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Therapeutic Relationship as a Change Agent in Psychotherapy: An Interpretative Phenomenological Analysis

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Abstract

The study qualitatively explored the clients' and their psychotherapists' perspectives on the mutative role of the therapeutic relationship. The sample comprised of 13 psychotherapist participants from four professional backgrounds, namely, Psychoanalysts, Clinical Psychologists, Psychiatrists trained in psychotherapy, and Trained Psychotherapists not belonging to the above three categories, as well as 16 clients who have successfully completed individual psychotherapy with any one of these 13 psychotherapists. Semi-structured interviews conducted separately with the clients and their psychotherapists were analyzed qualitatively using Interpretative Phenomenological Analysis (IPA). The themes that emerged suggested five major antecedent processes within the therapeutic relationship namely, listening, containing, reflection of past relationship, surrender and curative relational experience. These were related to one or more consequential change processes like, emotional unburdening, acceptance and validation of emotions, generation of emotional strength, setting stage for therapeutic interventions and reformulation of self or relationships. The clients and their therapists agreed on some functions, but not on all details. Relevance of therapeutic relationship was emphasized more by therapists working in psychodynamic mode.

Keywords: therapeutic relationship, client perspective, interpretative phenomenological analysis

Therapeutic Relationship as a Change Agent in Psychotherapy: An Interpretative Phenomenological Analysis

Historically, Psychoanalysis was the first school of modern psychotherapy that prioritised emotionally charged relationship between the therapist and the client for changes toward healing (Horvath, 2000; Strupp, 1973). Freud primarily focused on transference, advocating therapist neutrality, thus somewhat neglecting the healing potential of the authentic bond between client and therapist (Safran & Muran, ...). Greenson (1965) named this neglected aspect of the relationship, alliance, and defined it as the reality based attachment between client and therapist. Rogers (1951) claimed that, regardless of the theoretical framework of the therapist, the therapist provided conditions of empathy, genuineness and unconditional positive regard are necessary and sufficient for activating the innate healing and growth potential in the client. Rogers' conviction in the healing potential of the therapeutic relationship inspired researchers to closely examine this aspect (Barkham, 2002). Contrarily, the early Behaviorists conceived good therapeutic relationship as the consequence rather than antecedent of effective treatment. They championed the importance of specific intervention techniques as agents of change. However, later Behaviorists and Cognitive therapists have taken a less polarised stance, acknowledging the role of therapeutic relationship as a platform for other interventions (Horvath, 2000). Thus different schools have proposed different models to capture the elusive concept of therapeutic relationship. The theoretical literature supporting this line of thinking can be summed up in Strupp's contention that, across different therapy modalities, the interpersonal framework (therapeutic relationship) constitutes "an exceedingly powerful matrix within which a variety of influencing techniques become potentiated" (Strupp, 1973, p. 14).

However, the credit of systematising the concept of therapeutic relationship by developing a pan-theoretical approach goes to Edward Bordin (Horvath, 2000). Bordin's (1979) definition of alliance consists of three interlocking components: ***Bonds*** (the affective quality of the client-therapist relationship that includes dimensions such as trust, care and involvement); ***Tasks*** (agreement or consensus on the major activities in therapy and the extent to which the client finds them credible); and ***Goals*** (consensus on the short term and long term outcome expectations between the therapist and the client). Although Bordin may appear somewhat reductionistic, his proposal was an important landmark in psychotherapy process research. First, it facilitated trans-theoretical deliberations on the therapeutic relationship. Second, it has challenged the ego-centricism of the therapeutic community by acknowledging the client's contribution to the relationship. Early researches on therapeutic relationship had emphasised the therapist characteristics that determined the therapeutic relationship (such as accurate empathy, non-possessive warmth, etc.). Bordin's concept of alliance shifted the attention of the therapeutic community to the joint contribution of therapist and client (Safran & Muran, 2006). This is important because therapist and client ratings of the relationship are often different and client ratings have been found to be consistently and clearly superior in predicting outcome (Bachelor & Horvath, 1999; Fitzpatrick, Iwakabe, & Stalikas, 2005; Orlinsky, Grawe, & Parks, 1994; Tryon, Blackwell, & Hammel, 2007). Although this superiority of client's perception has been known for more than one decade, yet, paradoxically, researchers often employ traditional quantitative tools based on parameters set by the test constructors to measure and compare therapists' and clients' ratings of the therapeutic relationship. This area has practically been over-explored using the dominant positivist paradigm. Thus, as Safran and Muran (2006) rightly noted, the critical task now is to clarify in what way the therapeutic relationship plays a mutative role. To this we add the need to explore and appreciate diverse

avenues for understanding therapeutic relationship, including the pregnant voice of the psychotherapy clients.

Several questions may be formulated in this regard. Do the participants of therapy consider the relationship as essential to therapy? Is there correspondence between the therapist and the client in terms of perceived utility of the relationship in therapy? In the course of therapy, do they share their viewpoints, or leave it to flow its own course? Such explorations may have important cultural implications, as well. Intuitively, it seems logical that clients and therapists bring their culturally-shaped template of relationship to this encounter. We may be reminded of Neki (1975) who introduced the guru-chela paradigm of psychotherapeutic relationship in the Indian context. But Neki's proposition has not been empirically investigated. Moreover, there may be divergence within this theme, as well. Majority of the therapists, across the world, are trained in psychotherapy originating in the West. Thus, while navigating the therapy process, they may be unwittingly blending the relationship concepts of their respective cultures and those acquired during Western psychotherapy training. Similarly, clients from different cultural backgrounds may bring in fresh perspectives on curative value of this relationship. These intricacies within the therapeutic process motivated us to explore both the clients' and the psychotherapists' experiences on therapeutic relationship as a change agent in Indian context.

In this context, we intended to qualitatively explore the nature of significant processes within therapeutic relationships from the interview based narratives of selected therapists and their corresponding clients. Such exploration necessitates entering the subjective worlds of the therapy participants, demanding an epistemological shift from the traditional modernist position of discovering the objective truth to a post-modernist position of understanding the constructed truths (Hansen, 2004; Ryan, 1999). Therefore, we desire to clarify our

paradigmatic position. The study aimed at examining the clients' and the psychotherapists' conceptualisation of the therapeutic relationship as a change agent, in case of successfully terminated therapies. The assumption underlying this objective was that, within each therapist-client dyad, one participant's construal may or may not correspond with that of the partner. The objective and the corresponding assumption of the study acknowledge the existence of multiple truths, as built by the participants. Thus, we positioned ourselves within the constructivist paradigm of knowledge production which posits that human beings do not find or discover knowledge so much as they construct it to make sense of experience (Becvar & Becvar, 2003; Guba & Lincoln, 2005). However, a tinge of criticality cannot be excluded. Critical Theory paradigm champions the values of altruism, empowerment and liberation (Guba & Lincoln, 2005; Yardley & Marks, 2004) and considering the power structure of conventional psychotherapy research, the client's voice is usually the muted one. Thus, this study espoused Critical Theory to the extent it democratised the research process by making the marginalised voice of the client heard.

METHOD

Tool for Data Collection

We preferred open-ended interview format to elicit spontaneous unfolding of the participants' construal in their own language, with minimum interference from the interviewer. Separate interview guides were prepared for the clients and their therapists to explore their views on change process. At the outset three experts in the area of psychotherapy research were consulted. The final interview guide included loosely framed questions with provisions for probes. Initially we asked general questions about therapy experience to provide scope for the relationship issue to emerge spontaneously. However, towards the end, few specific probing questions were included to sensitise the participants to

the relationship theme, if it had been so far overlooked. An example of a relational question from the Therapist Interview Guide is, 'Can you describe in details the nature of the therapeutic relationship with this client through the various phases of therapy?' Similarly, example of a relational question from the Client Interview Guide is, 'What was the nature of your relation with the therapist? How has it changed across time?' Pilot interviews were conducted and minor changes were made in the guides, based on the pilot interviews.

Participants

There were two categories of participants: (a) Respondents (clients and their respective psychotherapists) and (b) Auditors (psychotherapists) who reviewed the qualitative analysis. A comment is warranted here to justify involvement of auditors in the process of analysis. Auditors are conventionally engaged in psychological research to ensure objectivity of the analysis. In this study, aim was to appreciate multiple representations of reality and Interpretative Phenomenological Analysis (IPA) was selected as the interpretative tool. Thus, in keeping with the spirit of IPA, and following the suggestion of Smith, Flower and Larkin, (2009), auditors were engaged in the process of analysis, to check for credibility and plausibility of analysis, rather than produce a single report with objective truth claim. The auditors studied the data and corresponding analyses to access whether the interpretations offered appeared reasonable and understandable to an outsider. Inclusion of auditors also helped to access whether the analysis was systematic and transparent.

The Psychotherapists (both Respondents and Auditors) belonged to the following four categories:

1. Psychoanalysts having formal training approved by Indian Psychoanalytical Society.

2. Clinical Psychologists having M.Phil. Degree in Clinical Psychology recognized by the Rehabilitation Council of India.

3. Psychiatrists having supervised training in psychotherapy.

4. Trained Psychotherapists not belonging to the above categories, but having a University recognized diploma/degree in Psychotherapy/Counselling.

The focus of the study was on capturing the richness of each participant's experience rather than making a conclusive statement about a normative sample. Thus an idiographic approach was chosen for this study and the number of participants was limited to 16 client-therapist dyads.

Psychotherapists (Respondents). We approached psychotherapists of Kolkata, with age between 30 and 65 years and with minimum five years of experience in practice in the metropolitan city of Kolkata. In case of Psychoanalysts, we obtained the list of Psychoanalysts practising in Kolkata from the Indian Psychoanalytic Association. Similarly the list of Clinical Psychologists in Kolkata was obtained from the West Bengal Chapter of Indian Association of Clinical Psychologists. Since few Psychiatrists in Kolkata formally practice psychotherapy, they were primarily tapped through snow balling technique. Trained Psychotherapists, not belonging to the above categories, were also contacted through snow balling though this search was not exhaustive. All who agreed to participate were taken. Finally 13 psychotherapists (three Psychoanalysts, three Clinical Psychologists, three Psychiatrists, and four Trained Therapists) served as respondents. Even though all the therapists reported having a flexible approach to therapy, twelve of them claimed to have a primary allegiance to one of the theoretical orientations of therapy. All the psychoanalysts primarily had a Psychodynamic orientation, while all the Clinical Psychologists primarily had

a Cognitive Behavioral orientation. Two of the Psychiatrists were psychodynamically oriented, and one had a Cognitive Behavioral orientation. One of the Trained Therapists primarily worked in the Psychodynamic mode and two in the Cognitive Behavioural mode. One of the Trained Therapists claimed that he did not have allegiance to any single theoretical orientation.

Clients (Respondents). Sixteen clients who had successfully terminated psychotherapy within the past one year with one of the above mentioned 13 psychotherapist participants were included in the study. Their initial contacts had been provided by the respective therapists. There were eight female and eight male clients, their age ranging between 16 years to 65 years. All of them were residing in Kolkata and had a minimum of ten years of education. Twelve of them had a psychiatric diagnosis and four belonged to the sub-clinical category. Those having history of psychotic symptoms or Substance Related Disorders were excluded.

Psychotherapists (Auditors). Four Psychotherapists, one from each psychotherapist category, participated as Auditors. On ethical considerations, none of the psychotherapist participants were asked to audit the analysis based on their own and their clients' interviews.

We are aware of a potential bias in participant selection. Although we were interested in comparing therapist and client perspectives, the clients were nominated by the therapists as we did not obtain ethical permission for locating clients on our own. Thus, it is possibile that the more favourable clients were nominated, and the selection reflects therapist's choice.

Procedure

Data collection. Firstly, identified psychotherapists were shown the interview guides. Those who gave Informed Consent were requested to identify clients who met the inclusion

criteria. If the identified clients considered the therapy successfully completed and agreed to participate, Informed Consent was obtained from them. All the interviews were conducted by the first author. The therapists and their clients were interviewed separately, at a venue chosen by them. Care was taken to see that the venue offered privacy and comfort to the research participants. Each interview required about two hours and was audio-recorded with permission.

Analysis. For analysis, we chose Interpretative Phenomenological Analysis (IPA) which has a hermeneutic and a phenomenological grounding (Smith, Flowers, & Larkin, 2009). IPA is suited for capturing richness of data generated in a small sample phenomenological study. As Smith, Flowers and Larkin (2009) have posited, "The issue is quality, not quantity, and given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus on a small number of cases." (p. 51)

Initially, after intensive and repeated reading of the transcripts of the interviews, we prepared detailed IPA notes for each of the 16 client-therapist dyads. One goal of IPA is to delve into the universe of the participants' meaning making. Interpretations offered were grounded in the data obtained. In keeping with the concept of hermeneutic circle (Smith, Flowers & Larkin, 2009), understanding of the entire text through multiple readings was used to make sense of specific parts of the data, while insights generated from the parts of the interviews were also used to interpret the entire text. According to Smith, Flowers and Larkin (2009), in the process of interpreting, there is often an element of personal reflection of the researcher. Thus, as researchers, we used our empathy with the participants to make sense of their experiences. Convergence and divergence between the experiential universes of the client and the therapist were interpreted. The initial notes were substantiated with excerpts

from the data. It took approximately 20 days to analyse the interviews of each client-therapist dyad.

Each of the initial IPA notes was reviewed by one of the four Auditors to check for communicability and gross misunderstandings of the data after disguising all identification information. We engaged in elaborate and often critical discussion with the auditors for each case. Subsequently, on the basis of our own understanding and suggestions from discussion, the Final IPA notes on the 16 therapy dyads were prepared. We did not assume the analysis to be value-free. Rather, we were acutely aware of our own reflexive engagement in the co-construction of meaning. We considered our motives and concerns facilitatory to the process of exploration rather than causing hindrance to the process. As Smith, Flowers and Larkin (2009) put it, analysis in IPA involves the "development of a dialogue between the researchers, their coded data, and their psychological knowledge, about what it might mean for participants to have these concerns, in this context,.... leading in turn to a more interpretative account" (p. 79). However, certain measures were utilized from the start to represent the voice of the participants in all earnestness. Intensive interviewing was emphasised during data collection to ensure depth and breadth of material. We constantly dialogued with each other to remain conscious of any unwarranted bias in either of us. We also richly illustrated the analyses with excerpts from the interviews to make our analysis open to scrutiny.

In this study, we have presented the analysis pertaining to the mutative role of the therapeutic relationship. However, in real life, conversation does not follow a linear path, and often one statement is criss-crossed with other intentions. For the purpose of presentation, we have selected those excerpts that we considered relevant for the present theme, and those that have not been severely contradicted in other parts of the narration.

Ethical Concerns

Ethical approval for the research was obtained from the Department under which the research was conducted. We obtained informed consent from each of the participants after explaining to them the nature of the study. We took special care to cause minimum interference to the therapy process or relationship by conducting the interview after completion of psychotherapy and refraining from making value-loaded comments on the process. Complete confidentiality was maintained, especially between the therapist-client dyad. Before showing the transcripts to the Auditors, anonymity of the participants was ensured by substituting their names and concealing vital demographic details.

RESULTS AND DISCUSSION

Our reading of the data suggested different processes operating within the therapeutic experience of the client-therapist dyads. Some are directly related to therapeutic relationship, and some are tangential. Some such processes are well known to us, like transference or listening, while some are not so widely recognised. The therapeutic processes, identified using IPA, are discussed in this section of the paper.

(A) The process of listening: According to several therapeutic dyads in the present study, the therapists' listening and understanding facilitated the clients' unburdening. The client participants expressed this function variously, in the form of their being able to 'share' hitherto silent suffering, or simply as the need to 'talk of the pain'. Here are two pairs of excerpts from two dyads (A-B and C-D).

> **Excerpt A:** Kunal (Client, male, treated in Cognitive Behavioural mode by Arindam, Clinical Psychologist) – I needed to talk to someone - get relief from sharing…… Nobody whom I could trust was there. …. He (the therapist) is one person on whom I could depend, share those experiences.

So at that juncture he heard the entire thing. Within his limited time, as much as he could, he listened to me.... That caused relief.

Excerpt B: Arindam (Clinical Psychologist, male, conducted Cognitive Behavioural Therapy with Kunal) – Initially, I was trying to move into a structure... (but) he was attaching more importance to ventilation, sharing - understanding his pain..... (Initially) I didn't pay attention to the ventilation process. But later I realised ..... that these aspects are also important. ..... So when I modified my stance, he felt better.

In this case, both the client and the therapist have emphasized the unburdening process in terms of listening, sharing and ventilation. Kunal's intrinsic urge was to 'get relief from sharing'. But this could not be realised owing to his inability to trust people. The therapist happened to be the only person on whom Kunal could depend and it is through the therapist's listening that he could unburden himself. On closer scrutiny, we could also discern some deeper dynamics centring on listening. Arindam acknowledges that he was initially more structure oriented, paying lesser attention to the sharing-listening component that led to important therapeutic communication. Kunal had probably noted this omission, and politely mentioned that the therapist had listened as much as he could within the limits, thus, probably expressing his desire to be heard even more. However, when Arindam modified his stance, through prioritising listening and encouraging ventilation, therapeutic change began.

As compared to the Kunal-Arindam dyad where sharing was facilitated after some initial struggle, the 'letting out' process was almost instantaneous in the Ananya-Subha dyad, and relief came as soon as the unburdening occurred.

Excerpt C: Ananya (Client, female, treated in Psychodynamic mode by Subha, Psychiatrist) - ..... each and every person needs somebody to let out. But this

> letting out – if you personally know the person with whom you share, it does not lead to the same change..... that person will always be judgemental.... but with a therapist, you are just yourself. He/she lets you be yourself. … (Subha's) personality is very pleasant and she can make you talk... She was always there for me. ..... I can be frank with her. ..... There are few things I have never talked about to anybody ….. and that when I spoke to her, that day I really felt light. When I came out I felt aah! – what a relief!

> **Excerpt D:** Subha (Psychiatrist, female, conducted Psychodynamic Therapy with Ananya) - …..How difficult it was (Ananya's trauma), she had to talk about this. .... I think, these trauma - spanning several years - she had kept within herself. After talking about this and obviously because she was talking to somebody neutral and somebody professional, she realised that there is somebody to understand the pain and not set judgment.

There were few things in Ananya's life which she had 'never talked about to anybody'. Owing to the social stigma associated with those events, she feared judgemental responses from others. However, the professional position of Shubha, coupled with her pleasant personality, enabled a smooth unfolding of Ananya's painful experiences, thus facilitating a communication – understanding process. Shubha's expression reveals her empathy with Ananya, which presumably facilitated her non-judgemental listening.

What good does the process of listening result in? In the cases cited above, the felt emotion was 'relief'. The therapist's patient listening seems to have created the space for emotional unburdening. According to Jonas-Simpson, Mitchell, Fisher, Jones, and Linscot (2006)**,** "If someone feels listened to, they feel good, gratified,

unburdened, satisfied, and cared about" (p. 51). This process of unburdening is similar, to some extent, to the psychoanalytical notion of catharsis. In recent times, the term has acquired a more generalised meaning, beyond the psychoanalytic vocabulary, to refer to the processing of difficult emotions. Grencavage and Norcross (1990) identified the opportunity for catharsis as one of the most consensual commonalities across all categories of therapy. Similarly, in a phenomenological study on the clients' experience of second order changes through psychotherapy, Murray (2002) found that one of the therapeutic experiences that emerged as facilitator of second order changes of transcendence of one's self was 'Catharsis'.

(B) Containing unacceptable emotions: A client treated psychodynamically by a Psychoanalyst has envisaged therapist's understanding and tolerance of her emotions as leading to activation and acceptance of unacknowledged emotions. The corresponding therapist corroborated the significance of such accepting ambience. An illustrative excerpt follows:

> **Excerpt E:** Jyoti (Client, female, treated in Psychoanalytic Mode by Ashima, Psychoanalyst) - When I don't speak, she says what I am feeling, that is exactly what I am feeling at that juncture..... When she understands me so well …… I can take a leap (toward acknowledging emotions).

Jyoti used the word 'take a leap' to indicate that she could acknowledge unaccepted emotions within her.

> **Excerpt F:** Jyoti -….no matter how much I get angry, Madam's attitude never changes. I have insulted her …….. Sometimes I felt guilty, "I said so

> many bad things, aren't you bothered?" She would say, "This is all in therapy!"..... My reservation kept decreasing…...
>
> **Excerpt G:** Ashima (Psychoanalyst, female, conducted Psychoanalytic Therapy with Jyoti) - First the faith comes from the analyst. If you are able to give the client the faith that you care for her, she starts going deeper.

The excerpts cited above indicate that in Jyoti's case, the therapist acted as a container which facilitated the client's experiencing of unacceptable emotions. The therapist could even predict accurately what her unspoken feelings were, an experience that probably helped Jyoti to forsake her resistance. Furthermore, the therapist's tolerance of Jyoti's aggression towards her deepened this sense of containing, providing her an ambience of absolution and acceptance, a safe haven for self-exploration. Containing emotions as a therapeutic process has been discussed at length by Bion (1963). Bion used the term to refer to the parent's (therapist's) tolerating the projected emotion of the infant (client) to provide the infant with an environment congenial for taking ownership for the emotion. The pathway indicated in teh above excerpt by Jyoti is simpler, whereby the therapist's tolerance of Jyoti's emotional intensity helped Jyoti to tolerate and accept those unacceptable emotions.

The working of containing as a therapeutic process is apparent from excerpts of another therapy, as well.

> **Excerpt H:** Chavi (Client, female, treated in the eclectic mode by Nandini, Trained Therapist) - …and she has given a lot of personal touch, …. Even when I go on a holiday, she rings me up there and she has given me a lot of personal touch to the whole thing. So she stayed with me …. So I have tremendous faith in her.

At another juncture Chavi said -

> **Excerpt I:** Chavi - She came up and hugged me and I was very surprised because so far, I had never seen any doctor giving me sympathy. They were always very very aloof and they would be always like 'so why are you doing this to yourself and don't you know you have to change.' Whereas this lady gets up and she shows me a lot of emotional support and she physically also hugged me. You know and that was the most touching moment and she made me realize that there was nothing that was wrong with me. In fact I had given up and I had sacrificed more than what was necessary in my life….

According to Chavi, Nandini gave a lot of honest effort and personal touch in terms of personally checking on Chavi's well being through phone calls, during stressful times. Chavi emphasises that the therapist had even gone so far as to physically holding her, when she felt vulnerable speaking about her emotional abuse and guilt in her marriage. This was narrated by the client as an emotional experience, which is different from all previous experiences with mental health professionals. In Chavi's case, the therapist's touch seems to have communicated a sense of the therapist being available to the client, deeply feeling her pain, containing and validating it. Eiden (1998) posited that touch can provide a sense of holding and a boundary to contain overwhelming emotions. According to him, the psychotherapist's touch conveys to the client the message that the therapist is present with her. Although, in this case, the therapist did not mention her use of touch in therapy, she narrated a similar process of containing through non-judgemental acceptance leading to the client's feeling validated, thus engaging in therapy.

> **Excerpt J:** Nandini (Trained Therapist, female, conducted Eclectic Therapy with Chavi) - I think that first of all, I became like a surrogate parent to her, and

> I actually accepted her unconditionally, whenever she had a breakdown or a behavior problem. I kept telling her that she has gone through so much of pain and suffering. Every action will have a reaction. So what she was experiencing is so normal. I think, if anybody else was in her position, it might have been worse. So I think it was the support or may be because I am a female, may be, I did identify with some of her social issues, and I was not judgmental at all. I think the greatest thing is the difference in attitude that she felt, when she visited me. She had visited a lot of psychiatrists in this journey and all of them had a judgmental attitude, and a very dictatorial attitude - you shouldn't be doing this, this might be harmful to you. Nobody tried to understand where did it stem from?

Touch being a tabooed area in psychotherapy practice, Chavi's narration raises concerns about boundary negotiation in therapy. None the less, according to Chavi, the process that was activated through physical touch seems to be salient to her therapeutic change process. Such therapeutic events question the utility of non-negotiable ethical codes of conduct and boundary creation, which disregard the nuances of the context (Zur, 2007).

(C) Therapeutic relationship as a reflection of past significant relationships

Two client participants of the study emphasised emotional support and strength generated through identification of the therapist with a past benevolent care-giver. Illustrative excerpts follow.

> **Excerpt K:** Arijit (Male, treated in the Psychodynamic mode by Sujata, Psychoanalyst) – my father's role in my life – if I was in a problem, I could talk to him and after talking to him, I used to feel relieved. After my father's

> death, I was unable to tolerate the emotional void, the absence of the support I was used to getting in my vulnerable moments. .... After his death, I have been able to talk in such details only with her (therapist). I feel, if I discuss something with her for a long duration, it works for me even if she doesn't say anything. I feel confident…… somehow I got a guardianship……..... The reason is that my father was like her..... there are several similarities..…. So that has been very contributory for me.

At the time Arijit sought therapy, he had just lost his parent and was feeling emotionally shelterless. From the client's excerpt it is clear that the therapist was identified with the lost parent and that provided Arijit emotional support even before active therapeutic work began. The therapist did not mention anything of this sort. Even when asked about such possibility, she did not see a direct linkage.

A similar process was noted in another client treated by a Psychiatrist.

> **Excerpt L:** Sayok (Client, male, treated in the Cognitive Behavioural mode by Bidisha, Psychiatrist) – I told Madam that I already knew everything she told me. My Sir (a past teacher) used to tell me these things. But I don't get much mental support from my family. I got this support from Madam, and previously from that Sir..... I find a similarity between Sir and Madam. So I told her, I knew what is to be done, but I felt this faith in her, a hundred percent faith that they (the teacher and the therapist) are my most suitable guides. ..... My confidence increased.

Sayok has identified a parallel between his emotional dependence on the therapist and his teacher from the past. He clearly indicated that the cognitive inputs from the therapist

were not the chief mutative elements. He says “I told Madam that I already knew everything she told me.” Rather, according to him, the emotional strength that he derived from the therapeutic relationship has revitalised his fight against adversities. Even though Sayok’s therapist was conscious of the fact that he was treating her as his teacher from the past, she did not conceptualise the strength generated from the relationship as a mutative element.

Thus, in the above mentioned cases, two clients of a Psychoanalyst and a Cognitive Behavioural Psychiatrist have discussed a similar process. Both these participants narrated feeling revitalised by identifying the therapist with a lost supportive care-giver. Both these clients seem to have used the template of their significant personal relationships to negotiate the therapeutic contact, thus impacting the healing potential of the relationship. We may refer to this pattern of relationship as transference, since the valence of the therapeutic relationship has primarily been credited to the therapist being a reflection of a significant other in the client’s life. However, the respective therapists of these clients have not identified this therapeutic process. Thus, these narrations illustrate how clients may shape the therapeutic contract, giving it meaning that is not available to their therapists. This may be conceived as a form of client agency in therapy.

On the other hand, two psychoanalytically oriented therapists have referred to this moulding of therapeutic relationship within past relationship templates as ‘transference’. They have identified this process as a therapeutic tool for generating client’s awareness of unacknowledged feelings.

> **Excerpt M:** Ashima (Psychoanalyst, female, conducted Psychoanalytic Therapy with Jyoti) – Any comment that she passed on me.... I picked on that..... I made her understand “this has nothing to do with me per se. It is all about your unconscious fantasy of other people that you are directing

towards me...” ...through countertransference I can step into her mind... I articulate those feelings for her and that’s how she recognises them...

Here the therapist has discussed using transference as a tool for activation of unacknowledged emotions in the client. According to her, she carefully drew the client’s attention towards her attitude towards the therapist, thereby facilitating the client’s understanding of her unacknowledged emotions in significant relationships. This, in turn, has not found resonance in her client’s narrations. In another case of a client treated by a Psychoanalyst, only the therapist conceptualised transference as vital for setting stage for client’s entering a collaborative partnership in therapy.

Excerpt N: Ishani (Psychoanalyst, female, conducted Psychodynamic Therapy with Animesh) - My assumption was, if I am unable to generate transference, I won’t be able to make him work in therapy. I felt this right at the beginning. Now how do I make him aware of the transference? ..... That realization was not surfacing in him (though guessed to be present) ……. After that, at one point, may be from the tenth or eleventh session, ... something I did with a lot of hesitation, I directly started asking him “what do you feel about me? I am going on talking to you day after day, giving you time..... So, what do you feel about that?”..... Once he realised his transference, I did not face problems any more (in implementing changes).

According to the therapist, since the client was emotionally guarded and dealt with circumstances cognitively, the therapist shared her positive feelings towards the client to evoke the client’s awareness of his feelings towards her. This, according to her, facilitated the client’s understanding of his emotional engagements in relationships. She further posited that the client’s acceptance of his feelings towards her helped her to activate other interventions in

therapy. On the other hand, the client has not attached much significance to the relationship factor in his conceptualisation of the change process.

In some cases, the narrations clearly indicated the operations of transference and countertransference within the therapeutic relationship, but how it was used was not clear. There was recognition of its occurrence without elaboration on the utility of the phenomenon. It continues to be a fuzzy area.

To summarise the findings in this area, transference has emerged as a phenomenon within the narrations of both therapists and clients, though, understandably, only therapists have explicitly used the term. We put forth two observations in this respect. Firstly, the client–therapist dyads have not resonated with regard to the operation of transference (for example, Arijit-Sujata). Secondly, when identified as a change process, the therapists have viewed transference more in line with the existing theoretical propositions, mainly as a vehicle for generation of emotional insight and for setting stage for deeper engagement in therapy. On the other hand, clients have viewed transference as generating emotional strength, thus, providing a fresh perspective on the utility of transference.

(D) Surrender-obedience as a therapeutic process

This function refers to the client's trust in the therapist's suggestions and the motivation to follow them. Thus this function seems to be most closely related to setting the stage for subsequent intervention. In this study, a Cognitive Behaviourally oriented Psychiatrist and her client reported that the client's reverential attitude towards the therapist made him receptive to her inputs.

> **Excerpt O:** Sayok (Client, male, treated in the Cognitive Behavioural mode by Bidisha, Psychiatrist) - If you give me an advice, I may not follow that. I may ask you, why? But I had the faith that whatever Madam would advice

me, it would not cause me any harm. I knew she was my well wisher. I had decided that I will have to follow whatever Madam would advice.

At another juncture Sayok said

Excerpt P: Sayok - Even now, if I face a problem, if I call up Madam, how long do I get to talk to her? May be one minute. I am hardly able to discuss anything within that time, but just that much interaction gives me enough confidence to face the problems.

Excerpt Q: Bidisha (Psychiatrist, female, conducted Cognitive Behavioural Therapy with Sayok) – He had this tendency to idealise me, the way he used to respect and idealise one of his teachers. He had made me his guru. So he followed my advices religiously. If it has been a long term therapy I would have tried to break this pattern of our relationship. I would have challenged this idealisation of the therapist.

Earlier, in Excerpt L, we have illustrated how Sayok's transference towards the therapist gave him emotional support. Here we see how his reverential attitude towards the therapist has been conceived as increasing his receptivity to therapy. Both Sayok and his therapist (Bidisha) used the allegory of teacher-student relationship to understand their therapeutic bond, with Sayok idealising the therapist and unquestioningly accepting her advice. However, it is evident that Bidisha was uncomfortable with this pattern of relationship, even though it rendered therapeutic gains. Thus, while Bidisha was sceptical about Sayok's change through unquestioned acceptance of Bidisha's inputs, Sayok seemed to be comfortable and satisfied with the trajectory.

This pattern of relationship emerged in the narrations of another client-therapist dyad.

> **Excerpt R:** Urmi (Client, female, treated in the psychodynamic mode by Pijush, Psychiatrist) - The good thing about Dr. Pijush was that he never imposed anything on me. Although he was very strict, some way or the other, he used to impose his say, indirectly. He has been successful in making me do things that he wanted to. But he never told me what to do. F I ever sought direction, he told me that I could myself decide whatever I wanted to do. But wherever required, he held the strings in his hands. That generated a sense of he being my guardian, someone I looked up to, I perceive him as a guru. What we understand from the term guru, exactly that. I believe that from the core of my heart. I find spiritual connectivity with him. Gradually, he started doing his work, and as a result of that, he became my guru. That's exactly what I mean. Whatever he said bore the authority of religious text for me.

Dr. Pijush's narration resonated with this.

> **Excerpt S:** Pijush (Psychiatrist, male, conducted psychodynamic therapy with Urmi) - although I was very non-directive with her but she felt that she could decipher from my expressions what I wanted her to do and what I did not want her to do. ..but that was again a projection. she chose, I believe, this model of relationship with me – slightly elevated position, like Ram krishna Dev (renowned religious guru of India), not guru in the sense of directing her, but kind of guiding her. That was her creation and therefore she felt this person will be rightly guiding me and therefore I should do this…she used to tell me, I constantly have conversation with you when I am depressed, and that helps me.

It is clear from the narrations of Sayok-Bidisha and Urmi-Pijush that the clients were very comfortable with the surrender – obedience model of relationship with their respective

therapists, while the therapists were clearly uncomfortable. Bidisha did not see much utility in this format of relationship, while Pijush seemed to be uncomfortable sharing the responsibility for emergence of this pattern of relationship, shifting the responsibility to the client, 'That was her creation'. Here, we offer a cultural interpretation for their discrepant stance. In these cases, the therapists and the clients have probably drawn their template for the therapeutic relationship from two diverse settings. Bidisha and Pijush have received their psychotherapy training in Europe, thus chiefly drawing from that template, while the clients chose the template for the relationship from their cultural setting. Obedience and uncritical following of another person's instructions as a corollary of trust, is, probably, more prominent in Indian tradition (Neki, 1975). This is also echoed in Kakar's (1991) formulation of the analogy between the guru-disciple relationship of Indian spiritual tradition and the analyst-analysand relationship of western psychotherapy tradition. He has coined the term 'guru fantasy' to depict "the existence of someone, somewhere, who will heal the wounds suffered in the original parent-child relationship" (Kakar, 1991, pp. 50). He conceived the relationship as requiring total submission of one (disciple/analysand) to the other (guru/analyst). However, he posits that the psychoanalytical model of healing, in contrast to the guru-disciple paradigm, involves another step after the idealizing transference leading to the merging experience with the analyst. The analysts require the re-emergence of the self, drowning and resurfacing, both being important constituents of psychological growth in the psychoanalytical model. The guru-disciple relationship with its element of surrender and obedience seems to be a vital template for two clients as indicated by excerpts O, P and R.

The surrender of the clients may have been strengthened by the fact that both the therapists are psychiatrists who also prescribed medicine to these two clients. Hegemonic position of the medical professionals, in general, and in India, in particular, makes their

clients place the physicians on pedestal within this set-up. Their corresponding therapists were clearly not comfortable with this mode of relationship.

Thus, several cultural factors may be responsible for the discrepant therapist-client attitude towards surrender and obedience in this relationship. Bidisha's (psychiatrist's) stronger rejection of the therapeutic value of this model of relationship may be further explained by the fact that she has been trained in the Cognitive Behavioural mode. This mode marginally conceives the client's submission to the therapist as a therapeutic event.

The next theme that emerged in our analysis is the emergence of a different emotional experience leading to renewal of self-perception and relational template.

(E) 'A good mother may exist somewhere': A curative relational experience

In some cases, the therapists have envisaged a pedagogic function of the therapeutic relationship, the relationship serving as a reformulating agent.

> **Excerpt T:** Ishani (Psychoanalyst, female, conducted Psychodynamic Therapy with Animesh) – I wanted to use the therapeutic relationship in a way that even if slightly, he may experience positive emotions without generating negative ones. A belief seemed to work like a fear within him - if there is any positive experience, a dreadful negative experience will eventually emerge from it. I tried to break this pattern. That's why I took great care to prevent the generation of negative emotions towards me ..… I tried to project that a good mother may exist somewhere. This could be projected to some extent.

> **Excerpt U:** Ashima (Psychoanalyst, female, conducted Psychoanalytic Therapy with Jyoti) - This is what she was looking for from her mother, but

she never got it..... So when the care comes from the person, self respect comes, with self respect comes confidence and insecurity decreases.

Some clients have had unpleasant, even traumatic early experiences. In some such cases, the therapeutic relationship has been envisioned as providing the client an emotional experience and model of relationship that is different from the pattern which the client generally tended to form. According to two therapist participants, the novel experience in therapy has altered the lens through which the client viewed self or relationships. This process of reformulation via relational experience has been named corrective emotional experience by Alexander and French (1946) and variously restated by recent authors like Hartman and Zimbaroff (2004). The corresponding clients have not envisaged the therapeutic relationship on these lines. Clients have usually narrated cognitive rather than relational pathways for reformulation of self or relationships. There may be several reasons for this incongruence in perspective within the therapeutic dyads. However, one reason may be that this process operates subtly within the clients, making self-observation difficult. Probably something similar has been proposed by Alexander and French (1946) in conceptualizing corrective emotional experience. They posited that this phenomenon may occur without generating insight into the origins of the problems.In this study, primarily, psychodynamic therapists mentioned this function.

CONCLUSION AND IMPLICATIONS

To summarise, the therapeutic relationship emerged as a mutative element in narrations of several therapy-dyads. Some of the processes may be construed as antecedents and some as consequences. Some antecedents were logically and empirically leading predominantly to one consequence; some to more than one. Figure 1 depicts the schematic representation of the antecedent processes activated by the therapeutic relationship and their

consequences. Emotional unburdening through listening was conceptualised by client-therapist dyads across therapist background and orientation. On the other hand, two processes, that is, acceptance and validation of previously unacknowledged emotions through containment and reformulation through curative relational experience were mentioned more within psychodynamically oriented therapies irrespective of therapist's training. Two psychodynamic therapists and two clients of other therapists recognised the role of transference, though the psychodynamic therapists conceptualised it as generating insight while the clients regarded transference as providing emotional strength. Surrender and obedience emerged as therapeutic process in the narrations of two clients of psychiatrists, across theoretical orientations. Cultural lens was adopted to make sense of the client-therapist discrepancy in assessing the therapeutic utility of this process. The clients' narrations generated fresh insights into the change process activated by the therapeutic relationship. Moreover, a form of client agency emerged through the narrations of the clients, whereby they utilised the therapeutic relationship to activate emotional strength within themselves.

There was more mention of therapeutic relationship as a mutative agent within psychodynamic therapies than in cognitive behavioural therapies, presumably because rational understanding of the problem is emphasized in the latter as the process of cure. However, on the whole it was found that the therapeutic relationship emerged as a significant process across therapy modalities. The emergence of therapeutic relationship as a significant phenomenon across therapy modalities partly helps to understand the results of Wampold's comprehensive meta-analysis of psychotherapies. Wampold's (2001) meta-analysis showed little advantage of one model of psychotherapy over another. The results of component analyses in the review indicated that the addition or subtraction of specific technical components had little impact on the core effects of treatments (Wampold, 2001). The

relationship factor, along with the other common factors, has probably overridden the effect of specific techniques on psychotherapy outcomes, thus demonstrating equivalence of psychotherapies.

The study is limited by the possible bias in sampling as stated before. We run the risk of representing the therapist's perspective more owing to the truncated selection of the clients. Also, only IPA was used for analysis, and triangulation was not attempted. Thus the study does not claim any singular generalisable conclusion. The study has highlighted the similarities and differences in the clients' and therapists' views on the mutative role of therapeutic relationship. These findings have both academic and clinical implications. The divergence in the clients' and therapists' narratives questions the relevance of existing research paradigms for studying psychotherapy process. According to Jorgensen (2004) "...most of the existing theories concerning the therapeutic factors in psychotherapy conceptualize the active ingredients from a realistic point of view and thus aim to identify the objective factors in a successful therapy" (p. 517). Contrary to this approach, Frank (1971) has posited that the various theories of psychotherapy are culturally founded myths that help the therapist and the client to jointly generate meaning and coherence in the client's life. Similarly, adopting the Post modernist stance, Hansen (2006) posited that theories of therapeutic change are always by-products of particular cultures and they do not have to be objectively true to facilitate healing. The findings of the present study further indicate that even in case of successful therapies, the client and therapist may have discrepant personal theory about vital aspects of the mutative process. Such findings implicate a shift in research paradigm, a shift from seeking objective truth to attempting an authentic understanding of the experiences of the therapy participants.

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