INTERNATIONAL JOURNAL
OF
Psychotherapy & Critical Thought

VOLUME IV NUMBER 1 SPRING 1997

In This Issue:

THE REAL RELATIONSHIP
A Key to Therapeutic Success

INTRODUCTION

Historically, dynamic psychotherapy theory and training have focused almost exclusively on recognizing and interpreting manifestations of transference feelings. To acknowledge the centrality of the real relationship between therapist and patient has often been seen as a distraction from the work of interpreting the transference.

Is the real relationship non-existent or clearly present? Is it marginal or central? Is it unavoidable or to be avoided as much as possible? Is it to be regarded as a parameter of treatment which must later be analyzed or as an inherent part of effective psychotherapy? The answers to these questions are important for all of dynamic psychotherapy. We invite you, the reader, to answer these questions for yourself before reading further. Knowing your own *current* position on these issues will help you to critically evaluate the material we present to you.

It is our understanding that most of life, in and out of psychotherapy, is affected by realistic as well as transferential factors. Indeed, any transferential reaction is based on a current reality to which a patient is responding in a distorted way; this assumes that a non-distorted or sensible way to react or respond exists. Beyond transference, the realistic aspects of how we and our patients live together day-to-day make up the real relationship, the laboratory in which the transference can be properly and safely worked through. Even profound preverbal characterologic distortions can be effectively repaired and reversed if the real relationship is strong enough. However, when a patient's treatment is based on transference feelings without a solid real relationship, the psychotherapy process is compromised and will surely fail.

The more a therapist actually has the emotional health, skills, motivation and commitment to make strong real relationships, the more clearly the patient's transference reactions will stand out against the backdrop of that real relationship. In contrast, when a therapist is lacking some of these building blocks of the real relationship, the therapy is more likely to become a replay of the patient's original pathological relationships rather than a healing process. Resolving our own real relationship difficulties should be a primary, ongoing commitment for psychotherapists.

In this issue of the *International Journal of Psychotherapy and Critical Thought* we review the conceptual development of the real relationship and demonstrate its relevance to psychotherapy. By examining numerous clinical situations we explore how to begin making a real relationship, how to recognize and use it, how factors from the therapist's side can interfere with its development and some of the possible remedies for such difficulties.

We hope that this issue will elicit and encourage questioning, discussion and self-scrutiny among clinicians to further our knowledge in this important area. By examining our ability to use our "selves," we expand our competence and effectiveness in the exciting and challenging work of psychotherapy.

Joseph Gluski, M.D.

HISTORICAL DEVELOPMENT OF THE CONCEPT OF THE REAL RELATIONSHIP

Pamela Torraco, M.S.W.
James R. Stanislaw, M.S.W.
Victor R. Stoeffler, M.S.W.

Classical analysts have generally held strictly to the position that all meaningful interactions in therapy center around the transference relationship and interpretations of the transference. Over the years, however, a number of analysts have acknowledged the existence of another relationship between patient and therapist. They have speculated that a successful outcome of the therapeutic work depends also on "real" or non-transferential aspects of the relationship.

As early as 1937 Sigmund Freud made reference to the real relationship in "Analysis Terminable and Interminable":

> Not every good relationship between an analyst and his subject during and after analysis was to be regarded as a transference. There were also friendly relations which were based on reality and which proved to be viable. (p. 222)

Esther Menaker continued in 1942:

> It seems...important to distinguish between that part of the analytic experience which is relived as "real" (not to question the genuineness of this experience), and that part which *is* real, that is, which constitutes a direct human relationship between patient and analyst, which has an existence independent of the transference, and which is the medium in which the transference reactions take place. (pp. 172-173)

She made further distinctions between the transferential relationship and the real one, the former being only a reflection of the patient's past emotional life and the latter developing mostly out of the analytic situation itself. The real relationship involves two separate people as contrasted with

a transference relationship where all the ideas and emotions are the production of only one individual. Menaker attributed failure or limited success in many analyses to the interference of the repetition compulsion with the real relationship "even after the experience of the repetition compulsion in the transference has been analyzed" (p. 175). She categorized this partial failure as inevitable, pathologically masochistic, and a result of the treatment setting itself. More specifically, she points out that if the therapist avoids the real relationship, problematic masochism comes out in the therapy.

> Not only does the patient repeat his childhood wishes in the transference, but the analytic situation repeats in its actual form and arrangement the childhood situation of the patient, with the deliberate purpose of reviving the childhood reactions as we see them expressed in the transference. This set-up gives to the relationship between patient and analyst a real aspect (in contradistinction to the transference aspect) which becomes a kind of background for whatever else takes place in the analysis. In the nature of this background lies an opportunity for the anchoring of neurotic mechanisms. (p. 178)

Can such failure or partial failure be avoided? Menaker suggested that the real relationship needs to have content and substance beyond that created by the analytic situation itself. This can be therapeutically useful if the analyst allows his own personality to show, demonstrates "friendly interest toward his patient," and saves his or her "cooler objectivity" for the actual *content* of sessions (as differentiated from the *process* of the sessions). She believed that differentiating between the transferential and real aspects of the therapy would improve the results. The therapist must eventually intrude on the patient's tendency to live out the repetition compulsion.

Anna Freud addressed the subject in 1954:

> We see the patient enter into analysis with a reality attitude to the analyst; then the transference gains momentum until it reaches its peak in the full-blown transference neurosis which has to be worked off analytically until the figure of the analyst emerges again,

> reduced to its true status. But--and this seems important to me--so far as the patient has a healthy part of his personality, his real relationship to the analyst is never wholly submerged.
>
> With due respect for the necessary strictest handling and interpretation of the transference, I still feel that somewhere we should leave room for the realization that the analyst and patient are also two real people, of equal adult status, in a real, personal relationship to each other. I wonder whether our--at times complete--neglect of this side of the matter is not responsible for some of the hostile reactions which we get from our patients and which we are apt to ascribe to "true transference" only. (p. 372)

Loewald (1960) used the parent-child relationship as a model for psychoanalysis:

> The parent ideally is in an empathic relationship of understanding the child's particular stage in development, yet ahead in his vision of the child's future and mediating this vision to the child in his dealing with him....In analysis, if it is to be a process leading to structural changes, interactions of a comparable nature have to take place (p. 20)....Ego-development [which] is resumed in the therapeutic process...is contingent on the relationship with a new object, the analyst. [This] new object...has to possess certain qualifications in order to promote the process. (p.18)

He cited objectivity in regard to the patient's transference distortions as a qualification. As the distortions are analyzed, the analyst becomes available as an actual "new object." Loewald states that "[with] the object (analyst) mediating the process, depression is lifted...unconscious and preconscious are again in communication...[so that] infantile object and contemporary object may be united into one.". He also wrote of the "new object-relationship with the analyst [which is] gradually being built in the course of analysis...and which serves as a focal point for the establishment of healthier object relations in the patient's 'real life' " (p. 32).

Stone (1961) wrote of the necessity for the analyst to respond to patients' wishes for tolerance and understanding. He also referred to the inevitability of the real person of the analyst influencing the analytic situation. By 1967 Alan Roland had taken a pioneering step beyond simple observation of the phenomenon. He advocated that therapists actually develop this "real" relationship to enhance the therapy process.

> A real, reparative relationship must be developed and cultivated in psychoanalysis with these patients [severe character disturbances] so that character transference resistance may be fostered and eventually resolved before becoming an unworkable transference-resistance...Unless sufficient attention is paid to both the real and transference aspects of the paradoxical psychoanalytic relationship with severe neurotic patients, grave difficulties arise. (p. 508)

Fairbairn (1958) was "convinced that it is the patient's relationship to the analyst that mediates the...effect of psychotherapy" (p. 380) and DeWald (1967) continued:

> These new, first, "real" experiences in the transference neurosis are not replacements for the more traditionally understood therapeutic elements of the psycho-analytic process, but rather...they must be added to our concepts of how and why the patient's psychic organization changes as a result of analysis so that we may have a more clear conceptual understanding of the process. (p. 219)

Greenson (1967) contributed greatly to the growing body of knowledge about the real relationship. He wrote clearly and extensively about the concept, addressing the importance, necessity and *integration* of the real relationship into the treatment, defining it as "the realistic *and* genuine relationship between analyst and patient" (p. 217). These qualities separate it from transference reactions which are unrealistic although genuine, and the working alliance which is realistic, but is a tool in the treatment situation. Greenson and Wexler (1969) continued:

> Our emphasis on the non-transference relationship between patient and analyst is a result of our dissatisfaction with the current one-sided stress on trans-

> ference interpretations as the main, if not the only, therapeutic tool....It is our belief that only the development of a viable 'real' non-transference relationship, no matter how limited in scope it may be, is essential to effect the resolution of the transference neurosis. (p. 31)

In 1971 Greenson extended these ideas, pointing out how crucial the real relationship can be during the most troublesome days of therapy when the patient is experiencing intense pain and difficulty.

> The importance of the real relationship can be seen in the rigors of working through. A patient will break off an analysis of long standing when driven by a sudden eruption of an intense hostile transference. This may be understood as a failure to make the correct interpretations. Yet I have made many false interpretations which my patients knew or sensed, and they did not run away. The decisive factor was the relative strength of the real relationship existing between us, how much genuine and realistic liking and respect there was between us. (p. 217)

> The reliable, enduring core of the working alliance is the "real relationship" between the patient and the analyst, using the term as I defined it, the realistic and genuine relationship. The transference feelings, loving or hateful, from the most infantile to the most mature, may be helpful, but transference is an erratic and treacherous ally. (p. 222)

Irvin Yalom and his patient Ginny made an unusual contribution to our understanding in their joint account of Ginny's therapy, *Every Day Gets a Little Closer*. Their mutual involvement comes through clearly as each recounts personal feelings and thoughts about their relationship over several years. Yalom described the impact of the real relationship in his reflections after her therapy ended: "We knew one another, touched one another deeply, and shared splendid moments not easily come by" (p. 233). Gelso and Carter (1985) took the position that "one must assume that clients give up a transference for some sort of realistic perception and thus for some kind of real relationship" (p. 186).

Viederman (1991) noted from his own experience as an analyst: "Many analyses become sterile by virtue of the apparent detachment of the analyst." But, on the other hand, "the affective presence of the analyst often generates anxious states in the patient that are then available for analytic scrutiny" (p. 454). Viederman attempts to explain why the real relationship has been downplayed in the psychoanalytic community, speculating that placing so much value on the personal attributes and responses of the analyst understandably generates concern that the definition of the analytic process will be clouded and its scientific status compromised. It is for this reason, he believes, that psychoanalysts have been hesitant to recognize the importance of the influence of their "person" lest it cloud the definitions of transference, countertransference, resistance, defense and interpretation (p. 459).

> In a properly conducted analysis, strict abstinence and anonymity as a goal do not adequately describe the most effective analytic stance....It constricts the analyst in such a way as to encourage formality and rigidity in his work....Abstinence and a certain anonymity remain important elements of an analytic stance that should be conceptualized in such a manner as to permit the type of responsiveness that will facilitate the analytic process. (p. 464)

To date, Bar-Levav (1988) has described and utilized the issue of the real relationship most thoroughly. For him the concept is so specific and is of such central importance to the therapy process that he has hyphenated it to emphasize its special meaning. A strong "real-relationship" between patient and therapist is one of eight basic principles (pp. 220-227) upon which his system of psychotherapy is based, a system which aims to achieve actual cure of depression. This system is basically different from other psychotherapy systems in that the aim is to alter life-long physiologic reaction patterns through the use of a surgical model.

> Surgery is brief in duration, but psychotherapy that heals depression requires several years of hard work. During this time a powerful and close relationship normally develops between the therapist and his or her patient. The strength and quality of this relationship enable the therapist's personality to impact upon the wholly

> conscious patient. This is how the intrusions are achieved. The therapist is, in effect, the equivalent of the scalpel. (p. 222)

The patient and the therapist must develop and maintain two "parallel" relationships. The first is a real one based on honesty, mutual respect and a commitment from each to maintain their involvement even in the presence of powerful emotional expressions by the patient. Within the real-relationship is a parallel therapeutic relationship where the patient has the freedom to express all thoughts and feelings and requires only that he pay the therapist's fee and adhere to a non-acting-out contract. This approach differs markedly from that of psychoanalysts and conservative psychotherapists who are "cordial but formal" with their patients and also from "humanistic" psychotherapists who "encounter their patients with limitless 'love' and compassion" (pp. 222-223).

Bar-Levav holds that within such a clearly defined structure the patient has room to experiment with feelings and thoughts, transferential or otherwise. "What makes the real-relationship real is the absence of anything unreal in it."

> The human qualities of the therapist do not remain altogether secret if the relationship is long enough, nor should they. The therapist's capacity to empathize, and the degree of his or her true concern, compassion, and sensitivity (or the lack of them) eventually show through. Patients can thus assess the therapist as a human being and slowly determine to what extent realistic trust is justified. (p. 230)

Having put the development of the concept of the real relationship in an historical perspective, we can see how, over time, the importance of the actual person of the therapist has slowly been recognized. We are now in a better position to examine the work of several current clinicians who have opened themselves and their treatment rooms for our scrutiny. How they understand the real relationship and its development with each patient and how they use both their understanding and their "self" has considerable impact on the course and outcome of the therapy.

REFERENCES

1. Bar-Levav, R. (1988). *Thinking in the shadow of feelings.* New York: Simon and Schuster.
2. DeWald, P. (1976). Transference regression and real experience in the psychoanalytic process. *Psychoanalytic Quarterly, 45,* 213-230.
3. Fairbairn, W. (1958). On the nature and aims of psychoanalytic treatment. *International Journal of Psychoanalysis, 39,* 374-385.
4. Freud, A. (1954). The widening scope of indications for psychoanalysis: Discussion. *Journal of the American Psychoanalytic Association, 2,* 607-620.
5. Freud, S. (1937). Analysis terminable and interminable. *International Journal of Psychoanalysis, 38,* 209-253.
6. Gelso, C. & Carter, J. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *Counseling Psychologist, 13*(2), 155-243.
7. Greenson, R. (1967). *The technique and practice of psychoanalysis.* New York: International Universities Press.
8. Greenson, R. (1971). The real relationship between the patient and the psychoanalyst. In M. Kanzer (Ed.), *The unconscious today.* New York: International Universities Press.
9. Greenson, R. & Wexler, M. (1969). The non-transference relationship in the psychoanalytic situation. *International Journal of Psychoanalysis, 50,* 27-40.
10. Loewald, H. (1960). On the therapeutic action of psycho-analysis. *International Journal of Psychoanalysis, 41,* 16-33.
11. Menaker, E. (1942). The masochistic factor in the psychoanalytic situation. *Psychoanalytic Quarterly, 9,* 171-186.
12. Roland, A. (1967). The reality of the psychoanalytic relationship and situation in handling of transference resistance. *International Journal of Psychoanalysis, 48,* 504-510.
13. Viederman, M. (1991). The real person of the analyst and his role in the process of psychoanalytic cure. *Journal of the American Psychoanalytic Association, 39* (2), 451-489.
14. Yalom, I. & Elkin, G. (1974). *Every day gets a little closer.* New York: Basic Books, Inc.

Although this is their first collaborative writing effort, Pamela Torraco, James Stanislaw and Victor Stoeffler have had numerous clinical associations over the past 15 years. All three practice in the Detroit-Ann Arbor area and have worked together as co-therapists in groups and as co-leaders of workshops at various local and national meetings.