and their clients if they mistakenly, prematurely or naïvely focus on the transpersonal and, for example, overlook or minimise transferential or personal phenomena. In Chapter 6, I will explore the multiple meanings of these concepts and ways of organising our thinking and responses in this extremely complex arena.

James and Savary have contributed the notion of a third self created in such a dimension of between-ness when the inner core energies of the dialoguing partners merge: 'Third-self sharing, perhaps the most complete form of sharing, involves not only *self-awareness* (of the individual self) and *other-awareness* (of the relating self), but *together-awareness* (of the third self)' (1977: 325).

This resembles the archetype of the Self, which Jung refers to as the person's inherent and psychic disposition to experience centredness and meaning in life, sometimes conceived of as the God within ourselves. Buber was essentially concerned with the close association of the relation to God with the relation to one's fellow men, with the I-Thou, which issues from the encounter with the other *in relationship*.

Summary

This chapter has overviewed five kinds of psychotherapeutic relationship available as potential avenues for constructive clinical use. Each will be expanded in the following chapters. I have indicated some characteristics of each and begun an effort to clarify, specify and differentiate in theory and practice the nature and intentions of the multiplicity of psychotherapeutic

relationships available. As we shall see, different psychotherapies may emphasise different relationships for specific reasons.

It is time that psychotherapists acknowledged explicitly that these five forms of relationship are intentionally or unintentionally present in most approaches to psychotherapy or psychoanalysis. Which are used, and how explicitly and purposefully, may be one of the major ways in which some approaches resemble each other more and differ most from others.

> There are two major foci when describing the nature of the relationship in any therapy: the *role of the relationship* in the overall therapy process (the importance of the relationship as a curative factor vis-à-vis the other curative factors, as well as the extent to which the relationship per se is a focus of therapy), and the *characteristics of the relationship* in that therapy (the range of permissible and valued therapist behaviors, and the structure of the patient-therapist relationship). (Jacobs 1989: 26)

It may need to be recognised in psychotherapy trainings that experience and supervision are required to distinguish between these five *different* forms of psychotherapeutic relationship and in assessing and evaluating the usefulness of each at different stages of psychotherapy. Equally, different modes may be indicated for individuals with characteristic ways of relating, so that there is no slipshod vacillation due to error or collusive countertransference.