

THE PERSONAL RELATIONSHIP IN CARING

Introduction

SEVEN THESES *on being relational*

with commentary from an *Object Relations* perspective

1. Human beings are relational by nature
“with an absolute need to be able to relate in fully personal terms to an environment that we feel relates beneficently to us.” Harry Guntrip
2. Human beings maintain a need for supportive relationships
“in early and later relationships this need is never optimally met in consistent and adequate ways thus fostering to varying degrees an ongoing sense of insecurity and anxiety.”
3. Human beings do not lose but can adapt to relational dependency
“when successful we can move from child- to adult- (mature/mutual) dependency.”
4. Human beings seek out a secure place with others in their world
“starting with early *attachment* figures (Bowlby) we seek proximity to those who are able to soothe us when anxious, those who at the moment appear more resourceful than we are.”
5. Human beings seek out a transcendent place in religion and spirituality
“a fundamental sense of connectedness to and personal validation by the universe, the ultimate, all-embracing reality.” (Guntrip)
6. Human beings are their essential relationships
“we internalize and carry the relationships we experience with those who care for us – from our early child-caring days on to present experiences of caring and being cared for.”
7. Human beings both connect and disconnect in caring relationships
“the child’s *holding environment* (Winnicott) is the metaphor for a caring relationship – the place that holds you, and lets you go to become the unique person who you are.

For Individual Reflection and Group Conversation

- If you could choose one thesis to defend or amplify, which one would it be?
- If you could choose one thesis to question or argue with, which one would it be?
- If you could delete one thesis from further thought, which one would it be?
- If you could learn more about one specific thesis, which one would it be?
- If you could add another thesis (Luther posted 95) what would it be?

PERSONAL RELATIONSHIPS IN THE THERAPIES

While caring relationships are essential wherever people gather in social communities, relationships define the particular process of psychotherapy and the practice of spiritual care and counselling. Each school of psychotherapy (for a map of the various therapies see Appendix I) defines the therapist role and the therapy relationship from their own unique perspective as apparent in the following table:

Table 1 – profiles of the therapeutic relationship in the major therapies

THERAPY APPROACH	THERAPIST ROLE	THE RELATIONSHIP
Psychodynamic	Teacher	transference working alliance
Behaviorism Cognitive/Behavioral	Instructor Consultant	working alliance
Humanistic Existential	Partner	real dialogical
Constructivist	Consultant Companion	working alliance real
Marriage & Family	Coach	working alliance

This table brings together the various components in therapy relationships which will be differentiated and explored in this module:

- the **transference** relationship
- the **working alliance** relationship
- the **real** relationship
- the **dialogical** relationship

1. The Transference/Countertransference Relationship

Definitions

- *Transference* as the tendency of the care-receiver to experience the care-provider similar to a relationship with a significant other from the past.
- *Countertransference* as the tendency of the care-giver to attribute to the care-receiver qualities that come from the care-giver's own significant relationship experiences from the past.
- The two transferences, one in the care-receiver, the other in the care-giver, follow essentially the same process – each unconsciously experiencing the other not as a new relationship but one mixed with cognitive and emotional images coming from significant relationships of the past.
- Not only in therapy but every relationship is contextualized, to some extent distorted if not contaminated, by the experience of past relationships.

An overarching principle embraced by those of us who practice dynamic psychiatry is that we are basically more similar to our patients than we are different from them. The psychological mechanisms in pathological states are merely extensions of principles involved in normal developmental functioning. Doctor and patient are both human beings. Just as patients have transference, treater has countertransference.

Glen O. Gabbard, M.D. 1990. *Psychodynamic Psychiatry*. American Psychiatric Press.

A Case of Countertransference

The day Betty entered my office, the instant I saw her steering her ponderous two-hundred-fifty-pound, five-foot-two-inch frame toward my trim, high-tech office chair, I knew that a great trial of countertransference was in store for me.

I have always been repelled by fat women. I find them disgusting: their absurd sidewise waddle, their absence of body contour – breasts, laps, buttocks, shoulders, jawlines, cheekbones, everything, everything I like to see in a woman, obscured in an avalanche of flesh. And I hate their clothes – the shapeless, baggy dresses or, worse, the stiff elephantine blue jeans with the barrel thighs. How dare they impose that body on the rest of us?

The origins of these sorry feelings? I had never thought to inquire. So deep do they run that I never considered them prejudice

Irvin Yalom, 1989. *Fat Lady*. Pp. 87,88.

Questions:

Yalom graphically describes his countertransference feelings towards Betty –

- Do you think his reaction was dramatic and given such a negative preoccupation with her body, was it fair to Betty that he nevertheless decided to work with her?
- Is the presence of countertransference a persistent reality or can you become such a loving and accepting person that, without inner conflicts, you can work with just about any person?
- Is there a difference between managing negative, hostile feelings and positive, loving feelings in countertransference? Is the one more dangerous than the other in a helping relationship?

It takes honesty and courage to own one's inner damning feelings that distort the therapeutic relationship. Countertransference is fertile ground for discrimination since it projects negative feelings from earlier relationships to a present relationship, and often does so by generalizing and stereotyping an identifiable group of people.

- Can you draw a composite profile of a person who would be your “client from hell,” using such indicators as gender, age, social status, mannerism, religious or theological orientation, political leaning, level of education, ethnic origins, role in the relationship (such as dependent, jolly, demanding, etc.), job/vocation, sexual history/orientation, presenting problem for therapy or spiritual care, body size/shape/care, affluence, moral standards, health, etc.
- Or who would be your ideal person, the “client from heaven”?

The transference relationship in the therapies:

1) Psychoanalytic/Psychodynamic Therapy

The therapist maintains a neutral, non-reactive stance toward the patient's positive (loving) or negative (hateful) transferences, refusing to either reject or gratify the patient's expectations or needs, thus eliciting a full disclosure of the transference. In this way the patient's complaints of relationship problems will eventually surface in the therapy relationship. Psychoanalytic therapy amounts to the analysis of the relationship between client and therapist.

2) Self Psychology – a different kind of transference

Features three transferences that correlate to insufficiently responded-to childhood needs that are revived in the therapy situation:

- *mirror transference*
The need for those who respond to and confirm the child's innate sense of vigor, greatness and perfection.
- *idealizing transference*
The need for those with whom the child can merge as a source of calmness, infallibility and omnipotence.
- *twinship or alter-ego transference*
The need to be with those with whom one feels essential likeness, the experience of being human among humans.

Through these transferences the therapist focuses on persistent childhood needs in the process of structuring a more cohesive sense of self through such *selfobject* or therapist functions as confirming, validating, soothing and challenging the client.

3) Pastoral Care Literature

The following list of practical indications is designed to alert the pastor/spiritual care provider to countertransference problems: ¹

Indicators of Countertransference in the Spiritual Care Setting

- I am careless in keeping appointments
- I experience repeated erotic or hostile feelings
- I notice that I am bored or inattentive during conversation
- I permit or encourage misbehavior
- I try to impress
- I argue a lot
- I take sides prematurely in personal conflicts
- I prematurely reassure people to lessen my own anxiety
- I dream or think repeatedly about a particular care-receiver
- I feel that the care-receiver's welfare or need-fulfillment lies solely with me
- I behave differently toward one person than toward others in the same group
- I make unusual appointments or behave in a manner that for me is unusual

2. The Working Alliance

as used in some of the psychotherapies:

- i. in psychoanalysis/psychodynamic therapy
the therapist partners with the client's healthy ego and together they address the sick or maladjusted part of the client's ego.
- ii. in constructivist therapies
 - therapeutic conversations that elicit the client's strengths rather than his or her problems create the emotional bond and working alliance between therapist and client
 - therapist and client meet in facing a joint adversary: the presenting problem.
 - the client is differentiated from his or her problem:
the problem – not the client – is the problem
 - the problem is externalized as the “other,” the “stranger” in narrative terms
 - a collaborative intervention organized by the “two against one” strategy

exercise

see Appendix II: “*how to talk about your problem X*”

- iii. in spiritual care literature
 - the self-differentiated caring approach²
a non-anxious presence vs. emotional fusion with care-seeker
 - empowering the client's “inner healer”
The Wounded Healer paradigm.³
In every person there is both wound and healing. In spiritual care:
 - if we meet wound to wound, our identification may only intensify the pain as I pour my wounds into your wound.
 - If we meet healer to wound, I become a helper rescuer and may block your inner healer.
 - When we meet wound to wound *and* healer to healer my woundedness will not infect yours and my healer will call out the healer within you.

3. The Real Relationship

The “real” relationship in therapy is based on accurate, here-and-now perceptions in a caring personal relationship marked by openness and honesty. Each school of therapy is an integrated system of theory and practice. The personal relationship shows the human face of the practice of therapy. The “real” relationship is the face associated with humanistic psychotherapy – approaches of care that believe in and support the person's own inner wisdom, will and ability for growth.

The “real” relationship emphasizes hope and often includes references to an invisible, transcendent dimension in human life. This approach has been a dominant force in the

early pastoral care and counseling movement and characterizes much of the present practice of spiritual care.

The process of therapy is ... seen as being synonymously with the experiential relationship between client and therapist. Therapy consists in experiencing the self in a wide range of ways in an emotionally meaningful relationship with the therapist.

Carl Rogers.1951. *Client-Centered Therapy*, p.172

For the therapist this means an empathic identification with the client's felt world rather than a professional analysis of past events or a diagnostic observation of the client's present problems. Though identifying with the client, the therapist stays genuine and congruent within the relationship, in touch with her or his own separateness without emotional fusion with the client's difficulties and pain.

- Irvin Yalom (1989) in his tales of psychotherapy (p.13):

This encounter, the very heart of psychotherapy, is a caring, deeply human meeting between two people, one (generally, but not always, the patient) more troubled than the other. Therapists have a dual role: they must both observe and participate in the lives of their patients. As observer, one must be sufficiently objective to provide necessary rudimentary guidance to the patient. As participant, one enters into the life of the patient and is affected and sometimes changed by the encounter.

QUESTIONS:

- What are the similarities and differences between Rogers and Yalom?
- In a debate between the two relational stands of client-centered and existential therapy, where would you stand and how would you argue your case?
(see the *Human Actualization* theories module)

It is the relationship itself that becomes the place of "lodgement and germination" (T.S. Eliot) – a place that holds and empowers the person to change. What are the characteristics of a personal relationship in therapy that offers both a safe place and a place for growth and change? By general consensus it is Carl Rogers who has most artfully and succinctly described the makings of a therapeutic relationship in his "person-centered" therapy. He envisioned that the relational triad of *congruence*, *acceptance*, and *empathy* create a growth climate where healing will naturally follow.⁴

4. The Dialogical Relationship

Dialogical psychotherapy is based on the anthropological philosophy/theology of Martin Buber. The dialogical relationship generates a new reality – *the between* – beyond the imagination and expectations of both client and therapist, revealing the uniqueness of who the client is and can become with the empowering presence of confirmation. Who we are and can become in pursuit of the meaning of our existence is not embedded in our psyche but emerges in the dialogical relationship of the *I and Thou*.

For Reflection:

One's sense of identity requires the existence of another by whom one is known. (R.D.Laing). How do you understand from your own experience: *No I without a Thou?*

Three Kinds Of Dialogue (Buber.1947, 37):

- genuine dialogue – the *I and Thou* – a whole process
“where each of the participants really has in mind the other or others in their present and particular being and turns to them with the intention of establishing a living mutual relation between himself and them.”
- technical dialogue – the *I – It* relationship – a part process
“prompted solely by the need of objective understanding”
- monologue disguised as dialogue – a nothing process

For Reflection:

How do you experience your own practice of care and professional activities in terms of these three kinds of dialogue?

THREE KEY DIALOGICAL CONCEPTS

A. Confirmation as distinct from Acceptance

- The goal of dialogical therapy is to discover and confirm the client's personal direction, to locate the client's special place in life. Confirmation highlights the uniqueness of the person's place and direction, essential to one's human existence.
- Note the distinction:
 - *accepting* (as you are now)
 - *confirming* (to become who you are).
- Martin Buber questions Rogers' belief that life unavoidably tends to growth and thus distinguishes between affirmation and confirmation: “I accept you as you are” does not mean “I don't want you to change” but “I discover in you just by my accepting love what you are meant to become” (Buber, 1966, p.181). This means “I may *struggle with* and *oppose* you precisely in order to *confirm* you“(Friedman, 1985).

B. Inclusion, Identification and Empathy

- A definition of *inclusion*:
 - “imagining the real,” “a bold swinging, demanding the most intensive stirring of one's being into the life of the other” (Buber, 1988, 71) while staying connected with one's own ground of reality and sense of self yet open to being changed in ways beyond one's control.
- Inclusion as distinct from
 - o Identification
the therapist identifies with the other by experiencing similarities between the two– the uniqueness of the client is lost
 - o Empathy
The therapist empathizes by submerging oneself in the client's perceptions and feelings – the uniqueness of the therapist is lost

C. Mutuality in the Helping Relationship

-For Carl Rogers the therapist-client relationship can be fully mutual.

-For Buber, in love and friendship experiencing the other side is mutual, but helping relationships are necessarily one-sided: the patient cannot equally well experience the relationship from the side of the therapist. Yet this “normative limitation” does not exclude an I-Thou therapy relationship. (see Buber’s 1958. *I and Thou* Postscript)

A Story

When I was eleven years of age, spending the summer on my grandparents’ estate, I used, as often as I could do it unobserved, to steal into the stable and gently stroke the neck of my darling, a broad dapple-grey horse. It was not a casual delight but a great, certainly friendly, but also a deeply stirring happening. If I am to explain it now, beginning from the still very fresh memory of my hand, I must say that what I experienced in touch with the animal was the Other, the immense otherness of the Other, which, however, did not remain strange like the otherness of the ox and the ram, but rather let me draw near and touch it. When I stroked the mighty mane, sometimes marvelously smooth-combed, at other times just as astonishingly wild, and felt the life beneath my hand, it was as though the elements of vitality itself bordered on my skin, something that was not I, was certainly not akin to me, palpably the other, not just another, confided itself to me, placed itself elementally in the relation of Thou and Thou with me. The horse, even when I had not begun by pouring oats for him into the manger, very gently raised his massive head, ears flicking, then snorted quietly, as a conspirator gives a signal meant to be recognizable only by his fellow-conspirator; and I was approved. But once – I do not know what came over the child, at any rate it was childlike enough – it struck me about the stroking, what fun it gave to me, and suddenly I became conscious of my hand. The game went on as before, but something had changed, it was no longer the same thing. Buber, 1947, 41-42

For Reflection:

- What changed the experience and what was lost?
- Does the story trigger any associations in your experience with relationships?

Conclusion:

In this module four components in the personal relationship in spiritual care and therapy were explored: the transference/countertransference, the working alliance, the real relationship, and the dialogical relationship. However, this does not mean that a therapeutic relationship is either one or the other of these four components. Rather they can be seen as various dimensions that can be simultaneously present in a caring relationship, even though one or two of the components may be predominant at any particular time.

The following verbatim is a case in point. In analyzing the process of this therapeutic conversation, see where and how any one of the relational components are present:

Verbatim:

Making Contact

Context: The counsellor, Jim, has seen Margaret for 8 times for ongoing problems of conflicted family relationships. Towards the end of the last session, Margaret had gotten up rather brusquely and, without any words, left.

Participants: Jim – J; Margaret – M

- J1: I was thinking of our last session last week. Our ending was rather abrupt – and I had the sense that you were upset. I would like to check that out with you.
- M1: I wasn't even sure whether I would be coming back for today's appointment.
- J2: You did feel upset. Can you tell me more about that?
- M2: I had told you 3 or 4 weeks ago that I don't want to talk anymore with my parents about my marriage. Yet, last week you asked me whether I had talked with them about this fight with my husband. You just don't listen.
- J3: It feels that I really don't pay attention or trust what you tell me.
- M3: Just what you are doing now. You are not answering me, just giving me one of those smart-assed therapy responses. I may be in deep pain, and you come up with some stupid question about how I am feeling.
- J4: Talking about feelings, I feel bad that we are not connecting. The only thing I feel good about is that you are angry enough to tell me, rather than just not showing up anymore.
- M4: Well how would you feel? We have met almost 10 times and I feel I have wasted my time and money. How do you feel about that?
- J5: I wonder why you have kept coming here, feeling that badly.
- M5: You see, again you are not answering my question.
- J6: You are right, I did not answer. I try to stay with you but it comes out just the opposite: rather than responding I am deserting you.
- M6: That's right.
a shared silence
- J7: This feeling of being deserted hurts. You know it well because you have experienced it many times before with your family. In fact that may have been the hurt that brought you here.
- M7: *(looking down)*
- J8: Even though it hurts a lot, this may be what our sessions are about.
- M8: What do you mean?
- J9: Rather than talking about the hurt that you have experienced at home and with your family, we address the hurt that happens right here in this office. That's a more direct and courageous approach and you started that today.

APPENDIX II

An Exercise: Having an Externalizing Conversation with Yourself

Pick a character trait, quality, or emotion that you feel you have too much of or that other people sometimes complain about in you. Make sure it is in adjective form, as a description of you, for instance, “angry,” “competitive,” “guilty,” “shy,” or “nitpicky.” In the following set of questions, fill in the trait or emotion where we have “X.” As you read these questions, substituting the trait or emotion for X, answer them to yourself:

- 1) How did you become X?
- 2) What are you most X about?
- 3) What kind of things happen that typically lead to your being X?
- 4) When you are X, what do you do that you wouldn't do if you weren't X?
- 5) What are the consequences for your life and relationships of being X?
- 6) Which of your current difficulties come from being X?
- 7) How is your self-image different when you are X?
- 8) If by some miracle you woke up some morning and you were not X anymore, how, specifically, would your life be different?

Note the overall effect of answering these questions. How do you feel? How does the future look in regard to this?

Now, take the same quality or trait you worked with above and make it into a noun (e.g. angry becomes anger). In the following questions, where we've written a “Y,” fill in your noun. Answer each of these questions to yourself:

- 1) What made you vulnerable to the Y so that it was able to dominate your life?
- 2) In what contexts is the Y most likely to take over?
- 3) What kind of things happen that typically lead to the Y taking over?
- 4) What has the Y gotten you to do that is against your better judgment?
- 5) What effect does the Y have on your life and relationships?
- 6) How has the Y led you into the difficulties you are now experiencing?
- 7) Does the Y blind you noticing your resources or can you see them through it?
- 8) Have there been times when you have been able to get the best of the Y? Times when the Y could have taken over but you kept it out of the picture?

Now note the overall effect of these questions. Think back to your experiences with X. How is your experience with Y different from X? By turning the quality or emotion into a noun, did you begin to treat it as an *object*, and in answering the questions did you *externalize* that object?

Taken from Jill Freedman & Gene Combs in *Narrative Therapy – The Social Construction of Preferred Realities*. 1996. New York: Norton

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Footnotes

¹ Adapted from E. Mansell Pattison. 1977, pp.76-77.

² See the *Self-Differentiated Caring* module.

³ Nouwen, H. 1972. *The wounded healer – ministry in contemporary society*. Image. Augsburger, D. 1986. *Pastoral Counseling Across Cultures*. Westminster.

⁴ See the *Person-Centered Caring* module.