The Psychotherapeutic Alliance and Change: A discussion on the healing aspects in a psychotherapeutic relationship

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Abstract

This thesis addresses the complicated nature of the psychotherapeutic alliance, by attempting to deconstruct what is already in practice. In piecing out the different aspects of the relationship between psychotherapist and client, and referring back to relevant literature, one can understand better the dynamics that exist within the therapeutic encounter. In the process, one can also see how the different principles of different psychotherapy schools fit into what we understand today as the profession of psychotherapy. Considered a profession, psychotherapy is bound to ethics, within which is the question of competence and accountability. The importance of understanding what really happens in a client-therapist meeting that is unique to psychotherapy, and that which leads to therapeutic change, is emphasized in this paper, with case studies from classical texts and referred back to modern day change-process research.

Keywords: *psychotherapeutic alliance, psychotherapeutic relationship, psychotherapeutic change, psychotherapeutic process, psychotherapeutic dialogue, I-Thou.*

Introduction

What really is a psychotherapeutic alliance? How different is this alliance from any other kind of healing profession? These are questions essential to the profession of psychotherapy, if this profession were to exist in its own right, clearly defined in its role and function. The working alliance in any psychotherapeutic modality is an important factor in psychotherapeutic work, without which there can be "no genuine assumption of responsibility for the client, nor any genuine long-term engagement on the part of the clinician" (Clarkson, 2003, p. 36). The therapeutic alliance is the powerful collaboration which energizes and supports process of psychotherapy. The therapist's work is not merely technical; it requires the therapist to be present as a fully alive and human contact to the client. The therapist is a skilled and objective director of the therapeutic process (Bugenthal, 1987, p. 49). It is not enough that the therapist learns to be technically knowledgeable in his/her therapeutic modality, but the therapist must also be available and present to the client during the therapy session. For this to be possible, the therapist needs to be fully aware of the client's being. Who is the client? Who is this other person sitting in the therapy room? What curiosity does this client inspire? In this paper, I shall discuss the importance of these questions to the therapist, how such questions lead to healing, and why these have ethical implications in the profession.

The therapeutic relationship is a kind of paradox. On the one hand it is an artificial relationship due to its purposefully set professional arrangement, on the other hand, it is an authentic contact (which is possibly closer than day-to-day relationships). This contact is fostered within the therapeutic meeting.

The many levels in a psychotherapeutic relationship

Interesting in Clarkson's writings on the therapeutic relationship is what she defines as *the five-relational Clarkson framework* (Clarkson, 2003). Using Clarkson's work as example, I am also aware of the somewhat polemic writing attitude of the author, which is not unlike many authors of her time and earlier, like e.g. Fritz Perls and Wilhelm Reich. That which seems to be consistent in all approaches in psychotherapy, Clarkson

teased out into what seems like five overlapping layers of the psychotherapeutic contact. In the following pages of this paper I shall refer to these levels of interaction as well:

1. The working alliance: This is the aspect of the client-psychotherapist relationship that enables the client and therapist to work together. It is not dependent on the desire of either party to be in this relationship (ibid. p. 35-66).

2. The transferential/countertransferential relationship: This describes the facet of the relationship that is the experience of wishes and fears transferred onto the relationship which works to distort the alliance (ibid. p. 67-112).

3. The reparative/developmentally needed relationship: This is the facet of relationship whereby the therapist has the role to provide corrective reparative or replenishing relationship or action, where previous relationships were deficient, abusive or overprotective (ibid. p. 113-151).

4. The person-to-person relationship: This aspect of the relationship is the dialogic *here-and-now*, subject-to-subject relationship, as opposed to object-subject relationship (ibid. p. 152-186).

5. The transpersonal relationship: Clarkson describes this aspect of the relationship as the timeless facet of the psychotherapeutic relationship, "though difficult to describe, refers to the spiritual dimension or post-positivist scientific aspects of the healing relationship" (ibid. p. 187-233).

This presentation of the psychotherapeutic relationship into these five layers actually provides an insight into the complexity of the psychotherapeutic alliance. Each of the five aspects is crucial to the relationship and these together bring about the change- process in therapy. Through the working alliance, the therapy gets initiated, while the codes and contracts act as foundation from which the therapy is supported.

Therapist-client power differences in the therapeutic alliance

Clarkson's representation of the therapeutic alliance can possibly resolve the argument between psychotherapeutic schools regarding the creation of power-dynamics between therapists and clients. This is a matter-of-fact, and also vital to the profession: The Austrian Health Ministry's professional codex, the Bundesministerium für Gesundheit

(BMfG) (2013) states explicitly that the unique aspect of the *relationship* between psychotherapist and client makes it contingent that the psychotherapist observes the extraordinary obligations and the rights given to the profession. The Psychotherapists duties are, moreover, the rights of the client (Bundesministerium für Gesundheit, 2013) (PthG, 1991).

Although there are different nuances within different psychotherapeutic approaches, the difference in attitude towards the client-therapist power difference can be divided in two very broad groups— I use the words symmetric and asymmetric following terminology used in Altemeyer (2013):

- The *symmetric* aspects of the relationship: In what is considered the humanistic approaches to psychotherapy, the therapist's work is to be there as a companion to the client, to work with the client in partnership sans analyzing, judgment and oftentimes "helping", but instead providing for *unconditional positive regard* towards the client. For this to be achieved, there must exist a coming together of two authentic individuals as in Carl Roger's person-centered psychotherapy approach that is "contact-building and acknowledging quality and empathy— without any techniques, means, aims or intentions" (Schmid, 2001, p. 1).

- The *asymmetric* aspects of the relationship: Within the psychoanalytic/psychodynamic schools, the therapist is often expected to be the one more empowered to help the client, as with a medical doctor would with his/her patient, providing analysis and nurturance, working on the interpretation of transference or dreams and the therapist's countertransference reactions, and being a guiding figure to the client (Scharf, 2016, p. 50-55). Similarly, in behavioral & cognitive therapies, the client relies on the therapist for instructions, to set agendas, to give structure to the therapy and provide assistance for forming new experiences (ibid. p.400).

Both standpoints, on closer look, are necessary for therapy to work. The therapist is a trained professional and has the theory behind him/her as tools to help the client through difficulties. Hence the therapist is the doctor and authority – and hence professional authority— with regards to psychotherapy. Concurrently, the healing process brought

about by psychotherapy comes from the empathic alliance that the therapist builds into the relationship.

How then, if all approaches are viable, do we resolve these seemingly conflictual ideas of the nature of the psychotherapeutic alliance?

We can get an answer by referring back to *the five-relational Clarkson framework*, we may see that the asymmetric aspect or the relationship actually belongs to the first three parts of the therapeutic relationship: the working alliance (point 1), the transferential/countertransferential relationship (point 2), and the reparative/developmentally needed relationship (point 3). See table 1. The therapist's role in these aspects of the relationship is clearly defined, and the switching of roles between therapist and client in this regard, is inconceivable. The psychotherapeutic relationship must remain, on this level, an asymmetric one since the therapist has the defined role of the one who nurtures, helps the client with analysis and is the one being paid to do the job. The therapist takes on an egalitarian stance when he/she gives attention to the mutual relationship and helps the client to experience his therapeutic observations.

In the relational approaches of psychotherapy, however, the therapist helps the client to focus on the *here-and-now* and actively reduces the power inclination within the relationship; this with the intent to engage with the client on a more emotional and experiential level (Altemeyer, 2013). From this vantage point, we can see that the fourth and fifth aspect of the alliance— the person-to-person relationship (point 4) and the transpersonal relationship (point 5)— comes into play. See table 1. With this understanding, we may be able to appreciate how and why all modality of psychotherapy schools work: because each of the 5 levels of the alliance is (albeit in different measures and emphases) present in the relationships. We may be able to also understand why psychotherapeutic approaches over time evolve from the analytical to relational and vice versa. Approaches evolve because therapists, through their experience working with their clients, have realized the need to modify their attitudes dynamically towards the therapeutic alliance in order be effective in helping their clients.

Psychotherapeutic Relationship	
Symmetrical	Asymmetrical
• the person-to-person relationship (point 4) • the transpersonal relationship (point 5)	• the working alliance (point 1), • the transferential/countertransferential relationship (point 2), • the reparative/developmentally needed relationship (point 3).

Table 1. Symmetric and Asymmetric Aspects of the Psychotherapeutic Alliance

It will become apparent that the goal of this paper is to bring to attention to the importance of this symmetric aspect of the relationship – i.e. the person-to-person aspect (point no.4) and the transpersonal relationship (point no.5)— and to show that this symmetric therapist-client relationship is unique to psychotherapy and different from other healing or counselling professions. In most schools of psychotherapy, we are expected to reach into the intersubjective aspect of the relationship, which will be explained in this paper as the *implicit* material (i.e. what is between the lines and not necessarily said), whereas in counselling the focus is on the *explicit* material (i.e. what is being openly discussed). The symmetric aspect of the relationship is the part of the alliance that brings about enduring change in psychotherapy.

In the following parts of the paper, I shall also point to the fact that it is this part of alliance that is actually the foundation of Freud's work— that which Freud, through Breuer, discovered and proved to be the way to actually cure what is actually a psychosomatic condition known as Hysteria. Further discussions will move deeper into the why's and how's on what this unique aspect of the relationship actually does to alleviate the patient's symptoms.

Breuer & Freud's pioneering of the concept of the psychotherapeutic alliance

Psychotherapy in practice differs from many other areas of medicine particularly with regards to the patient-therapist relationship. It has been observed that Breuer's work

documented by Freud paved the way for the less authoritarian attitude of the doctor who knows everything and opened the door to a different kind of therapeutic relationship (Bocian & Staemmler, 2013; Grubrich-Simitis, 1997). Freud wrote in the early days of psychoanalysis of his revered mentor, Jean-Martin Charcot, whose research on Hysteria and its treatment method of hypnosis greatly influenced Freud as a young practitioner, "Charcot, however, did not follow this path towards an explanation of hysteria […]." (Freud & Breuer, 1893). The work of Charcot, notwithstanding, greatly influenced Freud's transition from neurology to psychopathology (Grubrich-Simitis, 1997, p. 12-13). Freud acknowledges the contribution of Charcot's work towards bringing to scientific importance the study of Hysteria, that in having successfully inducing hysterical paralyses in hypnotized patients, Charcot proved that the hysterical paralyses were "the result of ideas which had dominated the patient's brain at moments of a special disposition" (ibid. p. 13). Freud's own studies on Hysteria with Breuer, however, demonstrated the importance of a change in the approach towards the therapeutic relationship in the development of the understanding and healing of a psychological condition. When Freud met Breuer, who became his friend and mentor, Breuer was already in his fifties and was a reputed medical practitioner and experimental physiologist. Breuer had already worked with Bertha Pappenheim, better known as Anna O., in 1880 to 1882, some 3 years before Freud went to study with Charcot. *Studies of Hysteria* (Breuer & Freud, 1955) were written in 1895, 15 years after the said therapy, and the client by then was known to have been cured of her symptoms. Breuer had, together with his patient— who suffered severe hysterical symptoms and who is often regarded as "highly gifted, and the true discoverer of therapeutic reconstruction"— uncovered the dynamics of mental pathology. Unlike the Charcot school, Breuer used hypnosis "not for the purposes of crude behavioral suggestion but as a route to the memories of pathogenic traumatic experiences that were not accessible to the patient in the waking state" (ibid. p. 21).

Relying on the doctor to carry out treatment while the client remains the passive recipient with the goal of attaining catharsis through hypnotic suggestions, Freud exerts, may not amount to a cure, but a *suggestion* of a cure. In the case of Breuer's work with Ms. Pappenheim – in listening with interest her narratives—the therapist and client were able to investigate the actual events in the client's life that precipitated the neurotic outcome; this is more than just the knowing of the existence of *psychic disturbance*, as

Charcot describes it, that are behind the symptoms and desensitizing through hypnotic suggestion. This step of gaining clear understanding required much more effort, attention and empathy on the part of the practitioner (Freud & Breuer, 1893). Early expert critiques of the Studies of Hysteria reflected Freud's sentiment of his own work, "[…] it still strikes me myself as strange that the case histories I write should read like short stories and that, as one might say, they lack the serious stamp of science. I must console myself with the reflection that the nature of the subject is evidently responsible for this, rather than any preference of my own (Freud & Breuer, 1895)" (Grubrich-Simitis, 1997, p. 19). With this admittance, we are lead to the understanding that procuring a cure requires the abandonment of the impersonal scientific learning, but an engagement with the client on a personal level that is different from the conventional attitude of that time, whereby treatment is based on empirical proofs (i.e. what is considered "stamp of science"). Here we get a glimpse of Freud's dilemma. He had found a good healing technique, but alas, it did not seem to conform to certain scientific procedures. It is also added that he who "wishes to plumb and describe the mental cannot completely escape the creative writer's methods of conceiving and describing, however rigorous the will to cool, sober objectivity" (Grubrich-Simitis, 1997, p. 19-20). In many ways we still find ourselves in similar situation today, in our discourse on Psychotherapy Science.

That which is more worthwhile to learn from the case of Anna O. is, however, not found in Breuer's account alone, but that the "psychodrama that took place in Breuer's treatment, (...), gave Freud raw material for his theories of the Oedipus complex, identification, transference and countertransference, repetition compulsion and acting-out" (Britton, 2003, p. 8). As if to prove the significance of this first case, Freud (1914) himself reviewed this case 20 years later, pointing out to us to this unique— and often ethically treacherous— aspect of the psychotherapeutic alliance. The word "treachery" is carefully used to emphasize the fact that the danger is insidious and that special attention is necessary to notice and avoid its consequences. In order to investigate a treacherous situation in a relationship, however, we need to understand what lies in it.

What lies within the therapist-client alliance?

Who and what is contained in the psychotherapeutic alliance? The "self" is not a singular, isolated entity, but a function of the person's life history and experience from living with others through social interactions from which the individual derives his/her identity (Altemeyer, 2013, loc. 250). The patient brings into the therapy room not only his/her psycho and soma, but rather, his/her entire intra-psychic relationships integrated. This concept famously relates to Kurt Kofta's Gestalt Psychology defining dictum, "the whole is more than the sum of its parts"; which Arnheim (1961) elaborates "we do not say: the whole is 'more' than the sum of the parts; we prefer to assert that the whole is 'something else' than the sum of its parts" (p. 91). Kurt Goldstein postulates this holistic concept to a person. He describes an individual as an "organism" that is not an isolated body, but as an indivisible whole which dynamically interacts with the physical-psycho-social environment (Votsmeier, 1995, p. 5). In context of an individual's sense of being and identity, we gain a sense of who we are largely through our social interactions, which is relational. When the relationships in this social environment is damaged, the individual experiences symptoms, which can be interpreted in today's world as psychopathology; which manifests in varying degrees, and described in the DSM. Conflicts in social relations in turn lead to further social conflicts, social dysfunction and sometimes somatic symptoms. Hence the psychotherapy patient comes into therapy essentially with the purpose of finding resolution of relational conflicts. This relational conflicts are inter-personal and intra-psychical. In the therapist's room, these conflicts play out in the *relationship between the patient and therapist* in which the problematic relationship between the patient and his/her world unfolds. Transference and countertransference enactments during therapy reveal the relationship patterns of the client. The therapist, however, does not merely talk about these conflicts. He/She gets involved in this relationship in order to help the client gain the necessary insight from the experience (Altemeyer, 2013).

Relationship between making analysis and contacting

This is the point whereby the differentiation –though not separation— between Clarkson's transferential / countertransferential relationship (point no. 2) and reparative / developmentally relationship (point no. 3) delineates from the person-to-person aspect (point no.4) and the transpersonal relationship (point no. 5)—i.e. the asymmetric relationship versus the "contact" in the relationship. The former is required of the therapist to take notice of the developing transference, like a *figure emerging from the background* as described by Polster & Polster (1978, p. 28-69). Bringing the focus of the transference "figure" *beyond* the reconstruction of life narratives leads the relationship towards the latter levels. Where the transference that occurs within the therapeutic relationship was once considered—in traditional psychoanalysis— a resistance phenomenon against unbearable memories, now memories come under suspicion in the service of the resistance against the transference relationship (Altemeyer, 2013, loc. 260).

Analysis-making is subject to the therapist's own experience

Wilfred Bion (1984; Bocian & Staemmler, 2013) provides another way of understanding the stratified nature of the therapeutic relationship using the metaphor of a painter painting a landscape. The experience by the painter of the landscape is captured by the painter as a subject onto canvas. While the landscape and canvas are very different things, what is being communicated from the painter to the viewer of the painting is what Bion calls the *invariant*. "The original experience, the realization, in the instance of the painter the subject that he paints, and in the instance of the psychoanalyst the experience of analyzing his patient, are transformed by painting in the one and analysis in the other into a painting and a psycho-analytic description respectively. The psychoanalytic interpretation given in the course of an analysis can be seen to belong to this same group of transformations. An interpretation is a transformation; to display the invariants, an experience, felt and described in one way, is described in another (ibid. p.4)." Interpretation, in other words, is the therapist's act of capturing the experience of his/her interaction with the client, transforming it into analysis, so as to communicate back to the client what the therapist understands of this experience. The nature of the

invariant that is transformed, Bion adds, depends on what the therapist understands from the experience. How the invariant is transformed depends also on the theory in which the therapist uses in order to understand his/her experience. Therapists from different psycho-analytic schools would thus use different invariants— which is not unlike a realist painter and an impressionist painter painting a similar landscape, both presenting different ideas and meaning of the invariants onto canvas. "As the painter's transformations vary according to the understanding his painting is to convey, so the analyst's transformation will vary according to the understanding he wishes to convey (ibid. p.5)."

What we can infer from Bion's analogy is that there are 2 main steps in a psychotherapist's work:

1. "creation of the invariant": like the therapist's sensing of the client,
2. "transformation of the invariant": like the therapist's understanding of the client's words and communication in analysis.

The above also illustrates different steps that happen in the process of the therapist's work: the first step requires the therapist to sense, and the second requires the therapist to understand and analyze. This, in relation to Clarkson's relational framework, we may be able to see the correlation between the first part with the person-to-person aspect (point no.4) and the transpersonal relationship (point no.5), and the second part with the transferential / countertransferential relationship (point no. 2) and reparative / developmentally relationship (point no. 3). On closer look, we may even be able to infer that analysis itself is dependent on the transpersonal. In other words, it is the person-to-person and transpersonal— symmetric aspect of the therapeutic alliance— that precedes and determines the quality of the therapeutic analysis.

Bion allows us to accept different methods of analysis like a unique style of the therapist in interpretation and communication of the analytical work. When the different analytic styles and theories used in therapy are seen in the same light as the use of different genres of painting, we may be able to accept the idea that eventually what matters is the *quality* of the painting, and the emotional engagement of the artist to the subject, and not only the style used.

If this were so, what, in psychotherapy, are the elements that determine this quality? It is fathomable that the quality of the analysis (and the eventual psychotherapeutic intervention) hangs upon the steps that come *before* the analysis itself. Bion describes the phenomenon that happens before the "creation of the invariant" as the "intuit". We can perhaps compare this with what we understand as "intuition". This sensibility comes from meeting with the client's being and his/her verbal and non-verbal (i.e. the implicit) communication together with the being of the therapist. When we follow Bion's track, we'll be able to understand the relevance of this initial intuition and sensibility to the quality of the alliance. The togetherness of the contact is here articulated to be more essential to the psychotherapeutic work, and affects the potential for psychotherapeutic change.

Contact & inter-subjectivity & the definition of the self through relationships

> *"The patient's unconscious and repressed desires and fears are constantly seeking release or, more precisely, contact with real persons and situations." (Reich, 1945/1984, p. 5)*

This relational contact between individuals, as well as the therapist and client, is a common reciprocating mutual co-influence on each other. Whereby one person's existence is realized only in the presence and perception of each other and the self in the interaction. This togetherness contributes to a co-creation of common meaning-making; a product which is more than the sum of two individuals put together. This personal contact between persons is an inter-subjective event. To further displace Descartes' dictum, "cogito ergo sum," the concept of inter-subjectivity maintains instead the notion of "I am seen, therefore I am". Buber (1936, p. 261) puts it shortly in quote, "Der Mensch wird am Du zum Ich", which implies the other is a part of the self. Self-identity is also determined by the internalized relationship of the self with the others, which in turn is a relationship between different (sometimes split) aspects of the self. As Kierkegaard (1941/1849) explains, "The self is a relation which relates itself to its own self, or it is that in the relation [which accounts for it] that the relation relates itself to its own self; the self is not the relation but [consists in the fact] that the relation relates itself to its own self." To further reiterate that this process of self-relating is a continuous dynamic

process and not a static one, "Man is a synthesis of the infinite and the finite, of the temporal and the eternal, of freedom and necessity, in short it is a synthesis. A synthesis is a relation between two factors. So regarded, man is not yet a self" (p. 9). Self identity is thus a continual self relation in relation to others. This process, however, involves a mutual recognition of the other, distinguishing oneself from the other, to acknowledge the other as an other self. Self identity, in other words, is implicit in relating of the self to the socio-cultural environment. This dimension of inter-subjectivity in contact is experiential, and considered in psychotherapeutic schools an essential part of the therapeutic hour (Staemmler, 2013).

The origins of an individual's self-concept and its relation to Inter-subjectivity is elaborated by development psychologists. Trevarthen (1993) writes, "The core of every human consciousness appears to be an immediate, unrational, unverbalized, conceptless, totally atheoretical potential for rapport of the self with another's mind (p. 121)." The infant's "primitive state of mind" is inherently aware of human presence and ready to follow and communicate with human mental states. This pre-learning stage is pre-linguistic— non-intellectual and primarily emotional— and is a "delicate and immediate with-the-other awareness." From birth there exists this human self-awareness which is a "manifestation of mind in a person who is capable of being a companion and confidant to the responses of the other, at an emotional level." This sets the stage for—and precedes— an eagerness and motivation for learning shared meanings with the community in his/her cultural setting (p. 122). Cultural learning (at about 9 months of age) involves the development of *self-perception*: the child learns to make meaning out of objects, and see him/herself in the eyes of another person – usually the adult (Tomasello, 1993). Through the child's interaction with his/her care-givers, he/she develops a sense of self-identity which is dependent on how the other perceives him/her, and relates to the meaning of worldly objects according to the other's perception of these objects. Kernberg (1976) and Kohut (1984) have hypothesized the development of infants' sense of self to be important clinically because it determines certain forms of adult psychopathology (Pipp, 1993).

In adults, the preverbal self is independent of cultural influences, and hence symbolic mediation. It is this aspect of the self that when reached for in the psychotherapeutic alliance, gets through to the transpersonal relationship. This dyadic system within the

alliance holds more information and is far more complex than what exists in the consciousness of each individual (i.e. therapist and client) in the alliance (Tronick, 1998). Vygotsky is noted by Staemmler (2013) to have been one of the first psychologists to develop the idea of the intersubjective relationship as a groundwork for the development and change process, as opposed to the assumption of change as an individual process alone. The intersubjective relationship, that which exists "in-between" during the meeting of persons, is the process to the change. The client benefits from the essence of the contact in the relationship; even more so than the content of the narratives during therapy itself.

Watzlawick et al. (2011) points out the impossibility of not communicating. As human beings, we cannot *not* communicate; even when we try to defer speaking or reacting to another person. It is also hypothesized that, in the case of psychopathological conditions like schizophrenia, where the client's strategy is not to say anything, perhaps to avoid communication, in doing so, however, he/she unwittingly communicates. Interaction between individuals ultimately exists communication. "Communication implies a commitment and thereby defines a relationship(...) Communication not only conveys information but at the same time it imposes behavior" (p. 51).

Bearing this connection between relationships and behavior, we can fathom how an alliance, like a psychotherapeutic alliance can support change in behavior in an individual. According to Vygotsky, the individual carries around with him/her his sociocultural interactions regardless of whether he/she is with others or alone. "It is necessary that everything internal in higher forms was external, (…). Any higher mental function necessarily goes through an external stage in its development because it is initially a social function. (…) Any higher mental function was external because it was social at some point before becoming an internal, truly mental function … the composition, genetic structure, and means of action [of higher mental functions]—in a word, their whole nature—is social. Even when we turn to mental processes, their nature remains quasi-social. In their own private sphere, human beings retain the functions of social interaction" (Vygotsky, 1981, p. 162-164). In other words, our social interactions, which are linked to our self-perception, are internalized.

Family therapy in many ways, can be seen as bringing to the external what is already internalized. The focus is on generating dialogues in the social system and also internalized voices. These voices are also known as Bakhtin's (1984) polyphonic voices. Virginia Satir calls dialogue of these internalized voices, "the theatre of the inside", which is unconscious until we realize and accept their existence, and become aware of the conflict that exist between these voices (Satir, 1978/2009). Generating dialogues in therapy means shifting the focus from the *content* of what is being said in the client's narrative to the unfolding of emotions that arises as the narratives are told. In therapy, the therapist gets to be witness to the client's unfolding and an intersubjective consciousness emerges (Seikkula, 2011). What therefore is mostly needed in the realm of psychological help is not the change of an individual as a person in isolation, but the change in the individual within his/her internalized societal interactions. In a therapeutic setting, change process occurs in the person-person contact between the client and therapist, in which both parties contribute to. The quality of the contact provides the client with new internalized experiences with another human being, eliciting a shift in prior internalized mental states. The newly internalized experienced gained during the therapy hour through transpersonal contact lays the ground for growth and healing long after therapy ends (Staemmler, 2013).

Internalization of the social environment and defence

The consequence of internalizing the outside world is the formation of defence mechanisms, described in the articles, *The Neuro-Psychoses of Defence* (1894) and *Further Remarks on the Neuro-Psychoses of Defence,* in which Freud describes to some detail the mechanism that lay behind hysterical symptoms, phobias and obsessions. As evidence for having observed the internalizing of an external event, Freud states, " For these patients whom I analyzed had enjoyed good mental health up to the moment at which an occurrence of incompatibility took place in their ideational life - that is to say, until their ego was faced with an experience, an idea or a feeling which aroused such a distressing affect that the subject decided to forget about it because he had no confidence in his power to resolve the contradiction between that incompatible idea and his

ego by means of thought-activity" (Freud, 1894, p. 47). The *act of defence* in this analogy is the *forgetting* of the distressing experience. Forgetting, while means of defence, is not a cure. It is an effort to disempower what is intolerable that cannot be eradicated (since it is internalized), turning it into something else; "but the sum of excitation which has been detached from it must be put to another use." In the case of hysteria, "the sum of excitation (is) transformed into something somatic. For this I should like to propose the name conversion (ibid. p.49)." Turning to other pathologic symptoms, Freud mentions that when the conversions is not somatic, "The idea, now weakened is still left in consciousness, separated from all association. But it's affect, which has become free, attaches itself to other ideas which are not in themselves incompatible, and thanks to this 'false connection', those ideas turn into obsessional ideas" (ibid. p.52).

Working through client's defense mechanisms

A development from Freud's idea, gestalt therapy writers like Polster & Polster (1978) describe the different uses of defense mechanisms as "the Commerce of Resistance". These resistances are the individual's way of dealing with the *present* environment. The strategies used, however, are anchored to internalized past experiences. These strategies of defense are needed in order to gain what is needed and avoid "troublesome feelings" which are emotionally painful, and situations that are deed too risky. In so doing, the individual must "divert energy in a number of ways" to avoid contact with the environment in an authentic manner.

To decide whether or not the use of these mechanisms are considered healthy, one must take into account context in which the individual exists at particular situations (Wheeler, 1991). To many gestalt therapists, for example, being "resistance-free" is not a considered a goal towards a healthy state. The individual has infinite ways of organizing the self in the environment, and there are various degrees of styles and outcomes that arises therefrom. These defense strategies that the individual adopts in response to his/her world is considered "creative". In a healthy state, the individual is able to tap into a repertoire of strategies. Where individuals show a narrowed range in this repertoire or limited choice of responses to his/her environment, this creativity is limited

(Clarkson, 2014, p. 58). The consequence of this limitation is the repeating patterns. These patterns show up in behavior and way of thinking that makes up the personality. In often traumatic situations, these patterns cause dysfunction and suffering. These defence strategies, learned during infant development, are adaptation to being in the (physical and social) environment through the process contacting with it (Burley & Freier, 2004). The result of internalizing fixed patterns of dealing with the environment, is the experiencing of levels of difficulty faced by the individual in his/her ability to function within the *present* environment.

In line with the idea that the individual's defense strategies are not in themselves seen as something to be eliminated but accepted as part of the individual's process of dealing with the social environment. Clarkson (2014) adds that therapy helps the client in "raising awareness of these preferences in order that they can be evaluated and more range might be discovered where appropriate" (p. 59). Since we know that the individual is not isolated, but also an embodiment of his/her social interactions, we can see that when a client enters the therapy hour, he/she brings his/her strategies of contacting with the environment into the therapeutic alliance. It is no wonder that the psychotherapy room and the alliance is considered a *crucible* (Hycner, 2009)— a space where the therapist and client work together in the spirit of exploration and experimentation. In the process of working within this "crucible" the client gains understanding of his/her patterns, and experiments with new ways of making contact with his/her world. For reasons discussed in the following paragraphs, this is a challenging process for both client and therapist.

Freud's theory of repression

The challenge in working with defence strategies in individuals is that these processes lie in the unconscious. The fact that these are considered *defenses* indicate that these patterns of being are not easy— almost threatening even— for the individual to let go of. A lot of energy is put into keeping the discovery of its source repressed. Freud (1915)*,* in his paper, *Repression*, explains how pleasurable experiences are blocked by the defence mechanism of the ego, reiterating how the internalized version of events get

locked in with the individual, and how these become converted into other forms of somatic and psychological symptoms. The theory of repression, Freud maintains, "is the corner-stone on which the whole structure of psychoanalysis rests. It is the most essential part of it." The reason is that, as Freud elaborates, "psycho-analysis could explain nothing belonging to the present without referring back to something past; indeed, that every pathogenic experience implied a previous experience which, though not in itself pathogenic, had yet endowed the later one with its pathogenic quality" (Freud, 1914, p. 2886). On closer look at this statement of Freud's: what needs to be done first and foremost, is to *observe what is going on in the present*. The process of psychoanalysis (and psychotherapy in general) is to observe what is going on with the client *at the present moment*, and then using past experiences to understand the *present* phenomena.

The present moment in the therapeutic alliance

The phenomenon of the present moment, often termed the *here-and-now* is the center of focus in the practice of other psychotherapeutic schools, and in particular gestalt therapy. This means that the said psychotherapeutic schools do have a common agency— to observe what happens in the *here-and-now* within the therapeutic alliance. Referencing back to Freud, we can see that he makes the distinction between doing analysis and working on the resistance of the client in getting the analysis done. Doing analysis alone deals with past material, while working on the resistance deals actually with the *here-and-now* which is the *attempt* at tracing the symptom back to the past, rather than the past per se. It is the process of the *attempt* that Freud explains is the key to the work: "It may thus be said that the theory of psycho-analysis is an attempt to account for two striking and unexpected facts of observation which emerge whenever an attempt is made to trace the symptoms of a neurotic back to their sources in his past life: the facts of transference and of resistance" (Freud, 1914).

Psychotherapeutic work, at its commencement, is an act of *attempt*— a process— to investigate. What emerges in during therapy sessions that works against and interferes with this *attempt* is what we learn to be *resistance* and *transferences*. The patient's unconscious resists analysis. The "resistance" that the therapist encounters during the

therapy session, and it is considered the point-of-focus at which to work through the client's neurotic symptoms. This resistance is an interference within the client to realize an emerging need. Simkin (1973/1990) explains metaphorically that this emerging need is the "figure" that emerges from a "ground", that, if not realized and met, cannot achieve completion. Unrealized/un-met needs (unclear figures) leaves the person with off-centeredness (*mangelhafte Zentrierung*) and their needs de-differentiated (*Entdifferentierung*) which become manifest as heightened arousal (*Erregungsschwelle*), which is lived as the neurotic symptoms (Votsmeier, 1995). The clearer a need is to the client, the more possibility for this need to be met. In therapy, the therapist leads the client towards sharpening this figure, and realizing the need. Needs that aren't met are also known as *unfinished businesses*.

The goal of almost all psychotherapy approaches, is to work through *unfinished businesses*, which are situations whereby completion is not achieved resulting in repetitive patterns in behavior that do not serve the client. Work is done by either bringing awareness to the unfinished situation, and/or through saturation/exaggeration by "continuing until you feel fed-up" (Simkin, 1973/1990, p. 87). Resolution comes when completion is achieved, and the figure goes back to the background, allowing other figures to emerge. So that the organism can make contact with the environment.

The *process* of psychotherapeutic work is initiated by, and consists of, the observation of the interruptions to the work, and not the *content* of the analysis per se. The resistance to the attempts, when dealt with in the *here-and-now*, brings about awareness of unresolved situations. This is fodder for therapeutic work.

What, then, does this process look like within the therapeutic alliance?

Process vs. content in the psychotherapeutic dialogue

Wilhelm Reich, in *Character Analysis* (1945/1984), illustrates the importance of working on the process of the therapeutic relationship – i.e. what is going on between therapist and client— before jumping into analytical work. Reich points out that neurotic character traits— being symptoms as the result of the failure of the individual to resolve unconscious conflict between repressed instinctual demands and the ego forces that

work against these instinctual demands— need to be worked with first before the client is able to benefit from any analytical work. Reich explains that interpretation is the process of bringing that which is unconscious into consciousness. However, the problem lay in "counter-cathexes"— which can be explained as strict censor of thoughts and desires in the preconscious— that critically selects the thought process of the client, rendering it difficult for the client to freely associate. At the same time, it is the need of the patient's unconscious to find release for this conflict through contact with the analyst (as it is a need for an individual to contact with any other individual or situations). The result is an establishment of a relationship with the therapist that is prompted by love, hate or fear— what is known as *transference*. This can come in two main forms:

1. positive transference, whereby there is cooperation/compliance by the client due to positive feelings and
2. negative transference, where the treatment is impeded due to ill feelings the client has to the alliance.

Reich points out that while negative transference is easier to detect – since it works against and irritates the therapist's intentions— as something to work on, positive transference is as important – or even more important. Positive transference often gets mistaken for progress until the positive feelings ultimately transforms into disappointment. For this reason, it is observed that the tendency of therapist to begin analyzing every material that the client presents prematurely, to rely on the routine passage of therapy sessions, without considering effects of transference, is not effective in bringing about resolution to unconscious conflicts and does not make for a successful healing alliance. Reich writes, "If the analyst interprets the material in the sequence in which it appears in each case, whether or not the patient is deceiving, using the material as a camouflage, concealing an attitude of hate, laughing up his sleeve, is emotionally blocked, etc., he (the analyst) will be sure to run into hopeless situations. Proceeding in such a way, the analyst is caught in a scheme which is imposed on all cases, without regard to the individual requirements of the case, with respect to the timing and depth of the necessary interpretations" (p. 8). In other words, it is almost impossible for the therapist to distinguish authentic, useful narrated content from, perhaps, words that are used to manipulate the therapeutic situation or relationship, unless the underlying situation of the relationship itself is understood. It could be difficult to be sure of what goes on in a rela-

tionship in which one is part of. For the therapist, time, together with an attitude of patient, phenomenological observation, allows the therapist to gain experience of being with the client. Setting aside this time helps the therapist to understand what is inbetween him/herself and the patient.

<p style="text-align:center">Reich's case examples</p>

In the third chapter of *Character Analysis* entitled *On the Technique of Interpretation and of Resistance* (p. 21-38), Reich provides snippets of case studies. These examples help us to understand what Reich means by working on what Freud calls the forces of "resistance and transferences" that interfere with the *attempt* at analysis before jumping into analyzing the content of the client's narratives— and the "chaotic situation" that can happen when attention to this is not observed. The case examples cited revealed instances where therapy sessions did not help the patient because the therapist failed to notice an observe resistances due to transference— and character— but instead delved into (or attempted to delve into) interpretation right away, without preparing the client – and therapist himself— for the analytical work first. I shall discuss some of the cases, and briefly discuss what kind of questions could have been asked by the therapist in the situations.

Case 1

 "A patient who suffered from an inferiority complex and self-consciousness enacted his impotence by adopting an apathetic attitude ("What's the use?"). Instead of divining the nature of this resistance, clarifying it, and making conscious the deprecatory tendency concealed behind it, I told him again and again that he did not want to cooperate and had no desire to get well. I was not entirely unjustified in this, but the analysis was not successful because I failed to probe further into his "not wanting" because I did not make an effort to understand the reasons for his "not being able to." Instead, I allowed myself to he trapped into futile reproaches by my own inability" (ibid. p. 23).

The therapist, frustrated at the client's perceived non-cooperation failed to acknowledge the process of how the client was unconsciously avoiding the work; by resigning to the belief that there was "no use". This *resignation* in itself is the defense mechanism and the ripe material for the work. In trying to fish for cooperation from the

client, the therapist missed what was present that could be worked on, as the therapist himself points out: (see above: *to probe further into his "not wanting" because I did not make an effort to understand the* reasons for his "not being able to."). The therapist, when unaware of his own need to get cooperation,–was in danger of re-enforcing the resignation and breaking contact with the client. Working on the *here-and-now*, the therapist in such situation may ask the following questions that address the client's resignation, and perhaps his lack of will to even try. These questions may lead the therapist and client to deeper understanding of phenomena in the alliance itself: "what does it mean for you when you say 'what's the use'?", "what would you imagine could happen if you tried?", "what would it mean if you tried and failed?", "I am interested to know if would you like to try for a couple of minutes and see how?" "If not, what can I do/not do to help you work this out?".

Case 2:

"In still another case, it happened that in a dream during the second week of treatment the incest fantasy appeared quite clearly and the patient himself recognized its true meaning. For a whole year I heard nothing more about it; consequently, there was no real success. However, I had learned that at times material that is emerging too rapidly has to be suppressed until the ego is strong enough to assimilate it" (ibid. p. 24).

What appears to be material, in this case, a narration of a dream, may be a way of resistance from being seen through story-telling. It is an example of a therapist focusing on "content", which is the dream story, and not noticing the "process" which is the fact that the client is telling the story in the first place. Content is enticing. The process is invisible. Unawares, the therapist missed the resistance because it is embedded in the process of what is being said. It would be helpful to ask the client questions that bring him back to the alliance: "I'm hearing your dream and it is really interesting to me that you are so clear about it, and my instinct is to ask you more about. I'm just curious, what is it do you want me to know from this?" "What is important right now for us to work on with regard to what you just said?" or "What is it like for you to tell me this?" With these questions, the client will have a choice to either work deeper into what is really disturbing him about the dream (if at all), or, he may reveal his need to impress or

help the therapist by being unduly cooperative as in positive transference (as will be discussed later).

Case 3:

"A case of erythrophobia failed because I pursued the material which the patient offered in every direction, interpreting it indiscriminately, without first having clearly eliminated the resistances. They eventually appeared, of course, but much too strongly and chaotically; I had used up my ammunition; my explanations were without effect; it was no longer possible to restore order" (ibid. p. 24).

In this case it is an example of the therapist focusing on content, and unsystematically using this content for analysis. The therapist probably failed to notice the *process* that was going on, i.e. the fact that there is so much unsystematic work in progress within the alliance itself. Possible way to make good the "chaos" is to stop and acknowledge the chaos ensuing. "I notice that we are doing much here and it feels chaotic. I am interested to know what you are experiencing right now." It may be also useful to check out how not interpreting can help the client. In this case, where a symptom "erythrophobia" is clearly acknowledged, the alliance could be a place for experimentation in the *here-and-now*— like inviting the client to blush "for a moment", or what would the client think if he saw the therapist blush— to help the client gain confidence within the alliance.

Case 4:

"Another patient, in the course of three years of analysis, had recalled the primal scene together with all material pertaining to it, but not once had there been any loosening of his affect-paralysis, not once had he accused the analyst of those feelings which-however emotionless-he harbored toward his father. He was not cured" (ibid. p. 23).

This case is representative of situations whereby the patient seems to have full acknowledgement of the unconscious material. The therapist is satisfied, but the client is not helped even after 3 years. Reich highlights the importance of the patient embodying the experience— feeling the emotions and physical reactions as if reliving the past— rather than simply intellectualizing the recall. Intellectualizing memories, which is easily observed because there is a lot of "talking about" without affect, is really a

form of resistance; a way to satisfy the therapeutic process while escaping pain. In gestalt therapy, this defense strategy is called "egotism". Egotism is characterized by the individual stepping out of himself, acting as a spectator or commentator of himself and his relationship with the environment (Clarkson, 2014, p. 65). This is what is happening to the client is this case. This resistance often gets overlooked by therapist because they are sidetracked by "interesting" client narratives. Noticing the interruption is a way to slow down the narratives and show the client that he/she is avoiding something potentially difficult to deal with.

Case 5:

"A patient with a number of perversions had been under analysis for eight months, during which time he had rattled on incessantly and had yielded material from the deepest layers of his unconscious. This material had been continuously interpreted. The more it was interpreted, the more copiously flowed the stream of his associations. Finally, the analysis had to be broken off for external reasons, and the patient came to me… It struck me that the patient uninterruptedly produced unconscious material, that he knew, for instance, how to give an exact description of the most intricate mechanisms of the simple and double Oedipus complex. I asked the patient whether he really believed what he was saying and what he had heard. "Are you kidding!" he exclaimed. "I really have to contain myself not to burst out laughing at all this" (ibid. S.26).

Here, Reich gives another example of a "knowledgeable" and "cooperative" client whose knowledge and cooperativeness *was* the resistance itself. Reich explains this behavior to be of narcissistic defense. The therapist is unaware of what Reich describes as "latent resistance", which he explains are "attitudes on the part of the patient which are not expressed directly and immediately", but expressed indirectly. The patient's negative regard towards the therapy (i.e. feelings of doubt, apathy, distrust, etc.) is disguised under the cloak of exceptional docility, or complete cooperation. Reich says that this is "more dangerous" than passive resistance, and the way to handle such situations is to tackle it as it happens, without hesitating to interrupt the flow of communication. Our challenge as therapist is to first notice that such-like phenomena are taking place. It is from this vantage point that Reich emphasizes the topic of character.

Reich tells us that through this process, can we avoid what he terms "chaotic situations" which occurs as the result of:

- *Premature interpretation* and work on unconscious materials, and symbols. Resistance to the therapy itself, when not yet exposed, prevents the patient from assimilating the work. The client ends up "going in circles completely untouched" (p. 26): This phenomenon can be explained as *egotism* in gestalt therapy. Egotism is a defense strategy whereby the client's ego distances itself from the experience, and sees the self from a distance, as if he/she is look at another person. This situation of the client going in circles may help to explain why some clients, though compliant, do not seem to get better.

- "Interpretation of the material in the sequence in which it yields itself, without due consideration to the structure of the neurosis and the stratification of the material" (p. 27): The mistake happens in interpretation, because the material is not worked through in it's full context, but worked on in unsystematic fragments, leading to loss of meaning.

- "The analysis is embroiled not only because interpretations are pursued in every direction but also because this is done before the cardinal resistance has been worked through" (p. 27): The main problem here is due to the resistance *not* being acknowledged and worked through *before* interpretation is done. The situation becomes confused when the work is entangled with the relationship to the analyst. The unsystematic interpretation works in a vicious circle to affect the transference relationship further.

- "The interpretation of the transference resistances is not only unsystematic but also inconsistent" (p. 27): When there is a lack of acknowledgment of the power of the client's resistance (and latent transference resistances) to need to conceal resistances. These resistances are also masked behind "sterile accomplishments or acute reaction formations" i.e. the client may seem to be cooperative, show signs that there is the change in direction expected, or the client may react to analysis in a way so as to deflect from getting to the authentic unconscious material. Therapists may tend to shy away from developing and following up consistently on these resistances in whatever

form, due to own feelings of discomfort (their own resistances) in dealing with the transference resistances in a consistent manner.

It is from the understanding of the effect of transference, that we may be able to appreciate the challenge of being aware of how the interpersonal feelings in the alliance get in the way of therapeutic work.

Unconscious feelings and countertransference within the alliance

To illustrate how a therapist's emotions towards client, though brought to awareness and allowed to be revealed, can also be mistaken for authentic reaction to the client's process, Ziembinski (2016), in a private lecture on experiences of unconscious effects on a therapist in therapy sessions, narrated a rather simple story he entitled, *White Linen*: the client, a middle-aged woman had come to therapy to work on very traumatic and emotionally tragic experiences in her life. The therapist found himself deeply moved by her experiences, and would find himself in tears each time she entered his practice. He questioned his emotionality towards the client only weeks later because he, like many would have, assumed that he was naturally moved by the client's plight. He subsequently noticed the client's perfume as she entered the office and asked her what she was wearing. "White Linen", she replied, which was the same perfume his beloved mother had worn for most part of her life.

In the story, the client instilled emotions in the therapist in which the therapist was unaware of. This gets interpreted somewhat inaccurately at first until the therapist was able to come to a self-awareness. This kind of experience faced by therapists is termed by Freud in a 7 June 1909 letter to Carl Jung, as *countertransference*, to which Freud explains, "(s)uch experiences, though painful, are necessary and hard to avoid. (…) (W)e need to dominate 'countertransference', which is after all a permanent problem for us; they teach us to displace our own affects to best advantage. They are a 'blessing in disguise'" (Freud, 1909). The unconscious nature of countertransference makes it difficult for the analyst to differentiate between the analyst's own unresolved

difficulties and emotional reactions and impressions that come to the ~~the~~ therapist's consciousness that are activated by the projective identification of the client.

While unlike Freud and Klein who considered strong countertransference feelings to have negative affect on analysis and something analysts should work on by gaining more insight into themselves instead, many analysts like Bion have found usefulness in the phenomena. Therapists of the intersubjective and relational schools share counter-transference that they have (and are aware of) as a means to bring authentic contact to the alliance.

Awareness of therapist's countertransference as support to the alliance

Countertransference, with awareness, supports rather than interferes with the therapist's work. Freud's mention of the need to "dominate" countertransference, can be taken as a call to be aware of dealing with the emotions within the alliance rather than rejecting them and becoming emotionally detached. Heinmann (1950, p. 81) considers this use of countertransference as "one of the most important tools for his/her work. The analyst's counter-transference is an instrument of research into the patient's unconscious" as a means of bringing to consciousness of the client what he/she does (consciously or un-consciously) to "get under the analyst's skin". How can the awareness of countertrans-ference experienced by the therapist be an advantage to the therapeutic alliance?

> *"(T)he analysis of the transference, i.e., that part of it which deals*
> *with the breaking down of the resistances, constitutes the most im-*
> *portant piece of analytic work." (Reich, 1945/1984, p. 5)*

The answer is explained by Racker (1953) who acknowledged that the therapist may react emotionally to a patient's enactments or behavior or personality, but he/she is not prevented from "identifying him/(her)self *intellectually* with his/(her) defense mecha-nisms and object images". When the therapist is aware of his/her own emotional reac-tion, this countertransference is actually instrumental into "*bringing to his notice a psy-chological fact about the patient*" for the feelings helps the therapist to detect the pres-ence of the client's psychological games. Even though the countertransference feelings

are neurotic, the therapist who is aware of this is able to react with understanding. For this understanding to be possible, Racker adds, the therapist has to first analyze and overcome his/her own situation and be able to identify him/herself with the patient's ego. Within the therapeutic alliance and hour, the patient reenacts and recreates situations that are recurrent in his/her daily situations. These undisclosed and undetected activities, is an unconscious means of avoiding the therapeutic process, and thus "prompted by a desire to retain a defensive organization and probably to recruit the analyst into its personnel" (Britton, 2003, p. 77). In order for the impasse to be broken and the "enactments" to discontinue and therapeutic work can progress, Britton suggests that "until the enactment is recognized and described, the belief system that lies behind it cannot be disclosed, but, at the same time, until the patient's beliefs that drive it are disclosed the enactment will continue" (Mawson, 2011, p. 4-15).

Transference and countertransference is a phenomenon in the therapeutic alliance, Racker's comment— quoted also in Britton (2003, p. 55)— highlights the attitude towards acceptance of this human condition and working with it's existence in psychotherapeutic relationship: "The neurotic (obsessive) ideal of objectivity leads to repression and blocking of subjectivity and so to the myth of the … 'analyst without anxiety or anger' The other neurotic extreme is that of drowning in countertransference. True objectivity is based upon a form of internal division that enables the analyst to make himself (his own countertransference and subjectivity) the object of his continuous observation and analysis" (Racker H. , 1968, p. 132). Objectivity, in many respects, is the priced commodity in psychotherapy. If the therapist is caught up in countertransference and is unaware of the fact, his/her endeavors to work with the clients in an objective manner would be unproductive.

Objectivity as a concept itself needs some careful consideration. For this we can turn to Maturana & Varela (1980): "(O)*bjective knowledge* seems possible and through *objective knowledge* the universe appears systematic and predictable". Objective knowledge, according to the authors, *seems* possible. It is prized for the very fact that it gives the impression of predictability. When things are systematic and predictable, we feel safe. The authors go on to explain: "Yet *knowledge* as an experience is something personal and private that cannot be transferred." The explanation for this is that objective knowledge must be *created by the listener*. The listener understands and the objec-

tive knowledge *appears* to be transferred (p. 5). The therapist therefore needs to be aware of this phenomenon: that the information being shared between him/herself and the client is experienced and mentally processed by both parties. The reality is, however, that the assumption that common understanding is achieved is only apparent.

The benefit of keeping this in mind to the therapist is that he/she will be constantly on guard and self reflective of his role as observer. The therapist as an observer is part of the system (in this case the client) in which he/she is observing. Since he/she communicates with the client and the client communicates back, and the client is also the observer in return. "Anything said is said by an observer" (p. 8). The observer cannot but interact with the system; the observer is also observed.

The observer, if self-reflective, is also able to observe him/herself. So in the therapeutic setting, the therapist has the work of observing two individuals: the client and himself. What is achieved is a hermeneutic and cyclical process of understanding. This is discussed later in the paper. Maturana & Varela explains this as such: "If an organism can generate a communicative *description* and then interact with its own state of activity that represents this *description*, generating another such description that orients towards this representation…, the process can in principle be carried on in a potentially infinite recursive manner" (p. 29).

This back-forth movement of allowing experiences (via emotions) to occur and then stepping away from the self in acknowledgment and understanding of what has arisen. This acknowledgment of "what-is" happening at the moment describes what Gestalt therapy literature describes as the *paradoxical theory of change* (Beisser, 1970), whereby healing change happens not by forcefully eliciting change itself (in this case, by repression or ignorance), but by understanding and acknowledging what is happening to the self at the moment. Through assimilation of the situation, in the case of a countertransference effect encountered by the therapist, the therapist is able to understand what is going on in him/her. The clarity of this self awareness and acceptance empowers the therapist to overcome and make informed choices. Self-awareness has much to do with being in contact with the self, existentially, in the *here-and-now*. This is a phenomenological attitude in observing what-is in the present in contact with the client, while being conscious of one's own biases.

With the awareness of the self as observer, there will also be an awareness that the other person is *different*; the other person actually processes his/her own objective knowledge. We will be able to appreciate that there is room for questioning and discussing the 'facts' and 'truisms', and to investigate the *differences* between the self and the other. Resnick (2016) tells us that it is the differences between two individuals that initiate the contact. Without awareness and acceptance of these differences—as often happens when people operate in confluent relationships— there is no sense of the other person for who he/she is. Confluent relationships result in the feeling of loneliness in the presence of others, because there is a push for consensus and the authentic presence of persons are thereby not felt. In therapy, this kind of relationship happens when client tries to please therapist and therapist tries to help client. Both try to find compliancy without first looking at the differences. The result is often an alliance without real contact.

Self-awareness & the phenomenological attitude

Owen (2015), in *Phenomenology in Action in Psychotherapy,* explains "Understandings at explicit and implicit levels form worlds with others where there are common objects of attention." In the therapeutic relationship (as with any relationship), contact is made when there is awareness that what each individual understands of the situation is subjective. This understanding functions to bring common ground in the relationship. Owen adds that "People have unique personalities and inhabit social contexts and culture, in larger contexts of society and history, through being aware of meaningful cultural objects (although such conscious awareness is influenced by implicit and biological forces). Therefore, a special attention is provided for what it means to relate in a context, (…) This includes the consideration of meaning within an attention to the therapeutic relationship in psychotherapy" (p. 2). The therapist, for the maintenance of the alliance, needs to first be conscious of these socio-cultural biases of the therapist's *self* towards the phenomena of the on-going present situation in the therapy session. As discussed earlier, awareness of transference and countertransference forces within the alliance is the tool for the therapist to work through the patient's resistance, and providing effective psychotherapy. Absence of this awareness on the part of the therapist, renders the therapy process at best non-effective.

Understanding vs. analyzing in psychotherapy

It is through the awareness of the phenomena within the therapeutic relationship that understanding of the "what-is" happening with the client can be clear. Within this process of gaining understanding lies the challenge for the therapist to be objective— i.e. to make observation of the "what-is" sans being influenced by his/her prejudices. This is the point of contention between the analytical and humanistic psychotherapy schools. Questions are: How can one be objective if one uses pre-gained knowledge and experiences in the face of a phenomenon? And how can one understand anything at all without pre-conceived knowledge and experiences?

Consequence of not understanding

To continue answering the questions, it is necessary to emphasize the importance of understanding and the dangers of misunderstanding caused by pre-conceived ideas. Stammler (2009) cited a story written by Gabriel Garcia Márquez (1994), which I find interesting to relate:

A young woman, whose care breaks down on a country road in the pouring rain and who tries to get a lift to the next telephone. After a long time, the driver of a van picks her up. In the van are a group of sleeping passengers covered with blankets. As she is cold and wet the woman gets a blanket too.

After a while the van stops. Together with the other passengers she gets out and enters a building. She meets a woman in uniform and tells her she wants to make a phone call. She is ordered to join the other women in the communal dormitory. Suddenly awake to the fact that she is in a psychiatric hospital, she tries to escape—to no avail. Her explanations, protests, and attempts to leave the building were unsuccessful; they were answered with force and sedation. The next day she is introduced to the medical director of the hospital. He deals with her in a very friendly and patient manner. She tries to convince him that she has only come to make a phone call and repeatedly demands to be permitted to call her husband and inform him of her whereabouts. The doc-

tor speaks to her in a fatherly voice saying "Everything in due course"—and finishes the conversation.

A few weeks later she manages to send a message to her husband. The price is high; she has to give in to the sexual advances of the night nurse. The visit of her husband to the hospital from which she expects her liberation begins between him and the medical director. The latter explains to the former the mental disease of the wife. He talks of the states of excitation, vehement outbursts of aggression and fixed ideas (especially the one to make phone calls); further treatments as well as the sympathetic cooperation of the husband for the sake of a positive course of the disease are strictly indicated.

After having been informed in this way, the husband sees the wife. He soothes her, encourages her, tells her that she will soon feel better, and promises to come to visit with her on a regular basis. At first she is perplexed; then she starts to rave and to scream like a maniac. On her husbands next visit, she refuses to see him. The doctor says to him calmly, "that is a typical reaction, it will pass" (p. 68).

This almost true-to-life horror story tells us what can happen to clients who slip into dependency on professionals for solutions, and end up being labelled by their diagnoses and misunderstood. It highlights the problem of non-active listening on the part of the professional who engage themselves in analyzing without consideration for what is really happening with the client. Therapists who are fixated on their pre-conceived theories tend to adopt a one-theory-fits-all, which deprives the client of exploring his/her own meanings. This mirrors what Reich was trying to explain with the case studies discussed above: where the therapist was too busy at doing the job of analysis to *see-and-hear* the client. In the story above the staff at the psychiatric hospital were so busy at being "professional" that they lost sight of seeing the client, not realizing that the client was not really meant to have been there. This is compounded by the influence professionals have on the public who hold the professional in often too high regard. This kind of misuse of professional status breaks the ethical code of *doing no harm*: "In providing services… (psychotherapists) bear a heavy social responsibility because their recommendations and professional actions may alter the lives of others" (European Association for Psychotherapy, 2002, p. §1.1.a).

Why do such oversights also happen in psychotherapy? Reich writes of this kind of failure to recognize what is really going on with the client (e.g. transferences), and being too much in need of being complimented (from others and also by the self) : "Undoubtedly, this can be traced back to our narcissism…" (Reich, 1945/1984, p. 25). Which leads us back to the reality that psychotherapy is about understanding the client and the process of which requires the therapist to first understand his/her self.

Hermeneutic circle of understanding

Putting aside, or the need to put aside, theories and pre-conceived ideas in favor of understanding the client does not mean the absence of interpreting. It also does not mean that therapists should not have pre-knowledge and theoretical understandings. It is impossible for anyone, therapists included to not interpret. According to Heidegger, "from the very beginning our essence is to understand and to create comprehensibility." To interpret and understand is to be human (Staemmler, 2009, p. 65). At the same time, it is through our pre-understandings that we can have any understanding at all.

For this understanding to be authentic, and not based on blind interpretations of theory, what counts is the attitude towards gaining this understanding. According to Gadamer (Gadamer, 1975/1960), the German word for "understanding" (*Verstehen*) is also used in the sense of a practical ability (e.g., *er versteht nicht zu lesen*, "he can't read"). This is the understanding when one goes beyond simply acquiring scientific knowledge— when one gets well versed in something, like understanding a text, or, in the case of therapy, the client. In efforts to access this kind of understanding, Gadamer writes, one would have "the accomplished understanding (that) constitutes a state of new intellectual freedom" (p. 251). Gadamer likens all such understanding to be ultimately self-understanding (*sich verstehen*). What this means is that understanding in this attitude is a dynamic process of self-involvement. Gadamer explains how when reading words written by someone else for example, the reader projects his/her own meaning for the words as he/she encounters them. As one reads or listens further, one has expectations for what meaning is to come, new meaning then emerges and expectations are revised according to what meaning emerges further. This is the process of understanding the subject matter through self-reflection and reinvestigation of the subject.

Heidegger (1971), in his writings on what and how art is, says, "What art is should be inferable from the work. What the work of art is we can come to know only from the nature of art" (p. 18). Heidegger adds that in discovering a piece of art, we are lead to a circle of questionings. While we are tempted to avoid this circle, we cannot avoid it if we are to understand that "The artwork is, (…), a thing that is made, but it says something other than the mere thing itself is, *allo agforeuei*. The work makes public something other than itself; it manifests something other; it is an allegory. In the work of art something other is brought together with the thing that is made… The work is a symbol" (p. 19). Through this circle of learning and self-reflection, Heidegger developed the concept of the *hermeneutic circle*.

Gadamer quotes Heidegger in *Being and Time*, "(The hermeneutic circle) is not to be reduced to the level of a vicious circle, or even of a circle which is merely tolerated. In the circle is hidden a positive possibility of the most primordial kind of knowing, and we genuinely grasp this possibility only when we have understood that our first, last, and constant task in interpreting is never to allow our fore-having, fore-sight, and fore-conception to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out these fore-structures in terms of the things themselves" (p. 269). Heidegger defines here the attitude towards authentic interpretive understanding. This attitude requires the interpreter to have an awareness of the self, and the prejudices (or fore-having, fore-sight and fore-conception). Gadamer states: "all correct interpretation must be on guard against arbitrary fancies and the limitations imposed by imperceptible habits of thought, and it must direct its gaze 'on the things themselves'." In the context of psychotherapy, the gaze should be directed on the client and what is happening in the alliance. "For the interpreter to let himself be guided by the things themselves is obviously not a matter of a single, 'conscientious' decision, but is 'the first, last, and constant task'." In other words, it has to be an attitude towards the understanding process. "For it is necessary to keep one's gaze fixed on the thing throughout all the constant distractions that originate in the interpreter himself" (p. 269). Gadamer adds that the process of understanding texts— and we can translate this to the verbal and non-verbal communication of the client— involves projection on the part of the interpreter: "He projects a meaning for the text as a whole as soon as some initial meaning emerges in the text." This projection is necessary in order to make meaning of

what emerges— "the initial meaning emerges only because he is reading the text with particular expectations in regard to a certain meaning". It is the working through of this projection and constantly revising the understanding as new material emerges, "is understanding what is there" (p. 269). It is also worthwhile to note that Gadamer found it important "… to distinguish the true prejudices, by which we understand, from the false ones, by which we misunderstand." However at the beginning of the Hermeneutic process it is difficult to tell one from the others (Staemmler, 2009, p. 86).

The psychotherapeutic dialogue

"Healing through dialogue is an eminently hermeneutical phenomenon indeed." Gadamer, quoted in Staemmler (2009, p. 65).

The psychotherapeutic alliance is a dialogue which is action. Through this dialogue, understanding takes place. This understanding comes about through a hermeneutic process. This process requires the authentic inclusion of the self of the therapist.

Staemmler goes on to emphasize that in the process of understanding, one needs to be asked to ask authentic questions, bearing in mind the tendency for therapist (perhaps to hide his/her own shame) of not being authentically available to the client by asking pseudo-questions, which includes pre-prepared list of questions or repetitive questions like "how do you feel?" without actual curiosity. Pseudo-questions also include questions that predestine their answers. Authentic questioning requires the bringing into the open what is *unexpected*, with the knowledge that the client has the answer. This means that the therapist needs to be open to listening, and living with the uncertainty of the answer that he/she is given. This requires that the therapist relinquishes any control over the client's answers and meaning-making, and this includes predicting what the client's answer should be before even asking the question.

This relinquishing of control in dialogue leads us away from Buber's "I-it" and towards the "I-Thou" way of relating. Incidentally, this forms the "symmetrical" aspect of the psychotherapeutic alliance as discussed earlier described by Altemeyer, and connected to Clarkson's the person-to-person relationship (point 4) and the transpersonal relationship (point 5).

Another way of understanding the "I-It" form of understanding is "to claim to understanding the other better than she or he understands herself or himself". Looking closely this can also be seen as an abuse of professional power "disguised as benevolence" (ibid. p. 91-92). The consequence to such behavior to the profession is the distrust caused by fear of the client from being misinterpreted and misjudged.

That which happens in an authentic I-thou dialogue is a mutual exchange. This happens in the "between". Gadamer, in agreement with Buber: "The dialogue has transforming power. When a dialogue succeeds, something remains for us and in us, which has changed us" (ibid. p. 93). "Dialogue that succeeds", is no ordinary dialogue, but that which is inclusive of the self and the other. Converse to the 'I-It' way of relating, it exists, as Carl Roger's is noted to have explained, "without any techniques, means, aims or intentions" (Schmid, 2001). This kind of dialogue is what Buber terms the 'I-Thou'. This is the dialogue with transforming power.

This is the transformative contact which many schools in psychotherapy strive to establish in the therapeutic hour. I use the word 'strive' to give meaning to the elusive nature of such a healing contact, and the powerful benefits in the event when such contact happens.

What's behind the transforming power of dialogue

Dialogue is a means of making contact, and it is a form of action that goes beyond verbal communication. That which lies intrinsic in an I-Thou contact? Is it a phenomenon we understand as *empathy*? This phenomenon is in itself a concept that leaves much to be discussed. In the context of this paper I'll refer to Schmid (2001). This paper entitled *Comprehension: the art of not knowing,* gives a perspective of Buber's philosophy in the context of psychotherapy, which is useful for this section of this paper (there are also parts of this paper which I have reservations about, which I will also discuss). Schmid states in the beginning that empathy is an "innate (inter-) personal quality" that reaches "beyond identification and interpretation". It is the act of allowing oneself to be impressed by the other, while expressing oneself in an authentic way in the presence of the other.

This way of explaining the empathic in a contact with the other is, whether through verbalized or symbolic communication (i.e. body language, a look in the eye or simply "being there"), empathic contact means to *put aside the need to use the other person* for any personal gratification at all. This means to be there with the other person without feeling as if one has to interpret the identity of the other or the need to establish one's own identity in the presence of the other. There is no goal in such a contact but a *process* of "being there", being authentically present, as an individual, and inviting the other to be there as well as an authentic person. This contact is at a transpersonal level.

What empathy may not be

That said, I'd like to add that I do not agree with Schmid's implication that empathy is about "try(ing) to understand, as exactly as possible, the accurate meaning of what goes on inside another person in the very moment". This is the common understanding of empathy, but it actually contradicts the principle of the I-Thou contact. "Trying to understand" is a process of someone *doing* something with an aim to furnish a need in oneself. In this case, it is the need to understand "as exactly as possible". If a therapist has this kind of goal, his/her goal may become a blockage to contact because he/she is distracted by the need to interpret *and* the need to establish his/her identification as therapist in the relationship.

Wouldn't this amount to *using* the client to find-out-something-so-that-I-can-do-my-therapist-job? This kind of objectifying the Other in the relationship leaves room for transference and countertransference neurosis. If empathy is as what is generally understood as described above, it is then not part of the I-Thou relationship, because the I-Thou relationship excludes objectification.

The I-Thou contact requires seeing the Other first, and not seeing the other in relation to oneself. This movement towards the other first is what Emmanuel Levinas considers the *ethical movement* (Schmid, 2001).

Schmid clarifies this disparity later in the article in stating the difference between Roger's and Buber's comprehension of the activity of making empathic contact. Besides what is mentioned, Rogers also believes that it is necessary "to put one's own un-

derstanding completely apart" if one wants to enter the world of another person empathically. Buber, on the other hand believes in the mutuality of the process.

That which lies beneath the I-thou contact is not empathy but something *more* than empathy. Buber (1970) uses the word, *Umfassung*, a phenomenon of embracing, which is "more than empathy". This process requires the recognition of *2 poles*, in encountering the other "as a partner in a bipolar situation" (p. 178). This implies a dynamic relationship of "swinging into" (*einschwingen*) into the experience of the other and at the same time maintain one's own reality of the self. It shows a dynamic process of being existentially affected by the other, and including the other person into one's own existence (Schmid, 2001).

This is not the same as to "trying to understand someone as exactly as possible", or to step into someone's shoes. It is rather about me being me, seeing you, and showing you how you affect me— at this present moment.

This way of relating in the present moment is what Buber calls, *personale Vergegenwärtigung*. It is an elementary way of relating and means to expose oneself to the presence of the other. This is a personal way of becoming aware of, a way of acceptance instead of perception, a way of acknowledgment instead of knowledge (Schmid, 2001).

The I-Thou relationship is basic existential relationship without the complications of identity and needs. The healing power of this relationship is in the confirming of the other for who he/she is. Buber is quoted to use the word *Realphantasie*, which indicates that what is happening is that "the Other's reality is touched" (ibid.). What is experienced through this form of relationship is the transpersonal, intersubjective acknowledgment of the other, affirming the identity of the other through the presence of the self. Both partners in the relationship attains affirmation of the self. This benefit is mutual, and the relationship is symmetric. What happens in this mutual exchange, Staemmler (2009, p. 96) explains is not a "fusion of horizons"—which happens with just empathy alone— but a widening of each other's horizons in such a way that that it is integrated with each other's personal background.

The I-Thou moment in practice

The challenge with humanistic psychotherapy today is to realize the philosophical concepts and theory put into practice. How do we see an I-thou moment in a therapy session?

My personal conviction in this topic is borne by the fact that I have experienced change moments – as a client of psychotherapy. Over the years, I have also been able to tell if these change moments had a lasting effect, or if they were just cathartic or temporary because of suggestion and coercion. Perception of from the client's point of view recorded over lifetime (a couple of years), may be essential aspect of psychotherapeutic process research.

The process of defining healing I-Thou moments in psychotherapy often gets lost in language. What some call the transcendental phenomenon (which I have in this paper related to an aspect of Clarkson's framework), is also called "miracle moments" (Santos, 2003), "sacred moments" (Pargament, 2007), and "moments of meeting" (The Boston Change Process Study Group, 2010).

What is typically experienced in this moment is typically described like this: "Every therapist knows that there are some special moments in psychotherapy. I experience them as "sacred moments" when immediate realities fade into the background, when time seems to stand still, when it feels as if something larger than life is happening. In these moments, I believe, a meeting of souls is taking place. This was one of those times" (p. 6).

I had the benefit of attending a presentation at a Gestalt Associates Los Angeles (GATLA) Summer Residential in Lisbon this year which discussed this very topic of defining these moments of encounter. Entitled, *I-thou moments in psychotherapy*, the study is the result of meta-analyses of psychotherapeutic literature and interviews with therapists. Hence it was found that these *I-thou* moments:

- o   are memorable, exists in psychotherapy and appears every now and then.
- o   are recognizable, significant events.
- o   is based on the quality of dialogue.
- o   short lasting (in seconds).
- o   is rare.

- o   is mutually experienced.

During these moments

- o   perception gets narrowed.
- o   there is an unusual level of understanding and acceptance of the other
- o   there is experience of being on the edge of something spiritual.

These moments lead to long term change in the therapy and result in motivation for the client to further therapy work. It strengthens the alliance, and has no negative affects (unlike transference relationship). For this to happen, client needs to be able to let go of defenses and the therapist's work is to set the stage for this to happen. Hence it depends on the attitude and commitment to dialogue. It is also a qualitatively viewed process, and is often arises from sharing of heavy topics and staying long enough at the painful place. Playing the role "I am the therapist, you are the client" prevents these moments from happening. Challenge in studying these moments is the very fact that in trying to grasp the moment, that moment is lost (Pernicka, 2016).

Recent Significant Literature on Psychotherapeutic Process Change

Notable is the work of the Boston Change Process Study Group (BCPSG) led by Daniel Stern et al. Since 1994 this group, comprised of analysts, development researchers and child psychiatrist, have come together to develop understanding of what brings about change in psychotherapy. What they have found is congruent to the works cited in this paper. They have come to acknowledge then non-interpretative mechanisms in therapy – "the 'something more' than interpretation" (The Boston Change Process Study Group, 2010).

Using an approach based on infant development studies and what they term as "nonlinear dynamic systems" and their relations to theory of mind, the authors coined the term "implicit relational knowing" for the interactional intersubjective processes that happen in a therapeutic alliance. Congruent to the work cited in this paper by Reich— who highlighted the need to be attentive to the pre-analytic phase of the relationship— the Group recognizes two kinds of processes that take place in the relationship:

1. The *explicit* process: which is the declarative, verbal content matter of interpretations that alter the conscious understanding of the patient's intra-psychic organization. It is the work of analysis that aims to bring to consciousness what is repressed.
2. The *implicit* process: which is procedural and operates outside both focal attention and conscious verbal experience. This knowledge is represented symbolically in what the group calls "implicit relational knowing" (p. 4).

These two different processes that exist in the therapeutic alliance is also differentiated as the attention to words vs. action (or content vs. process), the focus on undoing repression vs. change in psychical structures, and aim at obtaining mutative information exchange vs developing a mutative relationship (p. 2).

The 2 key events remembered of the psychotherapeutic process that is recognized by patients who have completed successful treatment are:

1. Key interpretations that rearranged their psychic landscape.
2. The special "moments of meeting" of authentic person-to-person connection with the therapist that altered the relationship with him/her and thereby the patients sense of self. As mentioned by Pernicka, the group also mentions that these moments are memorable and recalled with great clarity as pivotal event of the treatment.

Like Reich, who emphasize the need to hold off analytic work till the implicit happenings in the relationship is brought to light, the group also mentioned that good interpretation requires good preparation.

Interpretations, added the group, alone does not work to change the intersubjective environment if the therapy involves only strict interpretation. Where the therapist is not involved authentically in the relationship, the patient may gain knowledge, but not the embodiment the experience.

The consequence of these transpersonal "moments of meeting" is a creation of an opening that alter the intersubjective environment. From developmental studies they learn that this is where two parties can be alone in the presence of the other, sharing a new context; and hence an intra-psychic shift is made possible.

In application to therapeutic practice, they have described preparatory processes which includes "moving along" and the bringing the alliance to the "present moments".

This bringing to the present is congruent to what is discussed here as the "here-and-now". It is the attempt to bring the therapy to the here-and-now that moves the relationship towards the "moment of meeting" (p. 22). This is often set off as a result of either one or both parties losing the need to resist contact, as this exercise in bringing to the present is an exercise in self-awareness as well. This act of bringing awareness to the present moment brings into surface the transference–countertransference in the relationship, the dissolution of which results in the healing *I-Thou* contact.

Back to the case of Anna O.

What can we, in acknowledgement of what is discussed here on the psychotherapeutic alliance, understand *hermeneutically* from the case of Anna O.? Freud, after all, had himself come back to this case-study, twenty years after having published the Studies of Hysteria.

My first instinct is to determine what is *explicit* (declarative) what was *implicit* (procedural) in Freud's record of this case. Explicit was the content of Breuer's interpretations and the narratives of the client; that which made up the interesting bits of information that gave rise to analysis of the cause of the patient's symptoms. Implicit is that which is not written but can only be understood upon learning the (social) context in which the treatment of Anna O. had taken place. Britton (2003, p. 7-26), writes an interesting perspective of the case taking into account the happenings in the lives of Breuer and his patient at the time of the analysis. The impact of the alliance affected Breuer to the extent that he did not pursue any further analytic method, and referred them to Freud. He was quoted in Grubrich–Simitis (1997) as having said: "I vowed at the time *never* again to subject myself to such an ordeal." According to Breuer, Freud (1914) quoted, "the element of sexuality was astonishingly undeveloped in her and had contributed nothing to the very rich clinical picture of the case." We know now that there was sexual motivation and hence neurotic transference in the relationship. Freud elaborates, "Anyone who reads the history of Breuer's case now in the light of the knowledge gained in the last twenty years will at once perceive the symbolism in it – the snakes, the stiffening, the paralysis of the arm - and, on taking into account the situation at the bedside of the young woman's sick father, will easily guess the real inter-

pretation of her symptoms; his opinion of the part played by sexuality in her mental life will therefore be very different from that of her doctor. In his treatment of her case, Breuer was able to make use of a very intense suggestive rapport with the patient, which may serve us as a complete prototype of what we call 'transference' to-day."

What Breuer went through was and experience of an erotic countertransference as a result of a projective identification created through the relationship with the client. As a therapist too caught up in the "work" of healer and too engrossed in interpretation of what was explicit failed to confront the implicit goings on – the manipulation of the alliance by the hysterical personality and the physician's own vulnerability. Since Breuer's work preceded such understandings, he could not have known this. But what could have made the difference in this case? Would it have worked if he interrupted her narratives from time to time and asked (himself or the client) "what is really happening here implicitly?" What if he were able to bring to the surface the sexual motivation in the implicit?

The alliance and professional ethics

In Psychotherapy, the professional obligation lies exclusively within the Psychotherapeutic alliance or relationship itself. The *Berufskodex* (2012), and the PthG (1991) stipulate this clearly. The purpose of this relationship is the treatment of existing symptoms – psychosocial or psychosomatic in nature— induced by or associated with behavioral disturbance and/or suffering with the use of scientific psychotherapeutic methods, with the goal of alleviating and/or removing these symptoms; so that with the change, the client can develop and improve in health. The Psychotherapeutic profession is also responsible for the fulfillment of this function (p. 4), in other words, the client's rights are the therapist's duties. In further understanding of this obligation, Strupp (1975) mentions that it is the therapist's responsibility to inform the client explicitly what the psychotherapeutic alliance entails, citing three important points that the psychotherapist needs to address, and for the client to comprehend:

- That the therapist's function is in the healing or alleviation of emotional suffering through understanding, support and reassurance;

- That the therapist will help clients gain understanding and insight thereby promoting growth and maturation;
- That the therapist will help clients with techniques that can help clients to change or modify behavior.

The emphasis on the therapeutic alliance shows that it is in itself central to the psychotherapeutic work, and central to the alliance is the focus on the client's emotional welfare, education in self-understanding and awareness and ability to find resources through behavioral change.

While there are many levels within what we understand as the psychotherapeutic alliance, it is the working through transpersonal during the therapy session that is unique to psychotherapy; and it is known to provide the more than transient alleviation of symptoms. This level of relationship involves the awareness of the implicit, and often escapes the awareness of the therapist. The transpersonal level of the relationship requires the therapist to pay attention to the person of the client in the here-and-now.

The client's responsibility

In considering the ethical in psychotherapy, Korber (2015) confronts us with the question, "who is the client?". This question is fundamental to the understanding, preventing problems and solving of ethical dilemmas faced in the profession.

When we consider Reich's case studies— whereby the therapist was too focused on the symptoms and did not invite the client to be part of the process— we realize that the therapist's asking of "who is the client?" reflects his/her attitude towards wanting to understand the client and getting the client involved. This process inadvertently requires the therapist to constantly self-reflect. In so doing, the therapist acts responsibly and with competence.

Unlike typical medical professionals, psychotherapists work – what The Boston Change Process Study Group (2010) also terms as – *co-creatively* with the client (p. 95-106). The client is responsible to a key extent to the outcome of the therapy. Both client and therapist belong in a field whereby both persons work through uncertainty within the dialogue in order to make meaningful connections. This contribution of the client's

willingness to be part of a successful alliance allows for the transcendental phenomenon to occur.

Difficulty arises when the client is not able to cooperate. This happens very often with clients who are not aware of the therapy process, not able to focus, or is "coerced" (as often seen with some teenagers, the aged sick, people with psychosis and the incarcerated) into therapy. In such situations, the skill and patience of the therapist to administer to this very fact is depended upon (Korber, 2015). He/she uses the other aspects of the psychotherapeutic alliance: the reparative/developmentally needed relationship (point 3 of the Clarkson classification mentioned above). This is perhaps a kind of initial support such clients need to gain security within the alliance. In many schools of psychotherapy, different strategies are adopted through "methods" like using art, music or role-play etc. to bring the attention of the client to the alliance.

Ultimately, for therapy to function, the transpersonal aspect should still be expected, and worked towards. When the effort towards the transpersonal contact is forgotten, the use of the abovementioned therapeutic techniques is administered without awareness, and without goal of reaching and contacting with the client. In itself, these techniques alone become distraction from knowing "who is the client?", and getting the work done.

Therefore, it can be seen that the psychotherapeutic alliance has a transcendental aspect which is essential. This aspect also has ethical significance. Different psychotherapeutic schools may offer different techniques from which to engage the client. It is important perhaps to consider that these techniques are not the *active ingredient* of therapy per se, but are rather methods to lead the client into the working co-creatively with the therapist. It is this *co-creation* of the alliance with therapist and client, in an attitude of contacting on symmetric, intersubjective level, that allows a transcendental relationship to exist, and for therapy to elicit positive change.

Conclusion

I have used that what is termed *the five-relational Clarkson framework* by Clarkson to describe the multifaceted aspect in a psychotherapeutic alliance. One may rightfully argue that separating an alliance in this manner is arbitrary. It is true that there exists no clear separation between the aspects— the working alliance; the transferential/countertransferential relationship; the reparative/developmentally needed relationship; the person-to-person relationship; the transpersonal relationship. We know, however, that these exist in therapy, even though we may have different definitions for these aspects.

What is apparent is that all these are parts that exist as a whole and are essential to the psychotherapeutic alliance. It makes for a safe, professional setting in which very sensitive work between people can be done. It is not unlike a surgical room, whereby the environment is set up so that the surgeons can focus, have their instruments at hand and the room is safe from contamination.

These parts put together can also be compared to a pharmaceutical product. If we take a box of medicinal capsules, we'd first see the box with its labels. Inside this box one may find a paper pamphlet, and there would be bubble pack(s), usually made of plastic and aluminum foil in which the capsules are enclosed. Capsules are made of gelatin and contain powder. A large proportion of this powder is a starch carrier. Mixed into this starch carrier is a microgram of the active ingredient. We can perhaps also see that the different aspects of psychotherapy as the important support for and carrier for the *active ingredient* in psychotherapy. The question lies in what is the *active ingredient*?

From researching this paper, my trust is that it lies somewhere in the transpersonal relationship. Like an *active ingredient* of the pharmaceutical medicine, the transpersonal is the most intangible part. It also requires the other parts to package and support its use.

We can also see in pharmaceutics, how the same *active ingredient* can be packed differently and can look very different. The same ingredient can come in the form of capsules, tablets, syrup, inhalant, injectable etc. These various forms exist so that the *active ingredient* can be administered to the patient effectively, depending on the need

of the patient and the uptake of the drug. In psychotherapy, we could perhaps see that these different forms of administering an *active ingredient* represent the different modalities of psychotherapy. The *active ingredient* itself, in all modalities, then could be the same. This is perhaps where psychotherapy research can focus.

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DECLARATION

I hereby declare that the submitted work was produced independently and without outside assistance, and that any ideas, text and data derived from other sources are properly quoted and cited in the body of the text and in the bibliography. All quotations from books, journals, the Internet and other sources are marked and registered in the bibliography.

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Date   Student Signature