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THE REAL RELATIONSHIP
A Key to Therapeutic Success

THE ROLE OF THE REAL-RELATIONSHIP IN LONG-TERM PSYCHOTHERAPY

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The necessity of involving a patient in a therapeutic relationship begins from the first moment of contact and continues throughout the course of treatment. In an earlier paper (Duquette, 1993) I discussed the three essential components of the therapeutic relationship: working alliance, transference and real relationship. In this paper I shall limit my focus to clinical examples which highlight the power of the real relationship when consciously utilized by the therapist.

Greenson (1967) defines the real relationship as "the realistic *and* genuine relationship between patient and analyst" (p. 217). Bar-Levav (1988) adds that its basis is "complete honesty and mutual respect, combined with a two-sided commitment to remain involved even in the presence of powerful expressions of hurt, anger, or irrational fear by the patient" (p. 222). He continues:

> Powerful confrontations must occur during the process of therapy between the patient's health and his or her illness, between thoughtfulness and feelings, between rationality and irrational impulsivity, between mature living and infantile tendencies. All these inner struggles are expressed between patient and therapist. The latter steadfastly supports the healthy part of the patient (the first half of each preceding pair), adding the weight of his or her personality to it. This is how the emotional scales are repeatedly tipped in the desired direction. In this sense the therapist is not neutral. When properly confined to the therapeutic relationship, these confrontations often shake but only rarely destroy the real-relationship. (Since it has a special meaning here, this term will be hyphenated from now on.) This relationship is continuously being cemented by consistent support for the patient's self-sufficiency and by the therapist's unyielding intolerance of any actions based on pathologic needs. (p. 223)

I have decided to use Bar-Levav's hyphenated "real-relationship" construct in this paper since it so clearly sets forth the specific entity with which I am dealing.

For the therapy to proceed properly, the real-relationship must be used to ground the patient in the present and to highlight transferential confusion. And as the therapy proceeds the real-relationship becomes the more operative experience and transference fades, theoretically at least, to a negligible amount at the end of treatment.

When patients come for help they are frightened and feel alone in their crisis. In the first minutes and hours of contact it is essential to touch them emotionally on a common level of human experience. They will respond not only to the therapist's insightful approach but to the sum total of how the therapist addresses them: voice, manner, and the physical appearance of the person and the office. Patients may not consciously know what is happening, but their response is likely to be favorable if the contact is genuine and sensitive.

HarPaz (1992) has commented on the intrinsic difficulties in the therapeutic work, especially at the beginning. It is then that the therapist and patient are immediately at odds in regard to their intentions. The patient wishes to feel good, or at least better, while the therapist's goal is to treat the patient's illness. Thus the relationship starts on uneven ground. The patient would surely retreat from such a process unless he or she experienced some solid foundation from which to begin the painful and difficult work. This solid foundation is the developing real-relationship. The following clinical example highlights this point.

Cathy, 28 and recently married, had worked as a nurse until psychosomatic issues "forced" her into managerial positions. She was referred to me by a relocating female psychiatrist who had seen her for the previous two years. She had originally presented with obsessive ideation related to fears of contracting the HIV virus responsible for the AIDS disease and then transmitting the disease. She focused only on the possiblity of transmitting the disease and, surprisingly, not on any further implications for herself. She had, in the course of three years of clinical nursing in a surgery unit, developed an allergy to latex gloves which are required as a means of protection against the virus and other contractible diseases.

Cathy's previous therapy had been supportive in nature with antidepressant medication used from the beginning. She described her therapy as helpful and her previous psychiatrist as "nice" and "caring." In her first session with me she was uncertain as to whether she would continue therapy,

having been told by the referring psychiatrist that she was "stable" and could continue with or without treatment, as she saw fit. I questioned the previous evaluation openly with the patient. I noted much about her that still greatly limited her ability to reveal herself and connected this to unresolved self-image issues. As we spoke her anxiety increased noticeably, although she appeared to block much of her experience from conscious awareness. I approached her gently but directly to help her talk about herself and her experience in the moment. Her confusion was clearly evident. I was aware she appeared highly focused on me and any reaction I might have, with little apparent attention to or awareness of her own physical and emotional experience. She told me that no one had ever asked her the questions I asked and no one else had shown concern and interest in her as I did. She at first had no answers to questions such as: "What is your reaction to me?" "Are you aware of how quickly you speak?" "What do you feel in your body?" I agreed to help her continue to look at whether she should become my patient.

In the next session she verbalized awareness of anxiety in relation to our first meeting. She was only able to notice this after recognizing that she did have a physical response that she evaluated as I had suggested. "I found my arms were tense and my neck and back were too. All I could guess was that maybe I was feeling something and it might be anxiety." I continued to explore her current bodily experience while she wondered about her emotions. She was intrigued by my inquiries and had begun to question what she had been told by her previous doctor. She described concerns that her symptoms would return. She demonstrated a growing awareness that instead of resolving troubling issues, she had changed her life in order to limit contact with various stimuli. She resolved to remain in twice weekly sessions. With the increased involvement she has made considerable progress and I have not found it necessary to prescribe any medication.

Pointing out clues to her experience while piquing her curiosity and simultaneously making myself available to explore with her was essential for Cathy. She worried that she would not meet the expectations of others. This experience stimulated abandonment fears and she became hyper-vigilant or withdrew from involvement. My sensitive questioning and non-judgmental acceptance of her insensitivity to her own emotional experience were important for this patient. This helped lessen her anxiety

significantly. As she held on more to this real interaction, she could consider important issues more openly.

The manner in which I asked the probing and difficult questions I thought necessary was an important part of the process between the patient and me. A therapist's humanity is one of the most difficult issues to consider when attempting to develop theoretical concepts since it is seemingly intangible. Writers on the subject have considered such qualities as the therapist's patience, tolerance, empathy, and style in working his or her craft as some examples of how their humanity is relayed to the patient (Blum, 1992; Viederman, 1991). Viederman attempts to place the "real person" of the analyst "center stage as an aspect of the therapeutic process that leads to change" (p. 452). He includes several illuminating clinical vignettes which allow the reader to get some sense of his person as well as the clinical issues of the patient and how his person impacts on the patient.

> To pretend that these factors do not powerfully influence the interaction with patients is not only to ignore the obvious, but more important to ignore something positive that facilitates the analytic process. The patient's engagement will be a product of the experience with the analyst that goes beyond intellectual analysis of defense and other content. (p. 464)

Thus Viederman is helping us begin to describe theoretically how inevitable and yet important it is that a therapist express his or her "humanness." My work with a patient I met in the first year of my psychiatric residency highlights these issues clearly. Roger was the first patient assigned to me for evaluation for therapy, earlier than most residents as I had explicitly expressed an interest in long-term therapy. He was a young medical student referred from the school's counseling center after seeking help there early in his first year. He had attempted to move out of his parents' home and share living space with three other male students. Nearly overwhelmed with anxiety and struggling with homosexual fantasies centered on his roommate, he was not verbalizing concerns about his sexual identity but instead was concerned about his performance in medical school due to increased difficulties in thinking and concentrating. His conversation focused on his dysphoria, his inability to concentrate as he had in undergraduate school, and his fears about leaving his parents' home. There was no depth to the description of his family. He

sensed some emotional connection to his mother but could not describe it. He could only describe his life to date as "good," his childhood as "fine with no problems" and his family as "loving." Even though I knew a male therapist would be more appropriate for Roger, none was available so I tried to do the best I could.

We continued meeting on a weekly basis. He dutifully came to each session, mostly because of his own requirement to be a "good patient." He had no apparent need for insight into his experience. I was receiving supervision from an analyst prominent in my program. He was trying to instill in me an "analytic perspective and manner." I did not expect to continue working from an analytic perspective but was proceeding in a manner consistent with being a "good resident." For several months I dutifully related process notes and tried to grasp analytic ideas such as "self-objects" and "screen memories." I slowly became aware that I was not involving myself on an emotional level with my patient as I tried hard to remain "analytically neutral." My patient was with me in a limited and distant manner typical of other relationships that he had described to me as problematic in his life. I also noticed he was not expressing any affect, although he reported episodes outside of sessions in which affect surfaced. However, with me he remained detached from the experience. He denied any association of his affect to his experience with me. I clearly was not helping my patient relate to me any differently from the way he had always related. In my eagerness to please my analytic supervisor I was severely restricted in my self-expression, thus limiting the relationship with my patient to a continual one-dimensional existence. As he proceeded I became concerned that my poor contact was adding to his anxiety and dysphoria.

I recall distinctly the session in which I concluded that I had gathered enough data and I decided to proceed differently. I began to invite more spontaneous affective expression with me and closely monitored the patient's reactions to me. For example, if I expressed surprise at something he said and he continued on in a monotone, I stopped him and asked if he noted my response and then his lack of response. Or if I smiled or laughed and he continued on without any apparent reaction I would stop him and invite him to speak about what he might have experienced rather than continuing on as if nothing had happened between us. He then responded with more depth and began to spontaneously wonder more about his own

reactions that lay beneath his rigid surface. He also began to wonder about the "postcard perfect" image of his early life and relationships. His involvement in therapy deepened as more affect was expressed. His affect was more visible in his interactions, he smiled with less constriction and cried when relating painful experiences from his adolescence. This continued throughout the next few months. As I took on more patients and lessened my supervision of this case I found that I was less imitative and restricted. After a crucial week of consideration as to whether to continue therapy at all, Roger took my recommendation and increased to twice-weekly sessions.

> "You've been different," he said.
> "How so?" I asked.
> "Just different for the last few months, since mid-summer. You smile more, your voice is different, more natural."

Roger had noted an important change in his experience with me as I strove to be less of a "blank screen." He believed it had been more helpful to him as he felt more able to verbalize his thoughts and feelings since he had seen me as more spontaneous and personable with him. I had not revealed any details of my life in that time but had shown much of my personal warmth and the interest I naturally carry for other human beings. He continued with me in twice-weekly therapy for five years and then successfully transferred to a male colleague for further work.

An essential part of any patient's experience is a sense of safety with the therapist. Patients cannot be expected to develop such a sense of safety with a therapist who is not genuine. If the therapist expresses his or her self, not by revealing life history but, rather, with repeated respectful and authentic contact, the patient will gain an important sense of the therapist as a human being. "As the therapist allows his or her real self to enter into this relationship it can be used as a consistent referent for the patient" (Duquette, p. 59). This involvement lessens anxiety that might otherwise be overwhelming, a crucial step in the fight against the patient's illness. It can lend real weight to the patient's belief that someone is truly present who can and will see, hear, and talk with them about the issues that seem so frightening in solitude. Also, such an experience can help separate the current reality from the transferential experience (Bar-Levav, 1988; HarPaz, 1992; Viederman, 1991).

Bar-Levav states, "Only within the real-relationship of properly conducted therapy is there enough room for a parallel therapeutic relationship in which the patient is free to express every thought and feeling and which requires no mutuality except for the payment of a fee. No other lasting relationship allows such complete freedom ..." (p. 229). It is within the experience of the real-relationship that movement can be made to free the patient from the potentially damaging effects of transference distortions. The following clinical example may help to clarify this.

Beth was a 48-year-old woman, referred by a mutual acquaintance, who was seen in twice-weekly individual therapy. She presented with symptoms of intense anxiety and related physical complaints. She had circumscribed her life to limit exposure to many anxiety-provoking experiences such as driving any distance and taking elevators. Although she had been on anti-anxiety medication prescribed by her internist, she recognized it only lowered her anxiety to a limited extent and she did not wish to continue on such treatment indefinitely. After two years of therapy she was strongly attached to me and recognized her progress in being able to discontinue the medication, drive to visit her daughter in college, and take vacations. Further, she had recently undergone serious heart surgery and had relied on my steadiness which helped calm much of her anxiety. Both she and her family recognized she would have had a much more difficult time if she had not been in therapy. Friends commented on her "amazing" recovery from surgery.

Approximately three months after the surgery I was moving my practice from the office where I saw Beth to one across town. Her reaction was muted at first but soon rigidified: "I just can't do it. I just couldn't see myself driving that far. I am just too scared." I tried to help her express her anger at me for moving but she said little except, "Yes, I may be angry, but so what? Telling you doesn't matter." Rather than expressing her anger she acted it out by not making an appointment at the new office even though she acknowledged that she saw her therapy as necessary.

I offered an appointment time which fit into her schedule and told her that I expected her to take it. At her last session at the old clinic she was irritable and withdrawn, continuing to say, "I don't know how I'll do it," but she didn't raise the question of not meeting. When she called the night before her first session at the new clinic to cancel, I asked if she was

leaving therapy. "I just can't meet," she said sadly. I suggested that she reconsider her "decision" and told her I would keep her time open. She did not come. I called her that evening, telling her that I was aware she was scared and probably angry. I reminded her that in her therapy she had seen dividends on her investment in considering the implications of her behavior. I also reminded her that she had used my help before but I could help her only if she came to sessions. She agreed to meet at the next appointment time I offered.

At first she focused on external issues -- it was too much hardship for her to travel so far and created too much inconvenience in her work schedule. I repeatedly addressed her interaction with me, commenting, for example, on her voice and manner and inquiring what she might be feeling. She slowly began to express more affect but only after I repeatedly asked her what she might be feeling and pointed out physical clues such as her voice and posture. She could eventually look directly at me, observe herself, and say, "I'm angry that you moved this far and made it harder for me." Her expression of anger was followed by intense fear that stemmed from her early relationships in which any direct expression of anger was stopped quickly. She became quiet and looked visibly shaken with her eyes wide. She voiced the sense that she was fearful of my reaction to her anger. Acknowledging anger directly had always been experienced as unacceptable, even dangerous. She had grown up denying her anger and hiding from others and had become good at politely snapping back at people who never knew she was angry. She then took a step further in examining her tendency to "live" her anger as she stated aloud with a smile, "You know, I can be the queen of sarcasm!" At the end of the session she could acknowledge that her feelings had driven her earlier "choices" and she agreed to a three-session evaluation about continuing her therapy.

In each session I spoke directly yet sensitively, monitoring the level of emotional contact I was inviting her to experience. Concurrently I was trying to help her verbalize her reaction and also further describe relevant aspects of her relationship with me. I was watchful of my physical expression, my tone of voice, my eye contact, the inflection of my questions. I was no different than in other clinical sessions but knew it especially important with Beth at that time to consciously continue to invite a deeper affective experience and also help her gain a fuller expression of

it. She began to speak of her current behavior in regard to the ways it mimicked past experiences. She appeared relieved when at the end of the third session she agreed to continue therapy. We both knew it was a victory for her to have stopped the acting-out behavior of cancelling sessions and, instead, remain involved in a relationship in which she felt safer than any other. She was beginning to express her emotional experience more in words than action.

The real-relationship with me provided a steadiness and a reality standard that lessened Beth's anxiety and helped her make use of her observing ego. She knew me as a person who had worked from the position of her best interest, a significant aspect of the real-relationship I had with her. By contrasting her transferential response with how I had actually been with her over the years, she was able to re-evaluate her actions and filter out the emotional component. This emotional experience had been far underground most of her life and sometimes was not known to her at all. It was highlighted by the juxtaposition to her current experience with me as a new person in her life.

These clinical examples serve to define and highlight the real-relationship and the aspects most visible and relevant to the difficult work of psychotherapy. Patients come to us in crisis. The crises likely exemplify lifelong difficulties which developed as their emotions confused their perceptions of reality. An important component of therapy from early on is the real-relationship. It is the solid ground to "step on to" with another human being present to "hold on to." It can offer a frightened, lonely person a place safe enough to examine prior "truths" about the world and then explore other paths. This aspect of the therapeutic relationship must always be consciously monitored by the therapist. Sensitivity, self-awareness, thoughtfulness and a strong hold on reality are crucial for the therapist, and in employing these abilities we can be instrumental in our patients developing such qualities themselves.

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Background Point of Theory

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 emphathize, 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. Those who never have a chance to know their therapist as a real person can only have blind trust, something of little value. Only in extreme despair and fear do we trust that which we do not know. Besides, patients of a therapist who remains basically anonymous can never become equals; the inequality is artificially maintained without hope of resolution. But when genuinely involved, therapists convey rather clearly what they are as human beings by their facial expressions, tonal quality, manners, and general demeanor and also by their dress and the way they furnish and maintain their offices. Even some biographical details become known eventually in real-relationships of long duration.

Thinking in the Shadow of Feelings, p. 230