FROM The Handbook of Psychotherapy

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The psychotherapeutic relationship*

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In this chapter I want to present a theoretical and conceptual lens through which to view the many and varied contributions which follow in the rest of this book. Not every reader may find themselves in agreement with this, nor is it necessary to accept this perspective in its entirety in order to derive benefit from what follows. However, it is meant to provide a complete contribution in and of itself – a review of five different kinds of psychotherapeutic relationship which may be potentially available for constructive use in psychotherapy. It is also an invitation to engage in, reflect on and view the contributions which follow. Most of the approaches discussed in the previous chapter can be considered in terms of which, or how many, of the five relationships I have identified, are foregrounded or emphasised in the work of the practitioners from that discipline or from that approach. As you read the following chapters, you may be aware of how implicitly or explicitly the relationship is dealt with, and how aspects of it are treated more fully. It is nevertheless my contention that all of these five relationships are available in every psychotherapeutic encounter, available for attention or not, according to the nature of the people involved, the context, the approach and the setting. For example, it may be more difficult to acknowledge transpersonal influences on the psychotherapeutic endeavour in a highly rationalist, experimentally orientated, cognitive-behavioural clinic. Similarly, the ideologies and cultural constraints of some forms of psychoanalysis may impede and inhibit the therapeutic use of, say, the provision of an educationally needed, enacted rehearsal for a job interview, or a longed-for touch on the shoulder when in deep distress. It is my belief that these five modalities of relationship exist in every psychotherapeutic relationship (whether it be with individuals, groups, families or larger systems). Like the keys on a piano, some of them may be played more frequently or more loudly than others, depending on the

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nature of the music. But they are always potentially there in every therapeutic encounter whether or not the pianist uses them, whether or not the composer acknowledges their existence in the written score.

In this way, I think that the variety and nature of psychotherapeutic relationships is present implicitly or explicitly throughout the psychotherapeutic canon. In working with this material, experienced clinicians tend to recognise that in their own practices some aspects of these relationships are indeed more or less present. Novice psychotherapists have found it very helpful as a matrix from which to learn from many different traditions in psychotherapy and as a framework for integrating what they may still learn; helping them to order, categorise and prioritise the literature while developing precision and purpose in practice.

Relationship or the interconnectedness between two people has been significant in all healing since the time of Hippocrates and Galen. Relationship can be defined as 'the state of being related; a condition or character based upon this; kinship' (Onions 1973: 1786). 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 lifetime's preoccupying passion. According to the received wisdom of the late twentieth century, of all the forces of nature it is our familial relationships which often serve to cause the most damage. Statistically you are more likely to be killed by a relation than by a stranger. According to Boss, the great existentialist, all illness and treatment develop out of the patient's disturbed human relationships: 'In focusing on the physician–patient relationship, Freud called attention to the true locus of all therapeutic efforts, whether they were surgical, internal or psychotherapeutic' (1979: 257).

It is the intention of this chapter to make explicit what is often implicit in psychotherapy literature regarding the variety and nature of psychotherapeutic relationships. This chapter reaches for an elucidation of relationship, the *betweenness* of people. It is common knowledge that ordinary human relationships can have therapeutic 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 appear to have started to crumble in the twentieth century. Indeed, it is possible that psychotherapy as an institutionalized profession became necessary as a consequence of such a decline in the society and quality of healing relationships which were available in previous centuries.

As discussed in Chapter 3 regarding research, one of the most important factors to emerge is the significance of the therapeutic relationship, which is thought to be common to all psychotherapies. 'A constant focus has been on what it is that therapists do which leads to client change' (Barkham and

Elton Wilson, p. 58 in this volume). As discussed in the previous chapter and as emerges from the research, it is very difficult if not impossible to establish with anything more than partisan preferences that any one psychotherapy is more effective than any other: 'All have won and all must have prizes' (Luborsky *et al.* 1975). However, there is a consensus of agreement of the crucial importance of the therapeutic relationship. This has led to a development of integrative psychotherapy on the one hand, and on the other to the broadening and deepening of the understanding of interventions, and to theoretical explorations of many of the unimodal approaches to psychotherapy.

Research, empirical studies and reviews have failed to demonstrate clear advantages differentially attributable to different psychotherapy systems. Research has focused on the identification of the common factor or common ingredients. It seems that success in psychotherapy can best be predicted by the properties of the psychotherapist, the client and their particular relationship. Frank (1979) and Hynan (1981) are two of the many researchers who have found that the client, the psychotherapist and the therapeutic relationship between them are repeatedly more closely related to outcome than whatever technique has been used.

> Most beginning clinicians understand that it is important to live by the basic ground rules of therapy. Confidentiality must be honored, and the boundaries of the therapeutic relationship must be respected, which means remembering every moment that our clients are neither friends nor lovers. Most therapists know these rules, but until one has grasped just how subtle and complex the relationship can be, and how important the therapist becomes to the client, one is likely to seriously underestimate how easy it is to damage the therapy. The slightest breach of confidentiality can be magnified by the client into a major betrayal; a chance encounter with a client outside the consulting room can evolve into a problematic social situation and have serious repercussions. An off-hand remark or thoughtless joke can cause pain or confusion the client may not be able to acknowledge. . . . The second reason for attending to the relationship is that it gives one a major therapeutic advantage. This book will take the position that awareness of the subtleties and changes in the relationship provides the therapist with a powerful tool, perhaps the most powerful therapeutic tool of all. It will try to show why that is true and how that tool might be used in our work with clients.
>
> (Kahn 1991: 2–3)

It was after the publication of my paper that I came across Kahn's book, in which he introduces a perspective on using the relationship as a central factor in all of psychotherapy. Kahn's teacher said, 'The relationship *is* the therapy' (Kahn 1991: 1).

If indeed the therapeutic relationship is one of the most, if not *the* most, important factor in successful psychotherapy, one would expect much of the training in psychotherapy to be training in the intentional use of relationship. Some psychotherapists claim that psychotherapy requires use of only one kind of relationship, or at most two. Some specifically exclude the use of certain kinds of relationship. For example, Goulding and Goulding (1979), transactional analysts, minimise the use of transference, whereas Moiso (1985), also in transactional analysis, sees it as a central focal point of classical Bernian psychotherapy. Gestaltists Polster and Polster (1973) and the existentialist May (1969) focus on the existential nature of the therapeutic relationship. Some psychotherapeutic approaches pay hardly any theoretical attention to the nature of the relationship and they may attempt to be entirely free of content. For example, in some approaches to hypnotherapy or Neuro-Linguistic Programming (NLP), therapeutic changes are claimed to be made by the patient without the practitioner necessarily knowing what these changes may be.

Psychoanalysts, whether most influenced by Freud or Klein or Bion, consider the transference relationship to be the most important, if not the only, defining characteristic of the approach.

THE WORKING ALLIANCE

The working alliance is probably the most essential relationship modality operative in psychotherapy. Without such a working alliance psychotherapy is certainly limited in its goals and restricted in scope. This working alliance is represented by the client's or patient's willingness to engage in the psychotherapeutic relationship even when they at some archaic level may no longer wish to do so (see also Chapter 8 regarding individual adult psychotherapy).

In transactional analysis, the working alliance is conceptualised as a contract or agreement between the adult of the psychotherapist and adult of the client. 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). The attitudes and character traits which further the development of the transference neurosis are basically antithetical to those which further the working alliance (Stone 1961; Greenson 1965, 1967). So it is unlikely that both can become 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 each unique patient. Other modes of therapeutic relationship may also be present but may be more in the background at a

For many psychotherapists the working alliance is the crucial and necessary relationship for effective therapy (Dryden 1984). It certainly is the necessary co-operation that even the general practitioner requires in order to work effectively with patients, be it simply at the level that the patient takes the medication as prescribed. Anecdotal evidence and research have shown that this working alliance is frequently missing in general practice (Griffith 1990). '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). Bordin (1979) differentiated goals, bonds and tasks – three aspects of the working alliance which seem to be required for any form of therapy to be successful. Several studies emphasise the importance of further common factors:

> Among the common factors most frequently studied have been those identified by the client-centred school as 'necessary and sufficient conditions' for patient personality to change; accurate empathy, positive regard, nonpossessive 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)

Most forms of psychotherapy use this state of voluntary kinship or relationship more or less consciously and more or less in awareness. The Jungian Samuels states that 'the psychology of the soul turns out to be about people in relationship' (Samuels 1985: 21).

THE TRANSFERENTIAL/COUNTER-TRANSFERENTIAL RELATIONSHIP

This mode of therapeutic relationship is the one most extensively written about, for it is extremely well developed, articulated and effectively used within the theoretically rich psychoanalytic tradition and other approaches (Racker 1982; Heimann, 1950; Cashdan 1988; Langs 1976; Clarkson 1992). 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 people who wished to 'change' instead of analyse. So the transference relationship is an essential part of the analytic procedure since the analysis consists in inviting the transference and gradually dissolving it by means of interpretation (Greenson 1967).

Laplanche and Pontalis describe 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 at one point 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 therapeutic intentions, must control his urge for closeness and must "blanket" his usual personality' (Stone 1961: 20). Freud advocated that the analyst should refrain from intruding his personality into the treatment, and he introduced the simile of the analyst being a 'mirror' for the analysand (Freud 1912b: 118). This may not in fact 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.

For example, in a paper written in the same year (1912) as the one in which he cites the recommendations for emotional coldness and the mirror-like attitude, 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)

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 allows 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.

Berne wrote:

> Transactionally, this means that when the patient's Child attempts to provoke the therapist's Parent, it is confronted instead with the therapist's Adult. The therapeutic effect arises from the disconcertion caused by this crossed transaction.
>
> (1961: 174)

The patient's question 'How are you?' may often be met with analytic silence. Alternatively the analyst 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.'

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

A narcissistic, apparently generous but dynamically retentive patient whose mother over-fed him physically while never responding to his real feelings of isolation, abandonment or rage reports 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 1966: 172)

THE REPARATIVE/DEVELOPMENTALLY NEEDED RELATIONSHIP

The reparative/developmentally needed relationship is another relationship mode which can occasionally be differentiated from the others. This is the intentional provision by the psychotherapist of a corrective/reparative

or replenishing parental relationship (or action) where the original parenting was deficient, abusive or over-protective. 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 in the dream: 'How could you make such mistakes, this is terrible, you ought to be punished!'. In the dream the other psychotherapist says, 'Look, I myself received a D in this subject. I wasn't very interested in it, and you can see that you don't 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 unconscious 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 as much as 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 passing mark!).

The developmentally needed relationship as indicated in the cited 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. 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 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 instead of a renewed trauma for the patient.

The advocacy relationship proposed by Alice Miller (1983, 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 caretakers but which the psychotherapist ultimately has to provide. The holding environment of Winnicott (1958) is another example of such provision, as are the reparenting techniques of Schiff *et al.* (1975) in transactional analysis.

Freud (1912b) 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, nor try to educate, morally influence, or 'improve' the patient, and who should be tolerant of the patient's weakness. In practice, however, Freud conducted psychotherapy as no classical Freudian analyst would conduct it nowadays (Malcolm 1981); shouting at the patient, praising him, arguing, 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 hemmed in her patient Renée and bring her into some contact with life. In order to do this, Sechehaye not only took her on holiday to the seashore, as Ferenczi had done with one of his patients, but also took Renée into her home for extended periods. She allowed her to regress to the point where she felt she was re-entering her mother's body, thus becoming one of the first of those psychotherapists who have actually undertaken 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)

The psychotherapist's reply to a client who asks: 'How are you?' in this kind of relationship will be determined by the specific needs that were not appropriately responded to 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 therapist 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 therapist may reply, 'It is not necessary for you 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 the words of J. Schiff:

> 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 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 them. It is certainly true that this depth of long-standing psychotherapeutic relationship as the primary therapeutic relationship modality is more frequently reported between psychotherapists and more severely damaged patients.

THE I–YOU RELATIONSHIP

Particularly within the humanistic/existential tradition, there is appreciation of the *person-to-person relationship* or *real relationship*. This therapeutic relationship modality shows most continuity with the healing relationships of ordinary life. Buber (1970) called this the I–Thou, or I–You relationship to differentiate it from 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* used skilfully and ethically (Rogers 1961; Laing 1965; Polster and Polster 1973). However, there has always been, and there is again, growing recognition within psychoanalytic practice that the real relationship between analyst and analysand – following Freud's own example – is a deeply significant, unavoidable and potentially profoundly healing force also within the psychoanalytic paradigm (Malcolm 1981; Klauber 1986; Archambeau 1979).

With Freud's discovery of the importance of the transference relationship came deep suspicion of the real relationship – the therapeutic relationship most similar to ordinary human relationships. Certainly 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 analyst feelings or counter-transference reactions have been seen as valid and important sources of information to be used effectively in the psychotherapy (Heimann 1950).

Object relations theorists have offered psychotherapy profoundly useful concepts and theoretical understandings, but the I–You therapeutic relationship is the opposite of an object relationship. For Buber, the other is a person, not an 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.
>
> (Buber 1970: 55)

The emotional involvement in this relationship between psychotherapist and patient is that between *person and person* in the existential dilemma where both stand in a kind of mutuality to each other. Indeed, as Friedman (1985) points out, it is a kind of mutuality because the psychotherapist is also *in* role. However, in the immediacy of the existential encounter, the mutuality is almost complete and the Self of the therapist becomes the instrument through which the healing evolves.

An intuitive, introverted type of patient sadly remembers difficulty with differentiating right from left, along with physical discomfort in the real world and incomprehension when required to learn kinaesthetically. The psychotherapist bends down to show the 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, of course, to be done with extreme care and, in its worst, abusive form, has been an excuse for inauthentic acting out of the psychotherapist's own need for display, hostility or seductiveness. Genuine, well-judged use of the I–You relationship is probably one of the most difficult forms of therapeutic relating. Doubtless this was the very good reason behind the early analysts' regarding it with extreme suspicion. 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. Yet there are only a few trainings – for example, in Gestalt – which 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's about, or it is 'outlawed' in the analysis – as if this were possible.

'There can be no psychoanalysis without an existential bond between the analyst and the analysand', writes Boss (1963: 118). The I–You relationship is characterised by the *here-and-now existential encounter* between the two people. It involves mutual participation in the process and the 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 1969), specifically includes the I–You genuine encounter as a major therapeutic 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)

To Fromm-Reichmann (1950/1974), Sullivan's (1940) concept of the psychotherapist as 'participant observer' included spontaneous and genuine responses on the part of the psychotherapist and even, in some cases, reassuring touch and gestures of affection. This does *not* include transforming the professional relationship into a social one, nor seeking extraneous personal gratification from the dialogue with the patient. But it does include confirmation of patients as worthy of respect, and meeting them on the basis of mutual human equality.

Guntrip (1961) also rejected the traditional restriction of the functions of the psychotherapist to the dual one 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, true psychotherapy only happens when the therapist and patient find the person behind each other's defences.

Deep insight, as Fairbairn (1952) points out, only develops inside a good therapeutic 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 describing different therapeutic relationship modalities which are intrinsically different in *intent, in execution, and in effect; not merely a semantic blurring.*

Of course, the humanistically orientated psychotherapies (such as Gestalt which emphasises here-and-now contact as a valid form of therapeutic 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, respect and empathy became the cornerstone conditions for facilitating human growth and development. In psychoanalysis, even Anna Freud called for the 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' (1968: 360). It is the neglect of this side of the relationship, and not just 'transference' that may cause the hostile reactions analysts get from their patients, according to 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 benignity. He declared that a 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 therapeutic relationship changes the therapist as much as the patient. Both Jourard (1971) and Jung (1966) 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 therapeutic 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). I also quote Greenson directly: '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' (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 his long-range goals.

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 only accomplish the true task of regenerating the stunted growth of a personal centre 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' (1970: 179).

THE TRANSPERSONAL RELATIONSHIP

This refers to the spiritual dimension of relationship in psychotherapy. Within the Jungian tradition (Jung 1969) and also within the humanistic/existential perspective (Rowan 1983), there is acknowledgement of the influence of the qualities which presently transcend the limits of our understanding (as expressed by Hamlet with 'There are more things on heaven and earth, Horatio, than are dreamt of in your philosophy' (Shakespeare, in Alexander 1951: 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 1990).

'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 transpersonal 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 (Guggenbuhl-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 surprisingly little documented about the transpersonal relationship in psychotherapy. Peck (1978) mentions the concept of 'grace', as has Buber before him, as the ultimate factor which operates in the person-to-person encounter and which may make the difference between whether a patient gets better or not. Berne, too, was aware of it in 1966 when he quoted: '"Je le pensay, et Dieu le guarit" . . . I treat him, but it is God who cures him' (Agnew 1963: 75).

The nature of this transpersonal dimension is therefore quite difficult to describe, because it is both rare and not easily accessible to the kind of descriptions which can easily be used in discussing the other forms of therapeutic 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 1969: 7). It is also possible that there may be a certain amount of embarrassment in psychotherapists who have to admit that after all the years of training and personal analysis and supervision, ultimately we still don't know precisely what it is that we are doing or whether it makes any difference at all. This is the kind of statement one can only be sure of being understood correctly 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 beyond all expectation. At the other polarity, the client for whom the analyst had made an optimistic prognosis reaches plateaux from which in effect they never move, and the analysis is abandoned with a lingering sense of potential glimpsed but never to be reached.

The transpersonal relationship is also characterised paradoxically by a kind of intimacy and by an 'emptying of the ego' at the same time. It is rather as if the ego of even the personal unconscious of the psychotherapist is 'emptied out' of the therapeutic space, leaving space 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 the transmutation takes place' (Adler 1979: 21). It implies 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 of creativity 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.

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 realize that she does indeed speak French, she just speaks it very well. And sometimes she speaks Chinese.

This comment arose from the context 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 therapeutic container, allowing wisdom and insight and transformation to occur as a self-manifesting process. The essence of the communication is in the heart of the shared silence of being-together in a dimension impossible to articulate exactly, too delicate to analyse and yet too pervasively present in psychotherapy to ignore.

Another trainee in supervision brought the following ethical problem. 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 strategies for such cases to no avail. Indeed, the client refused to form any working alliance in the shape of an agreed goal for her psychotherapy. It was exceedingly uncertain what benefit there could be for her, yet she continued coming because (we speculated) this was the only human relationship which 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 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 truly 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 a trance-like meditation, the quality of which is conveyed by the being-with of highly evolved psychotherapists with patients who are in acute psychosis, such as Gendlin (1967), who affirm the spiritual dimension in psychotherapy. (It is quite possible that psychotherapists may be deluding themselves in ways which may be

dangerous for themselves and their clients if they mistakenly, prematurely or naïvely focus on the transpersonal and, for example, overlook or minimise transferential or personal phenomena.)

James and Savary contributed the notion of a third self created in such a dimension of betweenness 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). Psychosynthesis also recognises the notion of a higher self (Hardy 1989).

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*. This dimension in the psychotherapeutic relationship cannot be proved and can hardly be described, and Buber concludes: 'Nothing remains to me in the end but an appeal to the testimony of your own mysteries' (1970: 174).

CONCLUSION

This chapter has briefly described five kinds of psychotherapeutic relationship available as potential avenues for constructive use, and each will be expanded in following chapters. It has indicated some characteristics of each and begun an effort to clarify, specify and differentiate more acutely in theory and practice the nature and intentions of the multiplicity of psychotherapeutic relationships available in the consulting room. Different psychotherapies stress different relationships for different reasons. Whatever the orientation, the psychotherapeutic relationship is therefore a continuing theme throughout all the chapters in this *Handbook*.

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

It may need to be recognised in most psychotherapy trainings that experience and supervision are required in distinguishing between such different forms of psychotherapeutic relationship and assessing and evaluating the usefulness of each at different stages of psychotherapy. Equally, different modes may be indicated for individuals with different characteristic ways of relating so that there is not a slipshod vacillation due to error or neurotic counter-transference, nor a denial of the

Confusion and lack of clarity abound when types of psychotherapeutic relationship are confused with one other, or the validity of one is used as necessarily substituting for the other. It is possible that humans need all of these forms of relating, and that psychotherapists with flexibility and range can become skilful in the appropriate use of all of them, although not all are required in all psychotherapies or for all patients.

The far-ranging implications of this perspective for psychotherapy research, assessment and treatment need to be developed further. Integration of a multiplicity of therapeutic relationship modalities does not mean eclectic or unconscious use. Indeed, if such is the declared field, the responsibility is awesome. Freedom does not mean that we forgo discipline. Courage in actively embracing the fullest range of potentials of the self, theory or the *numinosum* needs to be accompanied by the severest form of testing, and forged anew with each client from moment to moment, no matter what the prescriptions or proscriptions of theoretical orthodoxy.

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