Relational Counselling and Psychotherapy

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Contents

2
Core Elements of Relational Therapy

> "In my experience as both client and therapist, I've become convinced that empathic connection creates a better context for growth and change than explanation or confrontation does."
>
> (DeYoung, 2015, p.41)

Introduction

This chapter explores seven interlinking concepts or qualities present in relational work:

- Being respectful and non-judgemental
- Presence
- Empathy, compassion and attunement
- Curiosity
- Therapist as 'container'
- Relational depth Care.

The '**Spotlighting Relational Processes**' section highlights some relational competencies and debates at stake.

While the therapeutic relationship in some form is central to all therapy, not all therapy specifically takes a relational approach. Relational therapy understands that emotional vulnerability emerges from relationships, be they neglectful, toxic, or in extreme situations, persecutory. From this, it follows that a relational context is needed for resolution or healing. A relational approach invites explicit exploration of the intersubjective dynamics of a person's relationships, particularly the therapeutic one.

Being Respectful and Non-Judgemental

Ask almost any person what helps them feel safe and they will probably mention a space where they are respected and not judged. The experience of being

listened to in a focused, genuine, respectful way in therapy can be hugely impactful and potentially transformative. How else will they feel we understand and that we are there for them? (See also Chapter 3 which examines listening further.)

In the following quotation, Stella explains how she was grieving for her child who died. She shares that her therapy was a place where her grief was both welcomed and accepted.

> [I would be] crying, crying, crying and she'd just go 'This is where you need to be'. And I even emailed her one time because something had really upset me and I'd said 'I don't want to come today because I feel like all I do is whinge.' And she just said, 'Please don't feel like you whinge. You have every right to say what you need to say. And you can say it as many times as you want. I don't hear it as whingeing.'

The therapist's words were so precious to Stella that she kept the email. It reminded her that all aspects of herself could be accepted: 'I've still got that email 'cos it's like she was accepting me for everything' (Finlay and Hewitt Evans, 2022, p.37).

Taking a respectful, accepting listening approach is the fundamental idea underlying Carl Rogers' (1957) client-centred ideas about what is needed for client change to take place. In practice, three 'core conditions' of *congruence* (the therapist being authentic and genuine; behaviour matches their internal experience), *unconditional positive regard* (non-judgemental, affirming warmth) and *empathy* are used as a form of shorthand to characterise his work (see Figure 2.1). These concepts capture the importance of clients connecting honestly with another human being who is empathetically attuned and open in their non-judgemental

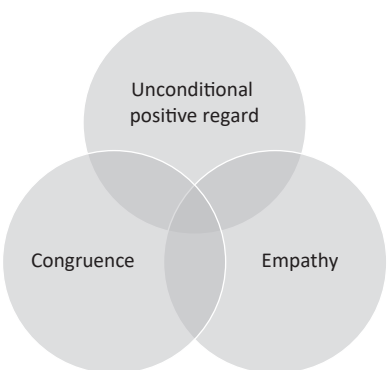

Figure 2.1 Rogers' core conditions

acceptance. When clients feel accepted by another, this paves the way for them to accept themselves.

While Rogers' conditions are mainly associated with *person-centred* work, therapists across all the modalities would probably support the view that the therapist's way of respectfully listening (and being open, supportive and not shaming or discounting) is a necessary foundation for the therapeutic relationship (Finlay, 2016a). However, not every element of Rogers' perspective is readily transferable to other approaches. For example, even within humanistic fields, some therapists would downplay the idea of unconditional positive regard in favour of honesty or authenticity (which Rogers also supported through his insistence on congruence).

The account from a client in Box 2.1 shows how important it had been for his comfort that his therapist respected him and listened rather than judged or made assumptions:

BOX 2.1

Case example: Feeling accepted and respected

I felt at home with my therapist because he was at home with me. I am a Sikh who wears a turban. When we first met, my (white) therapist indicated that he had noticed I was a Sikh. I could tell he understood something about that. In fact, he has visited India more than I have! Just one week before someone made the mistake of assuming I was Muslim. They didn't realise how offended I was. But this therapist understood. I particularly appreciated the way he asked me how important my religion and being a British Punjabi was to me. I was able to explain that my family and community ties were important but that I wasn't devout. While alcohol is prohibited with some members of my community, most of my family/friends are very Westernised and liberal and I freely drink alcohol. My therapist didn't make assumptions and make me feel uncomfortable. (Finlay, 2022, p.23)

Presence

Towards the end of his life, Rogers (1986) talked about presence as a foundational dimension, wondering if he had over-emphasised the core conditions while under-acknowledging presence. Therapeutic presence is generally understood as a state of being grounded in one's own embodied self in order to 'receive' the client's experience (Geller and Greenberg, 2012). It's a relational way of being solidly grounded, attuned, and spontaneously, intuitively responsive.

The notion of presence was explored in depth by the phenomenological philosopher Buber (see Box 2.2) and has since been extensively researched (see Box 2.3).

BOX 2.2

Theory: Philosophy of 'Presence'

Gestalt and existential therapists have built on the significant work of the phenomenological philosopher Buber (1923/1958) and his ideas about the twin dialogical processes of *Presence* and *Inclusion* (i.e., empathy where a person is able to take an other's standpoint while not losing their own). Buber sought genuine communication in the *dialogic I-Thou* relationship where one avoids habitual ways of interacting that are found in instrumental *I-It* relationships. The *I-Thou* relationship is free from judgement, self-centredness, manipulation, possessiveness, objectification, and expectation (Hycner, 1993).

Applied to therapy, when we have the courage to be fully present, we are met and confirmed by the other through what Hycner calls an 'embrace of gazes' (in Hycner and Jacobs, 1995, p.9). When present, the therapist gives up any instrumental desire to control, manipulate or be validated, and is simply present and open to being-with. The hope is that the client will experience their therapist offering a safe, containing, affirming solidness. The therapist's presence invites the client to be as present as possible (Finlay, 2016b).

BOX 2.3

Research: Presence

Geller and Greenberg's (2012) extensive research provides evidence of how therapeutic presence can promote a positive therapeutic alliance and therefore effective practice. Their model of presence comprises three domains: 1) *preparing the ground for presence* (pre-session and in life); 2) *process of presence* (inwardly attending, receptivity and extending/contact); 3) *experience of presence* (immersion, expansion, grounding and being-with/for client).

This model subsequently evolved into the development of a self-report measure (a research tool): '*the Therapeutic Presence Inventory*' (TPI). The TPI comprises two valid and reliable versions – one from the therapist's perspective; the other from the client's. Using these, Geller, Greenberg and Watson (2010) found that therapist-rated therapeutic presence predicts clients' perceptions of empathy, congruence and unconditional regard.

In the following dialogue, the therapist (Dave Mearns, a person-centred therapist) demonstrates an accepting presence while also being challengingly real in his use of words to show the client his concern:

Dominic 1: I shouldn't have come today. I'll go away if you like.

Dave 1: Because you've been drinking?

Dominic 2: Yeah – I've been drinking.

Dave 2: Do you *want* to go or do you *want* to stay?

Dominic 3: I wouldn't mind staying.

Dave 3: I would like that too…

Dominic 5: How do you feel about me…now…here?

Dave 5: Dom, I want to tell you that I feel absolutely *nothing* about the fact that you've been drinking. But you asked how I felt about you, now, here [pauses]. I feel… a bit…scared.

Dominic 6: Scared?

Dave 6: It surprises me too…I guess it *does* matter to me that you've been drinking…I'm scared in case we have to start again. […]

Dominic 7: Like it matters to you?

Dave 7: Yes it does Dom. … In fact, I *know* you know that Dom.

Dominic 9: Yes, 'sober me' knows it, but does 'drunk me'?

Dave 9: *I don't know. Does he? Do you?*

Dominic 10: Big question. Maybe I need another vodka before I can answer that.

Dave 10: Dom, *be* here, be here *drunk*, but don't play fucking games with me. Neither you nor I deserve that. (Mearns and Cooper, 2005, p.73)

Self-reflection 2.1

How does Dave make himself 'present' in the dialogue above? Would you be able to be as challenging?

Practitioners in some therapy contexts might have a 'no drinking' rule or decide not to let the session go ahead if the client is drunk. What therapeutic possibilities may have been enabled by Dave's acceptance?

It can be powerful for the client to see they have impacted the therapist – that *they matter*. The less the therapist is present, the more anxiety-provoking the situation is likely to be for the client, who may feel shame and/or abandonment in the face of therapist withdrawal or perceived lack of interest: responses which might well precipitate the client's own withdrawal.

Empathy, Compassion and Attunement

When we empathically and compassionately attune to another, we gently sense, resonate with, and stay with that individual in their experience. However, the multi-dimensional nature of this process, involving cognition, emotion, body, and developmental-relational elements, makes it hard to describe.

However, research demonstrates the way in which these interlinked components (empathy, compassion and attunement) propel the therapeutic relationship (Cooper, 2008). Other research shows how these elements can be used therapeutically. Emotion-focused therapy (EFT) (Greenberg, 2014), for example, is one evidence-based approach which suggests that empathic, compassionate attunement leads clients to develop affect regulation and their own ability for self-empathy and compassion.

That different theorists define these terms in varied ways adds to the complexity: while some use the terms fluidly and interchangeably, others distinguish sharply between them. Much depends upon the theoretical lens applied. Loosely speaking, humanistic therapists focus on 'empathy'; practitioners of relational CBT and mindfulness home in on 'compassion'; while relational psychoanalytic therapists favour 'attunement' (Finlay, 2016a). In practice, most therapists probably engage all three elements but to different degrees so it's worth considering them separately.

Empathy

When clients first enter therapy, they often struggle to articulate what exactly is troubling them and therapists need to check underlying *meanings*. 'Behind your words I'm hearing it all feels pointless. Is that how it feels?' Or, 'I'm sensing you feel betrayed. Is that around?' (Finlay, 2016a). Through these responses, therapists show empathy. They are gently sensing another person in order to better appreciate their experience; essentially stepping into their client's shoes. The process involves listening deeply to both the words and 'feeling tones' of the other: 'Can I resonate to what he is saying so deeply that I sense the meanings he is afraid of yet would like to communicate?' asks Rogers (1980, p.8).

When they experience therapist's empathy, clients feel that they are being listened to, understood and accepted. There is opportunity to make sense of their inner turmoil and develop self-compassionate acceptance and understanding.

Beyond technique, empathy is a relational process. When therapists empathically attune to the client's being, they resonate with them experiencing profound involvement in the client's world. However, empathy doesn't mean becoming fused with the client or assuming the client is like the therapist (as in 'I know your experience of raging against your father because I also hated mine'). Murphy and

Dillon (1998, p.88) argue empathy requires a shift in perspective: 'It's not what I would experience *as me* in your shoes; empathy is what I experience *as you* in your shoes'. In other words, we need to step back and appreciate the other's difference – their perspective and situation.

The extensive meta-analytic review by Elliott et al. (2018) indicates that empathy, while layered and complicated, is also a moderately strong predictor of therapy outcomes. The authors helpfully conclude with some tips about how to engage empathy which I've synthesised in Box 2.4.

BOX 2.4

Research: Synthesis of Findings on Empathy

- Empathy involves attuning to clients' experience, not simply reflecting back the content of their words.
- Therapists need to adjust their responses/understandings moment-to-moment, towards sensing clients' emerging experience.
- It helps if therapists explicitly explore the client's experience of therapist's empathy rather than assuming empathy has been shown. Client reports of therapist empathy predict treatment outcomes.
- Empathy is shown in therapists' listening, receptive attentive ways of being; not just in what they do.
- Empathy needs to be offered with humility; assumptions held lightly. The therapist needs to keep open to being corrected.
- Empathy is a co-created experience involving mutual communication.
- Empathy must be adapted to individuals. Some clients can find expressions of empathy too invasive or controlling.
- Empathy is not just a technique; it's part of being relational and offering authentic care. (Elliott et al., 2018)

Compassion

Compassion involves sensitive awareness of other and self, coupled with care. Wosket (2017) sees it emerging in stages. First, she is 'hit by' her feelings in response to what is going on for the client; she may shudder or feel a lump in her throat or tears may well up. She may even be momentarily 'struck dumb' by the impact of that feeling. But then thinking sets in, and this helps her give form to her feeling. She then shares this with her client, as in 'I felt like a weight fell on my chest as you described' (2017, p.214).

The important thing is to stay *congruent* (i.e., the therapist says what they mean/feel), advises Wosket, avoiding fake sympathy (as this will be picked up).

Simply trying to reflect back that a client finds it painful to relive the anguish of early child abuse, for example, is rather fatuous and potentially patronising (Wosket, 2017).

Paul Gilbert (2010) and colleagues have evolved Compassion Focused Therapy (CFT) which integrates techniques from CBT with concepts from Buddhism, neuroscience, and developmental psychology. It involves a process of nurturing self-compassion to increase well-being. In contrast to traditional CBT, particular attention is paid to collaboratively focusing on emotional expression, shame/validation, transference/countertransference and slowing down therapy to allow space to reflect rather than moving on to the next technique. The relational element is foregrounded as clients are seen to internalise therapists' compassion.

Self-reflection 2.2

Think about a time you found it difficult to attune empathically and compassionately to a client. What relational dynamics to do with your client and yourself might be arising between you?

Attunement

Attunement involves responding and adjusting to another in sympathetic, synchronous relationship. The attuned therapist *tunes into* the emotional tone of the client and is harmonically 'in sync' with them, tracking subtle shifts in the client's experience, and then focusing on what seems most salient for them. Like an attuned mother who notices a child's distress and offers comfort and soothing, the attuned therapist mediates emotion (Stern, 1985; Schore, 2014).

Erskine, Moursund and Trautmann (1999) describe how 'inquiry, attunement and involvement' are components of the overall empathic frame within which the client's growth is nurtured. It's about *kinesthetically sensing* and moving with the client in a contact-full way. The authors identify and characterise the multiple, nuanced versions of attunement:

Affective attunement – involves noticing and empathising with the client's emotion, vicariously feeling it, then responding by communicating a response.

Cognitive attunement – involves understanding the client's perspective, thinking and meanings.

Developmental attunement – involves attending to the person's ('child's') developmental needs, perhaps enabling their regression.

Rhythmic attunement – involves responding to the client's own rhythmic patterns, such as slowing the pace when clients are slow processors.

The story in Box 2.5 reveals a therapist's attunement and relational contactfulness as she shows compassionate tears while working with a client living with terrible grief.

BOX 2.5

Case example: Attuned responsiveness

George is a 70-year-old man who lost his wife to Covid which he may have inadvertently given to her. George feels responsible for her death; that he 'murdered' her.

The therapist wants George to experience her attuned resonance to his feelings. She invites George to look her in the eye and tell her about his wife.

He says he is haunted by not having been allowed to visit his wife in hospital. The therapist acknowledges how frustrating and 'crazy-making' that would be.

He describes that he is still confused about what happened, including how exactly his wife's body was stored given that the hospital morgue was full. When he says that he continues to have nightmares about that, the therapist acknowledges how disturbing that must be and she lets George see she is tearing up.

He then starts to talk about his wife and how she was a 'gentle soul' who everyone loved. 'She spread her love like music. She was always helping a friend or some lame duck.' As he speaks, he smiles through tears. 'She sounds extraordinary', the therapist says, 'a loss for the world as well as you'. As George continues describing joyful moments of their marriage, the therapist celebrates with him.

George spends several sessions talking about his relationship with his wife and together they recognise the magnitude of his grief and guilt. Over time, through the therapist's attuned empathy, his guilt lessens. It helps when she says, 'I definitely don't see you as a murderer. I don't believe your wife would blame you either.'

'You're right,' says George. 'She wouldn't want me to feel this way.'

'I think she would want you to remember her loving presence and your shared joy.' George nods and they smile together.

Self-reflection 2.3

Reflect on your capacity to (empathically and compassionately) attune to another. Are there certain people or situations which cause you to feel less empathy/compassion? What would help you develop your empathy/compassion/attunement?

Curiosity

When curiosity on the therapist's part is absent, empathy can feel smothering. 'Empathy alone can be the end of a conversation; with interested curiosity, empathy opens up new conversations' (DeYoung, 2015, p.84).

Curiosity is perhaps the most used, but least talked about, tool in the therapist's kitbag. Through our lively engaged focus, we convey our interest and join clients in the project of imagining new possibilities. You'll often hear therapists prefacing queries with 'I'm curious…?' Genuine, gentle curiosity from the therapist aims to raise the client's awareness of their issues and process (thoughts/feelings, experience, needs) and is important because it fosters their self-curiosity and reflection.

While it can be tempting to jump in with one's own understanding or perspective and/or well-meaning advice, it might prove more fruitful to take it slower, enabling the client themselves to wonder about their feelings/thoughts/responses themselves. In this sense, therapy is a process of opening a dialogue, posing questions, to enable to client to gain more self-awareness. With this self-awareness, the individual no longer relies simply on habitual behaviour; new possibilities arise.

In the Box 2.6 example, the therapist shows curiosity in different ways. Questions encourage a dialogue, which in turn becomes an exploration of their relationship as a possible microcosm of the client's wider relationships. First, the therapist interrupts a monologue and challenges the client, thereby placing the two of them in relationship. The therapist then offers some self-disclosure to model taking a compassionate approach, thereby encouraging the client to accept themselves with compassion (Germer, 2021). A further challenge invites the client to become more mindful of possible *transferences* onto the therapist (like seeing the therapist as his father) and assumptions that others are going to be critical.

BOX 2.6

Case example: Being curious

Pierre: You're probably thinking I should have been more assertive, but it didn't feel the right time and she...

Therapist: [interrupting] Can I ask you to pause a minute? It seems you're saying that I think you should have been more assertive. Actually, I think you were brave to have challenged your colleague. I couldn't have done that. And it wasn't the right time to be more assertive.

Pierre: You don't think I wimped out?

Therapist: No, I'm curious about what led you to think that of me.

Pierre: Dunno; just assumed.

Therapist: Who has said this to you in the past?

Pierre: My father. He was always telling me I was 'wet and weak'; that I should be 'more of a man'.

Therapist: Might you have been seeing your father in me?

To promote this mindfulness, variations of three open-ended questions can be usefully posed:

- *What's happening for you right now*? – This question invites the client to become aware of the present moment in terms of what is happening in their bodies, thoughts or feelings.
- *What would you like to happen*? – This invites the person to imagine a different scenario which opens up possibilities and invites further questions such as:
- *What might be getting in the way*? Are particular beliefs or emotions (like fear or shame) holding you back? Does your behaviour that you'd like to change have a useful function you don't want to lose?

How these kinds of curiosity questions are engaged varies across different modalities. In CBT, curiosity is shown through *Socratic questioning* (see Chapter 7). This technique is employed to ask questions that encourage reflection and problem-solving. In the humanistic field, *phenomenological inquiry* (see Chapter 4) is the preferred approach to explore 'What is this kind of experience like for this individual?' The aim is similar to Socratic dialogue in that the therapist asks questions that enable clients to make their own choices and find their own way through their specific life situation.

Integrative psychotherapists such as Erskine et al. (1999) ask questions about the client as a person in their life context (in all its infinite complexity) rather than as a 'problem to be solved'. The focus is on the client's experience by using:

- *bodily* questions ('What's happening in your body just now?')
- *cognitive* ones ('What sense do you make of that?')
- *affective* ones ('What are you feeling?')
- *relational* ones ('What's it like telling me that?').

Existential psychotherapist Ernesto Spinelli (2015) suggests comparing what might be happening in the here-and-now therapy relationship with what happens to the client outside in 'real' life; for instance, 'I'm curious that you seem to be trusting me here. What's different about what we are doing compared with your usual experience?' Through such curiosity, the client becomes more aware of their responses, while taking in the relational nourishment being offered (Finlay, 2022).

Therapist as 'Container'

The need for containment arises when a client's emotions become destructively overwhelming, such as when they are 'triggered' (where past trauma gets re-experienced) and they leave their '*window of tolerance*' (a functional state of

arousal; grounded thinking and feeling). Here, a client can become *hypo-aroused,* such as when anxiety turns to frozen terror or dissociation/numbing or *hyper-aroused*, such as when annoyance becomes rage.

The aim is to help them become more grounded and aware while being safely contained by the relationship. The client's unbearable experience gets contained, along with any emotional explosions, while the therapist supports them to better understand – and so deal with – their process.

In various integrative trauma approaches which draw on bodywork, containing might be enacted through '*anchoring*', '*braking*', '*stabilisation*' or even by holding the person physically. In psychoanalytic work, the containment involves managing *projections*. Both these versions are discussed below.

Containment in Trauma Work

Trauma work commonly starts with some containing *psychoeducation*; for instance, about the impact of trauma and how trauma responses can get triggered which can result in thinking shutting down with the person become 'dysregulated', going into flight/fright/freeze. The therapist teaches that we encode early traumatic memories as bodily-emotional states and will encourage clients to become mindful of their embodied processes. The aim is to help the person regulate their trauma responses, for example, engaging *bodily-relational mindfulness* to help them recognise they are no longer in danger.

Herman's (1992) classic model consists of three stages:

- *Safety and Stabilisation* focuses on helping the person develop abilities to self-sooth which establishes a 'safe' environment for further trauma work, e.g., through breathing exercises, sensory grounding, progressive muscle relaxation, autogenic relaxation, use of imagery.
- *Remembrance and Mourning* aims to create a space to the person to safely process/work through unresolved harrowing/traumatic memories and begin to make narrative sense of them.
- *Reconnection* involves redefining oneself given the context of meaningful relationships and engagement in life activities. Interventions might include reassessing one's role as a 'victim', writing a letter to one's younger self, or having a memorial ceremony.

The technique of *anchoring* can be particularly helpful in early stages of trauma work where stabilisation is needed to help the client return to their window of tolerance (Siegel, 1999). A good anchor, says Rothschild (2000), gives the client a feeling of relief. When working with individuals who have a trauma history, it can be useful to help them stabilise themselves by linking to images of a safe place or to a pleasant sensory memory, to which they can return to when feeling

overwhelmed. For example, when facing an anxious situation, an individual might summon a sense of a supportive other by their side, or they could 'anchor' themselves by imagining a tranquil tropical beach they have enjoyed previously.

Containing Projections

The concept of containment has a particular part to play in psychoanalytic work (see Chapter 4). Analytical interpretations home in on clients' *unconscious projections* (where unacceptable feelings are disavowed and attributed to someone else). The therapist receives these, manages them, and then gives them back to the client in a contained, insight-promoting way. For example, when a person feels anger which is hard to own, they might accuse the other of being angry. When this anger enters the room, it can be explored and managed.

Sometimes, clients (unconsciously) project feelings they have about someone important in their lives onto their therapist – a process called *transference*. For example, a client may react to their therapist who reminds them of their mother or a problematic boss. Therapists will aim to notice such projections when they occur through attending to their own responses to the transference (counter-transference). On receiving the projection, the therapist-container takes in the feelings from the client, reflects on them, and then represents them back to the client in a modified, more understandable and less destructive way. This is the start of helping the client develop more awareness of their hidden emotions and needs. With such insights comes the possibility of healing, change and positive action.

The therapy relationship thus becomes a safe space, one which receives and manages emotions and unconscious processes which threaten to overwhelm. With time, the hope is that the client can become their own container, able to *emotionally self-regulate* in healthier ways (Gravell, 2010).

It should be emphasised that the therapist-container who holds potentially harrowing processes also needs to be held and contained. This is where *supervision* comes in as a container for the therapist. The kind of work therapists do, particularly when receiving dark projections (see Chapter 8), means committed self-care is necessary.

Relational Depth

The quotation in Box 2.7 comes from a client who took part in research about experiences of finding a '*relational home*' with a psychotherapist (Finlay and Hewitt Evans, 2022). Here, 'Pia' expresses the trust, connection and sense of

BOX 2.7

Case example of finding a nourishing therapeutic connection

I *trust* she can and will hold me. I *trust* that she doesn't judge me. She sees me. She's the only one who does. One therapy session I remember early on was when I had been talking – a long monologue about my feelings – she just said, 'I'm not feeling it. You're talking about your feelings but I'm not feeling connected to what you're saying, and I don't think you are.' I got a bit upset and asked her what she wanted from me. I think I was almost a little angry that again I somehow, I wasn't…good enough. She just urged me to let go; that she was there with me; that she'd hold me. And, somehow, I'm not quite sure how, that is what happened… I started to get tearful and really connect with my feelings and she was there holding my hands with tears in her eyes. …

Now I look back, and at my relationship with her, and I can see that…I've changed. Something has shifted inside. …It took some time. She was patient with me. But we got there. For the first time in my life, I have found a relationship that is…profoundly nourishing. ('Pia' in Finlay and Hewitt Evans, 2022, pp.39, 40–41)

being seen that she experienced with her therapist, and how over time the nourishing relationship enabled her to change. In other words, she experienced some healing through relational depth involving both challenge and touch.

Relational depth is a term originally used in the humanistic literature (Mearns, 2003; Mearns and Cooper, 2005; Knox et al., 2013) to explain the profound co-created authentic, flowing connection between therapist and client that can occur. There can be a depth of human-to-human relating which allows the client to feel sufficiently safe to go deep within their own experiencing, move forward and grow.

Cooper (2013) summarises the extensive empirical findings on relational depth. He notes that most therapists (particularly humanistic) seem to have experienced moments of relational depth, and that these are often associated with positive therapeutic outcomes.

Much of the evidence base about relational depth relies on therapists' accounts. There are some significant exceptions, including McMillan and McLeod (2006), who identify potentially important differences between clients' and therapists' accounts – a critical issue for any collaboration. Their study also highlights the importance of the therapist being prepared to 'go the extra mile'. But it is the client's willingness to 'let go' and be fully involved in the relationship which characterises enduring relational connection.

As Knox et al. (2013) highlight, the research on relational depth refers both to the significance of a deep, sustained relationship and to the impact of specific moments of relational depth. Knox's own study (2011), also based on interviewing clients about their experiences, reveals how moments of relational depth

tend to follow challenges from the therapist and which shift in the relationship. Critically, these moments tend to occur once the clients themselves are ready to engage at depth and risk opening up.

Care

Probably all the elements discussed above can be subsumed under this broader heading of care. While therapists talk about the way we care-*for* and care-*about* our clients, Noddings (2013) extends these categories to recognise a 'feminine' version of *caring-with*, rooted in ethics of relationship, receptivity, responsiveness and reciprocity. This is all about being genuinely interested in, and concerned for, clients' well-being. There is a mutuality of care that is shown both when clients are moved by our responses, just as we are moved by theirs.

Research (e.g., Levitt et al., 2016) shows that therapists' care allows clients to feel safe enough to be vulnerable and able to put aside defences against self-exploration. Internalising the therapist's acceptance and care – a key dimension of relational work – clients embark on the road to *self*-acceptance and *self*-care.

Our professional codes commonly highlight the importance of *duty of care* to place clients' best interests to the fore and to provide an appropriate standard of service (e.g., BACP, 2018). This requires therapists to ensure clients are not harmed physically or psychologically (*beneficence* and *non-maleficence).* In practice, however, achieving this goal may prove challenging. Despite our best efforts, some clients leave sessions churned up, perhaps feeling worse. Sometimes the effect is a temporary part of the process. It's more problematic when clients feel damaged or hurt.

A key question is: how do we embody this care? (see Chapter 7 on being the safe 'body' a client needs). Research shows that therapy is compromised when clients perceive caring to be over-involved, insincere and/or patronising (including when treating the client like a child). It is therefore important – ethically and relationally – to reflect on how best to communicate care and offer it in the right way (Finlay, 2019).

Partly this depends on what the client needs and would accept. Many, but not all, clients appreciate the therapist's warmth or readiness to do something over and above what would normally be expected. When this happens, clients feel seen and that therapists are not just applying standard protocols. Our skill lies in 'titrating' (adjusting) our presence, generosity, validation, and so on. It also lies in us being sufficiently self-aware so as to catch ourselves when we start to care too much: for example, when we become over-invested in a client's outcomes or we want the client to reciprocally appreciate us. But genuine care doesn't involve asking for something in return (Knox and Cooper, 2015).

Problems arise when care morphs into control or abuse of power, or where there is an imbalance in the relationship: for example, when the transference is so potent that we are positioned in uncomfortable ways, or when the client has such a commanding presence that we feel squeezed out (or vice versa) (see Chapter 8). Undue imbalances of power can be especially challenging in instances when a young therapist feels shame in the face of an older highly educated, wealthy client, or when a Black working-class client suspects it will be impossible for a White middle-class therapist to understand their experience. For these reasons, it becomes important to be reflexive and to have some open and mutually reflexive dialogue (with the client and in supervision) about the impact of intersectionality (see Chapter 5).

Self-reflection 2.4

Consider the case studies in Chapter 1. How did each therapist demonstrate their care?

Then think about how you offer care to others (clients, colleagues, friends and family) and how it differs according to who you are giving it to. Can you identify any 'boundaries' which you wouldn't cross with some and not others?

Spotlighting Relational Processes

The relational elements discussed above are engaged from the first moment of contact when the client comes seeking a place of protection and the therapist opens to them. As Kapitan (2003, p.74) asks, where else is this 'sanctuary' if not in the heart of the 'therapist who is willing to face this living encounter and courageously open to it?'.

Thereafter, the key shift a relational therapist makes compared to a non-relational one is to move from 'How can I help my client? What should I *do*?' to 'What kind of relationship is my client needing? How should I *be?*' (Markin, 2014; Finlay, 2022).

As therapists sensitively and empathically tune in, they register subtle changes in the client's emotional expressions while being aware of their own intersubjective experience. At the same time, they *regulate* their own and their client's affect (Schore, 2014).

Working relationally, it is helpful to reflect on what is happening in the here-and-now relationship *with* the client. For instance, I might say, 'I'm struggling to feel you at the moment and I'm wondering about what's going on between us.' Or 'How are *we* doing?' These questions invite the client to reflect on their part and brings the therapy relationship more into the room.

Paul and Charura (2015), while noting that a relational approach is driven largely by philosophical principles, helpfully lay out specific *Relational Competencies* (see also the competencies discussed in Chapters 6 and 9):

Practical ones around developing good, collaborative therapeutic relationships;

Personal aspects such as being authentic, empathetic, reflexive;

Professional competencies concerned with attending to ethical and professional frameworks;

Contextual concerns which attend to the particular social context of the individuals involved.

While different theories of counselling/psychotherapy emphasise particular competencies (see Chapter 4), generic models are emerging. For example, the CPCAB model of helping and counselling (see www.cpcab.co.uk) suggests there are seven processes which support client change. These include working: ethically, with relationship, with difference/diversity, with a focus on the client, with self-awareness, within a coherent framework, and working reflectively. The relational therapist commits to all of these but maintains a relational lens. The focus on the client, for instance, acknowledges their wider social-relational context and their way of relating with the therapist.

Beyond professional competencies, therapists' *relational artistry* often comes down as much to the timing of interventions as to what we actually say/do. There is a tricky balance to be found between being intuitively, creatively, authentically responsive in the moment and being controlling, overwhelming or just over-involved. At what point (if at all) should we move from a compassionately empathetic listening stance to one that is more actively responsive and challenging (see Chapter 3)? When should we respond intuitively rather than ask questions? When might we interrupt a client's monologue or give the client space rather than insert our presence? (Chapters 6–8 offer a range of case studies which illustrate these processes.)

Of course, it is not always easy to attune compassionately or empathise with clients' challenging behaviour. Therapists can also be thoughtlessly clumsy, or their history may be triggered. Hopefully, any damage done to the relationship can be walked back, the relationships strengthened in the long term (see Chapter 8 on ruptures).

Final Reflections

This chapter has discussed intertwined elements of relational work: being respectful and non-judgemental; presence; empathy, compassion and attunement; curiosity; therapist as container; relational depth; and care.

Respectful listening can enable the client to develop self-curiosity and a sense of trust in the relationship: baby steps towards self-growth – the topic of the next chapter. As the therapeutic relationship is nurtured over time, therapists' attuned presence attends to clients' relational needs while validating, holding and challenging their process. Patricia DeYoung (2015) has highlighted the significance of relationally validating connections based in intuitive, holistic 'right-brain-to-right-brain' communication (Schore, 2014). In such communications, she recommends a playful, accepting, curious and empathic approach. The client internalises the therapist's care which helps to grow their self-awareness, self-worth, and compassionate self-acceptance.

This is the relational 'dance'. Think of a tango where the therapist and client twist and glide through a series of improvised steps, moving closer and then pulling apart. Some steps can be learned but the music and rhythm have to be felt in partnership.

Recommended Resources

1 **Article**: Tips for cultivating therapeutic presence with online work can be found in: Geller, S. (2020) www.sharigeller.ca/_images/pdfs/Cultivating%20online%20therapeutic%20presence_July2020.pdf
2 **Book**: Tales of Un-knowing: Therapeutic Encounters from an Existential Perspective by Spinelli offers powerful case studies of existential work.
3 **Book**: *Beyond Empathy: A Therapy of Contact-in-Relationship* by Erskine, Moursund and Trautmann highlights relationally orientated integrative psychotherapy.
4 **Book**: *An Introduction to the Therapeutic Relationship in Counselling and Psychotherapy* by Paul and Charura offers a wide-ranging exploration of the 'relational approach'.
5 **Video**: Carl Rogers on empathy – see: www.youtube.com/watch?v=iMi7uY83z-U