The Diamond Model of Clarkson's Five Modalities of the Therapeutic Relationship

The dynamic, paradoxical whole of the therapeutic relationship and the polarity of working alliance and enactment at the heart of relational therapy

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Overview

- **Integrative psychotherapy**
  - Advantages of integration
  - Difficulties/dangers/pitfalls
- **Clarkson's 5 relational modalities**
  - Advantages of Clarkson's model
- **Diamond model of relational modalities**
  - Advantages over Clarkson's model

Brainstorm: Approaches and Questions / Learning

- **Approaches represented here today**
- **Any questions/learning objectives you have for today**
  - **struggles / difficulties with integration?**
- **Your name**

Find client-therapist example

- struggles with integration:
  - **help each other find examples where …**
    - **you are torn between two approaches …**
    - **the client has different ideas or resists**
    - **switching approaches is difficult**
    - **underlying paradigm clashes manifest**

Psychotherapy Integration (1)

- **advantages of integration**
  - **Routes to integration:**
    1. **Common factors**
    2. **Technical eclecticism**
    3. **Theoretical integration**
    4. **Assimilative integration**
- **problems with integration?**
  - **since the beginnings of the integrative movement in the early 1990's, there has been concern over the distinction between integration versus eclecticism, based on the recognition that not all integration is a good thing, but that there are dangers and disadvantages in a potentially confusing, 'muddled', pick'n mix integrative approach.**

Psychotherapy Integration (2)

- **dangers of integration?**
  - lack of containment arising from a sense of inconsistency (between theories, techniques and underlying attitudes and values)
  - too pragmatic and eclectic an attitude tends towards superficiality
  - therapists using integrative flexibility in a defensive, avoidant way
  - therapist experienced as lacking a position, being 'all things to all people'
  - therapist's implicit, but unacknowledged 'medical model' attitudes in selecting different modalities
  - transferential and relational implications of switching between modalities are not sufficiently attended to

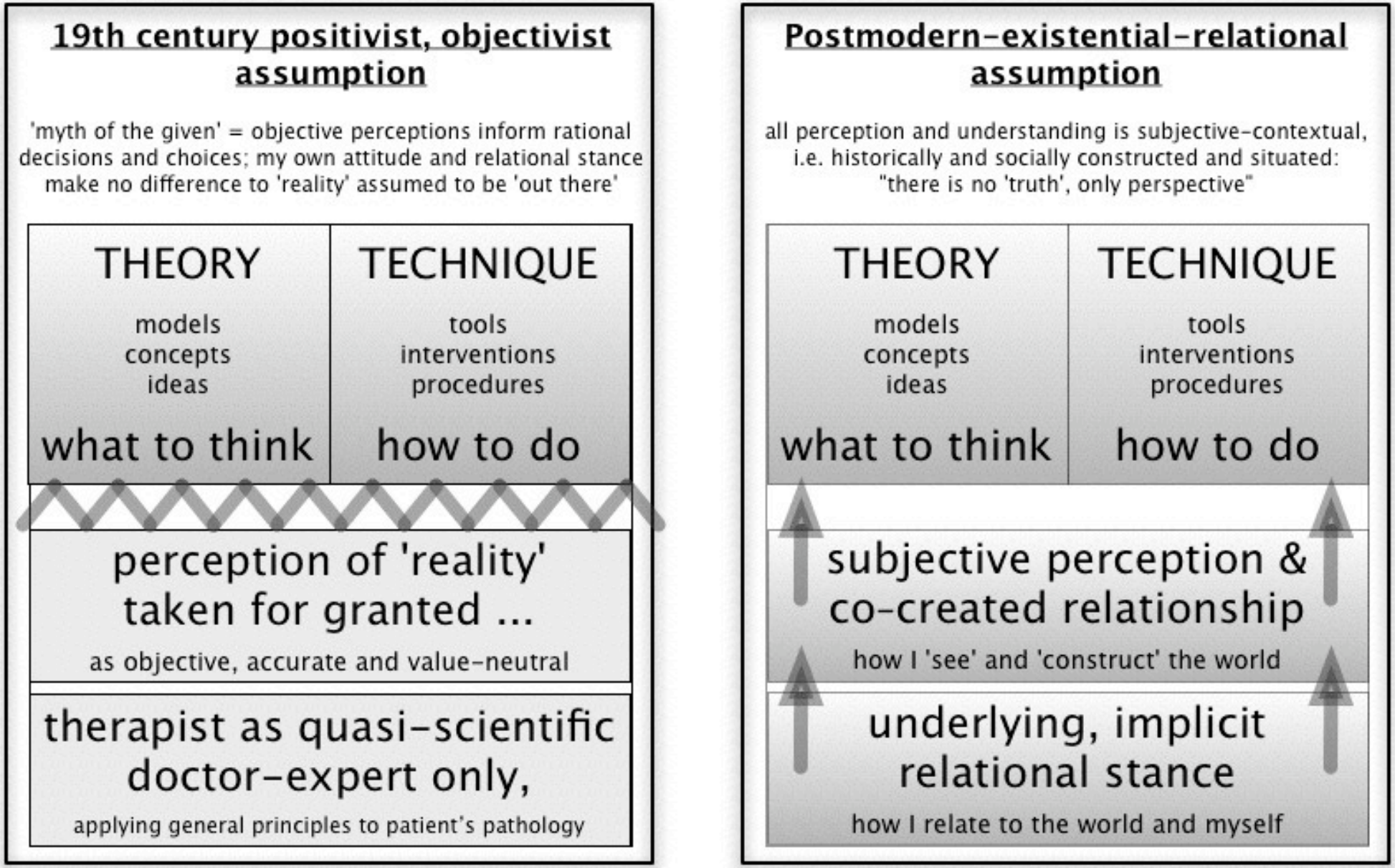
Psychotherapy Integration (3)

- **Lavinia Gomez:**

  'Humanistic or psychodynamic - what is the difference and do we have to make a choice ?' by Lavinia Gomez Self & Society Vol. 31 No.6 Feb/Mar 2004, p. 5 – 19

- **humanistic = alongside**
- **psychodynamic = opposite**

The 'implicit relational stance' underlying theory & technique



A Multiplicity of therapeutic relationships

- Petruska Clarkson 1991:
  - **integrative and non-partisan**

    from a fragmented and polarised field (where each tradition absolutises and takes for granted their implied relational modality) towards an integrative, pluralistic field where diverse and contradictory relational modalities are considered equally valid to begin with

  - **from one-person towards two-person psychology**
  - **from a perspective of two supposedly isolated minds towards the system of the therapeutic relationship (systemic intersubjectivity)**

A Multiplicity of therapeutic relationships

- Petruska Clarkson 1991:
  - **"it is the relationship that matters"**
  - **differences not in terms of theories or techniques, not in terms of models, not in terms of what the therapist thinks or does, but in terms of …**
  - **modes of relationship and kinship metaphors**
  - **therapist's underlying relational stance**

A Multiplicity of therapeutic relationships

A Multiplicity of Therapeutic Relationships

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

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

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
    - ego-ego alliance vs embodied alliance

2. Transference/ countertransference:

- transfer of past experience into the present relationship (The Presenting Past)
- projection of 'wounding relationship' and defences against it
- co-existence side-by-side of past relationship dynamics (habitual patterns) with present relationship dynamics

3. Reparative / developmentally needed:

- implies focus on negative patterns from the past, that have created psychological deficits but …
- provide "corrective emotional experience"
- positive or reparative – usually parental – presence that counteracts deficits and provides what never happened or antidote to what did happen

4. Authentic:

- here-and-now 'I-Thou' meeting of two humans
- I-I relating rather than I-it relating
- opposed to objectification and 'medical model'
- critical of therapist's persona
- 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

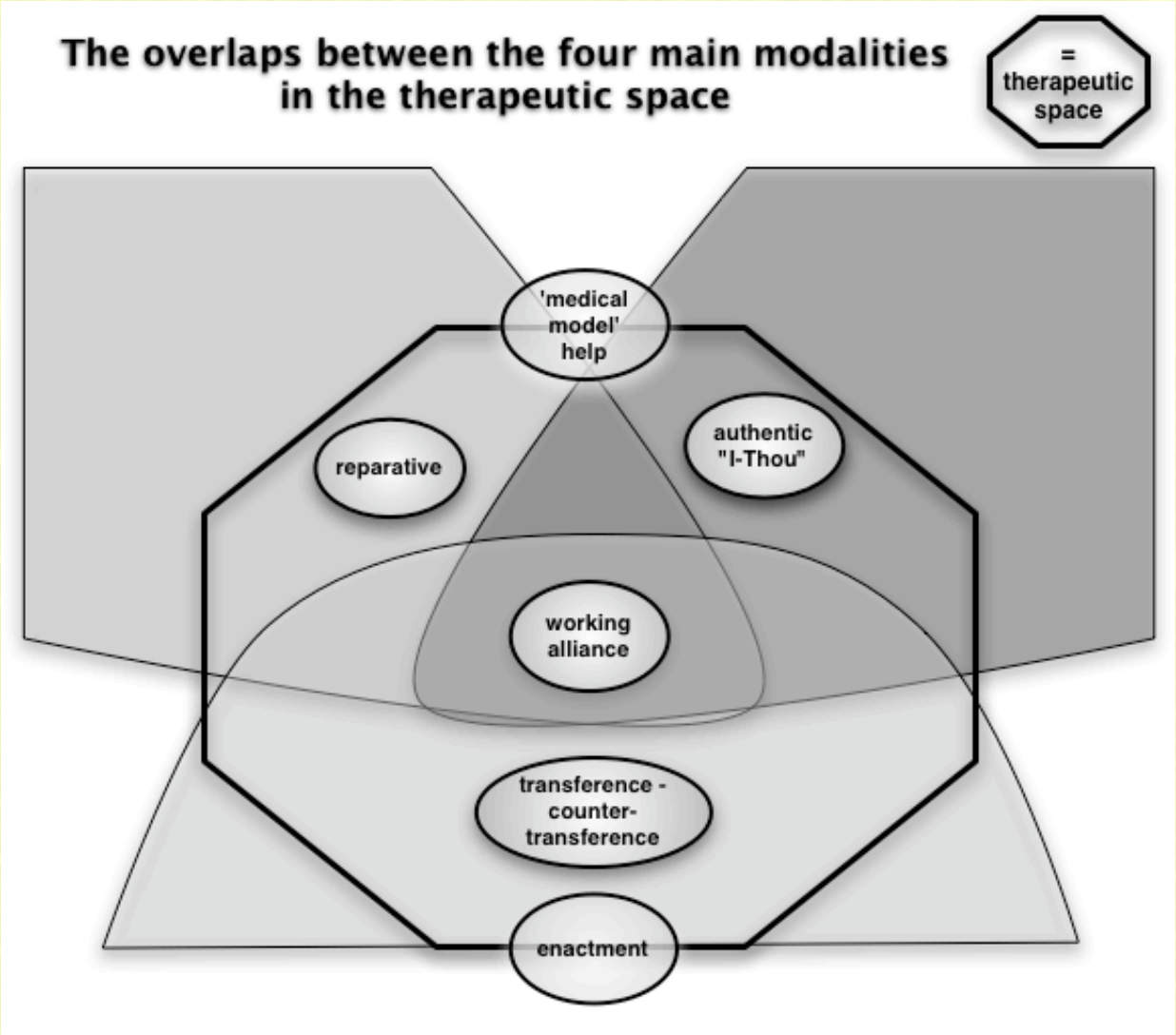
Modalities are associated with therapeutic approaches, but do not simply map onto them

- 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

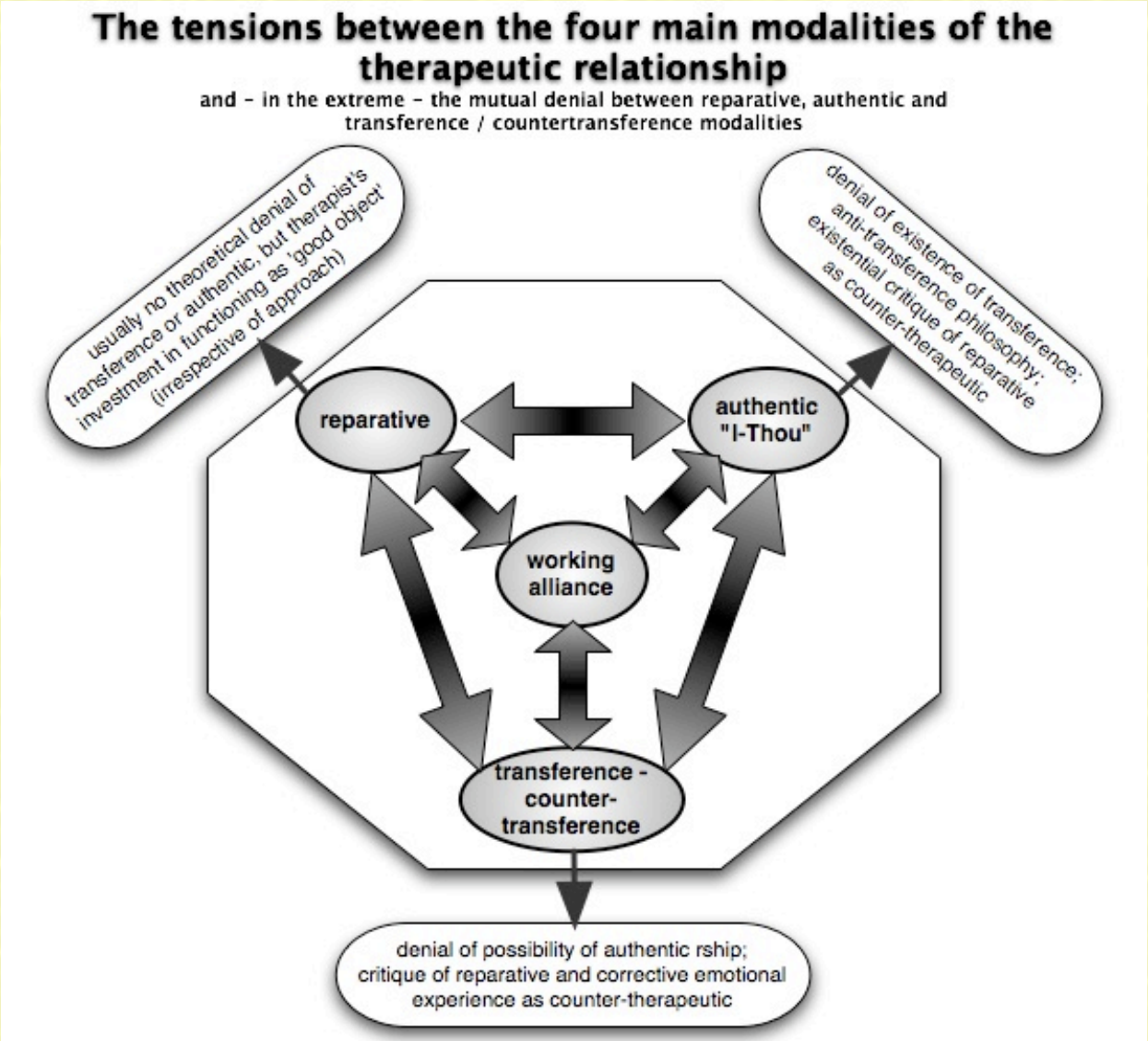
Overlaps between the main modalities of the therapeutic relationship



The 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



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'**

Michael's Diamond Model (1)

- **building on Clarkson's 5 modalities, but ...**
  - **from a diversity of supposedly linear sequential treatment options externally**
  - **into a dynamic system of simultaneous field forces internally, constellating the paradox of working alliance versus enactment in the here and now**

Michael's Diamond Model (2)

1. sequential treatment choices into simultaneous conflicted pressures

- i.e. from supposedly alternative strategies into a dynamic system of forces here & now

2. from concrete external treatment options into therapist's internal impulses and inclinations

- from external strategies and treatment plans into stream-of-consciousness fantasies in the therapist's awareness

Michael's Diamond Model (3)

3. add 'medical model' as one of the modalities

- sitting paradoxically on the edge of the therapeutic space, instead of it floating implicitly above all the other modalities as a hidden meta-position) = integrating subject and object relating (I-I and I-It relating

4. extend transference/countertransference modality into enactment

- also paradoxically on the edge of the therapeutic space - embrace more explicitly the notion of enactment as potentially transformative - enactment represents not just a further incremental evolution of the transference/countertransference paradigm, but a qualitative paradigm shift (see '3 Relational Revolutions')

Michael's Diamond Model (4)

5. underlying force-field between working alliance and enactment = central paradox of the profession

- structure the whole diamond of diverse modalities around those polarities

6. re-define working alliance

- not as ego-ego alliance, supposedly hovering outside enactment, but as including energetic/unconscious alliance, incl. attachment to 'bad object', for example

Michael's Diamond Model (5)

7. implying a spirallic deepening of unfolding process

- where the working alliance oscillates around enactment, analogous to the rupture and repair cycles in infant-mother bond = therapeutic process as oscillating between 3 kinds of contact (containment of successive enactments leads to deepening working alliance)

8. client's unconscious construction of therapy

- each modality not only as a realistic external given, but as an enactment of a fantasy/position in the client's inner world = understanding the forcefield of constellated modalities and the conflicts between them as a parallel process to the relationships in the client's inner world

Michael's Diamond Model (6)

9. each and every therapeutic theory and technique and modality can become a vehicle for enactment

- making more explicit the therapeutic and counter-therapeutic aspects of all therapeutic models, ideas and concepts

10. multiple alternative enactments

- often there is no such option as enactment versus avoiding enactment; there are multiple alternative enactments waiting to occur (by avoiding one we enact another) = there is no way out of enactment, only a way into them

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

The client's wound comes into the room and enters the ...	
1	... client's 'here & now' experience as non-verbal process
2	... client's *perception* of the therapist (= transference)
3	... client's *experience* of the therapist (= embodied transference)
4	... therapist's awareness (= countertransference)
5	... therapist's experience (= embodied countertransference)
6	... supervisor's experience (= 'parallel process')

- **Reference: Soth, M. (2006) "How 'the wound' enters the room and the relationship", Therapy Today, December 2006**

The wound and wounding enter the room

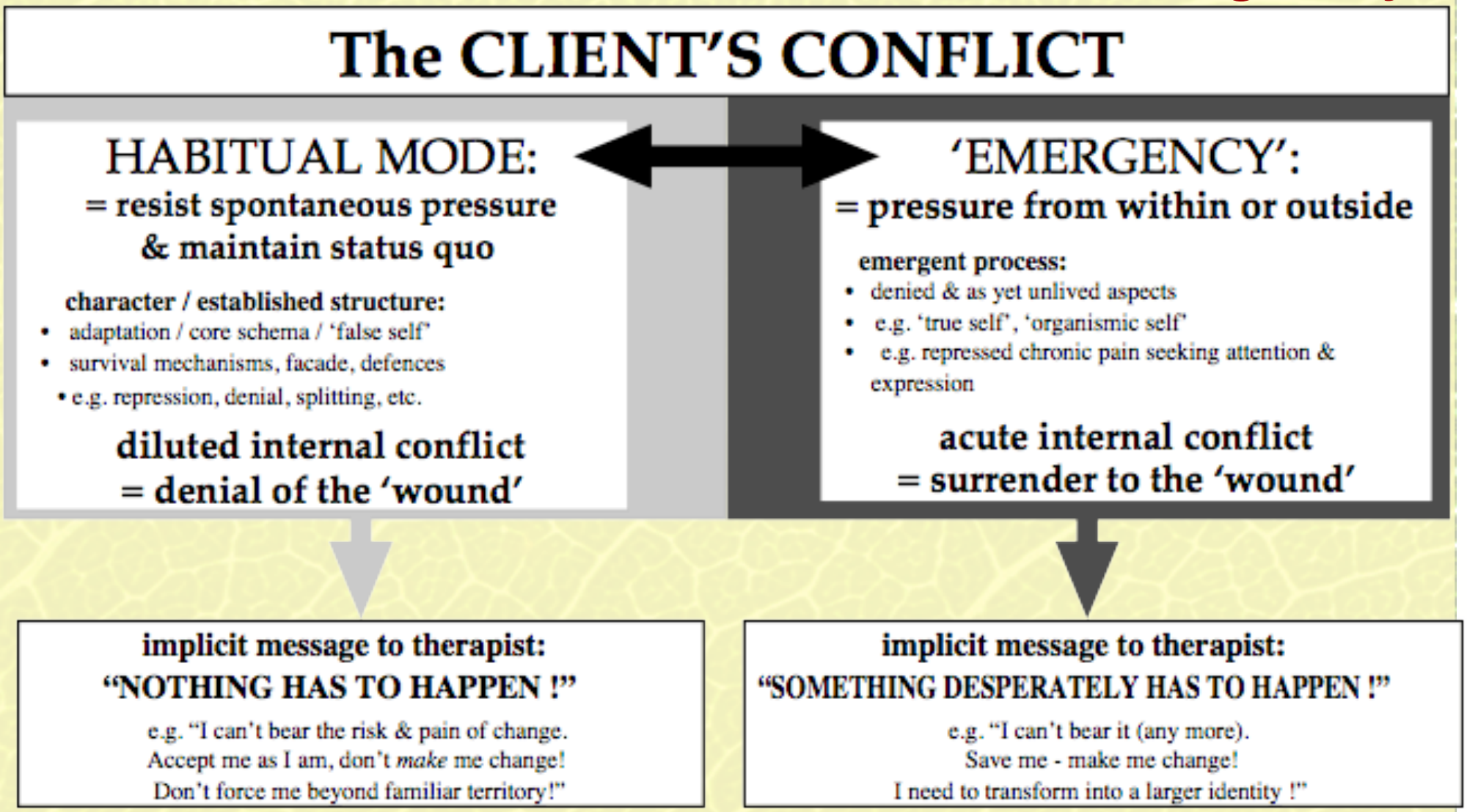
- There are two kinds of significant moments:
  - when the wound first enters the room
  - when the wound takes over in the dynamic between client and therapist

    (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

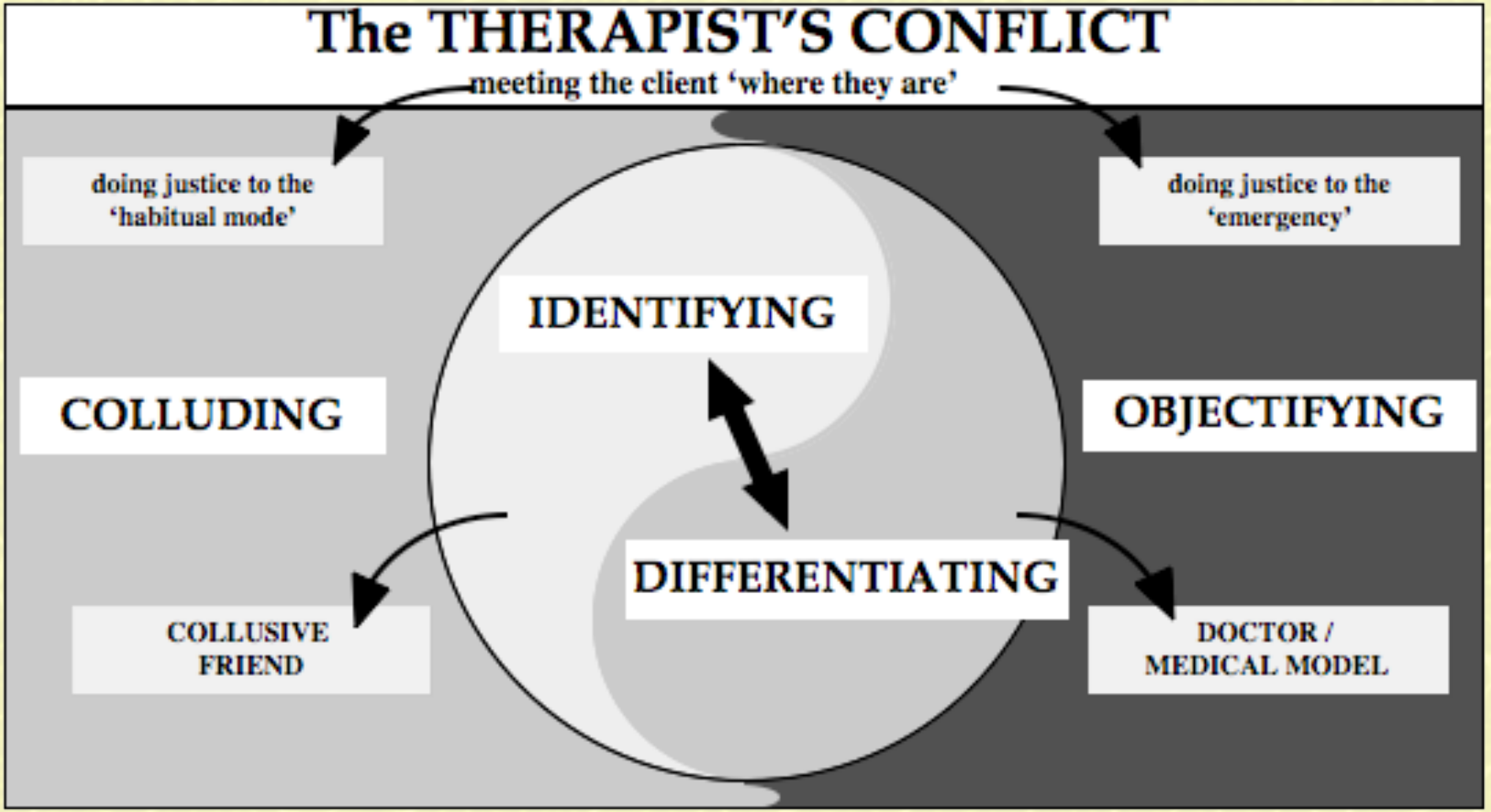
The most basic model for the client's conflict: habitual mode versus 'emergency'



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 …

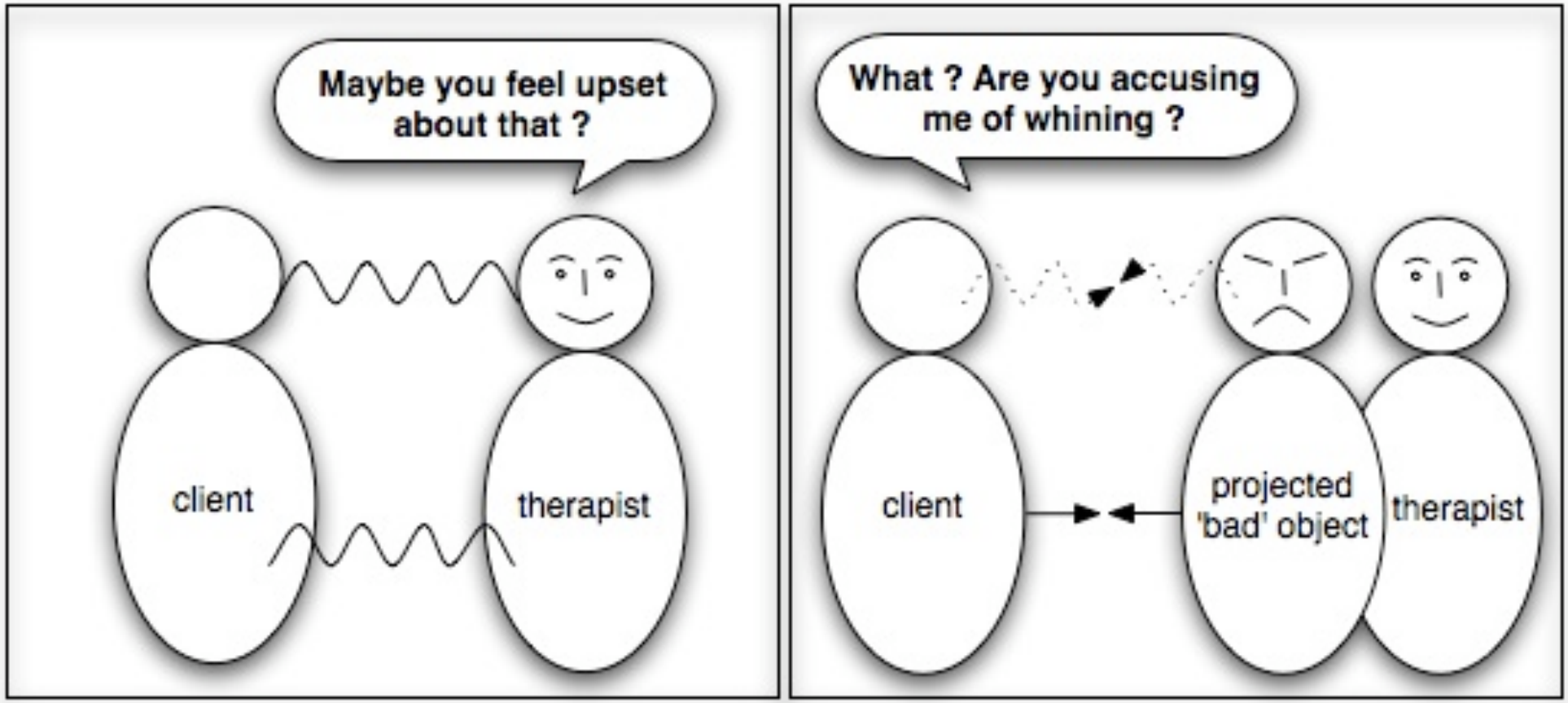
- is a sign that the client's wound has entered the space & relationship
- is a sign that the client's ambivalence in relation to their wound has entered
- inevitably touches on the therapist's ambivalence in relation to their own wounds
- is the precious first sign of enactment

"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 ?



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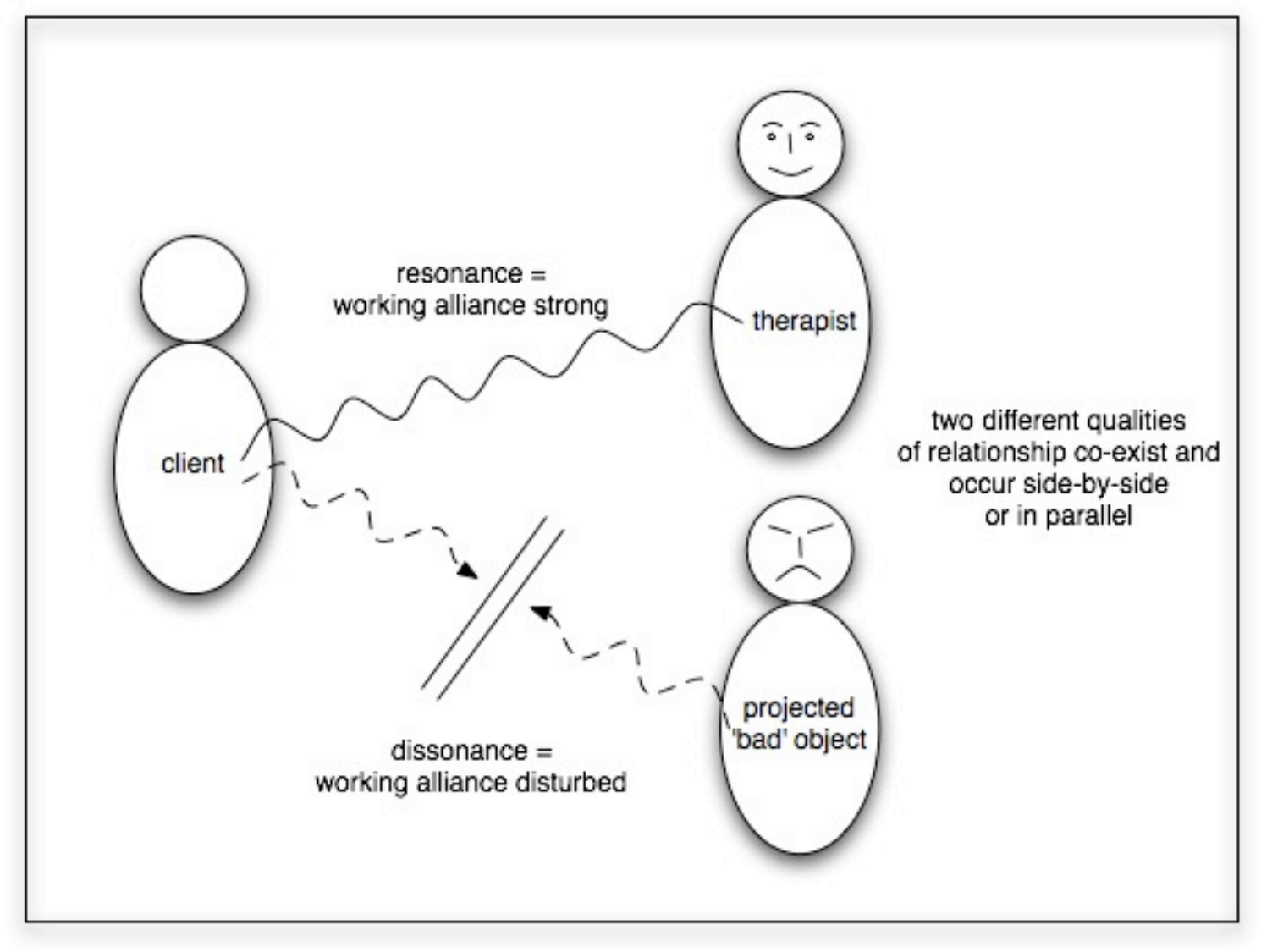
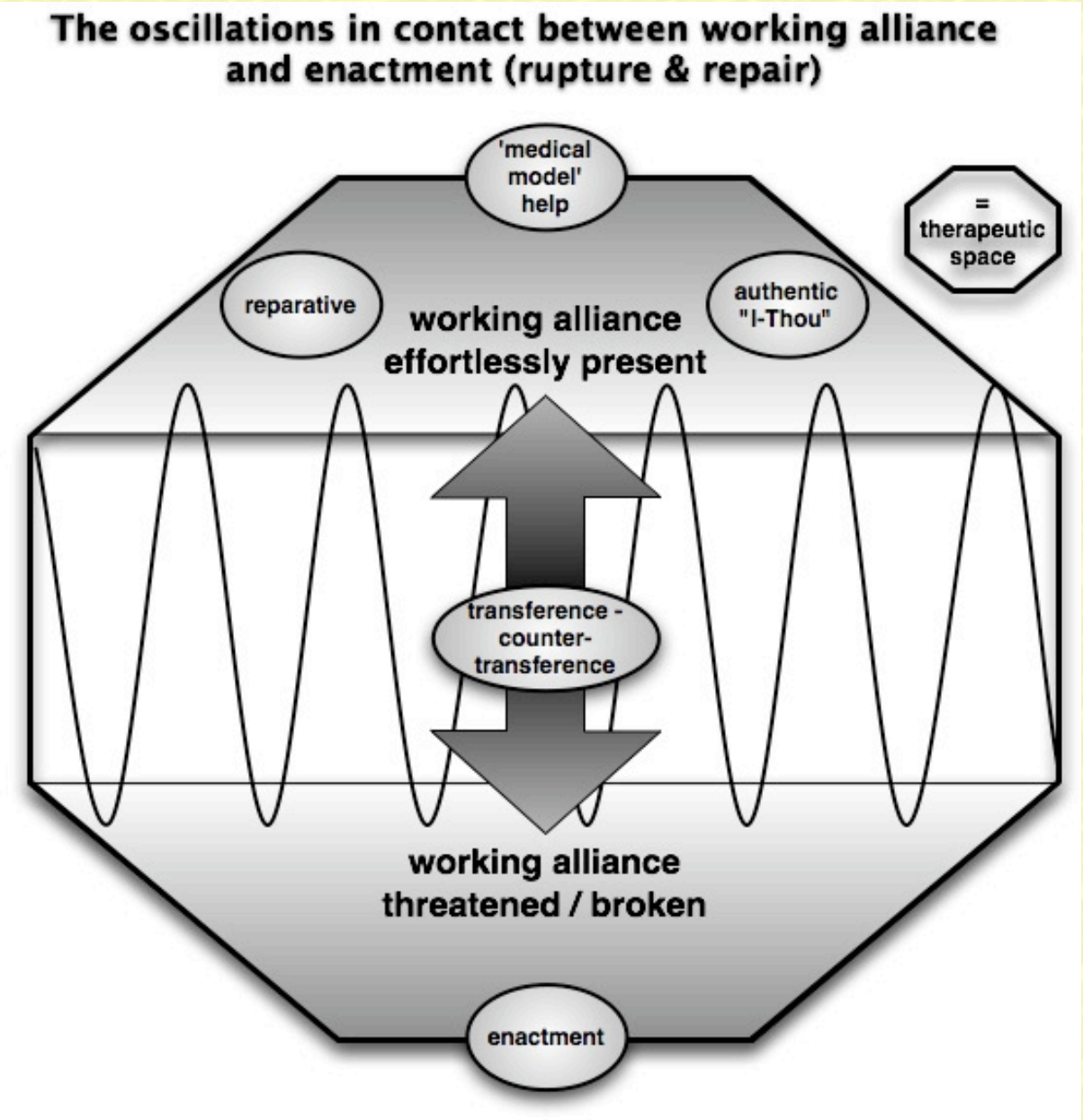
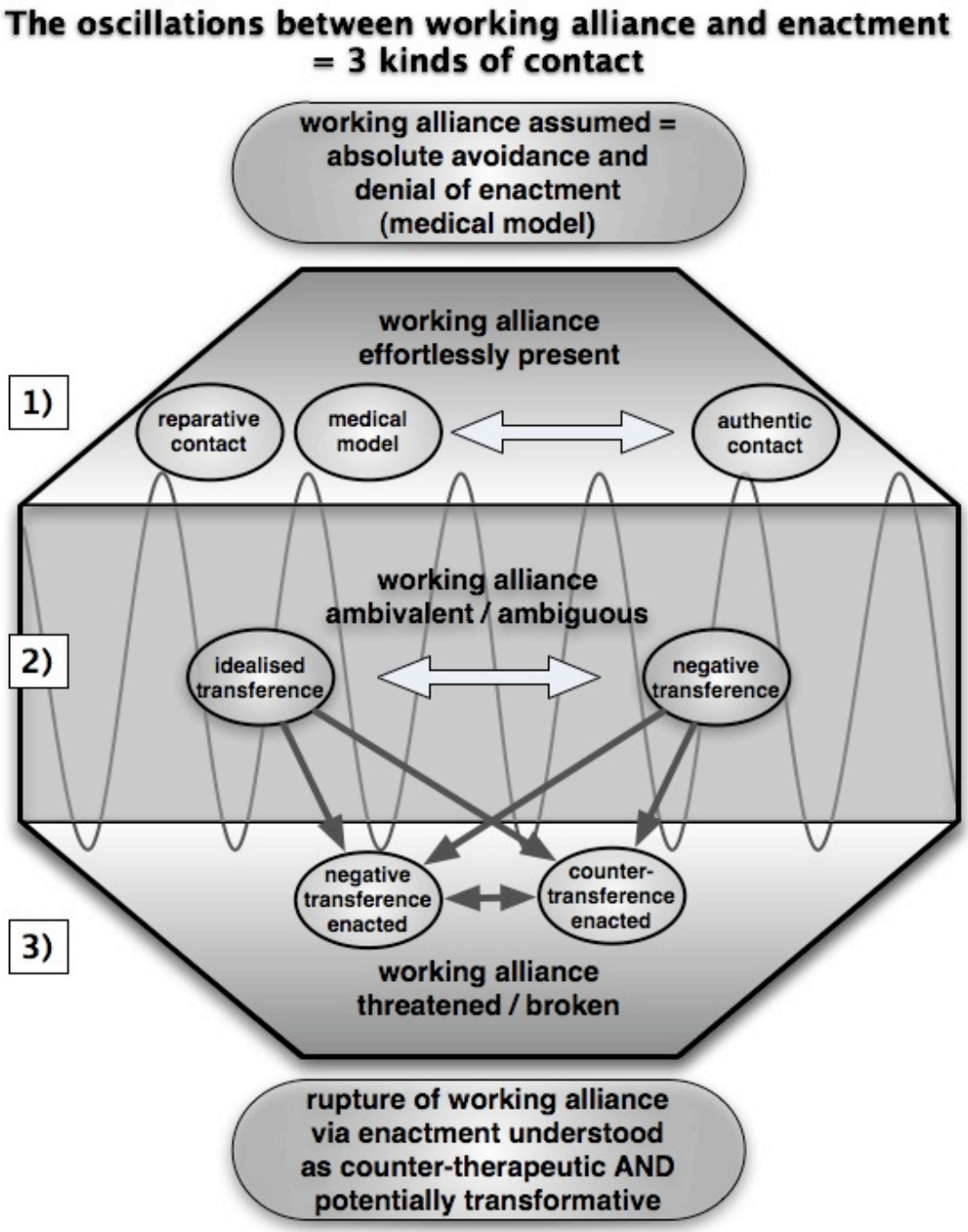


The ebb and flow of the working alliance

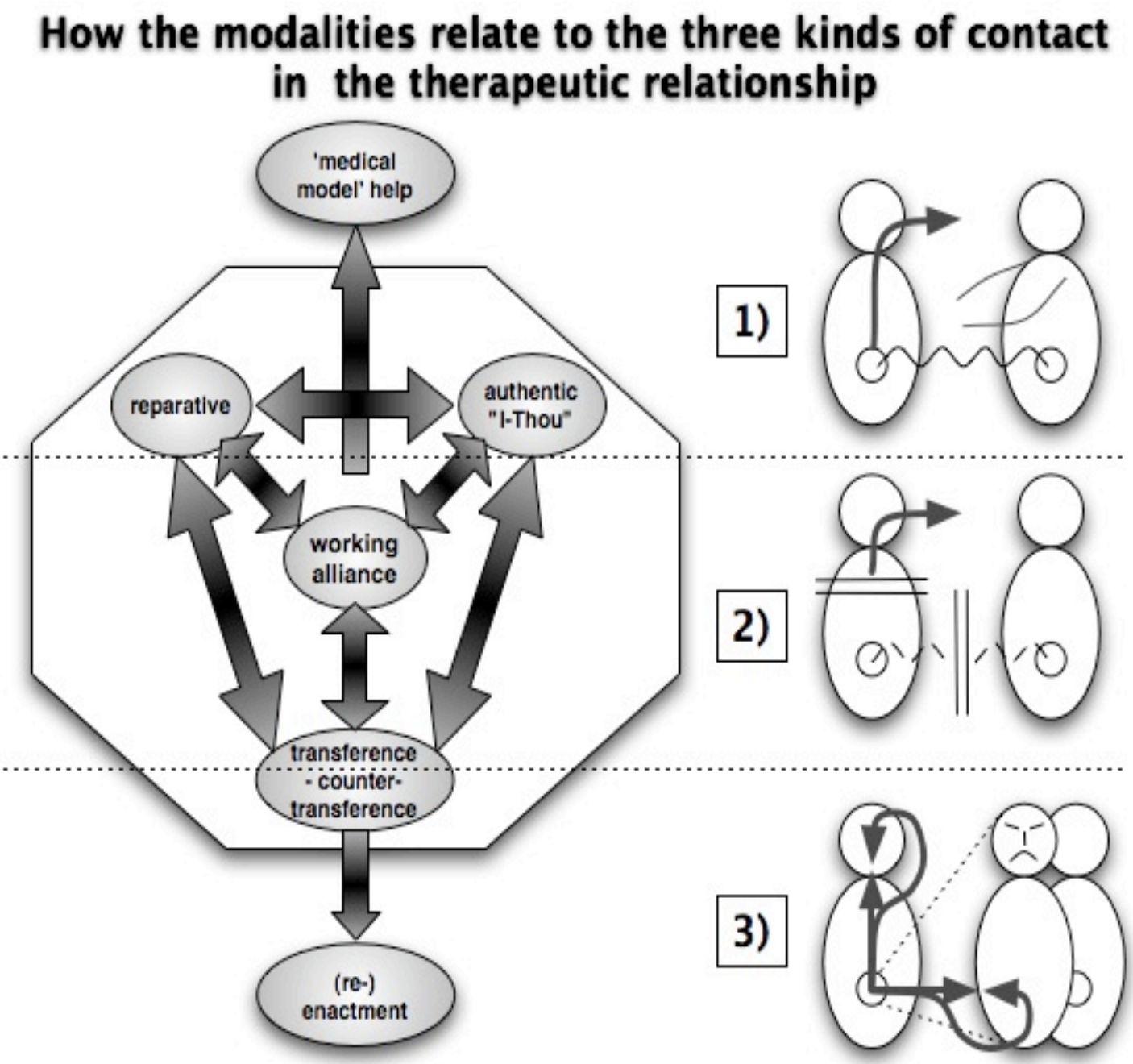


- diamond model: oscillations between working alliance and enactment within the therapeutic space



Three kinds of contact in the therapeutic relationship

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



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)

- challenge to 'medical model':
  - 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)
- Family Systems / Bert Hellinger: family constellations / transgenerational patterns
- James Hillman: archetypal configurations & narratives

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

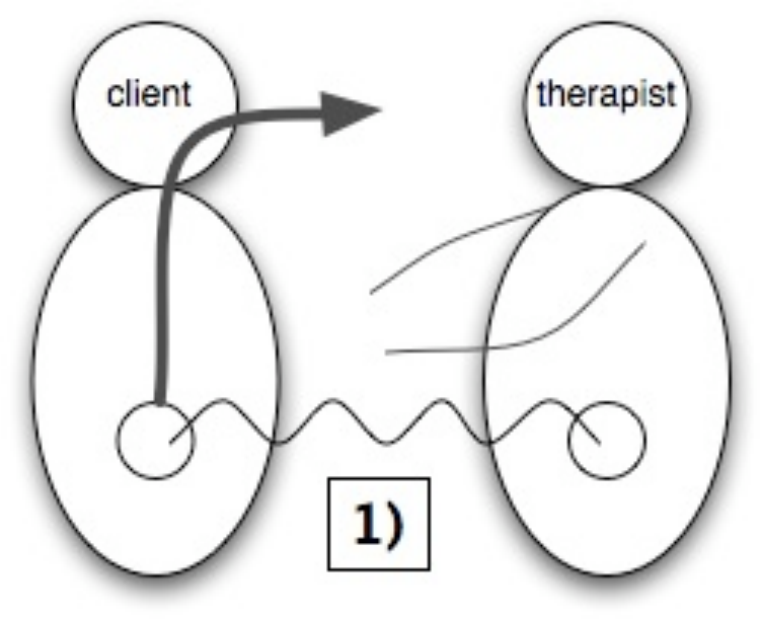
Applying the paradoxical diamond model to our practice

- 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:

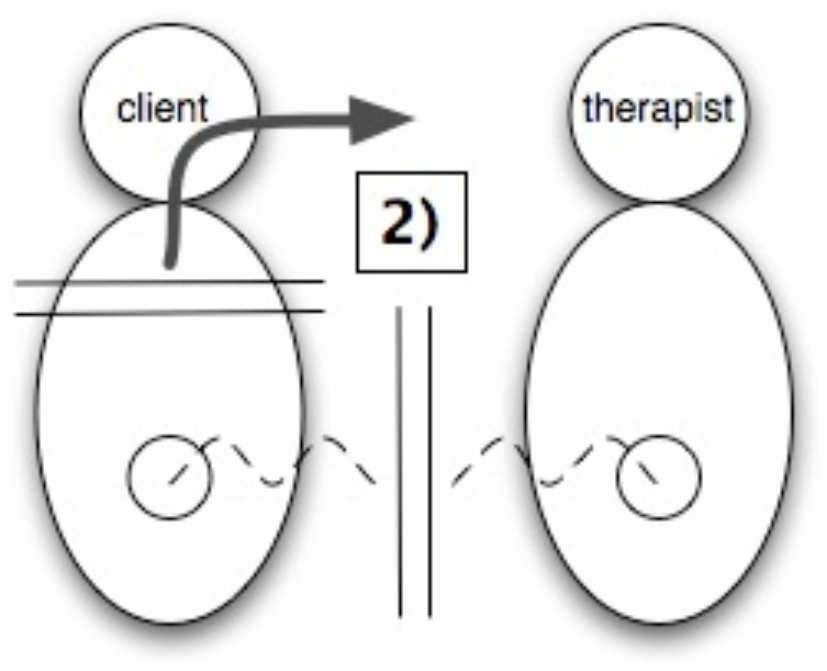
RESONANCE

(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



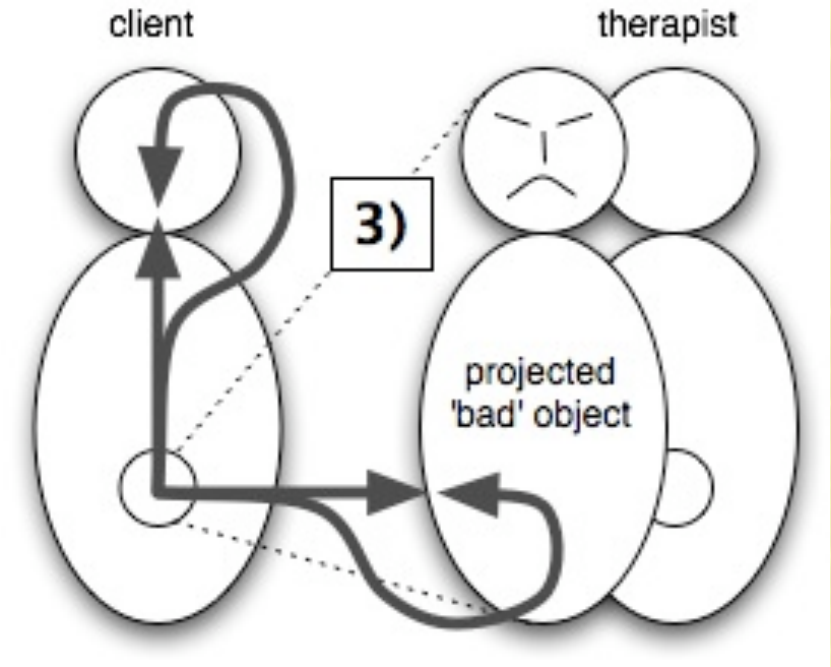
Therapist experiences:

DISSONANCE as well as RESONANCE

(explicit empathic flow disturbed or conflicted, doubts about working alliance)

therapist feels in doubts, unsure, worried, uncomfortable, ambivalent or in conflict about
a) understanding: "what's going on ?", or ...
b) intervention: "what should I do ?"
(often torn between conflicting impulses)

Three kinds of contact in the therapeutic relationship: 3. enactment



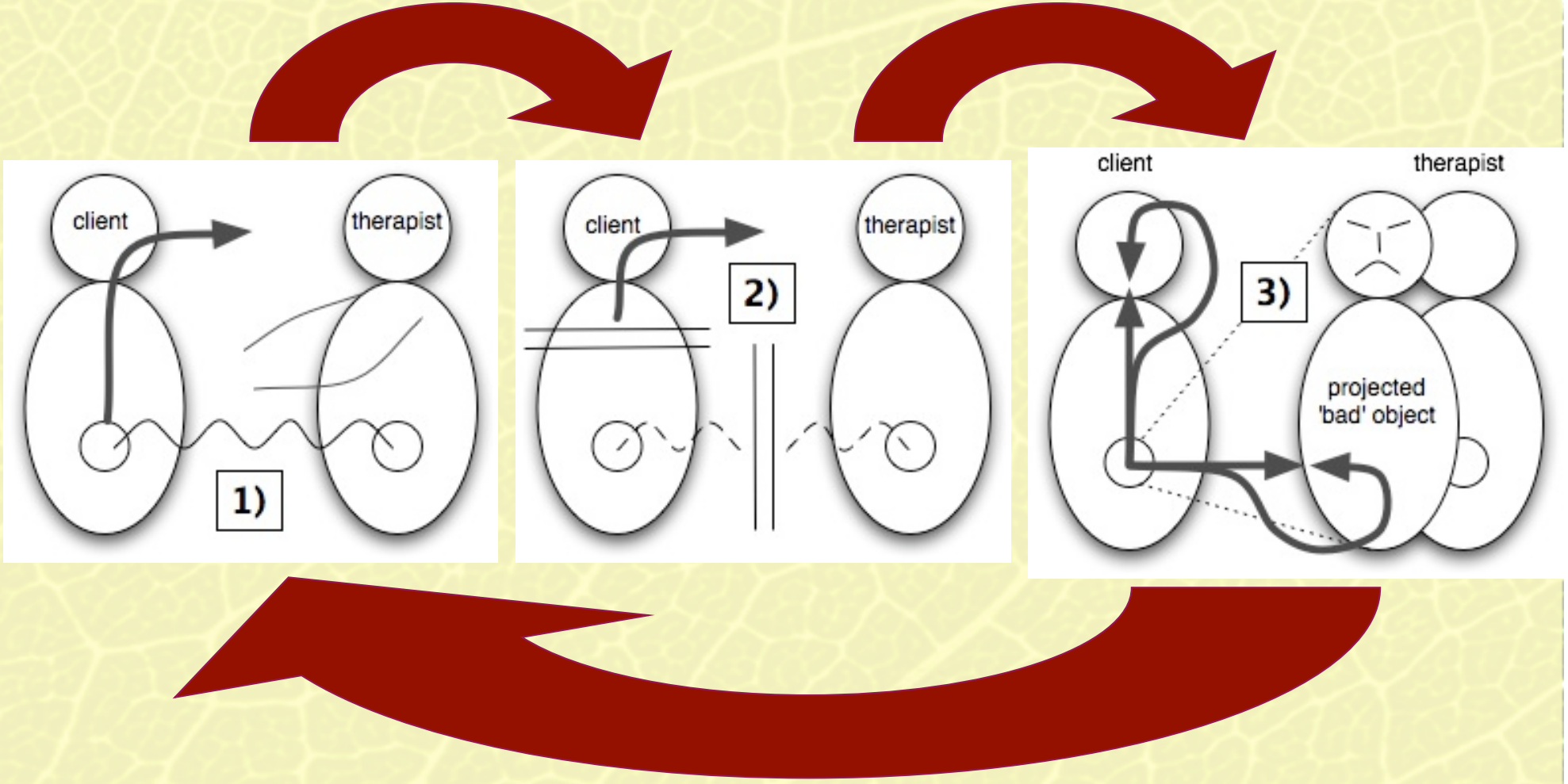
Therapist experiences:

INTENSE CONFLICT / PRESSURE

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

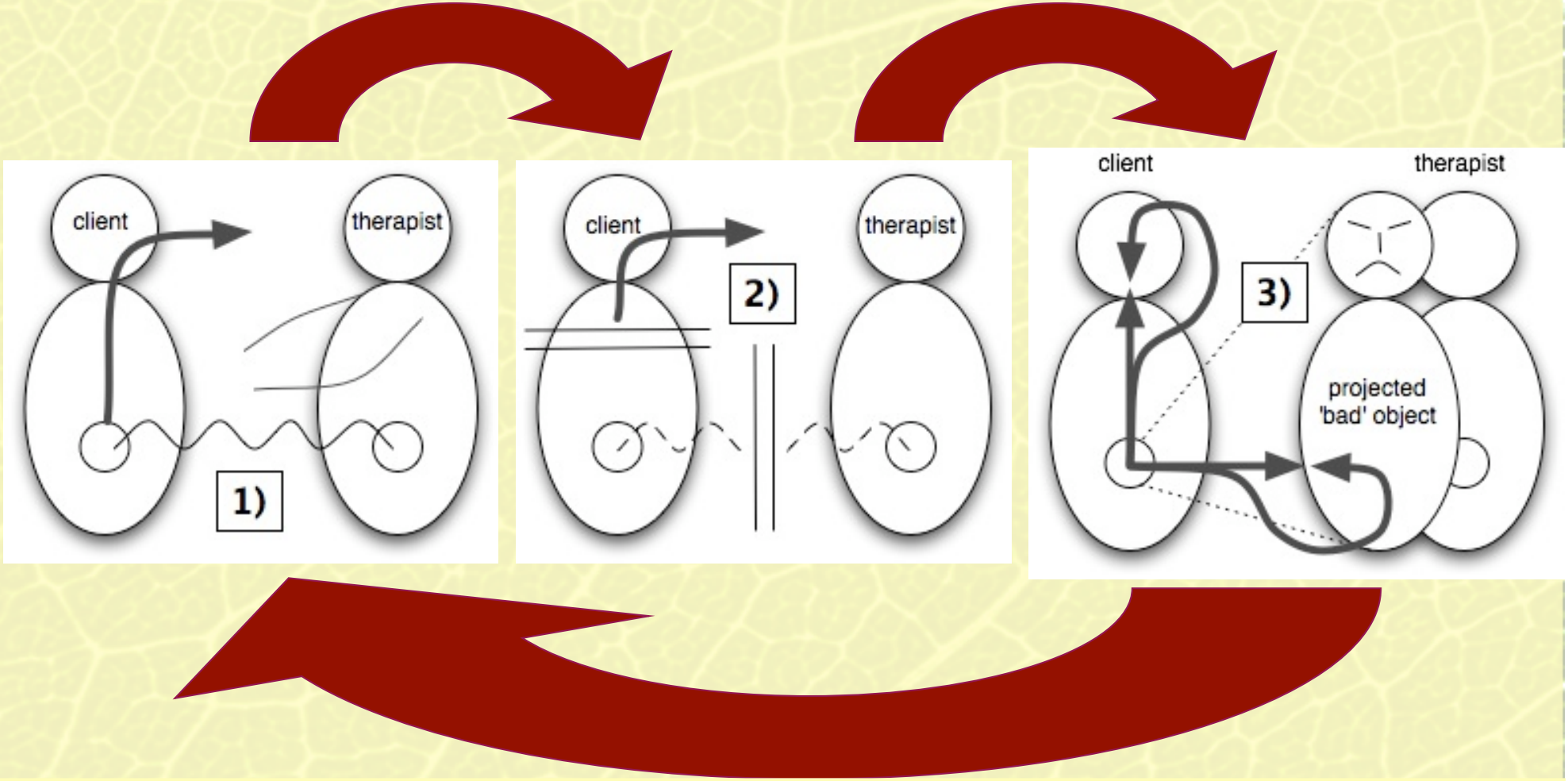
therapist intuits that possibility for re-enactment of client's wounding and negative patterns is strong = tendency to go unconscious

Three kinds of contact in the therapeutic relationship: the spiralling process



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

How to facilitate enactment into transformation (1)

see workshop leaflets or counsellingpsychotherapycpd.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

Extending Clarkson's model:

A Multiplicity of Therapeutic Relationships

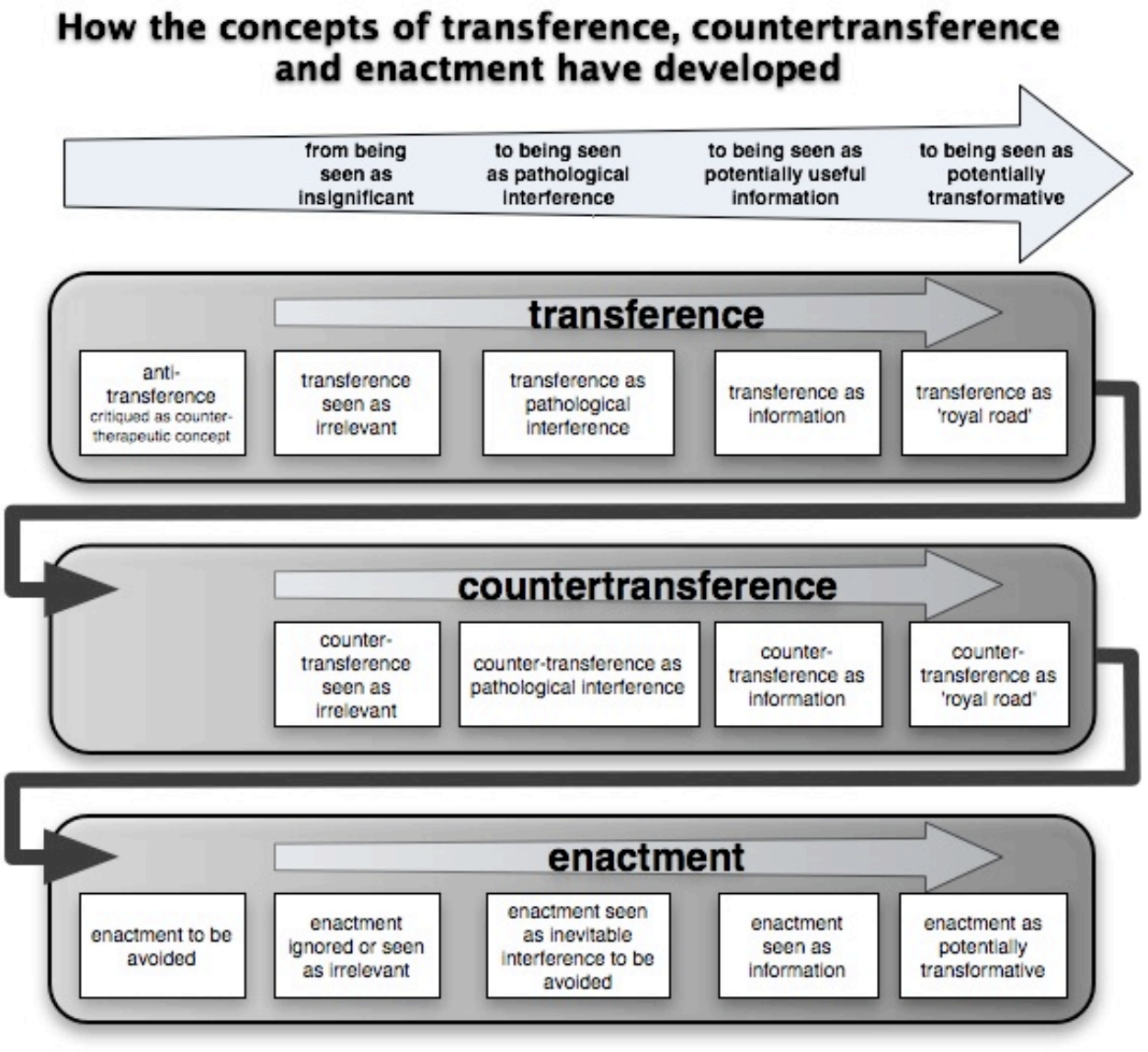
- (modalities 1 - 5 based on Petruska Clarkson's 1990 paper and 1994 "The Therapeutic Relationship";
- 'archetypal' based on James Hillman's "The Myth of Analysis";
- 'medical model help', although not usually used as a modality of psychological work, is nevertheless a relational modality and needs to be included)

	Modality of Therapeutic Relationship	Kinship Metaphor
	Medical Model Help	doctor-patient
1	Working Alliance	cousins incl. aunt/uncle - niece/nephew; = kindred loyalty though different parents)
2	Transference / Countertransference	step-parent / god-parent
3	Reparative / Developmentally Needed	parent - child
4	I-Thou ('authentic' / existential)	person - person
5	Transpersonal	marital pair
	Archetypal (Hillman)	Eros-Psyche

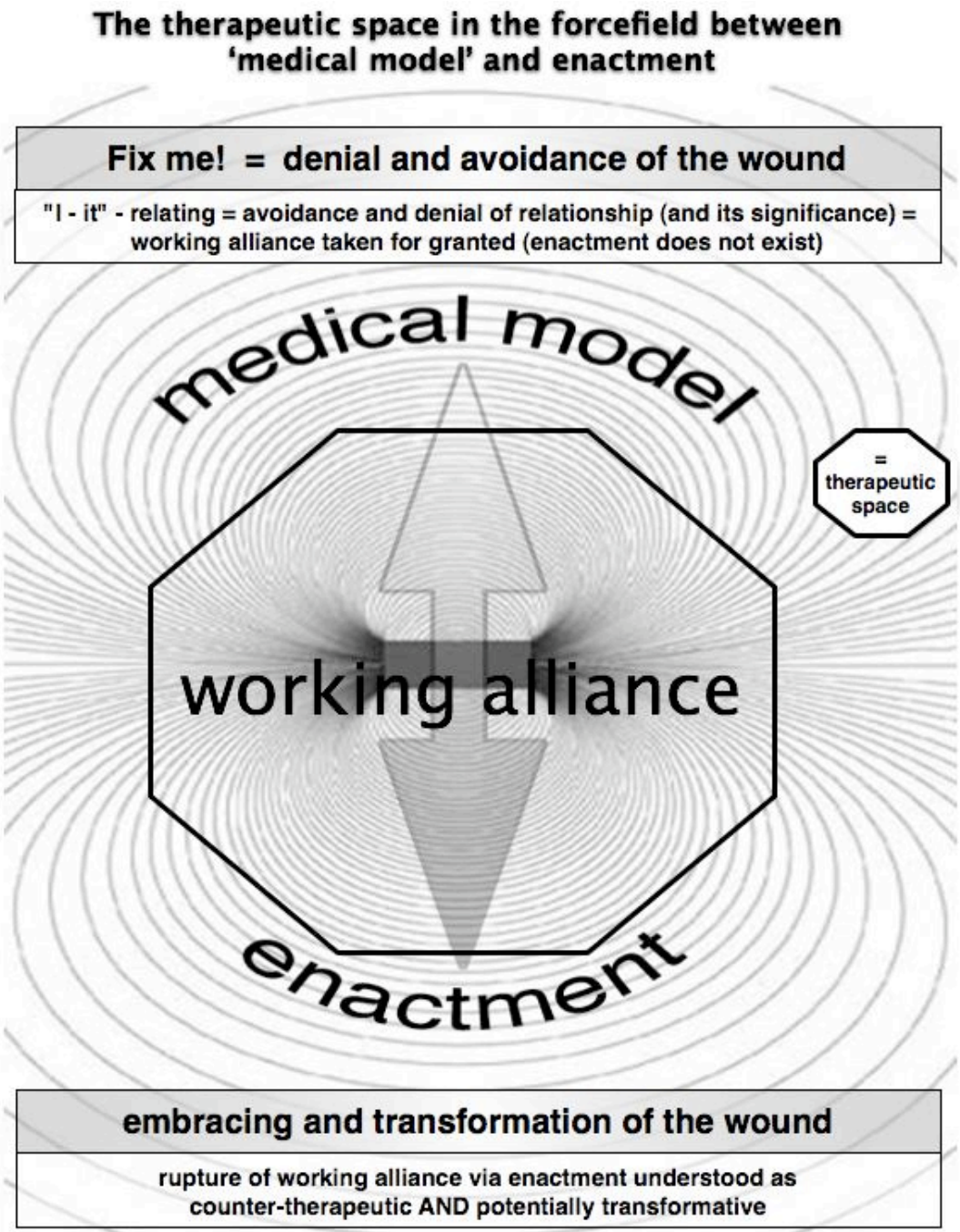
Experiential Questions:

- 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)

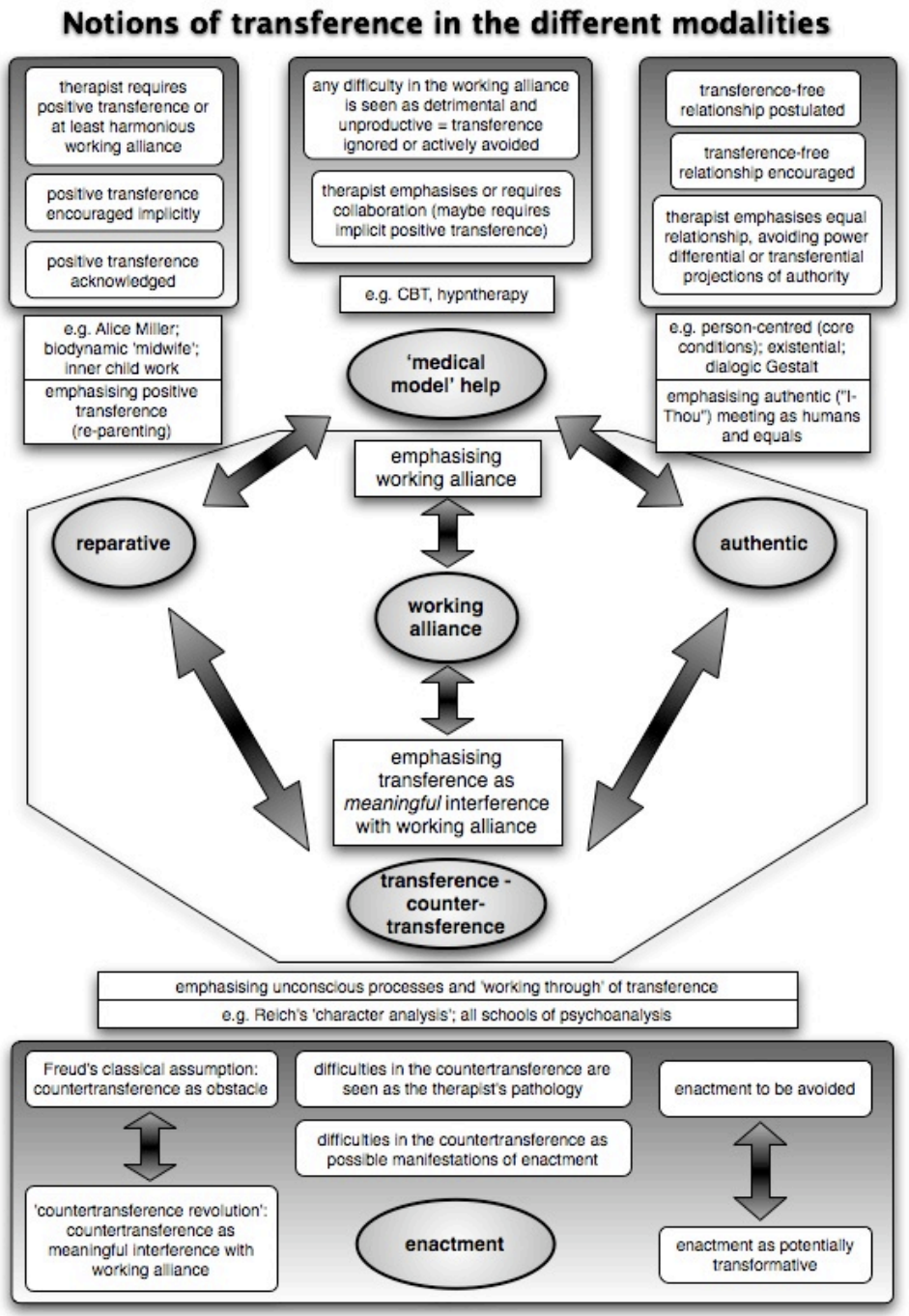


- How transference, then counter-transference and maybe now enactment can increasingly be embraced as valid and necessary, as ‘royal roads’ into the depth of the work



The working alliance hangs in limbo in a forcefield

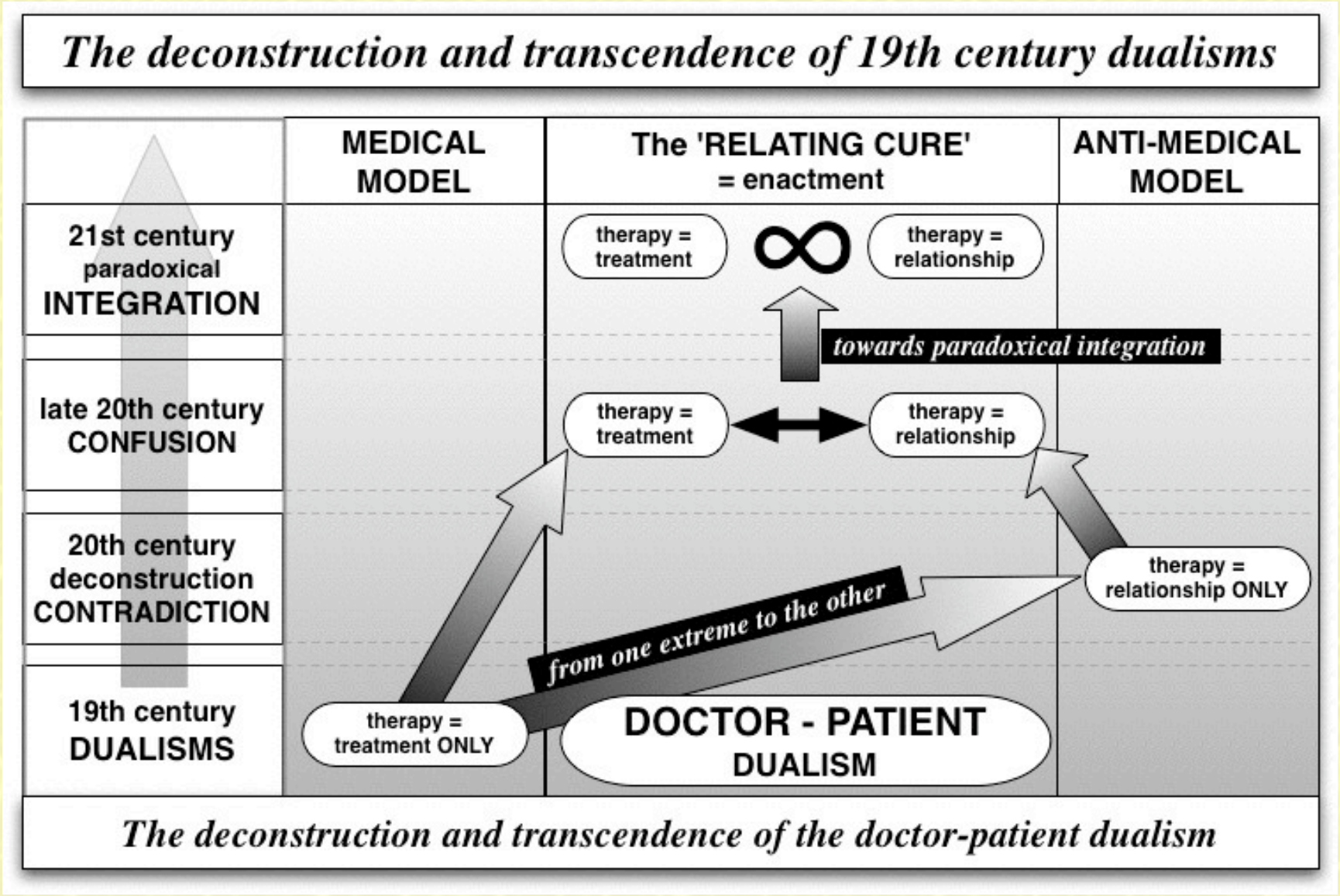
between the poles of 'medical model' and enactment



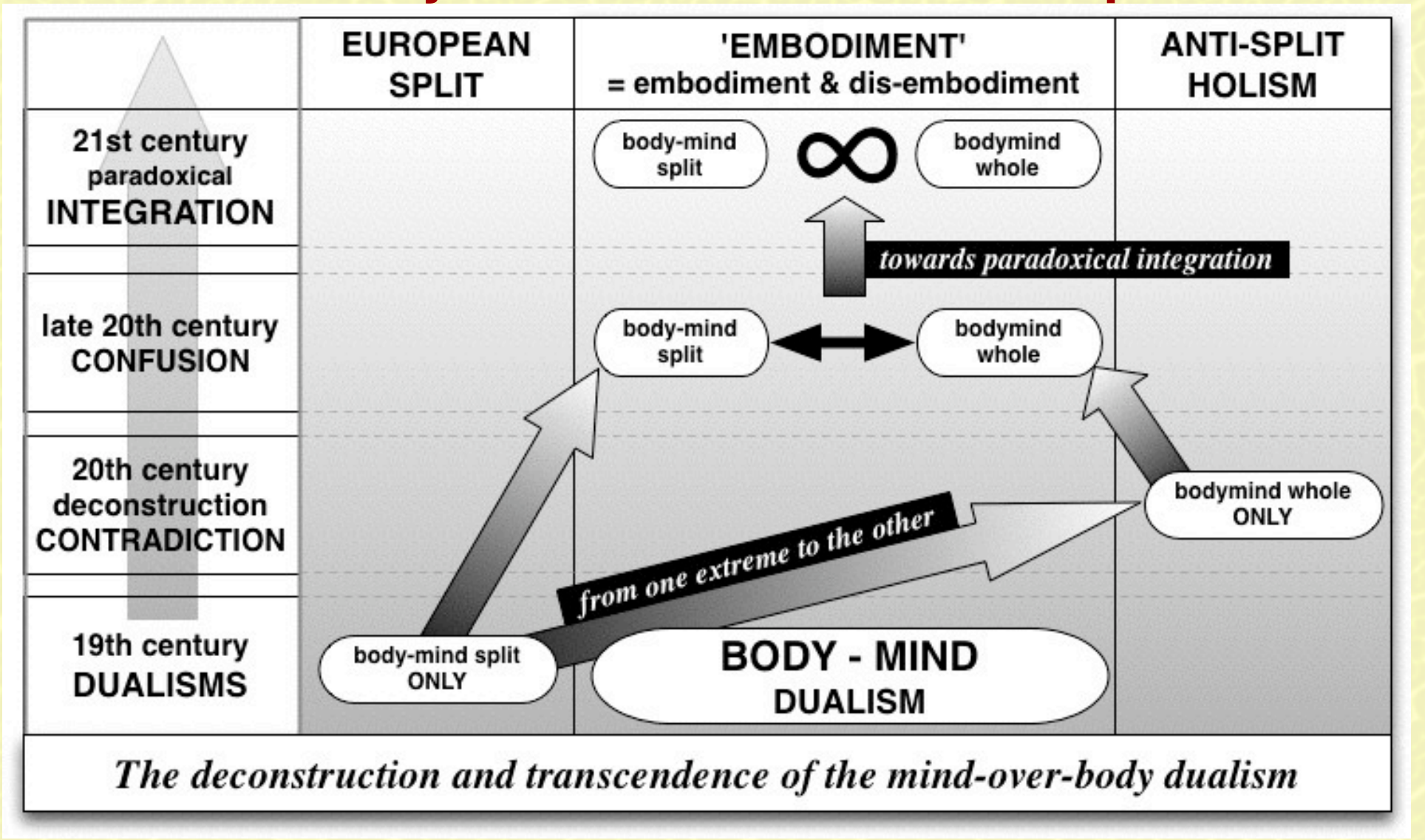
Integrative perspective on transference and enactment

- Notions of transference in the different modalities

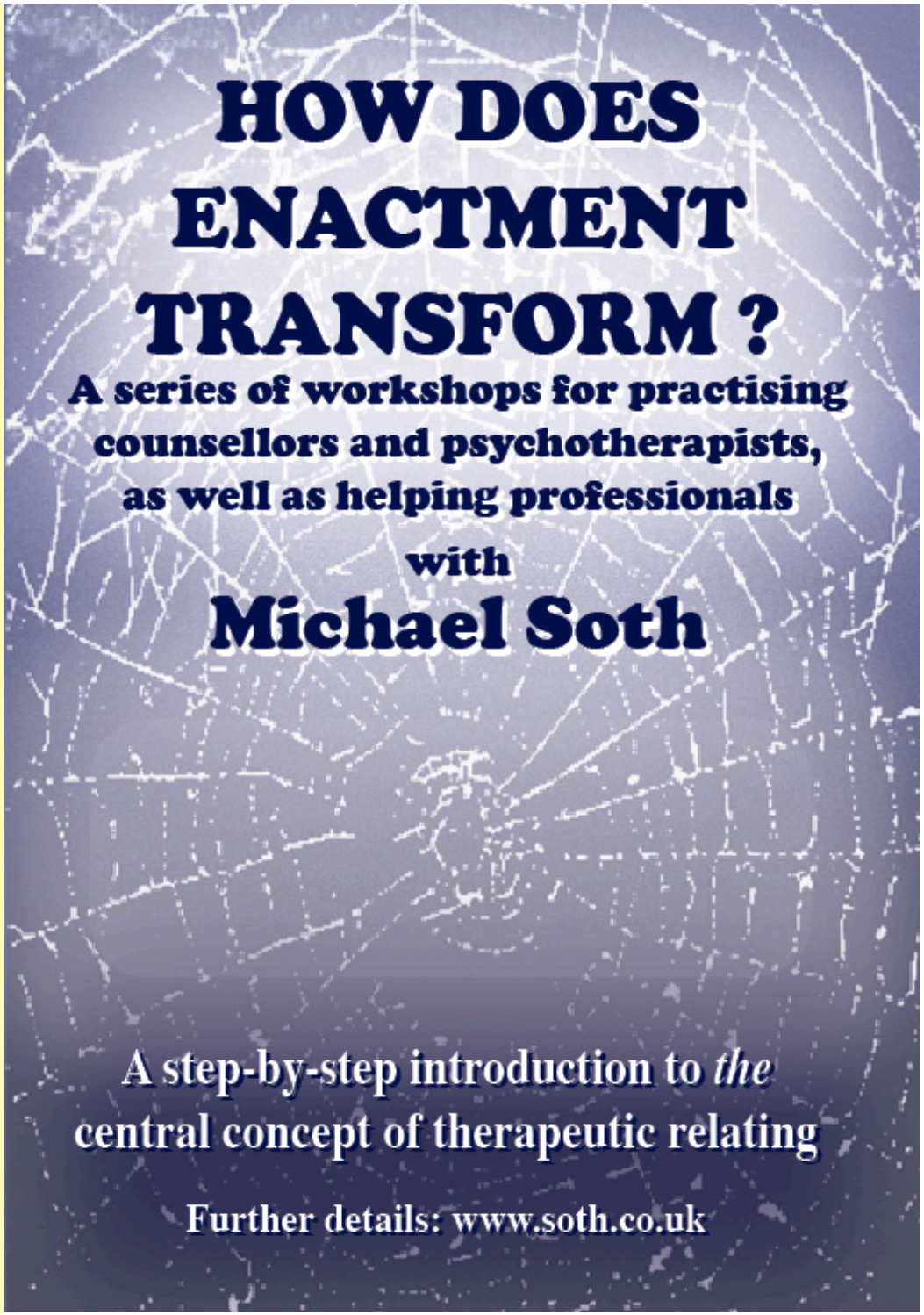
The swing from the taken-for-granted 'medical model' towards the 'anti-medical model'



The swing from the taken-for-granted mind-over-body dualism towards 'anti-split holism'



Enactment as *the* central concept of relational therapy



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:
  - Soth, M. (2006) How 'the wound' enters the room and the relationship, Therapy Today, December 2006
  - Soth, M. (2007) The Relational Paradigm Shift – is it '*complete*'?, presentation to 2007 CABP Conference 'The Client and I', available at www.soth.co.uk

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.

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