The core elements of relational therapy

While the therapeutic relationship in some form is central to all therapy, not all therapy specifically takes a relational approach. A relational approach is one which focuses on the therapeutic relationship and prioritises it as the key source of ‘healing’.

The starting point here is an understanding that emotional vulnerability emerges from relationships, be they neglectful or toxic or, in extreme situations, persecutory. From this, it follows that a relational context is needed for resolution or healing. Relational therapy works with this vulnerability via the therapeutic relationship.

Seven **key concepts or qualities** interlink in relational work:

* Respectful, non-judgemental listening
* Presence
* Empathy, compassion, and attunement
* Curiosity
* Therapist as ‘container’
* Relational depth
* Care

Respectful, non-judgemental listening

Ask almost any person what helps them feel safe and they will probably mention a space where they are respected, seen, and not judged. Clients need to know that we are seeing them and hearing their experience. How else will they feel we understand and that we are there for them? The experience of being listened to in a focused, genuine way can be hugely impactful, and potentially transformative.

When listening actively, a therapist will tune in and offer steady eye contact and responsive non-verbal expressions. The listening is engaged bodily; the therapist seeks to attend closely to the client’s words, non-verbal cues, and any changes in breathing or posture/movement. At the same time, the therapist opens to the client in a non-judgemental way, respecting difference. More than listening to words, we respond to the **metamessages** of what is being communicated (Finlay 2016), perhaps via questions such as:

 “I’m curious about what you mean when you say…?”

“What might your sigh be saying?”

 “I can hear you say these words but I’m sensing something else is going on.”

“You seem to be speaking calmly but your clenching fist seems to be saying something else. Is that right?

 “What’s happening to you in this silence?”

Presence

Therapeutic presence (as distinct from the ‘stage presence’ of an actor or politician) is generally understood as a state of *being grounded in one’s own embodied self in order to ‘receive’ the client’s experience* (Geller & Greenberg, 2002). Rather than being a specific skill, it’s a way of being solidly grounded, attuned, aware and responsive.

Rogers (1986) has described presence as those times when he is closest to his inner self and in a slightly altered state of consciousness: moments when intuitive spontaneous responses emerge that seem particularly valuable to the client. Towards the end of his life, Rogers talked about presence as a foundational dimension and wondered if he had over-emphasised the core conditions while under-acknowledging presence.

The notion of presence was explored in depth by the phenomenological philosopher Buber. It has since been taken up by different psychotherapeutic approaches and has been extensively researched.

It can be powerful for the client to see they have impacted the therapist and 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

Research demonstrates the way in which these interlinked components (empathy, compassion and attunement) propel the therapeutic relationship (Cooper, 2008).

When we empathically and compassionately attune to another we gently sense, resonate with, and stay with that individualin their experience. However, the multi-dimensional nature of this process, involving cognition, emotion, body, and developmental-relational elements, makes it hard to describe. 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’; relational *CBT* and *mindfulness* practitioners home in on ‘compassion’, while relational *psychoanalytic* therapists favour ‘attunement’. In practice, most therapists probably engage all three elements but to different degrees.

Curiosity

In the absence of curiosity on the therapist’s part, attuned compassionate empathy can feel intrusive, smothering or even voyeuristic. “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 and compassionate curiosity from the therapist aims to raise client’s awareness of their issues and process (thoughts/feelings, experience, needs) and 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. In this sense, therapy is a process of opening a **dialogue,** ofposing 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.*

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 mindfully 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 do you think is 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. ‘Socratic questioning’ is used primarily in CBT approaches while ‘phenomenological inquiry’ is largely engaged in humanistic and embodied approaches.

Therapist as ‘container’

The need for containment arises where a client’s emotions become destructively overwhelming such as when they are ‘triggered’ and re-experience past trauma, or when anxiety turns into terror or dissociation/numbing, or when the person becomes hyper-aroused (e.g., annoyance becomes violent rage).

The aim is to help the individual become more grounded and aware while being safely contained in the therapeutic space. The therapeutic relationship, in effect, contains the client’s unbearable experience, along with any emotional explosions, and then supports them to better understand – and so deal with – their process.

In various pluralistic/integrative *trauma approaches* which draw on bodywork, containing might be enacted through ‘braking’, ‘stabilisation’ or even by holding the person physically. In *psychoanalytic* work, the concept of containment has a specific meaning. Both these versions of containment are discussed below.

The therapy relationship thus becomes a safe space, one which receives, contains 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 receives and holds potentially harrowing processes *also* needs to be held and contained. This is where **supervision** comes in. The kind of work therapists do, particularly when receiving dark projections, means we have to do our own self-care.

Relational depth

‘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 connection** between therapist and client that can be present within a [therapeutic relationship](https://counsellingtutor.com/basic-counselling-skills/therapeutic-relationship-in-counselling/). 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. (See the 2006 special issue of *Person-Centered and Experiential Psychotherapies* journal, which is dedicated to this subject).

A key feature of relational depth is the importance of a **co-created, authentic** therapist-client encounter where the therapist stands firmly as one who faces the client as a person and responds to the client “from their own depths” (Mearns & Schmid, 2006, p.262):

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, reciprocity and relatedness. This is all about being genuinely interested in, and concerned for clients’, well-being. Research (e.g., Levitt et al., 2016) shows that therapists’ care allows clients to feel safe enough in sessions to be vulnerable and able to put aside defences against self-exploration. By internalising the therapist’s acceptance and care, clients also embark on the road to *self*-acceptance and *self*-care.

Our professional codes commonly highlight the importance of **duty of care** – our duty to place our clients’ best interests to the fore and to provide an appropriate standard of service (BACP, 2018a). This requires therapists to ensure clients are not harmed physically or psychologically (*beneficence* and *non-maleficence).* In practice, however, achieving this goal may prove problematic. Despite our best efforts, some clients may leave sessions churned up and feeling worse – even if only temporarily so.

Linda Finlay - May 2023