

# THE THERAPEUTIC RELATIONSHIP AND ACTIVATION OF THE HEALING FACTORS

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**Abstract:** *The aim of this article is to show, using a meta-theoretical approach and a qualitative methodology, the essential role of the main components of the therapeutic relationship in activating the healing factors in psychotherapy. To achieve this goal, we will analyze the key components involved in the establishment of the therapeutic relationship, namely the therapeutic relationship conceived as an empathic and supportive alliance, an essential curative factor (humanistic-experiential approach), empathy as a therapeutic factor, the achievement of the therapeutic commitment between the therapist and his client (the healing involvement), authenticity, unconditional positive acceptance, congruence and two case studies.*

**Key words:** *unconditional positive acceptance, the therapeutic relationship, resilience.*

## 1. Introduction

During the past few decades, the landscape of the family structure has changed dramatically. Every family faces situations throughout the course of life that present challenges to the manner in which family members relate to one another or how the family unit functions within the community (Patterson, 2002). Family adaptability or flexibility refers to a family's ability to modify its rules, roles, and leadership; thus, restoring balance between (a) family members and the family unit and (b) the family unit and the community (Olson, 2003; Patterson, 2002).

## 2. Family Adaptability and Resilience

Families have various degrees of adaptability, that fall along a continuum from rigid (very low), to structured (low to moderate), to flexible (moderate to high), to chaotic (very high) (Olson, 2003). Similar to the construct of family cohesion, moderate degrees of adaptability (e.g. structured or flexible) can allow for healthier degrees of family functioning than those on the extremes (e.g., rigid or chaotic). At one extreme, a rigid relationship has one individual who is highly controlling and makes most of the decisions. A structured relationship is characterized by a more democratic family

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leadership that includes some consulting with children before making decisions. In this instance rules are fairly consistent and are enforced with very little change in family roles. Families depicted by a flexible relationship have an equal leadership and democratic decision making between members of the family. Flexible relationships allow for open discussions between parents and children, rules that change according to developmental appropriateness, and roles that are shared among family members. At the other extreme, a chaotic relationship is defined as one devoid of consistent leadership. To function as a healthy system, families must be both adaptive and stable. Families that are able to determine the appropriate times to maintain stability or address change are more likely to be healthy, functional families (Olson, 2003).

Families that are successful in being adaptive are proactive in the socialization and development of individual family members, and understand the importance of maintaining the family unit (Patterson, 2002). Accordingly, there are two central components of family adaptability: adoption of optimal parenting styles and problem-solving practices, and developing a shared set of beliefs or values within the family unit.

This is consistent with an ecological framework that views both the interactions among family members and the relationship between the family unit and the community as essential pieces in developing family resilience. Resilience is traditionally defined as the ability to "bounce back" from adversity, to manage stress effectively, and to withstand physical or psychological pressures without showing major debilitation or dysfunction (Hartling, 2008).

Often resilience is described as:

- (1) good outcomes in high-risk children;
- (2) sustained competence in children under stress; and
- (3) recovery from trauma (Hartling, 2008; Masten, Best, & Garmezy, 1990).

### **3. Client-centered Therapy (CCT) and the Therapeutic Relationship**

Eclectic approach is an approach to psychotherapy that depends on the client's problems and that uses or integrates technique from various forms of therapy, also called psychotherapy integration. The most widely used humanistic technique is Carl Rogers person-centered therapy. A person-centered therapist focuses on the client's conscious self-perception rather than on the therapist's own interpretations. The therapist listens without judgment or interpretation and refrains from directing the client toward certain insights. The strategy has earned person-centered therapy the label nondirective therapy.

Believing that most people already possess the resources for growth, Rogers encouraged therapists to exhibit genuineness, acceptance and empathy. When therapists drop their facades and genuinely express their true feeling, when they enable their clients to feel unconditionally accepted, and when the empathically sense and reflect their clients' feelings, the clients may increase in self-understanding and self-acceptance.

There are three particularly significant qualities to the relationship or attitudes on the part of the therapists who must effectively communicate them to the client as both a necessary and sufficient condition for therapeutic change:

- 1) ***Genuineness (authenticity or congruence)***. The therapist must show themselves to be a real person, with feelings which should be expressed where appropriate. The client needs to feel that the therapist is emotionally involved and not hiding behind

a façade of professional impersonality, the therapist must be “transparent”. This is the most important of the three qualities or attitudes.

- 2) **Unconditional positive regard.** The therapist must show complete acceptance of, and regard for, the client as a separate person in his/her own right. The therapist must have a deep and genuine caring for clients as they are now in a non-judgmental way.
- 3) **Empathic understanding.** The therapist must try to enter the client’s inner world through a genuine, attentive listening, which involves intense concentration. This may involve restating what the client says as a way of trying to clarify its emotional significance (rather than its content) and this requires the therapist to be sensitive to what is currently going on in the client and to meanings which are just below the level of awareness. (Gross,1997).

Thorne (1984) believes that empathic understanding is the most “trainable” of the three therapist attitudes but is at the same time remarkable rare. He also suggests that a fourth attitude, tenderness, could be added to Rogers’ three. If these therapeutic conditions are established, clients will talk about themselves more honestly and this will bring about a re-establishment of congruence which will be sufficient to produce changes in behavior. (Fonagy & Higgitt, 1984).

Empathy, a complex process by which an individual can be affected by and share the emotional state of another, assess the reasons for another’s state, and identify with the other by adopting his or her perspective, is thought to be necessary for the cooperation, goal sharing, and regulation of social interaction. Such capacities are critical to infant and child rearing, as children, who are unable to care for themselves, signal to the caregiver that care is needed, a process that is then put to use to manage social relations among communities of adult individuals. Therapist expressed empathy is a primary common factor, but which also augments the effect of expectations.

According to Rogers, threat, anxiety and depression are responses to a lack of congruence between our experience and self-concept, this may arise because of our need to be positive regard. We may defend against these feelings by using denial and distortion, setting up a vicious circle, which may manifest in a neurotic or psychotic.

The aim of client-centered therapy (CCT) is to enable the individual to become a more independent, confident person by creating a therapeutic atmosphere in which the natural tendency towards self-understanding and self-actualization is allowed to develop. The therapist’s task is to help the client to increase their positive self-regard and to become fully integrated again. This is achieved through the therapist’s genuineness /authenticity, unconditional positive regard and empathic understanding.

Every therapy offers people a plausible explanation of their symptoms and an alternative way of looking at themselves or responding to their worlds. Therapy also offers new experience that help people change their views of themselves and their behaviors. Armed with a believable fresh perspective, that may approach life with a new attitude.

In the last years, the contextual model posits that there are three pathways through which psychotherapy produces benefits. That is, psychotherapy does not have a unitary influence on patients, but rather works through various mechanisms. The mechanisms underlying the three pathways entail evolved characteristics of humans as the ultimate social species; as such, psychotherapy is a special case of a social healing practice. Thus, the contextual model provides an alternative explanation for the benefits of

psychotherapy to ones that emphasize specific ingredients that are purportedly beneficial for particular disorders due to remediation of an identifiable deficit (Wampold, & Imel, 2015). The three pathways of the contextual model involve:

- a) the real relationship,
- b) the creation of expectations through explanation of disorder and the treatment involved, and
- c) the enactment of health promoting actions.

Before these pathways can be activated, an initial therapeutic relationship must be established.

#### **4. Case Study I**

**a. Personal data:** age: 12 years old, gender: female, education: pupil

**b. Case presentation**

The client came for therapy accompanied by her parents, her mother and her stepfather. As a result of the first clinic interview, I have identified the depressive state of the patient, of which she started to suffer a year before coming for therapy, in which she took part daily. In the last year, the patient has also lost her interest in most of her hobbies, which had been drawing her attention in the past. As a result of the multiaxial assessment (according to DSM IV TR and DSM 5), the presence of similar symptoms was noticed, as follows:

- I. On Axis I, it was noticed the presence of an emotional disorder, this being the distimic disorder, diagnosis code 300.4, the following symptoms being present:
  - a. chronic depression and lack of interest in formerly enjoyable activities (anhedonia), irritability;
  - b. continuous and uninterrupted presence of these symptoms during the last year;
  - c. depressive state accompanied by other symptoms, such as: psychomotor agitation, fatigue, poor concentration, feeling of being useless and guilty, recurrent suicidal thoughts and lack of appetite;
  - d. no evidence of the absence of the aforementioned symptoms in the last year, for more than two months;
  - e. no evidence of a major depressive episode.

Regarding the etiological factors related to depression during childhood, one must state that the greatest number of clinical trials and the statistics associated with them show that childhood (pre-puberty) depression is caused by environmental factors rather than genetic ones (Wilmshurst, 2007).

Environmental factors associated with childhood depression include: domestic conflicts, low levels of parental education, rejection by others or by other group of peers. Most common symptoms of childhood depression include somatization or conversion disorder, irritability, social isolation, anxiety and behavioral disorder. In several cases, first childhood depression symptoms vary from irritability or aggressive behavior (fury) to self withdrawal and isolation. In the case of the 12-year-old client, the first clinic interview revealed a low desire to communicate or share personal experiences (belonging to her emotional life, her inner world), as well as poor interpersonal communication skills. The patient shows signs of self-withdrawal and culpability.

On Axis III (according to DSM IV TR), meaning, General medical conditions, special expertise confirms the patient's (neurological) medical diagnosis as being benign

childhood epilepsy. Epileptic seizures intensified one month before the first psychotherapy session, causing an important physical and psychical distress for the patient. The patient was brought four times to the emergency room in *status epilepticus* having the following symptoms: temporary loss of consciousness, convulsions, spastic movements etc. The patient received no neurological or psychiatric medication.

**c. Therapy objectives**

- to eliminate the idea of worthlessness and increase patient's self-confidence.
- to eliminate the symptoms of depression and anxiety, to regain interest in activities and peer and interfamilial interactions.
- to control the emotional feelings and anxiety associated with the medical condition on Axis III (benign childhood epilepsy).

**d. Case elaboration and therapeutic strategy**

The client identified the beginning of the first depressive symptoms during her parents' divorce, two years ago. Due to this experience that the patient felt as being extremely traumatic for her, she developed feelings of excessive guilt. She blamed herself for her parents' separation, this having a traumatic impact upon her, and wanted for her father to return to the place where she lives with her mother. One must point that when her parents were together, her father had frequent violent outbreaks due to alcohol problems and jealousy crisis. During clinical evaluation on Axis IV, meaning, psychosocial and environmental problems, the following important aspect was identified: the presence, of one year and a half, of her adoptive father, her mother's partner having a stabilizing role in the family, providing the child with stability, protection and support, these playing an important role in regaining the feeling of being safe.

The main purpose of the first two therapy sessions was to create a therapeutic relationship, to gain therapeutic competence and provide a safe climate for the patient who, due to epileptic seizures, has lately experienced feelings of insecurity.

The most important factor of the session was related to the establishment of a therapeutic relationship based on mutual trust, and the feeling of being safe which for the client derived from the fact of being unconditionally accepted and understood in what she experienced emotionally, cognitive and behavioral. Ultra therapy techniques were used, but also methods that played the role of bringing emotional stability in the life of the client, relax her, increase her self-confidence and make her discover her own worth. The usage of the mirror technique encouraged the patient to look at herself in the mirror accompanied by the therapist who, by using an empathic and supportive look, and a verbal and, especially, non-verbal language, encouraged the client to accept and love herself unconditionally. This intra-therapeutic experience proved to be useful, as the client learned what self-worth and self-respect mean by changing her perspective on herself. Positive and unlimited beliefs such as faith in God and relationship with spirituality have also been used, these already being personal values for the client and her family. The development of confidence and self-esteem has also been encouraged by frequently involving the client in group and artistic activities, as she had folk artist skills, being remarked in her group.

Relaxation and self-awareness techniques were used in muscular decontraction in order to help the client face the anxiety and intrapsychic tension accumulated during epileptic seizures. Therapeutic counseling aimed to encourage the patient take part in formerly enjoyable activities, such as: walks in nature, peer meetings, artistic activities etc. (Dafinoiu, 2003). The aim of the therapeutic intervention based on clinic hypnosis was:

- a. cognitive rehabilitation including client's limited beliefs and intrahypnotic restrictive way of thinking;
- b. awareness of her own qualities and skills, aspects that aimed to increase the client's self-esteem;
- c. positive focusing on how to stop the negative recurrent cycle of disesteem and the one related to an inevitable epileptic seizure; the client was intrahypnotic and through daily counseling encouraged to remember ten positive experiences by focusing on them and reliving the positive emotion when narrating them.

The patient was trained to become aware of her thoughts and emotions, to intensify the number of positive experiences and diminish the negative ones. One must acknowledge the fact that apart from the intratherapeutic techniques and methods used on clients, the main factors that helped diminish until remission both psychiatric (depression) symptoms and neurological ones after three therapy sessions were the following ones: strong therapeutic relationship based on trust and mutual respect, empathic and supportive relationship as an emotional healing factor, a client-therapist healing involvement, authenticity regarding personal expression and exteriorization, unconditional self-acceptance and coherence.

As in what concerns this client, the development of the client-therapist relationship was the most important healing factor. This kind of approach made possible the complete remission of both the symptoms on Axis I that involve clinic disorders, in this case dystimic disorders, and the symptoms associated to the medical condition on Axis III, benign childhood epilepsy. This has been achieved in the absence of both psychiatric and epileptic medication. It must be mentioned that in the last two years, the client showed no dystimic or epileptic disorder symptoms, all remaining in complete remission.

## 5. Case Study II

**1. Personal data:** age: 36 years old, gender: male, education: Master's Degree

### **2. Case presentation**

The client came for therapy session experiencing anxiety symptoms caused by a poor medical condition. The diagnosis associated to the general medical condition (according to DSM4 TR) is of vertiginous syndrome. The patient complained of suffering from anxiety symptoms and somatizations that tended to produce an important distress in his individual and social life. The clinic interview showed that the patient fulfills the diagnosis criteria for Anxiety Disorder due to General Medical Condition (Diagnosis code 293.89, according to DSM4 TR, p. 479). In this case, the medical condition is vertiginous syndrome. The patient's clinic evaluation unveiled the following symptoms:

- a. major anxiety, panic attacks, obsessions, predominant in the clinical picture;
- b. Due to patient's medical history and symptoms (vertigo, temporary loss of consciousness due to vertiginous syndrome, frequent headaches and migraines, skull pains), it is obvious that perturbation is the primary physiological cause of this general medical condition.
- c. Perturbation cannot be better explained by other mental disorder.
- d. Perturbation doesn't appear exclusively in delirium.

Perturbation creates distress or significant clinic deterioration in patient's social and professional area, as he is forced to interrupt all his activities once Axis III symptoms begin to appear (the ones due to the mentioned condition).

What prevails in this type of disorder is a permanent state of anxiety accompanied by patient's excessive concern over the unexpected decline of his physical, emotional and cognitive condition.

### **3. Therapy objectives**

In cooperation with the client, the following objectives were identified:

1. Stress and anxiety management, symptoms that occur in general medical condition;
2. Identification and management of intrusive thoughts related to the serious distress caused by vertiginous syndrome;
3. Ways to reduce anxiety related to the poor medical condition;
4. Case elaboration and therapeutic strategy.

The therapeutic relationship created and consolidated during the first two sessions highlighted what Rogers described as client's unconditional positive regard. This aspect played an important part in the therapeutic relationship, giving the fact that the client had lately experienced feelings of insecurity and lack of acceptance from his family, correlated to the increase of medical investigations the patient was subjected to in order to get a diagnosis and a specialized medical treatment. Frequent crisis at his workplace, the patient being marine officer and having responsibilities associated to his job, accompanied by collapse and temporary loss of consciousness made him lose confidence and hope in finding a solution to solve his medical problems. The symptoms generated by the vestibular disorder generated a couple of anxiety disorder symptoms, such as panic attacks and anticipatory anxiety.

The first two therapy sessions aimed to create a therapeutic relationship with the client. Due to this relationship, based on mutual trust, unconditional acceptance of the client by the therapist and the former's extremely increased motivation, anxiety symptoms and the ones on the Axis III went entirely into remission. One must state that in the last three years, the client exhibited none of the problems, be it psychiatric or medical problems, related to ORL, for which he came for therapy session. The therapy lasted for four sessions. The success of therapy in this case was based on the components of therapeutic relationship as being the main healing factors.

Empathy, the main element of the therapeutic relationship, played a major role in reaching the therapy objectives, as the anguish, the client's inner conflict, derived from the feeling of being helpless once faced with an illness that severely affected his life. The patient received intratherapeutic support, solace, unconditional compassion. The therapist had an empathic attitude towards the client's self-approach when confronted with illness and suffering, fear, weakness, insecurity, empathy towards himself and others (responsive empathy), fear of being rejected by others (due to the fact that losses of consciousness at his workplace had a high-risk and were full of suffering). The therapist's empathic answer made the client increase his self-awareness.

### **6. Conclusions**

Case studies presented at the end of this article constitute the practical exemplification of the huge impact of the curative factors involved in the therapeutic relationship. Through the therapeutic alliance as a fundamental healing factor, we can achieve both the therapeutic change, the homeostasis process involved at the biological level and the balance that may exist at the psychological, social and behavioral levels as well. What we consider to be representative in both cases is the impact of all parts of the therapeutic

relationship as a healing factor, which surpasses both theoretical, methodological perspectives and the different techniques of various approaches to psychotherapy. People who seek help usually improve. So do many of those who do not undergo psychotherapy, and that is a tribute to our human resourcefulness and to our capacity to care for one another. Nevertheless, though the therapist's orientation and experience appear not to matter much, those who receive some psychotherapy usually improve more than those who do not. Mature, articulate people with specific emotional or behavioral problems often improve the most. Part of all therapies offer is hope, a fresh way of looking at life, and an empathic, caring relationship.

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