A Multiplicity of Relationships in Psychotherapy

from: The Therapeutic Relationship - Petruska Clarkson 1995 (Chapter 1: pages 6-22)

Petruska Clarkson (1994) The Therapeutic Relationship

Chapter 1: A Multiplicity of Relationships in Psychotherapy

I have identified an integrative psychotherapeutic framework containing five possible modalities of client-psychotherapist relationship (Clarkson, 1990a) as being present in any effective psychotherapy. It forms the structure for the Individual, Group and Advanced Integrative Psychotherapy trainings which I originated. It has also been used explicitly or implicitly in many other contexts for the training and supervision of counsellors and psychotherapists. This framework provides an integrative principle which focuses on similarities and differences between different approaches to psychotherapy and differentiates which relationships each approach tends to favour. A consistent and coherent integrative approach to psychotherapy has been developed using this framework. It is also one means of intellectually and experientially engaging with the systemic complexity of the relationship matrix in all psychotherapies or approaches to psychological counselling. It also provides a conceptual principle for integration between different approaches to psychotherapy, notwithstanding the apparently irreconcilable schisms between schools or theories.

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

1. the working alliance
2. the transferential/countertransferential relationship
3. the reparative/developmentally-needed relationship
4. the person-to-person relationship
5. the transpersonal relationship.

From a systemic integrative perspective these five forms of relationship in psychotherapy are all valid. Their intentional and informed use will of course depend on differences between individual patients and different phases in the psychotherapy over time. At any given moment in psychotherapy one of these relationships may predominate. For example, the development of the transference neurosis may appear to be antithetical to the furthering of the working alliance (Stone, 1961; Greenson, 1965, 1967) or reparative intentions. It is unlikely that two or more ‘can be operative at the same moment. Which one is allowed to become figure, or focus, must depend on the nature of the psychotherapeutic task at a particular time with a particular patient. Other modes of therapeutic relationship may also be present but may be more in the background at a particular time' (Clarkson, 1990a, p. 150). These themes will be further expanded in Chapters 3-7.

1) The working alliance

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

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

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

"The therapeutic alliance is the powerful joining of forces which energises and supports the long, difficult, and

frequently painful work of life-changing psychotherapy'" (Bugental, 1987, p.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. In other words: first the goals must be agreed, then there must be agreement on the necessary tasks, and there should also be a personal bond, i.e. a therapeutic relationship. Several studies emphasise the importance of further common factors. These include the significance of the early stages of the therapy work (Luborsky, 1984), and the patient's ability to form a meaningful relationship with the therapist (Strupp, 1980). In the study by Sloane et al (1975), patients listed significant factors for successful therapy as firstly the therapist's personality, grasp of problems, encouragement and help towards understanding themselves.

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

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

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

"I was with you and we were working - or engaged in something serious but having an enjoyable time. My mother was coming at three o'clock and I had an arrangement to meet her. You didn't know that and you said, 'I am available at three o'clock - why don't we carry on then?' I thought, 'Oh God, if I stay with you [the therapist] then I won't be there for my mother, if I go I may lose the connection with you'. I might break this thing that felt so good. It wouldn't actually be disastrous, since we would continue working again the next day, but it would be like breaking the energy. It is so pleasurable, the work is so good, we're both getting something from it. My mother is more of a shadowy figure than you are. I then decided to do neither and went off for a walk on my own. In this way I wouldn't be choosing one person or the other. I would be choosing myself. You would agree with that. If I went with my mother you would say, 'You needed to do that, but it would be less wise'. But you would absolutely appreciate me for doing my own thing."

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

2) The transferential/ countertransferential relationship

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

Laplanche and Pontalis define transference as follows: "For psycho-analysis, a process of actualisation 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 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, p. 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 psychotherapeutic intentions, must control his urge for closeness and must 'blanket' his usual personality' (Stone in Greenson, 1967, p. 389). 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, p. 118). For example, in a paper written in the same year (1912a) as the one where 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." (p. 105)

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. Alexander and French (1946) 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." (pp. 66-7)

In the transference/countertransference relationship 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.'

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

A narcissistic, apparently generous but dynamically retentive patient whose mother overfed 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, 1946, p. 172)

3) The reparative/developmentally-needed relationship

A Multiplicity of Relationships in Psychotherapy

from: The Therapeutic Relationship - Petruska Clarkson 1995 (Chapter 1: pages 6-22)

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 called the same name as his psychotherapist. The 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 was not very interested in it and you can see that you do not have to be perfect in all things'. The first psychotherapist responds with anger and accusations of unethical conduct saying, 'How could you say such things, you are just, encouraging him to make mistakes and setting a very bad example!' The client himself then steps in to arbitrate and explains to the first psychotherapist: 'Actually she is right. You have to understand what she is saying in the right spirit'. This is what the client needed to hear. Dreams often act as 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. Sandor Ferenczi (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.

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

The psychoanalyst Sechehaye (1951) was able to break through the unreal wall that hemmed in her patient Renee 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 Renee 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 Sechehaye became one of the first of those psychotherapists who have literally undertaken to 're-parent' schizophrenic clients. She allowed her to lean on her bosom and pretended to give milk from her breasts to the doll with whom Renee 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 Renee the nourishing mother that she had been denied as an infant. That this took an emotional toll far beyond the

ordinary is evident from Renee's own account that 'Mama was extremely upset' or that she regained consciousness and found Mama weeping over her." (Friedman, 1985, p. 188)

The advocacy relationship proposed by Alice Miller (1983a,b, 1985) can be seen to be the provision of the developmentally-needed force in a child's life which should have been provided by a parent or other significant caretakers but which the psychotherapist ultimately has to provide. The holding environment of Winnicott (1958) is another example of such provision, as are so-called 're-parenting' techniques (Schiff et al., 1975).

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 psychotherapist may reply: 'I'm fine, thank you, and I appreciate your caring'. Alternatively in response to the adult who as a child was burdened with parental intimacies a psychotherapist may reply '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, p. 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 it. The work of Grof (1985), Reich (1945), Lake (1966) and other controversial figures outside mainstream psychotherapies as well as some from the very centre belong in this category. It is certainly true that this depth of longstanding psychotherapeutic relationship as the primary psychotherapeutic relationship modality is more frequently reported between psychotherapists and their more severely damaged patients.

4) The person-to-person relationship

Particularly (but not exclusively) within the humanistic/existential tradition, there is an appreciation of the *person-to-person relationship* or *real relationship*. This psychotherapeutic 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). There has always been, and there is again, recognition within psychoanalytic practice that the real relationship between analyst and analysand - following Freud's own example - is a deeply significant, unavoidable and potentially profound healing force also within the psychoanalytic paradigm (Malcolm, 1981; Klauber, 1986; Archambeau, 1979).

With Freud's discovery of the importance of the transference relationship came deep clinical suspicion of the real relationship - the psychotherapeutic relationship most similar to ordinary human relationships. 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 countertransference reactions have been seen as valid and important sources of information to be used effectively in the psychotherapy (Heimann, 1950). Even so, the analyst as real person with real feelings which are not necessarily countertransference is still rarely publicly acknowledged.

A Multiplicity of Relationships in Psychotherapy

from: The Therapeutic Relationship - Petruska Clarkson 1995 (Chapter 1: pages 6-22)

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

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

Emotional involvement in the 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 psychotherapist becomes the instrument through which the healing evolves.

An intuitive introverted type of patient sadly remembers difficulty with right or left, physical discomfort in the real world and incomprehension when required to learn kinaesthetically: The psychotherapist bends down to show 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, extreme care and, in its worst abusive form, has been an excuse for inauthentic acting out of the psychotherapist's own needs, for example hostility or seductiveness. Genuine well-judged use of the I-You relationship is probably one of the most difficult forms of psychotherapeutic relating. Doubtless this was the very good reason behind the orthodox analysts regarding it with extreme suspicion. Also, of course, it is in the name of I-You relationship that many personal relationships have been destructive. It probably requires the most skill, the most self-knowledge and the greatest care because its potential for careless or destructive use is so great. Its influence is, however, unavoidable. Yet there are only a few trainings, for example in some Gestalt, which specifically address this experientially and theoretically. Sometimes a kind of lip-service is paid to the I-You person-to-person concept as if we know what it's about, or it is 'outlawed' - as if this were possible.

'There can be no psychoanalysis without an existential bond between the analyst and the analysand', writes Boss (1963). 'This means that to imagine there can be analysis without countertransference, without involvement and response on the part of the analyst, is an illusion. The analyst can deny but cannot avoid having an emotional relationship with the analysand: even the objectifying attitude of indifference is a mode of emotional relating' (Friedman, 1985, pp. 79-80).

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 psychotherapeutic modality but analysts are also addressing the issue.

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

To Fromm-Reichmann (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 dialogue with the patient. But it does include confirmation of patients as worthy of respect, and meeting on the basis of mutual human equality.

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

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

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

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

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

For Rogers and Stevens (1967), too, the establishment of a relationship of genuineness, respect, and empathy became the cornerstone condition for facilitating human growth and development.

Historically in psychoanalysis, even Anna Freud called for recognition that in analysis two real people of equal adult status stand in a real personal relationship to each other. 'There are differences in the ways in which we receive and send off patients, and in the degree to which we permit a real relationship to the patient to coexist with the transferred, fantasied one' (A. Freud, 1968, p. 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). He 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 psychotherapeutic relationship changes the psychotherapist as much as the patient. Both Jourard (1971) and Jung (1946) held this as a central truth in all healing endeavour. Searles (1975) also believed that the patient has a powerful innate striving to heal the analyst (as he or she may have desired to heal the parents), which can and does contribute to greater individuation and growth for the psychotherapist as they are *both* transformed in the psychotherapeutic dialogue.

'What is confirmed most of all is the personal 'realness' of the therapist that has arisen from and been brought into the therapeutic relationship' (Archambeau, 1979 pp. 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, p. 391).

Greenacre (1959) and Stone (1961) are clear that the analyst must be able to become emotionally involved with

and committed to the patient. It is important to like the patient; prolonged dislike or disinterest as well as too strong a love will interfere with therapy. The therapist must have a wish to help and cure the patient, and he or she must be concerned with the patient's welfare without losing sight of long-range goals.

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

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

In all cases the person-to-person relationship will be honoured by truthfulness or authenticity not at the expense of the client but in the spirit of mutuality According to Buber the genuine psychotherapist can 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, p. 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' (p. 179).

5) The transpersonal relationship

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

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

'If the analyst has been moved by his patient, then the patient is more aware of the analyst as a healing presence' (Samuels, 1985, p. 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, p. 162)

There is not a great deal of documentation about the transpersonal relationship in psychotherapy except for Rowan's important contribution to surveying and expanding the field (1993). Peck (1978) mentions the concept of 'grace', as has Buber before him, as the ultimate factor which operates in the healing encounter and which may make the difference between whether a patient gets better or not. Berne, too, was aware of it when he quoted: 'Je le pensay, et Dieu le guarit' ... 'we treat them, but it is God who cures them' (Agnew in Berne, 1966, p. 63).

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

psychotherapeutic relationships. 'The numinosum is either a quality belonging to a visible object or the influence of an invisible presence that causes a peculiar alternation of consciousness' (Jung, 1940, p. 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 by experienced psychotherapists who have been faced repeatedly with incomprehensible and unpredictable outcomes - the person of whom you despaired, suddenly and sometimes apparently inexplicably, gets well, thrives and actualises themselves beyond all expectation. At the other 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 reached.

The kinship relationship which is characterised by the creation of space as well as fruitful substance between the psychotherapeutic partners is analogous to that of the marital pair. Indeed in Jung's work the archetypal sexual relationship is used to represent the alchemical process of transformation (1946). Of course, the conjunction was to be symbolic, not consummated in an unethical, incestuous way.

The transpersonal relationship is paradoxically also characterised both 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 psychotherapeutic space, leaving room for something numinous to be created in the 'between' of the relationship. This space can then become the 'temenos' or 'the vas bene clausum inside which transmutation takes place' (Adler, 1979, p. 21). This dimension in the psychotherapeutic relationship cannot be proved and can hardly be described. Buber concludes: 'Nothing remains to me in the end but an appeal to the testimony of your own mysteries ... ' (1970, p. 174).

Implied is a letting go of skills, of knowledge, of experience, of preconceptions, even of the desire to heal, to be present. It is essentially allowing 'passivity' and receptiveness for which preparation is always inadequate. But paradoxically you have to be full in order to be empty. It cannot be made to happen, it can only be encouraged in the same way that the inspirational muse 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 realise that she does indeed speak French, she just speaks it very well. And sometimes she speaks Chinese'.

The context from which this comment arose is that of how he has perceived the supervisor at times intuitively to know facts, feelings or intentions of patients without there being any prior evidence to lead to the conclusions. It is these intuitive illuminations which seem to flourish the more the psychotherapist dissolves the individual ego from the psychotherapeutic container, allowing wisdom and insight and transformation to emerge as a process. The transpersonal relationship refers to the metaphorical Chinese in the psychotherapy.

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

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

should let go of expectations that she should be different from the way she was. The psychotherapist was even willing and able to let go of the healer archetype, allowing himself to become an empty vessel, a container wherein healing could have space to manifest, or beingness could be validated without any expectation even of the acceptance. This needs to be 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 suspension of ego-consciousness - a trance-like meditation. The quality is conveyed by the being-with of highly evolved psychotherapists such as Gendlin (1967) working with patients in acute psychosis.

It is quite possible that psychotherapists may delude themselves in ways which may be dangerous for them and for their clients if they mistakenly, prematurely or naively focus on the transpersonal and, for example, overlook or minimise transferential or personal phenomena. In Chapter 61 will also explore multiple meanings of these concepts and ways of organising our thinking and responses in this extremely complex arena.

James and Savary (1977) 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)' (p. 325).

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

Summary

This chapter has briefly overviewed five kinds of psychotherapeutic relationship available as potential avenues for constructive use. Each will be expanded on in following chapters. I have indicated some characteristics of each and begun an effort to clarify, specify and differentiate in theory and practice the nature and intentions of the multiplicity of psychotherapeutic relationships available. As we shall see different psychotherapies may emphasise different relationships for specific reasons.

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

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

It may need to be recognised in psychotherapy trainings that experience and supervision are required to distinguish between the different forms of psychotherapeutic relationship and in assessing and evaluating the usefulness of each at different stages of psychotherapy. Equally, different modes may be indicated for individuals with characteristic ways of relating so that there is not a slipshod vacillation due to error or collusive countertransference. Confusion and lack of clarity abound when types of psychotherapeutic relationship are confused with each other or if one is used as if substituting for the other. It is possible that all of these forms of relating are needed some of the time, or for some patients, and that psychotherapists with flexibility and range can become skilful in the appropriate choices.

The far-ranging implications of this perspective for psychotherapy research, assessment and treatment need to be developed further. Integration of a multiplicity of psychotherapeutic relationship modalities does not mean eclectic or unconscious use. Indeed if relationship 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,

A Multiplicity of Relationships in Psychotherapy

from: The Therapeutic Relationship - Petruska Clarkson 1995 (Chapter 1: pages 6-22)

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.