The Five Therapeutic Relationships

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Abstract: Founded on research evidence, Clarkson declares that it is not any specific psychological counseling paradigm itself that is the quintessence of therapeutic effectiveness but the tangible therapeutic relationship between the therapist and client. Clarkson states that there are five types of relationships potentially present in the therapeutic encounter. These are (a) the working alliance, (b) the transference/countertransference relationship, (c) the developmentally needed/reparative relationship, (d) the person-to-person relationship, and (e) the transpersonal relationship. This case study presents the theoretical framework of the five relationships; it demonstrates how this was utilized in the clinical context with a male client referred to as Harry and what were for him the implications of the therapeutic relationship assisting him to overcome low self-esteem, childhood sexual abuse, and depression.

Keywords: relational model; therapeutic relationship; working alliance; transferential/countertransferential relationship; reparative/developmentally needed relationship; person-to-person relationship; transpersonal relationship

1 THEORETICAL AND RESEARCH BASIS

Ever more research is discovering that exceeding every other aspect, it is the relationship between therapist and client that ascertains the significance and the efficacy of the therapy (Bergin & Lambert, 1978; Hill, 1989; O'Malley, Suh, & Strupp, 1983). For Goldfried (1980), relationship is the keystone of all psychotherapy. Kahn's (1991) teacher stated, "The relationship is the therapy." The relationship between client and therapist was found to be one of the most prominent dynamics in the therapeutic outcome by Frank (1979) and Hynan (1981).

The formulation of this case study is based on Clarkson's (2003) five-relationships framework for psychotherapy integration. Based on this framework, the case description will focus mainly on the therapeutic relationship between client and therapist. Different theoretical orientations are utilized in an integrative way, aiming to establish, develop, and serve the unique therapeutic relationship with this particular client.

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2 CASE PRESENTATION

The present case study describes the client's therapeutic journey within the context of Clarkson's five-relational model, utilized for eight sessions. The biographical details of the client have been disguised for ethical reasons. To make the description of this therapeutic journey easier for the reader, the therapeutic process of the first three (1 to 3) sessions is described separately, and then the other five (4 to 8) are presented as a solid continuum of the therapy where the client worked through his real issues.

3 PRESENTING COMPLAINTS

The family physicians based at this practice refer clients for counseling via referral letters. The counselors then contact the clients, by phone or letter, to arrange an appointment. This client, Harry (pseudonym), was referred for counseling by the family physician, whose assessment letter reported that Harry was "feeling rather low and stressed recently" and that he was "getting easily irritable with his daughter, which was making him feel very guilty." The family physician noted that he thought that "the client was not clinically depressed but that he would welcome the opportunity to talk through the difficulties in his life."

4 HISTORY

Harry is a 33-year-old male from the Indian subcontinent. He married 10 years ago and has a daughter, aged just younger than 2 years. He is educated to the graduate level and works in the information technology industry. His wife is a health professional. He came to the United Kingdom as a teenager to live with his siblings, who had moved to this country while he was still a child. Harry lost his mother when he was 15 years old. Harry said his mother had physically abused him many times during his childhood. This was something that his father had never done. He continued bedwetting until he was 8 years old. He claimed that he had a better relationship with his grandparents than with his parents.

5 ASSESSMENT

Harry presented as well groomed in all sessions. He usually was dressed in casual clothes (e.g., T-shirts, button-up monochrome shirts, pastel-colored pullovers and jeans, or casual trousers). In almost all sessions, Harry had his job's pass card and a group of keys hung from his neck or the waistband of his trousers. In therapy, Harry was very articulate, and he seemed to be psychologically educated, expressing and describing his thoughts, emotions, and events in a clear, rich, and direct way. During the first session, Harry wept a lot, and emotionally he seemed to be enormously

vulnerable. Harry was given space to express his emotions, and I acknowledged his distress. When Harry's distress calmed down, I moved to the initial contract with him. During the initial sessions (1 to 3), Harry seemed willing to work, yet he was quite unstable as to the therapeutic work (e.g., cancelled appointments, was not punctual). In the following sessions (4 to 8), Harry really engaged in therapy, and he revealed the real issues that were troubling him. Because these were the issues that he now wanted to work out in therapy, there was an alteration in the contract (i.e., the emphasis was given to those latter issues). Harry left therapy having released a significant amount of his repressed feelings of fears and anxiety and having improved his self-image and his self-confidence. These changes and their consequences were reflected in his real life, and Harry stated he was willing to continue working on his self-development and growth.

6 CASE CONCEPTUALIZATION

The content of this case study is based on Clarkson's five-relational model as a theoretical and clinical framework for psychotherapy integration. Based on research evidence, Clarkson (2003) declares that it is not any particular psychological counseling paradigm itself that is the essence of therapeutic effectiveness but the actual therapeutic relationship between the therapist and the client. Clarkson (2003) states that there are five types of relationships all potentially present in the therapeutic process. These are

THE WORKING ALLIANCE

This is the constituent of the client–therapist relationship that enables both the client and the therapist to work together even when one or both experience strong desires to the contrary.

> In the working alliance, the client's reasonable side . . . aligns with the counsellor's working side (which is his or her more reasonable side). This permits the client to experience negative feelings toward the counselor without disrupting the work . . . . It is the working alliance also, and perhaps more essentially, that creates the sense that the participants of the counseling relationship are joined together in a shared enterprise, each making his or her contribution to the work. (Gelso & Carter, 1985, p. 163)

THE TRANSFERENCE/COUNTERTRANSFERENCE RELATIONSHIP

This is the anticipated relationship in which the experience of unconscious wishes and fears onto or into the therapeutic partnership take place. This can take any of four forms, any of which could act in a facilitative or destructive way in the therapeutic process:

1. Proactive transference—what the client brings to the relationship or the client's projections of past experiences onto the therapist.
2. Proactive countertransference—what the therapist brings to the relationship or the therapist's transference toward the client.
3. Reactive transference (or countertransference)—what the client reacts to because of what the therapist brings in the relationship.
4. Reactive countertransference—what the therapist reacts to in the client (Clarkson, 2003).

THE DEVELOPMENTALLY NEEDED OR REPARATIVE RELATIONSHIP

> The developmentally needed or reparative relationship is an intentional provision by the psychotherapist of a corrective, reparative, or replenishing relationship or action where the original parenting was deficient, abusive, or overprotective. (Clarkson, 2003, p. 113)

THE PERSON-TO-PERSON RELATIONSHIP

"The person-to-person relationship is the core or real—as opposed to object relationship" (Clarkson, 2003, p. 152). Garfield and Affleck (1961), Sloane, Staples, Cristol, Yorkston, and Whipple (1975), Ford (1978), Adelstein, Gelso, Haws, Reed, and Spiegel (1983), and Gelso, Mills, and Spiegel (1983) have all shown that it is significant to the client that there be a real relationship from within which the psychotherapist can use whatever theory or technique he or she advocates.

> In contacting you, I wager my independent existence, but only through the contact function can the realization of identities fully develop.
>
> Contact is not just togetherness or joining. It can only happen between two separate beings, always requiring independence and always risking capture in the union. At the point of union, one's fullest sense of this person is swept along into a new creation. I am no longer only me, but me and thee make we. Although me and thee become we in name only, through its naming, we gamble with the dissolution of either me or thee. Unless I am experienced in knowing full contact, when I meet you full-eyed, full-bodied and full-minded, you may become irresistible and engulfing. (Polster & Polster 1973, p. 99)

Often this relationship only emerges toward the completion of the psychotherapeutic process.

THE TRANSPERSONAL RELATIONSHIP

"The transpersonal relationship is the timeless facet of the psychotherapeutic relationship, which is impossible to describe, but refers to the spiritual dimension of the healing relationship" (Clarkson, 2003, p. 187). Grof (1979) defined it as "experiences involving an expansion or extension of consciousness beyond the usual ego boundaries and beyond the limitations of time and/or space" (p. 155).

These relationships do not constitute a sequential and/or hierarchical structure of the therapeutic process. Different types can occur or overlap any time in the therapeutic task, even during one session. This model recommends a different way of viewing and experiencing the entire therapeutic process. In this manner, the therapist focuses on the actual relationship with the client and can deliberately utilize each type, aiming to fulfill the client's unique needs.

7 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

The setting for this case is a family physician's office (part of the U.K. National Health Service), where I work as a counselor. It is not a requirement to work from a particular theoretical approach in this setting. The contracts with the clients are preferably quite short (up to 12 sessions).

BETWEEN REFERRAL AND FIRST SESSION

I saw Harry for the first time after an administrative error regarding his first appointment. The receptionist failed to pass on the client's message that he confirmed to attend our first appointment and I was not in the office. I explored and dealt with ethical, boundary, and administrative issues that were involved in this incident because it could potentially threaten the establishment of the working alliance with the client before starting therapy.

SESSION 1

Harry turned up for his first real appointment, a fact that might show his determination and/or need to come into therapy. In terms of appearance, Harry was casually dressed and well groomed. He presented himself as having close emotional bonds with his child and wife as a father and husband. He seemed to be very caring, giving me the impression of a "low-profile," "family-centered" man (i.e., the well-being of his family was an important priority for him).

At the beginning of the first session, I openly invited Harry to discuss the administrative confusion and any thoughts and feelings around it. He expressed his frustration and his understanding regarding such organizational issues: "It happens," he said in an adult, here-and-now manner, indicating that a person-to-person level of relationship was potentially available. It felt as if a good working alliance had started to be established.

As the session progressed and we talked about the reasons that brought him to counseling, Harry wept a lot. He talked about his childhood, the difficult and traumatic relationship with his mother, and how he was feeling that his past experiences were affecting his present quality of life, his family, and his social relationships.

He also stated that he decided to come into counseling because his wife did not want to have "the psychologist's role in their relationship," as he said. This was indicative to me that Harry needed mainly a reparative/developmentally needed

relationship with me, something that his wife, who was "suffering depression" at the time, refused to offer. Harry seemed to acknowledge that coming to counseling would be the best way for him at the moment to deal with his own issues and that this would contribute toward maintaining "healthy" and clear boundaries in his relationship with his wife.

As Harry was describing his issues in a dramatic yet very articulate way, he had a rather frightened, almost frozen gaze (he was looking down toward the end of the room) and a low voice, and his eye contact was very poor. It was as if while talking to me he was recalling traumatic experiences and feelings. At this point, it seemed that Harry was in a state of spontaneous regression. I felt (my reactive concordant countertransference)[1] that it was really necessary for Harry to be provided a safe and supporting environment that would offer him space to explore and release his feelings. I dealt with regression by offering reparative and developmentally needed interventions based on the Rogerian "core conditions," as Mearns and Thorne (2002; Mearns, 2003). Clarkson (2003), referring to spontaneous regression, states,

> There are occasions when a client comes into the consulting room in a state of regression or when they spontaneously regress or go into shock in response to something the therapist says or does (but it was not necessarily intended to evoke the response). The therapist has little choice except to deal with it. Perhaps any intervention in this situation will be reparative, if not also developmentally needed. (p. 130)

Establishing the working alliance, what Harry wanted from counseling was to help him "improve the ways he communicates, in order not to be easily angry," because he did not want the "other people"—emphasizing his daughter—"to be scared of him." Later, in the discussion, it emerged that some underlying reasons were that he was "scared of change" and this fear was making him a "control freak." It seemed to me that Harry's inner child was feeling scared and that the critical parent was trying to protect him by acting as "the control freak." So, at this stage, I thought that Harry was possibly looking for an adult ego state to comfort the child and to teach the parent new skills. This would be provided to Harry through a reparative/developmentally needed relationship.

We agreed to work together for six sessions to explore the issues underlying his anger and his fear of change, which were blocking him from being his "real" self to others, which had impact on his communication. We met once a week, for 1 hour, with the option of additional sessions on review of progress. Confidentiality issues and how possible breaks and cancellations would be dealt with were discussed. The contract seemed to contribute into creating a stable and safe environment for Harry that would offer him the space to meet his needs.

BETWEEN THE FIRST AND THE SECOND SESSION

Harry informed me in advance that he wanted to cancel his next session. He decided to go for a 1-week holiday to his home country with his wife and their

child, and as he told me in the second session, he took this decision just after our first meeting. This gave me the sense that Harry was possibly using the therapeutic space as a containing starting point to work his issues, confirming the reparative/developmentally needed nature of our relationship.

SESSION 2

In the second session, Harry was rather enthusiastic about his decision to organize this trip, and he was experiencing it as an achievement. It felt as if Harry were experiencing me as a parental figure, the good mother, to whom he was expressing his great enthusiasm regarding his ability to take such an initiative expecting some sort of gratification. This transferential aspect acted in a facilitative way in the therapeutic process; Harry had a safe space, a cocoon, to celebrate his achievement from a child ego state, and this seemed to enable him to gain more trust in our therapeutic relationship.

This was also demonstrated later in the session, when Harry opened up more and talked about his vulnerabilities. For instance, he said that there are "childish" aspects of his behavior and that sometimes he deliberately presents himself to others as an unreliable and careless person. However, this is not representative of his "real self"; it is not the reflection of how he is "really feeling deep down," as he said, pointing at his chest about a situation and/or a person. He said that this helps him "to keep a safe distance from others."

It felt that Harry was confessing to me precious information about his inner psychological functions. It was as if he trusted to me the "golden key" for his weakest, most sensitive points. Harry was actually showing and informing me as therapist which path to follow to meet his real self, yet without hurting or threatening him. I thought that the therapeutic effectiveness would be maximized if I would fully accept and respect this "distance," as Harry named it—"resistance" as I as therapist call it—and acknowledge its wise purpose. According to Hycner (1993),

> All so-called resistance is a manifestation of just how vulnerable this person feels. It is an announcement of the fear of taking risks, which aren't supported by the prior experience of this person. It is an essential form of self-protectiveness . . . . Resistance is the wall that encloses early deeply felt wounds. It is a wall that is at best semi-permeable. (p. 138)

And he also states, "The resistance can be a deep expression of something this person desperately needs and it's the only way he knows how to take care himself . . . . Unfortunately, unlike a real care-giver, resistance is primarily defensive rather than nurturing" (p. 139).

BETWEEN THE SECOND AND THE THIRD SESSION

Harry forgot to come to his third session. Initially, I started having concerns about our working alliance; I wondered whether this was possibly a vivid demonstration of

his words in our last meeting and whether it had to do with transferential issues because this behavior seemed to be in strong contrast to his willingness to engage and to work.

Very soon, he contacted me wanting to apologize and to confirm that he would attend the next session. I was feeling that Harry was testing the boundaries between us and that in this case it felt that it would be effective to accept him unconditionally offering a reparative/developmentally needed relationship.

SESSION 3

Harry came into the third session feeling very low. I invited him to communicate his feelings. He said he was feeling guilty and angry with himself because he has been intentionally testing out the limits in relationships with loved ones. He deliberately hurts them (e.g., by using bitter humor, being cynical, or intentionally giving them a hard time, and then he apologizes, thus creating a vicious circle; "I know I hurt them, and then I ask sorry again and again"). On further exploration, he said that he was feeling "extremely scared" and he did not want to be the "good child anymore." This indicated to me that there was a transferential relationship between him and me at this point and that in the last session he behaved the same way he was behaving to his loved ones. I communicated this to Harry, and as we were discussing it, he experienced a significant "insight," which was the realization of how his behavioral pattern was reflected and demonstrated in our relationship. I, as therapist, had to uphold the emotions that are enthused in him, rather than discharging them, to facilitate subordinating them to the analytic task in which the therapist functions as the patient's reflection as perceived in a mirror (Heimann, 1950). These intense moments in the session, which were followed by transference resolution via dialogue, enabled us to reach a significant level of relational depth.

In the middle of the session, Harry revealed that he had been sexually abused when he was 5 years old by a close male relative, an exceptionally horrific, traumatic, and overwhelming experience that he feels still has consequences in his life.

Client: I have been sexually abused. Does this disgust you?

Therapist: No, I just feel how painful and terrible such an experience must be for you.

I felt that this confession showed now Harry trusted me fully. We continued working now on a deeper level, and it seemed to me as if the work had really started.

SESSIONS 4 TO 8

During the next four sessions, our focus was mainly on the sexual abuse and its consequences for him, for example, "feel insecure and forget that I am an adult sometimes," "feel threatened by physical closeness or contact with adult men," "since 13 to 14 years old have developed a very advanced and delicate intellectual network in order to protect myself from getting hurt," "feel embarrassed and ashamed for my experience, even guilty that I caused it," "I feel extremely overprotective towards my daughter." Now Harry was disclosing "this network and patterns

of behavior I have developed to defend myself has become a prison." This was not allowing him to experience life fully, as he desired.

I asked Harry whether he would like to work with me on the issues that seemed to block him from experiencing his life fully and more realistically. He accepted in a very genuine, person-to-person way, indicating trust and a strong willingness and commitment to work together through his issues. He disclosed that I was just "the second person in my life that I have told about the sexual abuse" and "keeping it secret for so many years and not dealing with it is very heavy."

On a cognitive level, Harry seemed to be trapped between two major "unrealistic inferences" (Trower, Casey, & Dryden, 2003), stating (a) "since I have been physically abused, I might physically abuse my daughter" and (b) "since I have been sexually abused, my daughter might be sexually abused." These thinking errors seemed to be a product of Harry's fears that originated from his own experiences of abuse, and we explored his unrealistic inferences in relation to them. He understood how his particular thinking process could be profoundly colored by his fears. He felt reassured, realizing that now he had the option of consciously choosing how to act on these fears without damaging anyone and/or being damaged by anyone, including himself.

I also explored Harry's underlying fears and emotions that resulted from his experience, and I was prepared to deal with possible regression states that might occur. I included role-plays (e.g., a two-chair dialogue about what his inner child wanted to say) in the sessions as one of the means of facilitating him to get in touch with his inner wounded child, whom he was scared to reach. This therapeutic intervention would discourage the transference and create space to provide him mainly the replenishing relationship that he seemed to need (Clarkson, 2003). He said that "it was the first time he was acknowledging this part of himself," it was actually the "first meeting" with the inner wounded child, yet he was not feeling diminished. These were powerful and peak moments in the therapeutic process that at times were touching transpersonal aspects of our relationship.

I found myself feeling deep empathy for Harry's experiences, sometimes influenced by my proactive countertransference of emotional abuse. Our relationship was growing steadily, creating a trusting and enriching environment. Harry could express his vulnerability, expose his fears, and still feel accepted. Such acceptance cancelled his transferential fear and expectation of being hurt and/or rejected. His eye contact significantly improved, and his nonverbal communication was much more open, as shown in his more expressive body language.

During the next session, Harry disclosed that he was simultaneously experiencing a "deeper emotional perception, a blossom" in his life and a noticeable improvement in his relationships with his daughter, his wife, and his mother-in-law. This was evidence for the effective corrective experience Harry had in therapy. He started to be gradually more aware of the impact of his experience-related fears in the here and now, something that was empowering him to gradually deal with them in a more realistic way. His self-confidence seemed to increase; he reported that he started being more assertive in his professional, social, and personal relationships, he started to own and to acknowledge his feelings (including the negative ones; e.g., anger),

and, when necessary, he was more confident to express them constructively rather than to just repress them as he was used to doing.

Toward the ending of therapy, we reached a point where we were sometimes experiencing person-to-person contact; for example, Harry seemed to genuinely acknowledge my limited self-disclosure (e.g., my cultural background or my professional plans). On the other hand, Harry seemed not yet to trust fully his own process and resources. It felt to me that the main type of our relationship was both reparative/developmentally needed and transferential/countertransferential.

In our final session, we shared the experience of his therapeutic journey and its effects on his real life. We discussed his concerns about possible regression states in the future and ways that he could deal with them (e.g., therapy). Harry seemed to leave therapy having experienced, as he said, "for first time in my life" how it feels to be self-accepted and in contact with his real self and the "physis."[2] Harry expressed his satisfaction from the outcome of the therapy in a rather genuine and appreciative way:

> At the beginning I was feeling bizarre talking to a stranger about my problems. But then, I was coming to meet you every week looking forward to see what I will discover about myself this time. I trusted you and I was feeling that I could be totally exposed before you. And do you know what it was that made me to trust you? It was that I could see my feelings on your face. It was like you were holding my hand and even *if* sometimes it was difficult, I knew that this time it would not happen the same to me again [referring to his traumatic experiences]. Before therapy, I was cynical about counseling and how it could help. Now, I do not just feel really grateful to you but I also deeply respect your profession.

8 COMPLICATING FACTORS

The administrative error that took place at the very beginning of Harry's therapeutic journey was a significant complicating factor that could have potentially damaged the working alliance and therefore the effectiveness of therapy.

As Harry's therapist, I had to take into consideration any possibilities of Harry being potentially suicidal, directing his anger inward, especially during regression states, and/or potentially abusive or threatening to others, directing his anger outward in damaging and unhealthy ways. The positive and strong rapport we had established gave me the space to communicate such considerations to Harry and deal with them therapeutically.

9 FOLLOW-UP

No follow-up sessions were scheduled because as soon as the therapy was finally agreed to finish, Harry would move to another area of the United Kingdom and the therapist would move from the United Kingdom.

10 TREATMENT IMPLICATIONS OF THE CASE

WORKING ALLIANCE

Harry showed from the beginning of therapy that he was really willing to work with me and that his own determination was really fundamental and essential for the effectiveness of his therapeutic journey. Yet especially at the initial stages of therapy (Sessions 1 to 2), before Harry disclosed his sexual abuse, parts of the working alliance were potentially shaken by transferential aspects of the therapeutic relationship (e.g., Harry was testing the boundaries by canceling appointments or being late to the sessions). Through these moments or phases of the therapeutic process, I as the therapist was taking a lot of information regarding the needs and the gaps that had to be met and filled through a developmentally needed relationship. When Harry trusted me fully, he disclosed his real issues, and the working alliance was subsequently profoundly stabilized.

TRANSFERENTIAL/COUNTERTRANSFERENCE RELATIONSHIP

The transferential/countertransferential relationship with Harry was also profoundly significant for the effectiveness of his therapy. It seemed that I was a good mother or a magical healer figure for him, mainly from an archetypal perspective as Jung describes it.

Samuels, Shorter, and Plaut (1986) say about transference (from a Jungian perspective):

> Jung separated transference into its personal and archetypal components . . . . Personal transference included, not only those aspects of the patient's relationship to figures from the past such as parents which he projects onto the analyst, but also his individual potential and his shadow. That is, the analyst represents and holds for the patient parts of his psyche which have not yet developed as fully as they might and also aspects of the patient's personality he would rather disown.
>
> Archetypal transference has two meanings. First, those transference projections which are not based on the personal, outer world experience of the patient. For example, on the basis of unconscious fantasy the analyst may be seen as a magical healer or a threatening devil and this image will have a force greater than a derivation from ordinary experience would provide.
>
> The second aspect of archetypal transference refers to the generally expectable events of analysis, to what the enterprise itself does to the relationship of analyst and patient. (pp. 19-20)

In addition, the facilitative transference because of culture, style, and/or temperament similarities between the client and the therapist (Clarkson, 2005) cannot be overlooked. As therapist, I am aware that my personal style, culture, ethnic background, and/or temperament (i.e., physical characteristics, dress code, nonverbal cues, etc.) compose a factor that is able to color the transferential interaction with clients. In the present case, it seemed that this factor contributed in a facilitative way.

Harry was coming from an Eastern ethnic background, with which I was familiar (because of my ethnic background, which has Eastern influences, and because I have some experience of working in multicultural counseling settings). In addition, Harry has been an immigrant in the United Kingdom, where he studied on an academic level, similar to my experience. Such similarities probably affected Harry in a positive way, possibly making him experience the therapist as a familiar figure and therefore engage more easily with the therapeutic relationship.

DEVELOPMENTALLY NEEDED/REPARATIVE RELATIONSHIP

Countertransferences are an excellent gauge of the nature of the developmental deficit encountered by the client and can bring into focus the requirements of the reparative or developmentally needed relationship (Clarkson, 2002).

By the second session, Harry had started confiding in me and trusting me to hold his past experiences in much the same way as a mother would hold a child she was nursing. This was what he had needed from his own mother when he was a child. To facilitate the healing process, I intentionally offered him unconditional acceptance.

This set the scene to enable him to discuss disappointing those he loves in the third session and then to move on to the disclosure of his sexual abuse. At this point, the relationship moved into the person-to-person domain.

PERSON-TO-PERSON RELATIONSHIP

During the therapeutic process there were moments or stages when I met with Harry on a person-to-person level. For instance, when Harry said, "This network and patterns of behavior I have developed to defend myself has become a prison," I realized that he was now at ease to work through his trauma with me.

In addition, these particular revelations, "You are the second person in my life that I have told about the sexual abuse" and "Keeping it secret for so many years and not dealing with it is very heavy," confirmed both the nature of our relationship and the fact that our course of therapy was appropriate for his needs.

Also, the fact that Harry disclosed that he was simultaneously experiencing a "deeper emotional perception, a blossom" in his life and a noticeable improvement in his relationships was indicative for the effective experience Harry had experienced in therapy.

By the end of therapy, Harry was so much at ease with our therapeutic relationship and so confident of his progress that he was totally confident to express his feelings and his truths regarding the therapeutic experience in a way that was indicative of a person-to-person contact with the therapist.

TRANSPERSONAL RELATIONSHIP

The transpersonal domain of our relationship was demonstrated by the powerful peak moments in the therapeutic process. In such moments, Harry was either facing

existential despair or was discovering golden treasures on the path toward and within himself. And even if some moments and stages in the sessions were painful and/or exhausting, there was more and more larger space for more joy, for more wonder, and for silence. It felt as if the road had now opened and he could now continue his journey. During this process of "road opening," the therapist and the client were constantly changing and exchanging shapes and forms and density. At times, the therapist was becoming the spade in Harry's hands toward discovery, at other times the smooth air refreshing his scared face. At other times, Harry was offering to the therapist treasures, such as pouring warm honey in a cup, reaching a point where I just started wondering, "Now who is offering to whom? Now who is healing whom? Maybe none of us but both of us, maybe the process itself."

As John Rowan (2004) so wisely put it,

> For the therapist using his or her transpersonal self, the boundaries between therapist and self may fall away. Both may occupy the same space at the same time, at the same level of what is sometimes termed soul, sometimes heart and sometimes essence: what they have in common is a willingness to let go of all aims and assumptions. (p. 21)

11 RECOMMENDATIONS TO CLINICIANS AND STUDENTS

Clarkson's five-level model was an effective approach even within a brief, focused therapy context such as the present case. This particular theoretical framework offered me the flexibility to integrate several methods and techniques (e.g., Gestalt, psychodynamic, person-centered, cognitive-behavioral therapy) under the umbrella of the whole therapeutic relationship with the client. Accordingly, all the theories and approaches that I integrated served the actual therapeutic relationship with the particular client rather than fitting the client into a particular theoretical framework.

In 1928, Jung (1928) advised, "Learn your theories as best you can, but put them aside when you touch the miracle of the human soul" (p. 372). In 1946, he wrote that the soul "is a function of relationship" (Jung, 1946/1966). He too felt that theory was subordinate to the therapeutic relationship itself.

NOTES

1. According to Clarkson (2003), reactive concordant countertransference happens when the psychotherapist experiences the client's avoided experience or resonates empathically with the client.

2. Physis can be understood to be the life force, or élan vital, which is the term that Perls and his colleagues used. Physis was first named by the pre-Socratic Greeks as a generalized creative force of Nature (Guerriere, 1980). It was conceived of as the healing factor in illness, the energetic motive for growth and evolution, and the driving force of creativity in the individual and collective psyche (Clarkson, 2005).

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