An Introduction to the
THERAPEUTIC RELATIONSHIP in
Counselling and Psychotherapy

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A relational approach to therapy

In this chapter we outline the theory and practice of an approach to therapy from a relational paradigm. A RA is not based on one method of practice but is a paradigm or framework for the practice of therapy.

The aims of this chapter are for the reader to understand the RA, with a specific focus on the following:

- The key principles of this approach, underpinned by theory, research and practice.
- The context and underlying assumptions.
- The central ideas.
- The theory of personality and sense of self.
- How problems develop.
- The social context and its impact on the therapeutic relationship.
- The therapeutic relationship.
- The role of the therapist and therapist competencies essential to working therapeutically.
- The goals of therapy.

As we have seen, the TR is central to all approaches to therapy. Research has virtually proven its importance as an agent for change in therapy. New approaches have developed in all the different modalities focusing on the TR.

THE RELATIONAL PARADIGM

The relational paradigm has emerged in the past two decades, drawing upon the recognition of the importance of relationship in many different approaches to psychotherapy. The concept of 'relational' is now in common parlance across the

range of therapies. It is an approach that invites exploration of the nature and dynamics of relationships and their importance in the development of the person, difficulties in living and the therapeutic process. (Pelham, 2008: 114)

We noted in Chapter 1 that a new therapeutic paradigm has emerged which takes the relationship as central to both theory and practice. Alongside this development have come models of practice that are called relational and also, more broadly, the concept of relationship has come to be regarded as central in therapy (for example, as we saw, it is one of the common factors in outcome research).

By paradigm, we mean a framework through which to work. In a paradigm there may be a number of different positions which fit within the framework and conceptualize themselves differently. We therefore maintain here *a* relational approach as opposed to *the* relational approach. There will be different formulations of working relationally. Some may be embedded in psychoanalytic theory and some in humanistic theory, and so on. We propose a RA that allows each and every practitioner to make sense of what they do coherently and consistently within their own formulation.

As we have seen, there are strong historical foundations to the development of effective TRs. The different approaches to therapy all maintain the importance of the TR. Cumulative research over many decades clearly identifies the relationship as a prerequisite therapeutic factor. Working with the relationship in therapy is considered essential, regardless of what model of therapy the person practises or what philosophical position or school the therapist considers themselves to follow.

In laying out an approach to the practice of therapy we are mindful, therefore, that some aspects of practice may fit more for some than others. We present here what are considered the main therapeutic factors without adhering to one ideology of practice.

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THEORY CLIP 4.1   ORIGINS OF A RA

Context

The concept of 'relational' appeared in the 1980s in various forms of therapy. It has increasingly become an element of other forms of therapy as well as an organized methodological approach in itself.

From its psychoanalytical origins it draws from:

- Object Relations theory – we are motivated by a need to relate ('object' refers to the personal target of the need to relate)
- Self Psychology – our sense of self forms in the context of relationships.
- Intersubjectivity.

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From its humanistic origins it draws from:

- Gestalt and social psychological theory. We are always part of something greater than both the human psyche and social contexts. The organism will always seek to improve itself.
- Person-centred psychology.

More recent developments can be recognized in:

- Cognitive Behavioural Psychology (Third Wave), in which the relationship and collaborative working are now established as central elements to therapy.
- Transpersonal approaches in which the therapist-in-relationship is a key agent for change and both parties are part of a greater whole.
- Transcultural approaches.
- Research into effective factors in therapy.
- Current research in neuroscience.

The key principles of the approach are expressed as:

> *Relations between people are the basis of social and individual life and relational concepts are used to understand human life in all its complexity.*

Relationships are of fundamental importance in:

- The development of personality and a sense of self.
- The difficulties clients bring to therapy (relations with the self and relations with other people).
- The therapeutic process (the therapy relationship is the heart of the process).

(Paul and Pelham, 2000: 110)

All models of therapy work through the relationship and make sense of it from different perspectives. For some it is the instrument for change, while for others it is the medium for forming a good working relationship. What matters is that the relationship is an essential factor in therapy.

Relational approaches draw from a basic given: *we are motivated by a need to relate*. From the moment of birth our phenomenological (subjective) worldview is grounded in and developed through our relationship with others. This can be illustrated in Object Relations theory, humanistic views of human development, Gestalt and cognitive psychologies.

Most importantly, our sense of self forms in the context of our relationships. In relational approaches we have seen that interactions between client and therapist are considered the vehicle for change.

The traditional psychodynamic and existential-humanistic approaches viewed the person as coming into the world pre-wired, with a predetermined instinctual nature. The person then encounters an environment that might encourage, facilitate, suppress, repress or distort this innate drive. In this approach there is one person meeting their environment.

In a RA there is still an innate drive but this drive is more focussed towards fulfilment *in relation* to others. Primary attachment experiences very much influence the development of internal security. Personality develops in a 'two-person' field: Who 'I' am is a co-creation of self and others. My identity is moulded through my experiences with others.

Central ideas

It is through relationships that we become and maintain who we are. Our sense of self is determined in relation to our life experiences in relation to others and the physical and socio-cultural environment in which we live.

All relationships take place in a social context. Every life interaction inhabits an environmental setting. We grow and live in a constellation of human engagements.

It is through the TR that change takes place. The relationship itself is the medium for change. This is examined and explained fully as we discuss the practice of therapy.

Principles

In the practice of therapy we consider these to be the main philosophical principles that underpin the relationship.

- **We are part of a growthful and evolving universe.** Every organism in our universe is part of a greater whole which is in a constant state of development. As human beings we are not separate from this process.
- **We are social beings. Without relationship we do not develop. Science show us this.** As human animals we need warm, caring relationships to grow. With such relations we are more likely to be happy and fulfilled. Without such relations we are likely to be unhappy, cope less well with stress, and form less productive relationships in adulthood.

- **We have a built-in propensity to grow to our full potential.** All organisms move to fulfil their potential given the right conditions. The organism will seek to fulfil itself, and will choose what may be called 'lesser ways' to meet its needs if thwarted in its movement by external circumstances.
- **We are born in and grow through relationships.** We learn in relationship to our primary caregivers in early life. Through our relations with friends, family and others in adulthood we learn and are fulfilled.
- **Our personal problems arise in and through relationship.** Life issues are, in the main, caused and/or maintained through our relationships with others. This is often as a result of early life experiences which lead us to perpetuate problems in relating in our adult lives.
- **Our ability to resolve practical problems is often facilitated when we can access our own internal resources.** We are all subject to the problems of day-to-day living and trauma. Those who are most likely to cope better are those who have had secure early relationships.

Basic assumptions for change in therapy.

Our problems are resolved in therapy through:

- **A relationship which offers the right conditions for healing and transformation.** Research and the wisdom of therapists of all persuasions show that a relationship with an empathic therapist is an essential ingredient in therapy.
- **A relationship which helps us work through issues from our past in relation to the therapist.** We believe that the working out, in the here-and-now, of relational difficulties arising from the past enables an individual to develop insight into the arising of these difficulties and explore new and growthful ways of relating.
- **A meeting with the therapist which enables growth and transformation.** A therapist can offer to their client the possibility of discovering or rediscovering their own internal natural tendencies to make positive life choices.

We believe the above conditions to be the cornerstone of good therapy. This necessitates in the therapist a number of factors:

- An explicit philosophy of life.
- A psychological understanding of the human psyche, of how problems develop and how they can be resolved.
- A discrete and coherent model of practice.
- The ability to form and sustain good relationships.
- To be living or working towards a fulfilling life outside the practice of therapy.
- Reflexive self-knowledge and awareness.

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THEORY CLIP 4.2   KEY THEMES OF A RA

Central ideas

Key themes underpin a RA:

- It is through relationships that we become, know and maintain who we are.
- Relationships are important in:
  - o Forming our personality/sense of self – early relationships are particularly important here.
  - o The difficulties people bring to therapy.
- Relationships take place in a social context.
- It is through the TR that change takes place.

The importance of relationships

For the therapist, relationships are important for three reasons (Figure 1.2): It is through relationships that we become and regulate who we are; relationships take place in a social context; and it is through the TR that change takes place.

1. Relationships are important in understanding both what we call personality, the combination of characteristics, qualities and ways of relating that make up an individual's distinctive identity and sense of self, how we view and experience our self, including our attributes, behaviours and how we think and feel about ourself in our environment. Psychological therapists believe early relationships are particularly important.
2. In the main, the difficulties people bring to therapy are grounded in issues in relationships, both current and/or in the past, or the impact of traumatic experiences on relationship.

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CLIENT CLIP 4.1   WORKING IN THE HERE-AND-NOW

Jim comes to therapy because he is not having much success with his work at university. In the course of counselling he reveals that he doesn't socialize with the people in his shared house. They are noisy and seem to be always partying. He says he keeps himself to himself and that is how he is, he prefers to be *alone*. Something in the tone of his voice suggests to the therapist that there is more to this. So the

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therapist wonders if he is not perhaps alone but is in fact *lonely*. Jim hesitates, moves to deny this, and then rather quietly says: 'You might be right. I have never had any real friends. I have just accepted this is how I am.' This is a crux point in therapy and Jim then goes on to reveal the story of his childhood and domineering father.

In the example above, working in the present and the presenting symptoms, client and therapist are led to explore the causes based in the past.

The TR is the medium in which change takes place. The more present relational factors are, the more likelihood there is for therapeutic change.

> We are borne of relationship, nurtured in relationship, and educated in relationship. We represent every biological and social relationship of our forebears, as we interact and exist in a consensual domain called 'society'. (Cottone, 1988: 363)

Personality/sense of self

The human personality develops in relation to interactions with others. Primary caregivers are very important in the forming of this emergent personality. Life experiences and our reaction to them in relation to the love and support we receive from the important people around us are formative. Our sense of self, how good or not we feel about ourselves and the world we inhabit is determined in relation to these experiences.

We internalize early primary relationships as a template for future relationships. If we have a fulfilling relationship with our father, it is likely to set down a pattern for both future relationships with men and for our sense of self-worth. There is much evidence that points to the imprinting of these formative relationships in the developing child. We internalize early relational experiences as a template for future relationships. These become patterns of relating we play out in life, as illustrated in Client Clip 4.2.

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CLIENT CLIP 4.2   PAST EXPERIENCES LEAD TO RELATIONAL PATTERNS

As young child John was constantly humiliated by his father. He has internalized a template of this *relational pattern*. Being shamed and shaming others: both are part of a dynamic he has introjected. He has the same attitude towards the self that the parent projected on to him, 'You're pathetic!'

In adult relationships John's internalized relational template leads him to expect others to ridicule and humiliate him (being shamed). He can also be like Dad and respond from the part of himself that humiliates others (shaming others). For example, he may respond by criticizing others or putting them down when he feels in danger of being criticized or put down himself.

Social context

All relationships take place in a social context. The home, the family and the environment all have an effect on the individual. The wider context impacts on this experiencing.

Prevailing socio-cultural attitudes and values all impact on relationships: for example, what it means to be a man/woman, to be white/black, to be gay/heterosexual, or to have a religious upbringing, physical ability or disability, a position in society, the agency or power and control you have in your life, and so on. (We look explicitly at social influences in Chapter 10. The example of Phil in Client Clip 4.3 shows how internal conflicts caused by the impact of family values can be played out in social contexts.

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CLIENT CLIP 4.3   SOCIAL CONTEXT AND FAMILY VALUES

Phil is a white, male, heterosexual who works in a local government office. He carries with him a deep sense of inferiority because he feels he did not live up to the perfect image of the handsome, successful executive who had lots of money. He has internalized this from his father, who grew up in a different era. He has become aggressive and demeaning to one of his team, whom he believes to be gay.

Phil is conflicted due to his seeming failure not to live up to the expectations of his father. He is taking out his conflicts on a member of his team who he perceives as not being a true man, as he himself feels.

(Note: The film, *The Believer* (2001) illustrates similar themes.)

THE THERAPEUTIC RELATIONSHIP

The TR is co-created. Both parties are instrumental in it. It is created in context and in relation to the context. This is unlike a traditional classical approach where the therapist sets the scene for therapy or applies techniques to, or for, the client.

The relationship is fluid and changing and both client and therapist impact each other consciously and otherwise. In fact, therapist and client influence one another from moment to moment. The therapist helps the client to find meaning and understanding. This is a mutual co-constructed, intersubjective, process. The therapist is not the source of meaning, knowledge or answers, and does not attempt to overlay their meaning on the client's frame of reference. The therapist is not the expert.

All elements of the relationship are important to therapy. What we may call the *real relationship* and *transference relationship* are equally important. The here-and-now relationship between client and therapist and other dimensions to the relating are important, for example the transference relationship, where the client projects thoughts and feelings on to the therapist based on past experiences. The dimensions of the relationship as a whole are central to the joint work both parties engage in.

Role of the therapist

The role and functions of the therapist are key to the process of therapy. We propose the following principles for effective relational practice.

1. The therapist endeavours to enter into a real relationship with the client. They seek to be authentic and human, bringing with them human qualities.
2. The therapist is a participant in the therapy and therefore does not observe from an objective place, for example as the 'expert', the 'analyst', the 'doctor'.
3. The therapist knows that relational difficulties are likely to come to the fore in the room as the work develops. They are prepared to work with and through these with their client in a non-defensive way with the focused intention of helping their client.
4. The therapist knows that their own relational patterns will have an impact either in their own internal reaction to their client and/or their way of relating to their client. The therapist aims to be mindful of their own patterns and to ensure they do not negatively affect the therapy process. The therapist may to some degree 'bracket' thoughts and feelings that occur that may not be considered helpful.
5. The therapist helps clients to explore their difficulties and seeks to make sense of clients' past stories in terms of their present relationships, and vice versa.
6. The therapist is aware that clients' difficulties may be relational even if the story they are telling appears to have no other people in it.
7. The therapist trusts that the client will find their own resolution to their problems. The therapist further trusts that the client is doing the best they can in their present circumstances.

Goals of therapy

There are no specific goals of therapy as each case is unique and each client will bring their own problems and needs. The therapist will work with the client's perceived goals. However, there are general principles:

1. Therapy may help to bring to awareness the client's way of relating to their self and how this relates to current everyday problems.
2. Therapy may provide a safe, secure and supportive relationship in which the client has a positive, transformative experience with the therapist, as an 'other'.
3. Therapy may contribute to a more productive model or template of relating for the client.
4. Therapy may help a person become more integrated or congruent in relation to the different aspects or 'parts' of self.
5. Therapy may help a person be in touch with their own authenticity and make choices that are fulfilling and growthful.

WORKING WITH *THE* RELATIONSHIP

We now look at the relationship and explore ways of working with, and in a relationship. Kahn was one of those who proposed that the relationship *is* the therapy (1997). For him, there are two reasons why we need to study the relationship. First, relationship is the crux of therapy; through relationship therapy happens. Secondly, by raising our awareness of the relationship and its dynamics we have a powerful tool in our work with clients.

Kahn (1997) lays down five propositions for studying and working with the relationship:

1. Insight is not enough. We may see really clearly what we consider to be a central element to our client's life problems, and in the communicating of that to our client, nothing may change for the client. As Kahn says, 'Insight is necessary but not sufficient' (1997: 4).
2. Along with insight we need understanding of the relationship and what is happening in it. As Kahn says, virtually all schools of thought agree on this, even though they disagree on how to conceptualize the understanding and how the therapist should work with it.
3. The potency of the TR is that it is happening in the here-and-now. It is the live material that can be worked with.

4. An approach based on the relationship incorporates working with an under-standing of relationship, historically the realm of the neutral analytical therapist, *and* working with acceptance and warmth, as per a humanistically-trained thera-pist. Therefore, the therapist may be considered doubly equipped in their work.
5. There has been a coming together of the analytical and humanistic approaches and now there is no need to choose between one and the other.

Kahn suggests that many analytically-trained therapists were torn between the need for theoretical reasons to maintain a blank-screen neutrality versus a need to create a therapeutic ambience of trust, warmth and acceptance.

Freud himself was much more personable in his early work with clients, main-taining that it was love that cured (see page 47). However, as he developed his practice he believed the patient's working out of the transference patterns to an objective therapist to be central to cure.

A relational therapist therefore works with relational patterns in a warm, accepting manner in the here-and-now of the relationship.

Existential-humanistic perspectives

The existential and humanistic schools believed the relationship to be central to change. There were distinct differences, though, in approach. Rogers and others, in the mainly American humanistic schools, believed in the *genuineness* of the therapist which was directed towards the client with positive regard and warmth.

Kahn notes Rogers' 'contribution to our understanding of the relationship between therapist and client was … monumental' (Kahn, 1997: 36), and 'If we exclude those of Freud, it is hard to name another set of books that has an impact on clinical practice equal to Rogers' (Kahn, 1997: 37).

Other humanistic therapists saw **authenticity** as more allied with an honest, open, 'no punches pulled' approach to human *encounter* (Kahn, 1997). The mainly European existential schools were concerned more with the authenticity of the therapist. By this they mean being as truly oneself as one can be in each moment and being with others in that way. The focus therefore was more on a truthful intimacy than the communication of warmth.

Existential writers (Heidegger, 1962) used the term '***Dasein***', literally meaning 'being there', to be truly present with another. Authenticity is one of a number of similar concepts, such as genuineness, congruence and being real in the TR. All these terms describe a process whereby the therapist does not try to hide their feelings behind a professional mask, but meets the client in a person-to-person relationship, with a willingness to share experience in the relationship.

The person-centred concept of *congruence* is an importance example of the humanistic perspective. A congruent response requires the therapist to be aware of

their own inner experience and to communicate this to the client. The belief here is that the therapist's ability to be real will deepen the TR and the therapist's example will enable clients to take the risk of becoming more real, both to themselves and to the therapist. Rogers (1966: 185) states:

> Genuineness in therapy means that the therapist is his [sic] actual self during his encounter with his client. Without façade, he openly has the feelings and attitudes that are flowing in him at the moment. This involves self-awareness; that is, the therapist's feelings are available to him – to his awareness – and he is able to live them, to experience them in the relationship, and to communicate them if they persist. The therapist encounters his client directly, meeting him person to person. He is being himself, not denying himself.

> …the therapist denies to himself none of the feelings he is experiencing and that he is willing to experience transparently any persistent feeling that exist in the relationship and to let these be known to the client. It means avoiding the temptation to present a façade, or assume a confessional-professional attitude.

Within the humanistic approach, the human quality of the TR is considered a core element in healing. The therapist seeks to meet the client in a person–to–person relationship. In Gestalt therapy, Parlett and Page (1990) propose such an open-ended enquiry can flourish only within a 'dialogic' relationship based upon the 'I–Thou' kind of person-to-person meeting and dialogue described by Buber (1958). They further state that this involves each party meeting the other as a person, not a role, and that Gestalt therapists let themselves be themselves and encourage those they work with to do the same.

Kohut (1971), who saw empathy as central to therapy, suggested that clients saw the cool neutral objectivity of some analysts as the most cruel rejection. Kohut (1982) and Gill (1982) were psychoanalysts who believed in working with what we may call unconscious processes and a warm TR. They and others (such as Kahn) suggest a middle way between the warm humanistic and cool analytical approaches.

Both Kohut and Gill saw *non-defensiveness* as vitally important for the practitioner. The therapist is willing to look at any response from their client in an open and reflective way, knowing that they don't need to be right or have all the answers. In the meeting of therapist and client, the healing or transformation happens not from the expertise of the therapist.

THERAPY AS A LOVING RELATIONSHIP

Consideration of music or the arts will illustrate the importance of love in human society. The basis of therapy as love has been noted by many theorists of differing orientations. Allport (1950: 80) wrote: 'Love is incomparably the greatest psycho-therapeutic agent.' In considering an encompassing description of the therapeutic

relationship, Burton (1967 102–3) wrote: 'After all research on psychotherapy is accounted for, psychotherapy still resolves itself into a relationship best subsumed by the word love.'

Rogers believed that what the Greeks called '***agape***', a selfless non-possessive approach to another love quite different from Eros or erotic love, is what is offered in therapy. Object Relations theorists Guntrip (1953) and Fairbairn (1954) used the word *agape* with regard to the therapy relationship: 'This kind of parental love … *agape* … is the kind of love the psycho-analyst and psychothera-pist must give the patient because he did not get it from his parents in sufficient measure or in a satisfactory form' (Guntrip, 1953: 125). For Freud, the patient had to be treated and cured. For Rogers, the person had to be accepted and loved.

As we have seen, the TR is accepted as the most important factor in therapy that the therapist can impact on. The therapeutic functions include the conditions of empathy, warmth and acceptance. Patterson (1974: 89–90) believed that these conditions 'constitute love in the highest sense or *agape*'. If therapy provides some resolution of suffering for people who are missing love in their lives, then perhaps it is not implausible to suggest that some kind of love (*agape*) is *an indispensable ingredient* in the TR itself (Paul and Charura, 2012).

There have been developments within the psychoanalytic field and particularly an openness to explore both the TR, as a living dynamic, and the issue of love as curative. Ferenczi (1932: 169–70) wrote:

> …But if the patient notices that I feel a real compassion for her and that I am eagerly determined to search for the causes of her suffering, she then suddenly not only becomes capable of giving a dramatic account of the events but also can talk to me about them.

This view aligns itself with what Rogers and other broadly humanistic writers suggest. For Rogers, technique was not important; what was important was the successful communication of love – *agape*. Transpersonal and humanistic therapists may see the relationship created between client and therapist as facilitating love and growth.

Buber invited us to consider what it is to be human in relationship. He postulated the I–Thou quality of relating, rather than an I–it relationship in which the other is an object (Buber, 1958). In describing the quality of this love, Worsley (2008: 188) proposes:

> Love is near the heart of the I–Thou intimacy. Love is between the I and the Thou. Love is inherent in relating. I do not possess the one I love. In love all aspects of the other are open to acceptance. The good and the bad, the beautiful and the ugly, each may become engaged in accepting Loving.

In relational terms, this unconditionality in relationship is active, each moment acknowledging and communicating connection and working with the obstacles

and difficulties as they emerge. This includes when therapist and client struggle to be in relationship and when it is difficult to be in contact. I–Thou relating is about being authentic and being with the other. 'If someone could give the suffering person a significant experience of the love so sorely missing, the confusion and pain would go away by itself' (Kahn, 1991: 36).

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RESEARCH CLIP 4.1   NEUROSCIENCE AND LOVE

Research in neuroscience has recently continually evidenced the importance of love in human development and the importance of love in laying down the foundations for the healthy development of the brain many years after original neglect of abuse has impeded normal growth (Cozolino, 2010b; Joseph, 1999; Siegel, 2007).

Loving in therapy cannot be reduced to particular words or therapeutic skills but rather is a relationship encounter with a quality of relating, dialogue, contact and process with each other moment by moment in a way that fully embraces our experiencing (Paul and Charura, 2012: 23).

THE INTERSUBJECTIVE CONTEXT

As such, there is no one reality of the client but both client and therapist have their own view of the world, their own subjective reality. Basically, there is not one real-ity (the client's) and an objective observer (the therapist) in the therapy room but
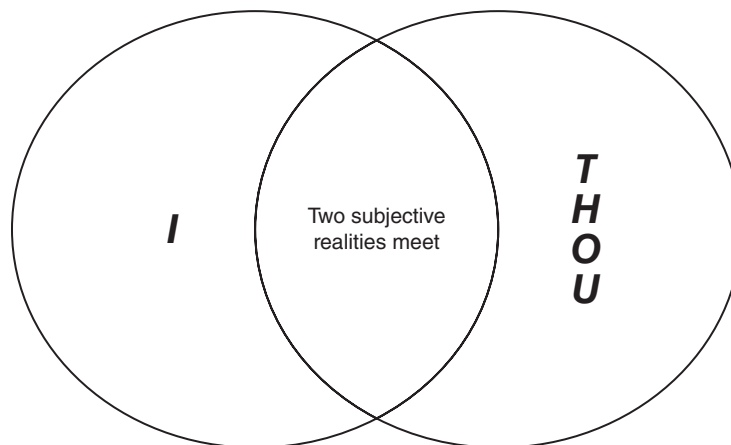

FIGURE 4.1   Intersubjectivity

two subjective realities. Stolorow and others call this **intersubjectivity** (Stolorow, 1994). There are two subjective participants in the therapy room, each of them trying to make sense of the client's issues.

As Kahn (1997: 70) explains it:

1. 'Therapists exert significant unconscious influence on the interaction, influence they can learn about only from the client.'
2. 'They must learn to be gently skeptikal [*sic*] about their own objectivity and their own view of the client's reality.'

There is no objective reality as such but a number of ways of making sense of experiences. The client tries in the best way they can to make sense of their past. In a sense, it is a *social construction* with accompanying strategies to help understand and work with its tensions. Hence, transference and inner resistances are the healthy striving of the psyche to resolve internal conflicts.

KOHUT AND SELF PSYCHOLOGY

Kohut (1984) was a classical psychoanalyst who developed his theory and practice around empathy. He believed mental health is the ability of an individual self to realize its own unique '*nuclear program in the course of its life span*' (a concept very similar to humanistic notions of self-actualization). He developed a theory that has become influential but differs significantly from classical analytic theory and practice. He called his approach **Self Psychology**. His approach is very similar in many ways to Object Relations, especially to Fairbairn and Winnicott, and to the Interpersonal approach of Sullivan. However, Kohut always denied being influenced by Object Relations theorists, and indeed sees Self Psychology as somehow different from all predecessors.

According to Kohut, the newborn is not born with a cohesive self, but the parents act and respond as if a self existed. The child's self arises out of this relationship – the interplay between the infant's innate potential and the responsiveness of the adult selves or **selfobjects** (very similar to Winnicott).

Classical theory implies intact structures of the personality: id, ego, super-ego. For Kohut, theory is based in the idea that the Self is a central structure of the personality, and it is formed over time in relation to impressions from parents or significant others by what he called **transmuting internalizations**. This is a process by which aspects of the selfobjects are absorbed into the child's self. Parents normally respond to the child by empathic attunement to the needs of the child. This empathic attunement will often fall short of the child's needs, but if the frustration is minimal (optimal) the child will take in an aspect of the selfobject in the form of a specific function (such as self-soothing). The child withdraws some of its magical (narcissistic) expectation from the selfobject and forms a particle of self-structure. The inner

structure of the child then performs some function previously performed by the object. Due to needs being unfulfilled, this process may be defective and the person may develop secondary defensive or compensatory structures.

Kohut believed that the individual has three needs which must be fulfilled as the child grows for the self to develop fully:

1. The need to be '*mirrored*', which in essence requires the child to be accepted totally by the parent. This term is not be confused with the skill of mirroring in therapy. When a child has experienced significant mirroring over a period of time they are able to cope with times when they are not mirrored by adapting. Gradually, a self-structure develops with a healthy sense of self.
2. The need to idolize. The need to know that at least one parent is whole and powerful. If we have had and internalized a calm and powerful adult figure when we grow up, we develop the capacity to self-regulate our own feelings. Kohut further believed that the higher aspects of the personality are more readily developed in those who have internalized their idealized parent.
3. The need to be like others. The child needs to know that they are like a primary care figure. This helps with developing a sense of belonging in the world and that they fit in; that they are not odd.

For Kohut, if all these needs are adequately met, the growing child will develop in a healthy way. If they are not, and they often aren't, the child will develop what he called *compensatory structures* to enable them to cope.

> I began to entertain the thought that these people were not concerned with me as a separate person but that they were concerned with themselves; that they did not love or hate me, but that needed me as part of themselves, needed me as a set of functions which they had not acquired in early life; that what appeared to be their love and hate was in reality their need that I fulfil certain psychological functions for them and anger at me when I did not do so. (Kohut, 1991: 9)

A co-created relationship

It is clear that the TR is co-created and that both client and therapist are instrumental in it. The TR is created in context and in relation to the context. This is in contrast to traditional classical approaches where theory hypothesizes the direction of therapy through setting the scene and employing techniques. Within this approach the therapist and client impact on each other moment to moment.

The therapist helps the client find meaning and understanding and provides a safe, secure and supportive relationship. Therapy may contribute a template of relating for

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the client which helps them become more integrated or congruent in relation to the different aspects or 'parts' of self. This relational encounter is transformational and fosters conditions which enable the client to be in touch with their own authenticity and make choices that are fulfilling and growthful. As each client case is unique, there are no specific goals of therapy. Each client will bring their own problems and experiences and the therapist will work with whatever the client perceives to be their goals.

PRACTITIONER CLIP 4.1   MIRRORING PAST RELATIONSHIPS IN THE PRESENT

Ken presented to me (Divine) following a period of three weeks' sick leave from work. He stated that he faced a lot of pressure at work and was off because of stress. He shared that what contributed to his stress was how he did not get on with his team and always felt he had to compete with two particular junior team members. He stated he also felt that although his managers never said it, he could tell they felt he was not good enough. His initial goals were therefore to manage the stress and to cope better. As therapy progressed, he stated that he wanted to drop out because there were other people 'out there' that needed it more than he did.

As we began to explore and work together, it emerged that this feeling of being in competition and not good enough was a feeling which emerged in his family since he was a child. Ken stated that his father always criticized him and that he could never do anything which was considered good.

Through therapy, Ken was able to see how his experiences at work and feelings of not being good enough mirrored his primary relationships with his father and sisters. They played out in the therapy room through him wanting to leave therapy when he stated he wanted to give others a chance. They may 'need it more than he did' – as if they were competing with him. He self-judged, as he had done in his family and at work. Therapy enabled him to see this and to self-accept in the 'here-and-now' of the reparative therapy relationship.

From our experience, even when clients share what they perceive to be their goals, once the therapy begins, past relational patterns, and the impact they have had on the client, often surface, as we have seen in Practitioner Clip 4.1 above. This then impacts on what the client perceived as their goal as new realizations emerge.

Thus the relational therapist's ability and competence to work with the clients' relational patterns in the here–and–now of the relationship enhances the potential of therapy.

RELATIONAL COMPETENCIES

While a RA is driven by philosophical principles and is not explicitly skill based, a professional practitioner needs to develop key competencies to be effective in their practice. We now present relational competencies for working effectively with all clients. These have been divided into four main domains: practical, personal, professional and contextual (Table 4.1).

TABLE 4.1   Relational competencies

Practical	Ability to foster and maintain and develop a good therapeutic relationship in the here-and-now.
	Ability to work with the client to establish and work with an agreed therapeutic aim.
	Ability to undertake relevant assessment (relevant history and identifying suitability for therapy).
	Ability to work collaboratively with the client, understanding their experiences and 'world view'.
	Ability to conclude the therapeutic relationship.
Personal	Ability to maintain authenticity in the therapeutic relationship.
	Ability to experience and communicate empathy and work with dynamics in the here-and-now
	Ability to respond non-defensively to client feedback.
	Ability to recognize and address own prejudices.
	Ability to work with difficult and complex processes.
	Ability to help clients reflect on and develop and articulate their emotions, experiences and personal meanings.
	Ability to be reflexively self-aware in relation to the client.
	Ability to facilitate the personal power and self-determination of the client.
Professional	Knowledge of, and ability to operate within, professional and ethical guidelines.
	Knowledge and understanding of a RA, mental health problems, and the ability to understand and employ the model in practice.
	Ability to undertake assessment using appropriate methodologies (assessment measures, tools, and so on).
	Ability to make use of supervision.
	Ability to recognize limitations in professional practice.
	Commitment to ongoing personal and professional development.
Contextual	Knowledge and understanding of how the particular context in which the therapist works impacts on the client–therapist relationship.
	Ability to reflect on how the therapist's own social and professional context impacts on their worldview.
	Ability to draw from the client how their social context is impacting on their experience.
	Ability to work collaboratively with the client in exploring potential barriers to change or challenges when considering the client's social context.
	Ability to record all elements of client's progress in relation to the professional context.

Source: adapted from Roth, Hill and Pilling, 2009

We developed these competencies building on the work of Roth et al. (2009) to maximize the effective practice of a relational therapist. In Chapters 6 and 7 we introduce the different competencies that are essential in establishing and developing the relationship. In Chapter 8, we build on the practical and personal competencies in facing challenges to the relationship and, in Chapter 11, in working with difference. A practical competency, for example, *an ability to conclude the therapeutic relationship*, is essential in managing the ending of a therapy contract. Other competencies, such as the therapist's *ability to be reflexively self-aware in relation to the client*, are explored more in the work in Chapter 10 on the therapist's self in relationship.

REFLECTION POINT 4.1   DEVELOPING YOUR CORE MODEL

A RA is described as operating within a paradigm which is not in itself a core model.

- What key elements can you draw from this chapter to inform your core model for the practice of therapy?

RESOURCE BOX 4

Cozolino, L. (2010) *The Neuroscience of Psychotherapy: Healing the Social Brain* (2nd edn). New York: W.W. Norton.
   An overview of neuroscience, attachment and the TR.

Kahn, M. (1991) *Between Therapist and Client*. New York: W.H. Freeman.
A classic text which looks at psychoanalytical and humanistic elements in a relational paradigm.

Kohut, H. and Stepansky, P.E. (1984) *How Does Analysis Cure?* (Vol. 52). Edited by A. Goldberg. Chicago, IL: University of Chicago Press.
   An important book looking at self-psychology and empathy.

Paul, S. and Charura, D. (2012) 'Accepting the therapeutic relationship as love', *The Psychotherapist*, 52: 22–3.
   A simplified proposal for the place of love in therapy.

Roth, A., Hill, A. and Pilling, S. (2009) *The Competencies Required to Deliver Effective Humanistic Psychological Therapies*. London: University College of London.
Key competencies which have become central to therapists in evaluating their knowledge, practice and skills.

CHAPTER SUMMARY

A RA is not based on one method, but is rather a paradigm or framework for the practice of therapy. It has increasingly become an element of different models as well as an approach in itself.

Underlying assumptions

- A RA is based on self in relation to others and is thus a two-person psychology.
- Relational therapies posit that we have an inner drive, which is for connection, attachment with others.
- The personality develops in a 'two-person' field: who I am is a co-creation of me and others.

Central ideas

- It is through relationships that we become and maintain who we are.
- Relationships take place in a social context.
- It is through the therapeutic relationship that change takes place.

Personality/sense of self

- The personality forms in relation to primary experiences.
- Early relationships are particularly important.
- We internalize early relational experience as a template, or prototype, for future relationships.

Social context

- All relationships take place in a social context.
- Prevailing attitudes and values have an impact on relationships, for example, what it means to be a man/woman; to be white/black; to be gay/heterosexual; rich or poor, and so on.

Therapeutic relationship

- The therapeutic relationship is co-created.
- Therapist and client influence one another from moment to moment.
- Meaning is co-constructed between them.
- The here-and-now relationship and transference relationship are important.
- Therapy can be seen as a loving relationship.
- The relationship is the vehicle for therapy.

(Continued)

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Role of therapist

- The therapist enters into an authentic, human relationship with the client.
- They do not observe from an objective place, e.g. the 'expert', the 'teacher', the 'doctor'.
- They know that interpersonal relational difficulties are likely to occur in therapy.
- They are prepared to work these through.
- They know that their own relational patterns will have an impact on the encounter.
- They help clients to explore their difficulties.
- They understand clients' stories in terms of what is going on in the day-to-day life of the client.
- They believe clients' difficulties are likely to be relational even if the story they are telling appears to have no people in it.
- They work from practical, personal and professional competencies.

Goals

Therapy aims to:
- Increase awareness of the client's way of relating to self and other (intellectual insight) and how this relates to current difficulties.
- Provide a safe and supportive relationship in which the client has a positive 'self with other' experience.
- Contributes to a new and more productive model of relating for the client.

5

Developmental factors in a relational approach

The aims of this chapter are for the reader to understand the formation of relational problems from a developmental perspective. This includes:

- Childhood attachment.
- Theories of human development.
- Neurobiology and neuroscience.
- How problems develop.
- Psychoanalytic and person-centred viewpoints.

In this chapter we introduce theories of human development and childhood attachment and their impact on interpersonal relationships. We review the evidence of neuroscientific research and the impact of developmental experiences on the brain. We also consider theories of personality development and psychological maladjustment based on the work of Carl Rogers and others. The material offered in this chapter offers a sound basis for the practice of therapy from a relational perspective.

DEVELOPMENTAL FACTORS

Many human problems have their origins in early experiences and in the ways of relating that an individual has learned to allow them to cope in everyday life. Understanding the roots of relational problems and childhood attachment is therefore central to a RA.