VARIABLES IN THE PSYCHOTHERAPEUTIC RELATIONSHIP

CHAPTER 3 - THE THERAPIST AS A VARIABLE IN THE PSYCHOTHERAPEUTIC RELATIONSHIP

The therapist is an essential element of the psychotherapeutic process which attempts to change the patient for the better. Frank, 1961, states that the therapist is the most important, but least understood, part of the psychotherapeutic equation (Strupp, 1971). Any technique or type of psychotherapy used will necessarily be influenced by the personality of the therapist (Bergin & Garfield, 1971). Thus, it is important to consider what and how the therapist contributes towards the psychotherapeutic encounter, process and any change in the patient. Obviously this will differ for each patient with whom the therapist interacts.

Although the therapist can exert a positive influence on the psychotherapeutic relationship, one must realistically accept that the therapist may also cause harm. This is highlighted by Grunebaum's 1985 study in which 10% of mental health professionals reported being harmed in their own psychotherapy experiences (Lambert and Bergin, 1992). Lambert and Bergin accurately point out that some patients are worse after psychotherapy than before treatment started. However, this is not necessarily the result of a failure in the psychotherapeutic process or on the part of the therapist. The patient may be in the process of a general decline that few interventions could prevent. Other patients may experience external life traumas which exacerbate the current problems being explored. Lambert and Bergin report that research indicates a variety of reasons for negative outcomes in psychotherapy. These include external events, patient characteristics, therapy interventions and therapist attitudes. However, the therapist still has an enormous responsibility towards the patient which must never be under-estimated. There is an awareness of all who work in the field of the unprofessionality of certain colleagues who abuse their trust and harm patients. It is sadly a phenomenon that should be reported more often to protect both the patients in question as well as the name of the profession.

Despite the fact that a minority of patients experience the therapist in a negative manner, Luborsky found strong evidence that therapists contribute positively to successful outcome (Bordin, 1986). Strupp (1971) indicated that there are specific skills that the therapist has which enhance growth in the patient. Dialogal psychotherapy views the therapist as the "steward of the dialogal" (Hycner, 1991, p. 48) and a fully participating partner in the psychotherapeutic relationship. Despite the uniqueness of each therapist, it is possible to identify certain therapist variables which cut across theoretical approach and affect both the process and outcome of psychotherapy. These include both personality characteristics and skills.

1. **Accurate empathy, non-possessive warmth, genuineness/authenticity.**
Rogers (1954) contends that there are three essential behaviours necessary for the therapist to provide a climate in which the patient is able to explore, grow and change. These are: accurate empathy, non-possessive warmth and genuineness. He stated that these conditions were necessary and sufficient for successful outcome. Bergin and Garfield (1971) and Truax and Carkhuff (1964) aver that virtually all phenomenologically

oriented as well as most behaviouristically oriented therapists have agreed to the clinical importance of these three. Lambert and Bergin (1992), however, assert that there is a limit to how much these characteristics affect the process "casting doubt on the accuracy of Carl Roger's bold attempt at specifying the necessary and sufficient conditions for positive personality change" (p. 373). Stubbs and Bozarth (1994) found that despite four decades of research including these factors, Rogers' statement has not been adequately tested. Whether the conditions are sufficient remains a question but it appears that most authors would agree that they are important or at least facilitative. These three basic characteristics will be dealt with together.

Whitehorn and Betz, 1954, and Rogers, 1954, were the pioneers in the study of the role that these factors play in facilitating positive psychotherapeutic change (Bergin & Garfield, 1971). Whitehorn and Betz found a significant improvement of 75% compared to 27% in patients whose psychiatrists showed these qualities despite the fact that they had all had the same training. This is supported by findings made by Rogers, 1962; Truax, 1963; and Gendlin and Kiesler, 1967, in studies conducted over a 5 year period (1962 - 1967) and again in follow-up studies done in 1969 by Truax as well as Horowitz and Tausch and his colleagues (Bergin & Garfield, 1971). Truax and Carkhuff (1964) found that the absence of these factors tends to be followed by deterioration in the patient's psychological state.

1.1 **Accurate empathy**.

Greenson states that empathy is a "partial and temporary identification with the patient" (Friedman, 1985, p. 196) and it requires the therapist to become one with the person he is listening to. Empathy implies a willingness for the therapist to become emotionally involved by feeling "oneself in the client through giving up the ground of one's concreteness" (p. 197) but never losing one's own identity and experiencing of the moment. Wolberg (1954) suggests that an optimal amount of tension between being the therapist and being in the patient's world of experiencing is necessary for psychotherapy to progress successfully. Thus, the degree of empathy shown needs to be carefully balanced.

Despite the distinct and positive advantages of self-exploration and growth which may result when a psychotherapist is empathic, it has been found that too much direct expression of accurate empathy too early in the psychotherapeutic relationship may be deleterious (Truax & Carkhuff, 1964).

With deeply disturbed patients, Prouty (1994) believes that empathy should be focused on the patient's efforts to communicate and on the "lived experience of the psychosis itself" (p. 50). In order to enter the experienced world of the patient, the therapist needs to be empathic.

1.2 **Non-possessive warmth**.

Bergin and Garfield (1971) discuss two important studies on this factor conducted in 1969. Wyrick and Mitchell conducted an empirical study on the effectiveness of 40 undergraduate student counsellors. Wagner and Mitchell studied the effects of 316 students' perceptions of their 29 instructors' levels of accurate empathy, warmth and genuineness on the students final examination scores. These authors found a

significant correlation between therapist/instructor warmth and the patients'/students' perceptions of the therapist or instructor's effectiveness. In fact, patients seen by therapists who were low on these skills exhibited deterioration in personality and behavioural functioning. Whitehorn and Betz, 1954, conducted a retrospective study of seven psychiatrists who had achieved a 75% improvement rate in their schizophrenic patients (Truax & Carkhuff, 1964). The successful psychiatrists were perceived as warm people who attempted to understand the patient in a personal, immediate and individual way. Whitehorn and Betz thus found non-possessive warmth to be positively correlated with constructive personality change. These findings suggest that non-possessive warmth has a significant effect on the final outcome in psychotherapy.

1.3 **Genuineness/authenticity**.

In the dialogal approach, being genuine means meeting the other as oneself, as a whole human being, but not necessarily divulging personal information. Thus, one's therapeutic identity is defined by one's personal identity (Eckler-Hart, 1987). Eckler-Hart studied 15 doctoral students in clinical psychology who described their experiences of learning and the development of their identities as therapists. The therapists discovered that the professional identity or False Self they developed offered security, but limited their own sense of aliveness and genuineness in the psychotherapeutic encounter. It created a distance which led to an "undermining of intimacy" (p. 609) and trust. It was recognised that one needed an "emotional body sense of being with the client. And you have to use your whole self" (p. 690).

Truax and Carkhuff (1964) found that a lack of genuineness, on the therapist's part, actually limited self-exploration. Genuineness includes the ability to be open, real, spontaneous and involved as a whole human being in the relationship. Rogers et al. (1976) state that the realness of the therapist allows the patient to express his real feelings without fear which allows for exploration and growth. Buber (1958) believes a genuine meeting can only occur when the person (therapist) attempts to meet the other as a 'Thou'. That is, there must be a genuine interest in the patient as a valuable, separate and unique person. Without this attitude, the patient will only be viewed as an object or 'It', something to study and fix. Being genuine and authentic as a therapist allows the patient to reciprocate and be open in return. Buber views help without genuineness as being like an attempt to practice magic. There has to be a real meeting otherwise a "false dialogue" or "monologue disguised as a dialogue" is created (Friedman 1960, p. 123).

The above three qualities are important for a trusting and open rapport which is essential in allowing the patient to drop his defences, gain insight and move towards the freedom of being himself. Rogers et al. (1976), in an empirical study of schizophrenic patients in psychotherapy, found the group showing the "greatest openness to experience, the greatest spontaneity, the greatest capacity for communicating themselves" (p. 85) was the group which had been exposed to "the highest level of therapeutic conditions" (p. 85). These qualities profoundly affected the level to which the patient was able to explore and experience himself. This study thus supported the findings that these three qualities are positively associated with improved psychotherapeutic involvement and change in the patient but could not prove the hypothesis that these qualities were sufficient conditions for change.

2. **Gender of therapist**.

In the Wyrick and Mitchell study discussed above, gender differences were found to be of some importance. There was a significantly high correlation between accurate empathy and the female patients' perception of female therapist effectiveness suggesting that gender-similarity played a role there. Cartwright (1955) speculates though, that patients progress better in psychotherapy with a therapist of the opposite gender which implies that successful psychotherapy depends, to some extent, on the establishment of a satisfactory heterosexual relationship. In only one instance, in the Angus (1992) study, was the gender of the therapist viewed as negatively affecting disclosure but the final outcome was still viewed as a success and there was a statistically significant reduction in the client's symptomatology. This indicates that, although at times it is difficult for a client to disclose freely with an opposite-gender therapist, the overall result can be positive. One could speculate that the nature of the problem being dealt with plays a role and perceived therapist-patient congruence is more critical for self-disclosure and effective psychotherapy to occur.

3. **The therapist's experience**.

Garfield (1992) states that psychotherapy is "a complex, interpersonal process that requires both personal qualities and a high level of skill" (p. 344). Joslin, 1965, (in Carkhuff, 1966) and findings by Grigg (in Truax & Carkhuff, 1964), based on patient-assessment in a study of 249 patients, found no relationship between the level of the therapist's experience and positive outcome. In that particular setting, the therapists did not seem to have benefitted from the training thus far obtained. The patients found the inexperienced therapist to be more prone to being active and giving advice but this did not adversely affect the perceived success of the psychotherapeutic experience. In contrast, Bergin and Garfield (1971) found that more experienced therapists were more successful than inexperienced therapists. The study also indicates that many of the patients in psychotherapy with inexperienced therapists were making little progress or even deteriorating. Studies by Fiedler, 1950; Bradley and Stern, 1965 and Fretz, 1965 support the above findings that inexperienced therapists may be less effective (Carkhuff, 1966).

Strupp (1986) provides an excellent analogy to describe the skill of the therapist when he states that "it is largely meaningless to examine the surgeon's scalpel to discover why a particular operation is successful, but one may learn a great deal by focusing on the manner in which the surgeon ... employs it" (p. 125). Strupp considers the therapist's skill to include the ability to resist participating in the patient's dysfunctional ways of communicating and relating thus providing him with a new experience. The therapist provides role modelling of "reality and adult behaviour" (p. 126) which fosters exploration and deeper understanding of the dysfunctional thoughts and behaviour. Thus, the therapist's level of competence is important and is shown by the ability to foster a new way of being within the interpersonal relationship.

Fiedler, 1950, in studying the characteristics that make an ideal psychotherapeutic relationship, found that experts created relationships significantly closer to the ideal than non-experts and were better able to maintain an appropriate emotional distance (Rogers, 1965). However, both Malan (1963) and Strupp (1971) found that neophyte therapists are often more successful due to their energy and enthusiasm despite

missing valuable clues.

Although only 67% of the patient sample in the Angus (1992) study perceived the therapist as having sufficient experience, of the 22% who did not, only one subject perceived psychotherapy as having totally failed. Despite not being perceived as having sufficient experience 11% found the therapist to be very high on positive qualities and psychotherapy to be a success. The other 11% found the therapist critical, unaccepting, bored, withdrawn and insensitive. Notwithstanding this, one of these subjects still found a significant level of symptom relief despite not viewing psychotherapy as successful overall. This suggests that neophyte therapists are often capable of providing a sound and safe psychotherapeutic environment in which patients can heal.

Hycner (1991) points out the need for the therapist to be practical and philosophical, to deal with specific issues and yet retain a grasp of the bigger picture. He is also required to distinguish between pathological behaviour and what is a consequence of the personality characteristics which an individual is born with and the circumstances of life he is unable to avoid. This requires flexibility which can only be attained with experience. Friedman (1985) points out that the therapist "has no monopoly on reality" (p. 216) but he brings more experience to the relationship of "inclusion, in imagining the real, in experiencing the other side of the relationship as well as his own, in seeing through the other's eyes as well as through his own" (p. 216).

Overall, the literature supports the theory that the more experienced the therapist is, the better the psychotherapy will be and the more successful the outcome.

4. **Theory and knowledge**.

This is obviously important for the understanding of pathology and health. Theory is essential but can interfere with the genuine encounter between therapist and patient. What is most important is to view the patient as a person first with knowledge and theory in the background. Hycner (1991) suggests this delicate balance is critical for the quality of the relationship that is established.

Gendlin (1974) warns of the harmful uses of knowledge and theory when therapists use theory rigidly without viewing the individual as a whole, unique, feeling being. There is then a tendency "to turn the persons we work with into knowledge" (p. 270). Buber states that the therapist's task is to be "the watcher and healer of sick souls" and the therapist "again and again confronts the naked abyss of man, man's abysmal lability" (Hycner, 1991, p. 22). Buber understands the therapist's desire to use theory and objectification to control the situation but warns of the dangers of making the other into an 'It' in the process.

It is, therefore, extremely important to use knowledge and theory to provide guidelines and to deepen our understanding of the patient's world. Lawner (1981) is of the opinion that it is our "training and self-understanding" that are the "only things that keep us from often removing ourselves from the process of being overwhelmed" (p. 311) by the psychotherapeutic process. But, this must never result in a disruption of the story unfolding. And no method can teach the therapist to meet the other in a genuine, authentic encounter. Buber, 1976, states that theory is only an entry point and that the

therapist is always responding to the individual in that unique moment (Hycner, 1991).

5. **Therapist's ability to listen**.
Listening is a skill which requires attention and concentration to both the spoken and unspoken communication and is a basic component of psychotherapy (Garfield, 1989). The better the listening is, the greater the understanding of the problem will be which provides a more meaningful experience for the patient. Garfield believes that good listening allows the therapist to understand the patient's internal frame of reference with greater clarity. Mathieu-Coughlan and Klein, 1984, feel that good listening also facilitates focusing (Rice & Greenberg, 1984). This suggests that if the therapist is sensitive to what the patient is trying to communicate the chances of successful outcome are enhanced. Boelen (1963) defines authentic listening as being an openness where "only he who wonders can truly listen" (p. 93). Farber, 1976, describes Buber's approach to listening as "the ability to attend imaginatively to another's language" ((Friedman, 1985, p. 81). Chessik (1996) believes that this requires tolerance, flexibility and a certain maturity to achieve. Rogers (1973) recounts how he followed a patient's need in psychotherapy and simply listened rather than trying to fit a diagnosis. He describes the psychotherapeutic relationship as being a "far more personal relationship" (p. 9) which had good results.

Listening becomes more critical when the therapist is lost in the darkness of the unknown or what Van den Berg (1972) refers to as the "not-knowing" (p. 118). Shainberg (1983) advises the therapist to focus on "listening and attending to what he saw" (p. 166) in the psychotherapy thus encouraging the therapist to experience the felt-sense and be with the patient without the need to do something. Chessik (1995) supports the dialogal concept of the therapist bracketing his own ideas/ formulations to hear the patient. Chessik states that this is difficult as it contradicts the therapist's tendency to create a "neat, consistent, and holistic theoretical explanation ... even if it is wrong" (p. 597).

Rogers (1973) gives a pertinent quote from Lao-Tse which highlights this need to listen and hear to shift the process.
"It is as though he listened
and such listening as his enfolds us in a silence
in which at last we begin to hear
what we are meant to be" (p. 12).

6. **Therapist expectations**.
Generally, findings suggest that therapists prefer patients who are not too severely disturbed as the more emotionally balanced patient is usually more sensitive, intelligent and willing to talk about himself (Truax & Carkhuff, 1964; Bergin & Garfield, 1971). Truax and Carkhuff (1964) also found that therapists tend to regard symptomatic relief and improvement in social relationships as indicative of successful outcome whilst the patients assessed their own levels of self-understanding and confidence.

7. **Patient attractiveness**.
Strupp (1971) supports the belief that the therapist's personal reaction to the patient may influence the outcome of psychotherapy and Nash et al., 1965; Heller and

Goldstein, 1961, report outcomes favouring attractive patients (Strupp, 1971). Strupp and Williams, 1960 (Strupp, 1971), found that, despite contradictions, a favourable prognosis is generally predicted for more likeable patients. Barbara Sullivan (1989) believes that it is not possible to provide a healing environment for someone one does not like as it is the therapist's love/liking that allows the patient to achieve inner emotional healing.

8. **General personality characteristics**.
Holt and Luborsky, 1958, view a successful therapist as being one who is genuine, socially adjusted with his co-workers, free from status-mindedness, able to obtain self-objectification, has adequate emotional control and the ability to display warmth, acceptance, spontaneity and empathy (Strupp, 1971). Langs (1989) also stresses the importance of neutrality and relative anonymity. Truax and Mitchell's 1971 literature review confirms that the personality of the therapist is more important than his techniques (Stubbs & Bozarth, 1994).

9. **Therapist attitudes**.
Strupp (1986) stresses the importance of both the therapist's verbal and non-verbal behaviour which must be experienced as meaningful to the patient. Therapist attitudes include both attitudes towards the patient and towards the self. Ingham and Love (1954) state that the primary function of the therapist is to promote attitudes in the patient that are favourable to psychological progress. This can be done by encouraging the patient to approach his own difficulties with a healthy attitude of tolerance, objectivity and sincerity. To do this the therapist must display respect for the patient so that he perceives himself as an intrinsically likeable and worthwhile person (Ingham & Love, 1954; Rogers, 1965). This respect includes an honesty in dealing with the patient (Ingham & Love, 1954).

Another important dimension is the degree of authoritarianism shown by the therapist as the amount of control the therapist exercises has a powerful effect on the psychotherapeutic outcome. A healthy balance of control and permissiveness allows the patient to work at his own pace and in his own direction whilst still affording the therapist the chance to gain information and guide the patient. The exact balance is unique to each psychotherapeutic alliance.

Wolberg (1977) states that the therapist's attitude must inspire hope, faith, trust, liking and a freedom to respond in the patient. Ingham and Love (1954) believe that the therapist ought to maintain a sufficient degree of psychological comfort about his role and level of competence and have a tolerance for his own errors. This involves an optimum tension between complacency about his own competence and a feeling of adequacy to do the job. An openness to his own fallibility and the honesty to accept and learn from errors is critical. Winnicott (1977) stresses the need for the therapist to be receptive. In being an alive and perceptive presence, with the ability to play, the therapist offers a rich psychotherapeutic environment for exploration. In fact, Stone emphasises that failure to show a reasonable human response at appropriate times can invalidate the patient work done in good psychotherapy (Friedman, 1985).

Stubbs and Bozarth (1994) refer to Lambert, Shapiro and Bergin's 1986 study which

supports the findings that the therapist's attitudes form a vitally important part of the psychotherapeutic outcome. They add that techniques are not irrelevant but that their "power for change is limited when compared with personal influence" (p. 112). Sloane, Staples, Cristol, Yorkston and Whipple, 1975, found the following factors to be very important for the patient in successful outcome for 70% of their sample: the personality of the therapist, the therapist helping them to understand problems, encouragement from the therapist to gradually practice facing the issues that bothered them, being able to talk to an understanding person and the therapist's helping them to a greater self-understanding (Arkowitz, 1992).

The dialogal view is that the therapist must recognise that psychotherapy does involve paradox, conflict and opposing qualities and he should strive to integrate them. Hycner (1991) views health as an "ever elusive rhythmic balance of separateness and relatedness" (p. 9). This requires the therapist to become involved and fully present in the process and yet maintain an objectivity in order to understand the process unfolding. Buber (1965) describes this as a "detached presence" (p. 71). The therapist must have the ability to understand the patient's experience and yet also be aware of what this raises within himself. The therapist must also be alert to what is occurring in the psychotherapeutic space between himself and the patient and what and how each person is contributing to the process. Finally, the therapist must recognise that the relationship created is greater than the separate aspects which each has contributed. Thus, the therapist is required to flow with the patient in a never-ending dance of separateness and relatedness, providing a balance in the psychotherapeutic relationship. For example, if the patient is being too intellectual, the therapist needs to guide the patient gently into feeling emotions and being more connected with his body.

10. **The therapist's self**.

Eckler-Hart (1987) explores the therapist's sense of self in a study based on Winnicott's True and False Self concepts. In this article he describes how the training therapist forms a "psychotherapeutic false self" or "professional identity" (p. 683) in order to protect himself from the demands made on his own psyche. He stresses the importance of the therapist being open, creative, spontaneous and giving of his whole self in a deep relationship with the patient. Winnicott maintains that this can only occur when the real, authentic core of the self (True Self) is allowed to communicate with the patient. However, this very openness is threatening to the vulnerable core of the therapist who may then resort to the mask of the False Self or professional identity to protect himself. May (1958) comments that therapists can protect themselves by resorting to technique or give theoretical explanations to distance themselves from the vulnerable situation. It is critical for the therapist to attain and maintain a balance between being too exposed and vulnerable and yet being present in an authentic manner in the relationship.

This is of vital importance as Hycner (1991) states that the therapist's theoretical orientation is not the major factor in success or healing but the "wholeness and availability of the self of the therapist" (p. 15). Ultimately it is the therapist's whole self which must be fully present. By being fully present in the psychotherapy, the therapist is already providing the basis for a deep, respectful, sound and solid psychotherapeutic relationship in which to begin healing. Being fully present allows the therapist to

experience the patient's world more deeply and thus with more understanding. May (1958) in describing presence states that "the relationship of the therapist and patient is taken as a real one, the therapist being not merely a shadowy reflector but an alive human being who happens, at that hour, to be concerned not with his own problems but with understanding and experiencing so far as possible the being of the patient" (p. 80). So, presence is not simply a sentimental attitude but how the therapist views human beings. This means that the therapist does not impose his ideas and feelings on the patient but follows the patient's lead and feelings. One may be present even in silence.

It is difficult to create a balance between being a genuine and authentic human being in the encounter and not being drawn into the whirlpool of emotions and chaos that will result in the therapist becoming as chaotic as the patient. This does not, however, preclude the therapist from feeling lost in the unknown at times (Lawner, 1981). Lawner supports Eckler-Hart and May's views and affirms that when the anxiety and vulnerability of being in the unknown is strong, the tendency is for the therapist to allow the False Self to step in and protect - but this can be at a cost to the psychotherapeutic encounter. Lawner (1981) thus warns the therapist to "avoid trying to create light where none exists" (p. 307) but to learn the value of simply waiting and being with the patient.

Trüb, 1947/1964, speaks of the overall role of the therapist as embodying a real person and being an example of the broader relationships the patient will experience in his world (Hycner, 1991).

11. **Confidentiality**.

Langs (1989) stresses the importance of confidentiality. If a patient in any way feels that this factor is not very high on the list of the therapist's priorities there will be little trust and a psychotherapeutic alliance will be difficult, if not impossible to form.

Overall, Angus (1992) found that the positive qualities in the therapist as assessed by the patient, clearly indicated that the therapists provided a climate where the patient felt heard, liked, accepted and cared for. The therapists themselves were generally perceived as interested, empathic, genuine and sensitive. Factors which were perceived as leading to improvement in outcome were mainly qualities of the therapist which created a psychotherapeutic space, insight, attitude change and a belief in the self for the patient. Self-disclosure was inhibited, to some degree, for 33% of the subjects by the therapist. For example, the therapist's silence, non-involvement, lack of challenging, lack of focus on present issues and lack of self-disclosure inhibited the patient's self-disclosure. These reasons were seen as factors which hampered psychotherapy and it was felt that their presence would have facilitated progress. On the whole, successful outcome was largely attributed to therapist qualities. It can be concluded, therefore, that the personality characteristics and skills of the therapist are critically important and can positively or negatively affect outcome. Friedman (1985) wisely cautions us not to turn "healing through meeting into injury through mismeeting" (p. 191). Perhaps the dictum 'primum non nocere' is the most essential baseline for any therapist to adhere to.

Basically the therapist's personality is more important than any technique he uses. But, valuable techniques in the hands of an empathic, warm and genuine therapist, are of

inestimable value in assisting the patient to view himself more objectively and accept all those elements which make up the whole person.

In conclusion, despite divergent viewpoints, most authors agree that there are basic characteristics that are shared by effective therapists. Bergin and Garfield (1971) give the following breakdown: "(1) an effective therapist is nonphony, nondefensive and authentic or genuine in his therapeutic encounter; (2) an effective therapist is able to provide a nonthreatening, safe, trusting, or secure atmosphere through his own acceptance, positive regard, love, valuing or nonpossessive warmth, for the client; (3) an effective therapist is able to understand, 'be with', 'grasp the meaning of', or have a high degree of accurate empathic understanding of the client on a moment-by-moment basis" (p. 302).