Enactment as *the* central concept of relational therapy

- recognising the client’s relational patterns, scripts or schemata
- recognising the client’s perception of the therapeutic relationship through their relational pattern
- understanding the client’s conflict: habitual mode versus ‘emergency’
- the ebb and flow of the working alliance: three kinds of contact in the therapeutic relationship
- the client’s conflict becomes the counsellor’s conflict: recognising enactment
- enactment as a bodymind process
Enactment

• unrecognised essential conundrum at the heart of our profession

• it is not a question *whether* enactment happens, but only whether it happens *with some awareness* or hidden, unconsciously, *outside awareness*

• It will make a crucial difference ….
  - a) as to how we as a profession survive the current onslaught of CBT and
  - b) to the strength of our profession in the future

• References:
An integrative language

• We need to find a language of talking about the phenomena which ...

• a) links up the concepts and notions which different approaches have come to use to approximate the experience, and

• b) does not privilege or exclude certain therapeutic orientations.
A Multiplicity of therapeutic relationships

• (Petruska Clarkson)
  - integrative and non-partisan
  - differences not in terms of theories or techniques, not in terms of models, not in terms of what the therapist does to or with the client, but in terms of …
  - *modes of relationship and kinship metaphors*
  - underlying relational stances
# A Multiplicity of Therapeutic Relationships

Petruska Clarkson’s 1990 paper and 1994 "The Therapeutic Relationship"

<table>
<thead>
<tr>
<th>Modality of Therapeutic Relationship</th>
<th>Kinship Metaphor</th>
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<tr>
<td>1. Working Alliance</td>
<td>cousins incl. aunt/uncle – niece/nephew; = kindred loyalty though different parents</td>
</tr>
<tr>
<td>2. Transference / Countertransference</td>
<td>step-parent / god-parent</td>
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<tr>
<td>3. Reparative / Developmentally Needed</td>
<td>parent – child</td>
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<tr>
<td>4. I-Thou (‘authentic’ / existential)</td>
<td>person – person</td>
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<tr>
<td>5. Transpersonal</td>
<td>marital pair</td>
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</tbody>
</table>

Clarkson overlap tensions wound enters client’s conflict therapist’s conflict oscillations oscillation central paradox what is 3 kinds contact transfer deconstruct arrow dualism website
1. Working alliance:

- often defined as the agreement and bond between the healthy part of the client and the healthy part of the therapist,
- manifest in clear contracts, boundaries, objectives and frameworks
- a whole lot more complex when we recognise unconscious processes
2. Transference/countertransference:

- transfer of past experience into the present relationship

- co-existence side-by-side of past relationship dynamics and habitual patterns with present relationship dynamics
3. Reparative / developmentally needed:

- focus on negative patterns from the past, but …
- provide positive or reparative – usually parental – presence that never happened (rupture – repair)
- “corrective emotional experience”
4. Authentic:

- here-and-now ‘I-Thou’ meeting of two humans,
- as advocated by person-centred and existential approaches
5. Transpersonal / collective

• depending on your own belief system,
  - spiritual
  - socially constructed / embedded
  - collective unconscious
  - evolutionary psychology

  = collective, beyond personal psychology

  I have not included it in what follows because it’s beyond consensus and I do not want to impose it as part of the bedrock of my theory
Modalities are associated with therapeutic approaches, but do not simply map onto them

- all the modalities are part and parcel of each and every therapeutic relationship

- different theoretical models each give us only a partial snapshot of the underlying wholeness of the therapeutic relationship

- each model/approach discloses and emphasises certain aspects of human reality and occludes or neglects others
Modalities are associated with therapeutic approaches, but do not simply map onto them

• examples:
  - person-centred/existential = authentic?
  - many humanistic therapists now do work with transference / countertransference
  - authentic – reparative tension
  - reparative – psychodynamic tension

• most practitioners do not hold a coherent, integrated, contradiction-free philosophy in practice

• inherent contradictions between theory and practice; models and philosophy, conscious stance and unconscious modes of relating
Overlaps between the main modalities of the therapeutic relationship

The overlaps between the four main modalities in the therapeutic space

- 'medical model' help
- authentic "I-Thou"
- reparative
- working alliance
- transference - counter-transferance
- enactment
The therapeutic space:

- *all* modalities have therapeutic and counter-therapeutic effects (all extend both inside and outside the therapeutic frame)

- i.e. each modality can become counter-therapeutic, as indicated by the areas outside the *therapeutic space*

- also outside the *therapeutic space*:
  - a) enactment as we will see, as it is implicitly counter-therapeutic, and also
  - b) the ‘medical model’
The tensions between the main modalities of the therapeutic relationship

- Reparative: Usually no theoretical denial of transference, but therapist’s investment in functioning as “good object” (intransitive approach).
- Authentic “I-Thou”: Denial of existence of transference, anti-transference, philosophical existential critique of reparative as counter-therapeutic.
- Transference - Counter-transference: Denial of possibility of authentic relationship; critique of reparative and corrective emotional experience as counter-therapeutic.
- Working alliance: 3 contacts / paradox, what is enacted? 3 kinds of contact / transfer, deconstruction, website.

Clarkson

The tensions between the four main modalities of the therapeutic relationship

and – in the extreme – the mutual denial between reparative, authentic and transference / counter-transference modalities.
Example from the group

• role-play client-therapist:
  – find modalities as they manifest in this particular session, then …
  – focus on the therapist’s experience of the working alliance
    – to complete the picture, add ‘medical model’
The bodymind phenomenology of the working alliance

- the sense of working alliance comes and goes (strengthens and weakens with the flow of the interaction)

- the working alliance is co-created between client and therapist

- i.e. NOT exclusively the therapist’s responsibility

- i.e. the working alliance is NOT a function of the therapist’s competence only

- the working alliance is partly conscious, partly unconscious
Why does the working alliance oscillate?

- the client is internally conflicted and ambivalent
- the client wants to resolve their pain whilst remaining defended against it
- the client transfers the wounding at the root of their pain into the therapeutic space and relationship
- the client experiences the therapist as a trusted helper and ally AND as the source of further pain
The safer the therapeutic space, the deeper the wounding that can manifest into it

• a good working alliance allows and invites deeper levels of wounding and pain

• once a deeper level emerges, the client becomes conflicted about the pain and ambivalent about the process = disturbances in the working alliance
The wound enters …

- the client’s wound does not remain confined to the person’s outer life (outside the session), nor confined to the client’s past or inner world (separate from the session or therapist)

- the wound enters the consulting room and the therapeutic relationship

- there are times when the therapist explicitly gets involved or drawn into the wound at the root of the client’s pattern

- we attempt to meet the client where they are, but to some extent they are in their pattern
The wound enters the here & now of the therapeutic relationship

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<th>The client’s wound comes into the room and enters the ...</th>
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<td>1</td>
<td>... client’s ‘here &amp; now’ experience as non-verbal process</td>
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<tr>
<td>2</td>
<td>... client’s <em>perception</em> of the therapist (= transference)</td>
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<tr>
<td>3</td>
<td>... client’s <em>experience</em> of the therapist (= embodied transference)</td>
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<td>... therapist’s awareness (= countertransference)</td>
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<tr>
<td>5</td>
<td>... therapist’s experience (= embodied countertransference)</td>
</tr>
<tr>
<td>6</td>
<td>... supervisor’s experience (= ‘parallel process’)</td>
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</table>

The wound and wounding enter the room

• There are two kinds of significant moments:
  – when the wound first enters the room
  – when the wound takes over in the dynamic between client and therapist

  (i.e. when the wounding relationship gets enacted between client and therapist)
The client’s conflict

• as the client is internally conflicted about their wound and about experiencing or feeling it *fully*, they are also conflicted about it emerging into the therapeutic space (and thereby manifesting externally)

• the client’s ambivalence towards the experience of their wound will manifest in ambivalence towards therapy and therapist
The most basic model for the client’s conflict: habitual mode versus ‘emergency’

**HABITUAL MODE:**
- resist spontaneous pressure & maintain status quo
- character / established structure:
  - adaptation / core schema / ‘false self’
  - survival mechanisms, facade, defences
  - e.g. repression, denial, splitting, etc.

**diluted internal conflict**
- denial of the ‘wound’

**‘EMERGENCY’:**
- pressure from within or outside
- emergent process:
  - denied & as yet unlived aspects
  - e.g. ‘true self’, ‘organismic self’
  - e.g. repressed chronic pain seeking attention & expression

**acute internal conflict**
- surrender to the ‘wound’

**implicit message to therapist:**
- ‘NOTHING HAS TO HAPPEN!’
  - e.g. “I can’t bear the risk & pain of change. Accept me as I am, don’t make me change! Don’t force me beyond familiar territory!”

**implicit message to therapist:**
- ‘SOMETHING DESPERATELY HAS TO HAPPEN!’
  - e.g. “I can’t bear it (any more). Save me - make me change! I need to transform into a larger identity!”
The client’s conflict becomes the therapist’s conflict

- am I going to side with the habitual mode or the ‘emergency’?
- because they are mutually exclusive and opposed, I cannot side with both of them at the same time
The client’s conflict becomes the therapist’s conflict
The therapist’s sense of internal conflict ...

- is a sign that the client’s wound has entered the space & relationship
- is a sign that the client’s ambivalence in relation to their wound has entered
- inevitably touches on the therapist’s ambivalence in relation to their own wounds
- is the precious first sign of enactment

“The therapy has not started until it becomes problematic for both participants.” C.G. Jung
How does the therapist perceive/sense disturbances in the working alliance?

• therapist senses dissonance, mis-perception, misunderstanding, mis-attunement

• this usually involves unconscious and subliminal double-messages

• or the co-existence of two contradictory relationship dynamics
How does the therapist perceive/sense disturbances in the working alliance?
How does the therapist perceive/sense disturbances in the working alliance?
The ebb and flow of the working alliance

The oscillations in contact between working alliance and enactment (rupture & repair)

- diamond model: oscillations between working alliance and enactment within the therapeutic space

Clarkson, overlap, tensions, wound, enters, client’s, conflict, therapist’s, oscillations, oscillation, central, paradox, what is, enacted? 3 kinds, contact, transfer, deconstruct, dualism, website
Three kinds of contact in the therapeutic relationship

- oscillations between working alliance and enactment = three kinds of contact

Three kinds of contact in the therapeutic relationship

- oscillations between working alliance and enactment = three kinds of contact

The oscillations between working alliance and enactment = 3 kinds of contact

1) working alliance assumed = absolute avoidance and denial of enactment (medical model)
   - reparative contact
   - medical model
   - authentic contact

2) working alliance ambivalent / ambiguous
   - idealised transference
   - negative transference
   - counter-transference enacted
   - negative transference enacted

3) working alliance threatened / broken
   - rupture of working alliance via enactment understood as counter-therapeutic AND potentially transformative

Three kinds of contact:

- oscillations between working alliance and enactment = three kinds of contact

What is enacted?

3 kinds of contact

Clarkson, overlap, tensions, wound, client’s conflict, therapist’s conflict, oscillations, 3 contacts, 3 kinds of contact, transfer, deconstruct, dualism, website
The modalities in relation to the three kinds of contact
The paradox at the heart of the helping relationship (1)

• working alliance not static

• swings between poles of spontaneous and effortless presence to being disturbed, threatened or broken down

• inexorable tendency for the wound to enter the relationship as a here & now dynamic between client and therapist

• once wound enters the therapeutic relationship like that, it inevitably disturbs the working alliance

• the wound has an inherent inclination to manifest – to be revealed in order to be resolved
The paradox at the heart of the helping relationship (2)

• something more than simple helping is involved in all helping relationship

• what is helpful and unhelpful is not linear and straightforward

• ‘helpful’ and ‘unhelpful’ are not simple logical (dualistic) opposites

• what makes things better and what makes them worse is not clear-cut
The paradox at the heart of the helping relationship (3)

- because as clients our relationship to our pain and our wounds is ambivalent (‘I want to heal it or have it healed’ versus ‘I want to get rid of it or have it removed’), anybody trying to help us will inevitably have to get involved and drawn into that conflict

- because as clients we are chronically, defensively internally conflicted, helping is not a straightforward endeavour, easily given or received

- as well as seeking help with our patterns, from within them we are also compelled to replicate them with our therapists, in and through therapy
The paradox at the heart of the helping relationship (4)

• in summary – there is a paradox implicit in any attempt to engage with the client’s fundamental internal relational pattern

• (rather than working within those patterns, which is comparatively uncomplicated)
The paradox at the heart of the helping relationship (5)

• the central paradox at the heart of the ‘helping relationship’ is that …

  – the healing of the client’s wounds *in* and *through* therapy
  – is inseparable from
  – the enactment of the wounding *in* and *through* therapy.
The paradox at the heart of the helping relationship (6)

• here is something CBT practitioners cannot get their heads around:
  
  – the repetition of the wounding *in* and *through* therapy *can* become therapeutic
  
  – therapy needs to ‘make things worse’ in order to ‘make them better’
The paradox at the heart of the helping relationship (7)

- The therapist’s conflicted sense of entanglement and trappedness can then be recognised as an avenue into the depth of the therapeutic process.

- The working alliance needs to break down in order for it to exist (and to deepen).
The phenomenology of enactment

• What is being enacted?
• The wounding relationship dynamic at the root of the client’s habitual patterns.

- CBT: negative patterns/schema
- Daniel Stern: RIG’s (Representations of Interactions which have been Generalised)
- internal(ised) object relations
- Carl Jung: complexes
- Wilhelm Reich: character structures
- Stephen Johnson: character styles
- Eric Berne (TA): scripts
- Stan Grof: COEX System (Systems of Condensed Experience)
The notion of ‘enactment’ is threatening to our habitual therapeutic identities

• many counsellors / therapists …
  - are invested in helping and want to avoid helplessness
  - want to ‘get it right’
  - extrapolate the *feeling* of failure into a self-judgement (lack of competence)
  - are invested in being seen as the ‘good object’
  - avoid conflict and prefer harmony
  - are afraid of the client’s hostility
  - are caught in ‘medical model’ assumptions about linear progress and accountability
  - don’t want to risk losing their client
  - want to (or feel required to) be ‘in control’ of the process
  - feel threatened by the unpredictability of paradox

• resistance to understanding the concept of enactment
Applying the paradoxical diamond model to our practice

- most counsellors and therapists:
  - well-developed and uncanny sensitivity to enactment
  - valid intuitions about its counterproductive nature
  - tendency to avoid the crunch of its obvious counter-therapeutic effects
  - feel responsible for the inherent sense of failure
There is no way out (of enactment), only a way in!

- every (unconscious) attempt to get out of or circumvent enactment …
  - later tends to exacerbate it
  - gives subliminal messages of avoidance and defensiveness to the client
  - procrastinates and then makes the enactment more uncontainable when it eventually does become explicit
Three kinds of contact in the therapeutic relationship:

1. resonance

Therapist experiences: RESONANCE
(explicit empathic flow and attunement, no doubts about working alliance)

a) spontaneously, without effort or intention
b) through therapeutic persona (good will, intention)
Three kinds of contact in the therapeutic relationship:

2. ambivalence
Three kinds of contact in the therapeutic relationship:

3. enactment

Therapist experiences:

**INTENSE CONFLICT / PRESSURE**

(charged and conflicted moment - working alliance acutely/intensely threatened = loss of therapeutic position seems imminent or already happened)

therapist intufts that possibility for re-enactment of client's wounding and negative patterns is strong = tendency to go unconscious
Three kinds of contact in the therapeutic relationship:
the spiralling process

1) Wound enters client's conflict
2) Arrow deconstructs dualism
3) Projected 'bad' object

Clarkson overlap tensions, wound enters client's conflict, therapist's conflict, oscillations, oscillation, central paradox, what is enacted?
3 kinds of contact, transfer, deconstruct arrow, dualism, website
How to facilitate and/or contain the transition from 1) to 2)?

How to facilitate and/or contain the transition from 2) to 3)?

The transition from 3) back to 1) happens spontaneously.

Three kinds of contact in the therapeutic relationship:

1) The transitions between contacts

2) How to facilitate and/or contain the transition from 1) to 2)?

3) How to facilitate and/or contain the transition from 2) to 3)?

The transition from 3) back to 1) happens spontaneously.
How to facilitate enactment into transformation (1)

- see my workshop series leaflets or www.soth.co.uk

- the therapist *is* part of enactment

- the starting point: attend to therapist’s necessary sense of conflict, manifesting as uncertainty, helplessness, feeling torn between different perceptions, hypotheses or therapeutic impulses

- this is not incompetence, but information!

- the therapist needs to experience *failing*

- then (and only then) attend to implicit conflict and ambivalence also in the relationship
How to facilitate enactment into transformation (2)

- becoming aware of the wholeness of enactment is impossible as long the counsellor / therapist ...
- is compelled by ‘making it better’
- is insecure about position or needing to be liked by client
- is focused mainly on content / narrative / verbal
- is compelled by ‘medical model’ thinking
- is compelled by a linear model, technique or theory (progress)
- avoids being ‘constructed as an object’
- is unaware of projective identifications
- wants to get it ‘right’
How to facilitate enactment into transformation (3)

• surrender to enactment
• then attend to positive and negative relationships co-existing in parallel
• interpretation, explanation, education, feedback are often not sufficient
• enactment (like transference) is a partly unconscious bodymind process
• as the crucial relational patterns are assumed – by modern neuroscience - to reside in implicit memory, enactment happens largely implicitly, spontaneously, unconsciously
How to facilitate enactment into transformation (4)

• much counselling and psychotherapy theory and training is too linear, goal-oriented, making out that there is a ‘right’ and ‘correct’ set of theories, approaches, techniques that – if applied properly – will ‘work’ and will help you avoid feeling conflicted, confused, torn as a practitioner

• it thus does not prepare us for real-life necessity of these experiences of enactment and their usefulness
How to facilitate enactment into transformation (5)

- intuitively (and understandably) we avoid enactment, often automatically and unconsciously

- counter-intuitive response is also required: increasing awareness of enactment

- deepening the enactment, i.e. facilitating the full experience of it, bringing awareness to it
How to facilitate enactment into transformation (6)

- gathering the bodymind fragments of the wounding relationship from within it

- the ‘fractal self’ and parallel process:
  - the three parallel relationships
  - the five parallel relationships
Experiential Questions:

• let’s watch working alliance phenomenologically
• in practice, throughout the unfolding process, the working alliance comes and goes
• let’s watch moments when working alliance is disturbed or threatened what happens in those moments?
• the client’s pattern does not stay confined to the client’s life outside the consulting room, but enters
• moment X: the client’s pattern enters the here & now of the relationship between client and therapist
• it enters in spite of the clients and therapist’s intentions = it is a spontaneous and often unconscious process
• the wound enters
The three revolutionary moves (re-framing the counter-therapeutic)

- How transference, then counter-transference and maybe now enactment can increasingly be embraced as valid and necessary, as ‘royal roads’ into the depth of the work.
The working alliance hangs in limbo in a forcefield between the poles of ‘medical model’ and enactment.
Notions of transference in the different modalities

- Integrative perspective on transference and enactment

- Notions of transference in the different modalities

Freud's classical assumption: countertransference as obstacle
difficulties in the countertransference are seen as the therapist's pathology

countertransference resolution: countertransference as meaningful interference with working alliance

Freud's classical assumption: countertransference as obstacle
difficulties in the countertransference as possible manifestations of enactment

enactment
enactment to be avoided
enactment as potentially transformative

Clarkson overlap tensions wound enters client's conflict therapist's conflict oscillation central paradox what is enacted? 3 kinds contact transfer deconstruct dualism website
The swing from the taken-for-granted ‘medical model’ towards the ‘anti-medical model’

### The deconstruction and transcendence of 19th century dualisms

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<th>The 'RELATING CURE' = enactment</th>
<th>ANTI-MEDICAL MODEL</th>
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The deconstruction and transcendence of the doctor-patient dualism
The swing from the taken-for-granted mind-over-body dualism towards ‘anti-split holism’

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<th>21st century paradoxical INTEGRATION</th>
<th>EUROPEAN SPLIT</th>
<th>'EMBODIMENT' = embodiment &amp; dis-embodiment</th>
<th>ANTI-SPLIT HOLISM</th>
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**The deconstruction and transcendence of the mind-over-body dualism**

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