The importance of the relationship in psychotherapy

The manner in which the therapeutic relationship should be used in psychotherapy is a hot topic both in Norway and internationally. The importance of the relationship receives different emphasis in different psychological theories and within the field of therapy. The therapeutic relationship contains both rational and irrational elements. In cognitive behavioural, relational and psychodynamic therapy, the importance of the relationship in psychotherapy is understood and emphasised in different ways.

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It is often claimed that Sigmund Freud (1856–1939) developed a one-person psychology whereby the individual's drives and handling of these drives were the most important factor, and relationships were secondary. Harry Stack Sullivan (1892– 1949) is considered to be the founder of interpersonal theory. He was coloured by recent trends in scientific theory such as positivism, pragmatism and operationalism, in other words, what is perceptible, practically applicable and operationalisable is also relevant within the fields of psychology and psychiatry.

These currents, that were strong in the USA, were contrary to metaphysics, which had its roots in Europe and included Freud's ideas on the intrapsychic. Sullivan criticised Freud's definition of *the individual mind* as the fundamental unit of study, and launched another model of how humans are constructed. His foremost claim was that humans are by nature dyadic, in a continuous interaction with others (1).

Ego psychology

Ego psychology, a direct continuation of classic psychoanalytic theory, predominated for a long period, especially in American psychoanalysis, from the 1950s onward. Whereas Freud portrayed the ego as one who is not master of his own house, as a rider who believes he has control over his horse, ego psychology detaches the origin of the ego from what drives it, and ascribes to it primary autonomy (2).

Ego can be defined as «the system of processes that modify external and internal stimuli in order to achieve the best possible adaptive integration at any time» (3).

Object relations psychology

The contradictions between the internal and external were downplayed in object rela-tions psychology, which allows for both the intrapsychic and the relational – the inner world is also an interpersonal world. Object relations psychology has expanded our theories of what drives us, what motivates us. From birth, humans have a fundamental «drive» to form relationships with other people: a relational drive, parallel to sexual and aggressive drives (4, 5).

We can speak of three types of relational needs. First there is the need for security, central to which is the quality of early attachment (6). Second is the need for self-affirmation, the need for emotional feedback that confirms the feeling of «self» («the gleam in the mother's eye») (7). And finally, there is the need for companionship (5, p. 44). These needs may be unmet in childhood, in one way or another, and this may then have an impact on the therapeutic relationship.

Relationships in psychotherapy

In his textbook, Ralph Greenson (1911–79) defines transference as a special type of relationship. It is characterised by feelings towards a person that do not entirely *fit* in relation to that person, but are rather suited to another (8) – a person from the past. Transference is a *repetition*, a new version of an old object relationship.

It was his patient «Dora» who set Freud on the trail of the transference phenomenon (9). This concerned his experience of being the object of the young female patient's admiration, infatuation and love. Freud chose not to take this at face value since, as he said, he was by no means an attractive and charming person! It had to be a case of something else, for example a reactivation of an infantile core in the patient – the child pleading for her father's attention and recognition.

Greenson also discusses two other relational concepts, namely «the working alliance» and «the real relationship.»

In order to work effectively on their problems, patients must establish another rela-tionship with the therapist alongside their transference reactions. He calls this the working alliance. The working alliance consists of the relatively un-neurotic, rational aspect of the patient's relationship with the therapist, and is an indicator of the patient's capacity for purposeful work during the therapy. Greenson claimed that the working alliance could be considered as having the same importance as the transference reactions in the therapist-patient relationship. There is now a sound evidence base for regarding the working alliance, also known as the therapeutic alliance, as the strongest and most consistent predictor of treatment outcome (10).

The alliance may *be weakened* when the patient, based on his/her life experience, has low expectations for the therapy, a hostile interpersonal attitude and uncertain attachment. The therapist can help to *strengthen* the working alliance through technical skill, flexibility and the ability to regulate negative emotions – in addition to sensitivity to interpersonal processes, ensuring that the therapy is perceived as uncritical and undemanding, and that it is neither over- nor understructured (10).

Greenson calls the third type of therapeutic relationship «the real relationship». It is elucidated through clinical examples, the main point of which is that problematic traits in the therapist or imprudent interventions on the part of the therapist can trigger *realistic* reactions in the patient. These must be recognised as genuine by the therapist, rather than being made the subject of interpretations of resistance or transference.

Another definition of the working alliance, proposed by Bordin, is that it consists of three elements: the contact or the emotional bond between therapist and patient; agreement on the goal of the therapy; and agreement on the tasks that must be solved in order to achieve the goal (11). Such a definition may imply that elements of Greenson's other two relationship types
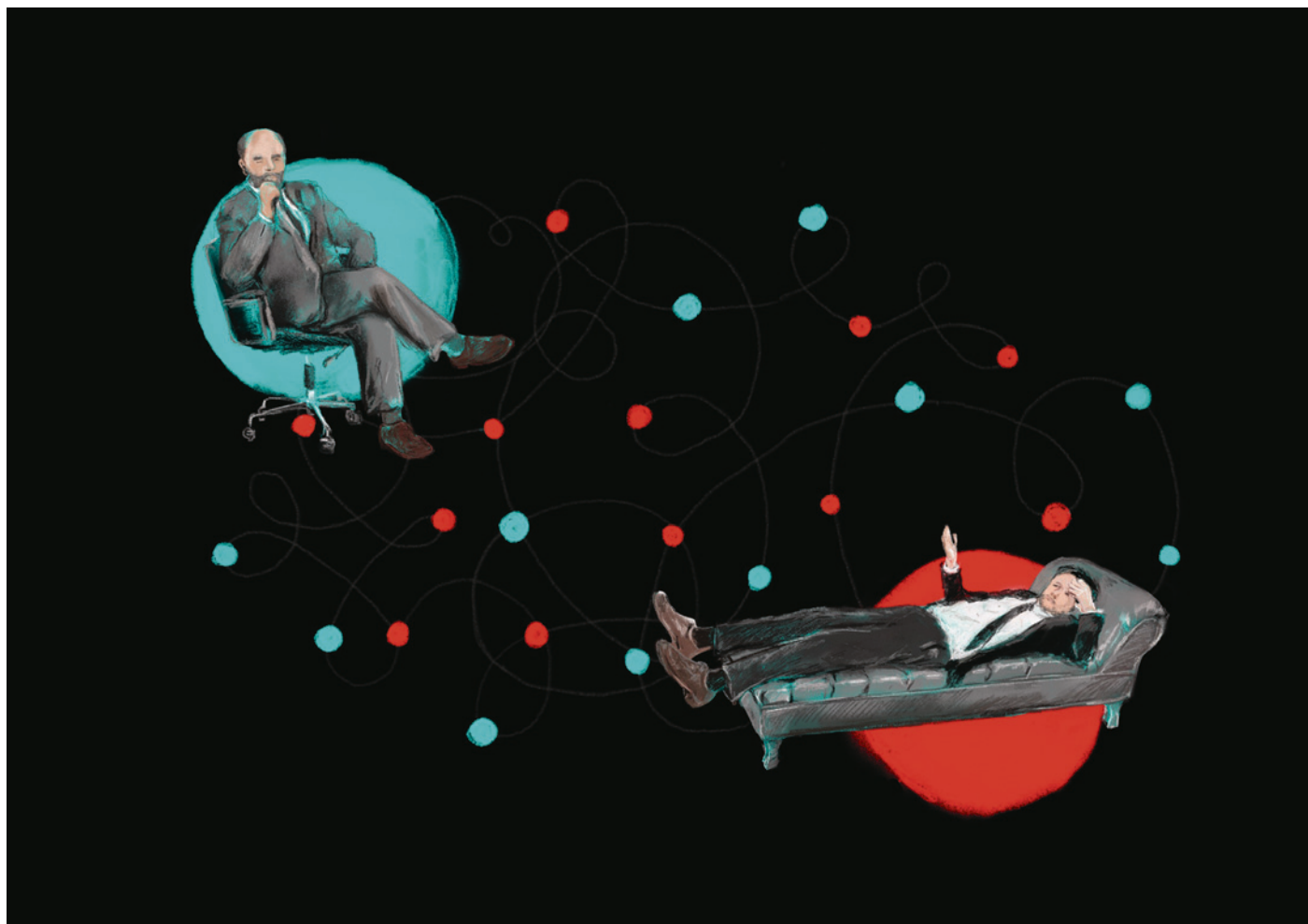
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(transference and real relationship) are included in the working alliance concept. It is therefore important to clarify which concept of alliance is being referred to when discussing the importance of the working alliance.

Common factors?

There is a widespread perception in psychotherapy research today that there is little to distinguish between the various schools of therapy when it comes to therapeutic effect. Rather, what are crucial are the so-called *common factors*, for example therapeutic alliance, empathy, respect, the therapist's attentive presence, and so on (12). However, it may be difficult to distinguish common factors from the techniques and change mechanisms that are specific to the various forms of therapy. Although some therapists may have innate abilities when it comes to dealing with these factors, it is also possible to learn them, for example by acquiring competence in managing transference and their own reactions to the patient

(countertransference) – which endows them with a *specific* relational competence (13).

Personal therapy is most likely an advantage in terms of enhancing the ability to regulate negative emotions, giving therapists an opportunity to achieve greater clarity with regard to their own vulnerabilities.

A spectrum of therapies

Interpersonal relationships are absolutely key to all forms of psychotherapy, but differences exist when it comes to emphasising the relationship in therapy – the degree to which the therapeutic relationship is used as a tool.

At one end of the spectrum lies cognitive behavioural therapy, where traditionally there has been less concern with the therapeutic relationship as long as it is considered good enough (14). At the other end of the spectrum are the intersubjective/relational forms of therapy, where the primary concern is with the relationship here and now. The co-created relationship is explored in tandem, without the therapist

adopting a more objective position than the patient, or the position of expert (15).

In my opinion, the psychodynamic therapies are situated between these positions, using the therapeutic relationship as an important tool while not surrendering the idea of the «objective» observer. Based on expertise and experience, and through self-reflection, the therapist has the possibility of creating sufficient distance to be able to observe what is occurring between the therapist and patient. This makes it possible to provide clarifying, indicatory and confronting input and interpretative suggestions.

Examples from research

An example may serve to elucidate the possible results of failure in the therapeutic relationship, specifically how the therapist's inadequate attention towards and management of the patient's transference and of the therapist's own countertransference leads to a poor result. Two groups of patients from the large-scale Norwegian multisite study of process and outcome in

psychotherapy were studied (16). In one group, the outcome was good, whereas in the other the outcome was poor or unchanged. In hindsight, the latter group appeared to be characterised by a more or less subtle rejection by these patients of the therapist's attempt to be helpful. A prolonged refusal to recognise the therapist's competence probably made the therapist more prone to react with some degree of subtle hostility and rejection in return. This was assumed to be the primary reason for the poor outcome for these patients (17).

Another example is from a randomised clinical study which investigated the effect of paying systematic attention to transference, compared to therapy where transference was not emphasised. In both groups relationships were emphasised – in one, mainly relationships outside the therapy room, while in the other, the relationship aspect was consistently brought into the therapy room: «How does this feel *here?*» (18). One of the main findings was that the most disturbed patients demonstrated the best outcome from attention to the therapeutic relationship, that is, transference work.

The protagonist in one's own life
Different forms of therapy emphasise different aspects of the relational element. The path chosen will depend on a number of factors related to patient and therapist, the situation at hand, and the objectives set for the therapy. Many patients do not have

a deep desire to understand themselves better; they wish rather to be rid of their symptoms. Others feel a greater need to cope with their symptoms and problems through improved self-knowledge.

It can be stated that some forms of therapy are focused on *change*, whereas others are more focused on *wondering*. In the final analysis, the objective will be the same: Becoming better at standing on your own two feet and liking yourself and others!

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