

CHAPTER 5 - THE PSYCHOTHERAPEUTIC RELATIONSHIP

Having discussed the variables which contribute to the psychotherapeutic relationship, this chapter explores the meaning and value of this relationship in the healing of the patient. This factor will be explored further in chapter 8.

The psychotherapeutic alliance is an interpersonal relationship involving two people with the aim of producing change in the one (the patient) through interaction with the other (the therapist) (Conrad, 1952). Any success or failure may be interpreted in the light of this mutual interaction. Each psychotherapeutic relationship is unique due to the inherent variability in both patient and therapist. Bugental, 1987, describes the psychotherapeutic relationship as "the powerful joining of forces which energizes and supports the long, difficult, and frequently painful work of life-changing psychotherapy" (Clarkson, 1990, p. 150).

The psychotherapeutic relationship is viewed as one whole unit. Jaspers (1963) stresses that the whole comes before its parts, it is not the sum of its parts but greater than and different from them. The whole cannot be grasped from its elements alone as the whole can exist even when parts are lost. The whole must rather be understood as a combination of its parts and the parts as being integral aspects of the whole. There is always a mutual interplay of parts and wholes which creates a constant movement in the ongoing process of psychotherapy. This is an important view as, although the characteristics that contribute to this relationship have been discussed as separate entities, the combination of these characteristics creates a new and unique entity. The psychotherapeutic relationship takes on a life of its own and is always in a state of growth and change. As the patient is affected and changes, so too is the therapist in a constant dance of creativity and growth.

Luborsky (1992) stresses the psychotherapeutic relationship as being an important factor in influencing outcome and Lambert and Bergin (1992) state that "relationship factors predict, if not cause, outcome" (p. 373). Glass and Arnkoff (1988), in a study of 76 patients' evaluations of change in psychotherapy, found that interpersonal and therapist interaction factors were very important. These authors cite Cross et al., 1982; Marcovitz and Smith, 1983, and Strupp et al., 1964/1969 as having similar findings. Stubbs and Bozarth (1994) state that Lambert's 1986 findings support the view that patients consider relationship variables as being closely related to successful outcome and that therapist variables are "fundamental in the formation of a working alliance" (p. 114). Lambert, Shapiro and Bergin, 1986, conclude that the psychotherapeutic relationship is "critical" (p. 113) as it provides a safe milieu in which the patient may heal (Stubbs & Bozarth, 1994). Thus, it is suggested that the most important factor in healing the patient is the psychotherapeutic relationship.

Prouty (1994) claims that certain pre-conditions are necessary in order to form a psychotherapeutic relationship. The basic one is "psychological contact" (p. 37) which requires the therapist to meet the patient at the most basic levels of his experiencing and give him respect, space and time to emerge and unfold his story. Clarkson (1990) reinforces this belief when he speaks of the fundamental importance of establishing a relationship with the patient who has lost his sense of inter-relatedness in order that he

may return to the world in relationship. This new relationship created between therapist and patient also assists him in correcting the problems experienced in his past and current relationships (Strupp, 1986). Brice (1984) describes how the patient has attempted to flee from the fears arising in the ambiguity and uncertainty of his world. The psychotherapeutic relationship aims at assisting the patient to view these problems from a different perspective in order to equip him to deal more effectively with the real world.

This is achieved by the therapist helping the patient to identify, understand and master the problems within the psychotherapeutic relationship (Strupp, 1986). Shainberg (1983) believes the therapist achieves more when he realises that his presence is the "healing environment in which the being is the doing" (p. 175). Change within a patient always occurs within the context of a personal relationship but May (1958) adds that "the essence of relationship is that in the encounter both persons are changed" (p. 63).

It is thus recognised that both the therapist and patient influence each other and the relationship. Rogers et al. (1976), in their study of "The Effects of the Therapist and the Patient on Each Other", comment that it is recognised that some patients are more difficult to work with and some patient-therapist combinations work better than others as each party has a strong influence on the other. In this study, the authors allowed chronic, hospitalised, schizophrenic patients to choose whichever therapists they wished to work with thus not limiting them to only one psychotherapeutic relationship. The patients in the control group were placed in a psychotherapeutic relationship that was low in empathy and congruence. The result provides evidence to support the hypothesis that the "levels of problem expression and immediacy of experiencing of the patient are a function of both the patient and the therapist ... and the particular patient-therapist combination" (pp. 357 - 358). Rogers et al. also found that the more meaningful the psychotherapeutic relationship, the more the schizophrenic patient developed the capacity to communicate with other people. The control group patients "showed no change or even regressive change" (p. 86).

Rogers et al. (1976) conclude overall that the relationship qualities are not supplied by either the patient or the therapist and that "high therapeutic conditions" (p. 90) are a product of the interaction between the patient and the therapist. The conclusion in the study is that there is substantial evidence that "relationships" high in genuineness and accurate empathy, as perceived by the patient were "associated with favourable personality changes and reductions in various forms of pathology, particularly in schizophrenic pathology" (p. 86). Results indicate that "the therapist and the patient influence each other's therapeutic behaviour as well as their own, and that the therapeutic behaviour of one is positively related to the therapeutic behaviour of the other" (pp. 355 - 356). The patient was found to have a greater effect on the relationship than the therapist. Rogers et al. infer that the more defensive, unmotivated and reluctant the patient is, the more difficult it is to deepen the relationship. The more positive conditions are present, the more likely it is that there will be positive outcome whether one is dealing with neurotics or schizophrenics. Hence, both patient and therapist are complexly interwoven in a cycle of dynamic interaction aimed at the patient's growth. The psychotherapeutic relationship is built on, but not totally limited

by, what each brings to the relationship. This stresses that the relationship between the therapist and patient is the most important element in growth and change in psychotherapy.

The dialogal view is that the "overall approach, the process, and the goal of psychotherapy" needs to be grounded in Buber's basic tenet that there is "healing through meeting" (Hycner, 1991, p. 4). Thus, the focus is not on the therapist or the patient but on the 'between' and the unique relationship created by the meeting of the therapist and patient. A basic dialogal principle states that "there are always two sides to an interaction" (p. 59). As there is tremendous risk involved with the deep exploration of issues and in genuine dialogue, either the therapist or the patient can set the limits as to what is explored and to what extent (Hycner, 1991). Usually the patient is the first to draw a boundary as it is his life and world that are being explored.

Buber (1953) stresses the importance of the relationship when he says "the inmost growth of the self is ... accomplished ... in the relations between the one and the other ... in the making present of another self and in the knowledge that one is made present in his own self by the other" (p. 249). In the relationship the therapist is called to enter "into the elementary situation between one who calls and one who is called" (pp. 94 - 95), that is, "the between" (Buber, 1957). Buber (1965) stresses that meaning "is to be found neither in one of the two partners nor in both together, but only their dialogue itself, in this 'between' which they live together" (p. 75). This requires the therapist to be a person first and a professional second. In genuine and open meeting the therapist can move into the world of the patient where "a soul is never sick alone, but always a betweenness also" (Buber, 1957, pp. 96 - 97).

Friedman (1985) points out that the responsibility of whether the psychotherapy works or not does not lie entirely with the therapist or the patient but in the 'between' of the relationship. Hycner (1991) describes this as the "rhythmic alternation between separateness and relatedness" (p. 48) which occurs in the space of the 'between'. It is only in the relationship that both therapist and patient can explore the depths of the psyche. Colm (as cited in Friedman, 1985) comments on the psychotherapeutic relationship stating that "healing does not result merely from greater knowledge of oneself but from experiencing oneself (as one is) in relation to another person" (p. 190). Trüb, 1952 (as cited in Hycner, 1991, pp. 67 - 68), maintains that "it is in the framework of this basic partnership relation that the psychic conflict tension arrives at a psychotherapeutic resolution."

Rogers (1965) reports Fiedler, 1950, as stating that almost all therapists agree that the relationship is a critical factor in facilitating psychotherapy. He found that the characteristics of this ideal relationship include, in order of significance: the therapist's ability to participate completely in the patient's communication; his ability to make comments that are always right in line with what the patient is trying to convey; viewing the patient as a co-worker on a common problem; treating the patient as an equal; understanding the patient's feelings; and always following the patient's line of thought and conveying, by tone of voice, the ability to share those feelings. Jaspers (1963) emphasises the need for the therapist to understand and question his own feelings, needs and motives in the psychotherapeutic relationship as well as the patient's.

Clarkson (1990) speaks of three authors' views on the psychotherapeutic relationship. Guntrip, 1961, claims that the genuine, personal relationship between the therapist and patient is the basic and major psychotherapeutic factor from which all other therapeutic factors and healing grow. Boss, 1979, believes that the importance of the psychotherapeutic relationship lies in the fact that each participant discloses himself as a human being. Anna Freud states that "two real people of equal adult status stand in a real personal relationship to each other" (p. 157) in the psychotherapeutic relationship.

Shainberg (1983) stresses the importance of the therapist understanding that work is always ongoing and that one can never fully know the patient's experience. It is only in the "mutual participation of discovering the essential quality of the patient that the healing can take place" (p. 164). This requires two people being together without theory and labels. Categorisation reinforces an objective approach to the patient preventing the therapist from seeing and relating to the individual. Thus, the therapist is required to allow the patient's experience to appear and simply be lived together in the psychotherapeutic space. However, patients are frequently dependent on others for a sense of direction and have little insight into their problems. They can then disrupt the psychotherapeutic relationship when they do not achieve the results they expect or are not treated the way they believe they should be. In those situations, the therapist can gently guide the patient back into the realisation that psychotherapy is a mutual process.

It is thus evident that a good psychotherapeutic alliance is critical for change and growth as it serves as a valuable relearning experience allowing the patient to take what he has learned in psychotherapy and generalise this corrective experience to relationships in the world (Wolberg, 1977). Norcross, 1986, states that successful psychotherapy is best predicted by three components, that is, the patient, the therapist and the psychotherapeutic relationship (Clarkson, 1990). Stubbs and Bozarth (1994) explored the question Paul posed in 1967 when he asked "what treatment by whom is most effective for this individual with that specific problem under what set of circumstances?" (p. 115). It seems that this question cannot be adequately answered despite years of research. Certainly all the variables combine to provide a unique psychotherapeutic space for the patient and therapist to strive for the patient's healing and growth. The focus should not be on what the therapist does, but **how he is** with the patient. As long as one has respect for the patient and some form of relationship has been created, some level of success can be reached with even the most regressed, uncommunicative and fragmented patients.