

Relational Needs of the Therapist: Countertransference, Clinical Work and Supervision. Benefits and Disruptions in Psychotherapy

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Abstract:

Relational needs are the emotional needs which underlie our social connectedness and help sustain and nurture our attachments to others. In doing psychotherapy, therapists must be attuned not only to the needs of the client, but also to their own relational needs. Through self awareness and knowledge of healthy and appropriate boundaries, therapists can ensure the best interest of the client is kept foremost. In this article, the influence of the therapist's own relational needs in the psychotherapy process is examined in terms of the possible benefits and disruptions to the client's emotional growth. This is discussed in the context of the Integrative Psychotherapy model based on the core concepts of inquiry, involvement and attunement. Clinical supervision is seen as an important part of working through counter-transference.

The concept of relational needs has for some time been accepted as a useful clinical construct in guiding treatment interventions in psychotherapy (Erskine, 1998). Relational needs are different from the hierarchy of needs as defined by Maslow (1970) which relate to survival and physical safety. Relational needs emerge out of our social connectedness, and help sustain and nurture our emotional attachments to others (Erskine, Moursund, & Trautmann, 1999).

Relational needs remain through the life cycle, although the intensity of certain needs may change as we mature. When these needs are not met, we experience psychological distress. If there is a chronic failure to get these needs met we are likely to experience disturbances in mood, thought, body and behavior – in other words, the type of symptoms that cause people to seek psychotherapy.

The eight primary relational needs are: 1. Need for security in relationship. 2. Need to be validated and affirmed as significant. 3. Need for Acceptance by a

stable, dependable and protective other. 4. Need for mutuality or confirmation of personal experience. 5. Need for self definition. 6. Need to make an impact on the other. 7. Need to have the other person initiate. 8. Need to express love.

When we think of relational needs, most often we are considering the relational needs of our clients. That is how it should be if we are doing our jobs properly. However, we therapists are human and have the same relational needs as our clients. For most of us, there are times when our own relational needs do not get met, or when the urgency of unmet needs increases due to stress or losses in our personal life.

All of us know of colleagues who have crossed boundaries and used clients to fulfill unmet relational needs. Most of us will know of some blatant examples of this where the experience has been devastating for clients and they have been re-traumatized. Again, their own needs have been missed by a trusted other and they feel used and betrayed. The experience is often devastating for the therapist as well, in terms of guilt, shame and loss of professional reputation. The examples of gross professional misconduct stand out for us and the boundary violation is really clear. There are many other ways for the therapist's relational needs to get tangled up in the therapeutic relationship through dynamics that are more subtle, less easy to label and often out of conscious awareness.

As therapists, it is our responsibility to be aware of how our relational needs may be expressed overtly or covertly in the work with our clients. This is one reason it is important to do our own therapeutic work and get regular supervision throughout our careers so we have more awareness of how we may be using our clients to meet our own emotional needs. This is an aspect of countertransference that is often overlooked in supervision.

It is inevitable that in a relationally focused therapy, our own needs will enter into the equation. In a therapy of Inquiry, Involvement and Attunement, "Involvement" requires that we bring our humanness to the therapy, and that includes our needs. In examining the ways in which our own needs might be met through the relationships with clients, I hope to convey this is not an issue that can be neatly divided into right or wrong. There will be a full spectrum of consequences to the client ranging from being powerfully affirming and validating to the client, to neutral, to a clearly destructive impact.

Being attuned to our own relational needs within the therapy relationship can also be diagnostic - being aware of the ways clients try to meet our needs, or fail to be sensitive to our needs can tell us a lot about their history, the defensive systems in place, and how they relate to significant others in their lives. As with many aspects of doing psychotherapy, bringing the interface between our own needs and those of our clients into conscious awareness is the best strategy to avoid doing harm to our clients.

At this point, I would like to note the distinction between current relational needs and archaic relational needs. Current relational needs are those needs which can realistically and appropriately be met through our adult relationships. Archaic needs relate to unmet relational needs from earlier developmental

stages. While it is possible to find relief from the symptoms of unmet archaic relational needs (e.g. profound feelings of emotional emptiness, confused sense of self, perceived powerlessness or crippling fears of abandonment) it is not possible as adults to fully meet those needs since the developmental window of opportunity has long since passed. We can respond to those needs by recognizing, empathizing, and validating them and helping our clients (or ourselves) find ways to manage the pain and relinquish defenses which prevent current relational needs being met. We can also promote the emotional growth of our clients through many other different avenues, such as treating developmental fixations within the child ego state or mitigating the impact of destructive introjects.

Each of the eight relational needs will be discussed in terms of examples and implications of the therapists' needs being a dynamic part of the therapeutic relationship.

Need for security: having our physical and emotional vulnerabilities protected. (For a relationship to be secure, it must engender a sense of being protected and of safety to be open and vulnerable without ridicule or shame.)

A situation where a therapist prolongs dependency of a client longer than necessary is one way a client might inappropriately be used to meet a current need such as financial security. If dependency is prolonged because the quality of the relationship with the client fulfills an archaic need of the therapist, then this would also be inappropriate and exploitive of the client.

If a therapist brings his/her archaic needs for security into session, then there's a likelihood he/she will communicate in covert ways messages such as "I need to be taken care of", or "I'm overwhelmed by your needs." For example, a therapist disclosed the presence of the sad and lonely little boy within himself to a client who then became obsessed with wanting to nurture and heal the therapist's wounded child. Attempts by the therapist to redirect attention to the client's unmet childhood needs fueled an escalation of the client's obsession with the therapist's wounded child. The therapist was unable to resist the outpouring of nurturance and slipped deeper into his child ego state. The outcome was that therapy had to be terminated, and even after termination the client made calls and wrote letters attempting to heal and nurture the wounded therapist. In this example, the therapist thought that openly disclosing something about his unmet needs might fulfill the need of mutuality of experience for the client. Because that wound was still very open and raw for the therapist it engendered an intense caretaking response from the client, which the child ego state of the therapist was unable to resist.

On a personal level, I used to experience a sense of abandonment when clients terminated prematurely, cancelled sessions, or even came late for sessions. Resolving my own abandonment issues and a pervasive script belief of "I'm inadequate" has helped me be non reactive to perceptions of

abandonment, leaving me able to focus fully on the psychodynamics at play with the client.

The therapist's experience of feeling abandonment or "I'm not OK" in relation to clients seems to come up regularly in supervision. It is difficult to provide the secure base our clients need in order to let go and be vulnerable themselves if we aren't able to contain and then process our own insecurities away from the session. In other words, bringing our emotional fragility into session is not generally therapeutic. This doesn't mean that you can't be emotionally honest or vulnerable with clients but bringing our unmet archaic relational needs for security into the session can evoke a role reversal.

In situations where a client is angry, threatening or overtly hostile towards us our sense of security is naturally affected. If we feel physically or emotionally unsafe, then our need for security is not being met. Unless clear boundaries are established and the threat removed we are limited and compromised in our effectiveness. For example, a client once came and sat beside me and started rubbing my knee and suggesting sex. Clear boundaries were established around this behavior in order for me to feel safe in continuing to work with this client, and for the client to feel secure that I would not replicate his previous sexual abuse. The incident also provided weeks of material to work with in therapy exploring the meaning of this 'testing' behavior, eventually revealing his unconscious strategy to make me reject him and confirm his underlying script belief: "I will be abandoned".

Need to be validated and affirmed as significant: Confirmation that affect, fantasy and construction of meaning are significant. (This is the need to be appreciated, cared for and to be respected not only for what you can do, but for who you are. It is the need to be recognized and understood by others.)

In an in-depth psychotherapy clients will project onto the therapist their unconscious transference life story, therefore, it's not surprising that at times we might feel our clients don't see us, either in our therapeutic capacity or as real people. This can leave us as therapists feeling unappreciated or used which can become difficult to deal with when doing long term work. This is particularly true with those clients who, because of their characterological issues, may not have the capacity to have any empathy for us, or see us as anything other than a filling station for their need to be mirrored. If we are needing or expecting to be validated and the client fails to validate us, there is the risk of us being resentful and feeling wounded when it doesn't happen. If we are not conscious of our own process around this, there is the risk of retaliating in passive ways such as withdrawing emotionally.

Having a strong need for validation from our clients can stimulate caretaking from adaptive clients who try to meet our needs and thus win our affection or be special to us. If we have a blind spot in this area, we are reinforcing an old pattern of "other people's needs are more important than mine" for the client, perhaps missing the issues surrounding conditional acceptance

they have not yet dealt with. In addition, a strong need to be idealized may lead the therapist to set themselves up as “the expert” which can lead to misattunement to the client’s rhythm, developmental level, cognitive style and affective processes. While being in the role of expert might fulfill the client’s need for the presence of a powerful, protective other, leading to an idealizing transference, (Erskine, Moursund,&Trautmann, 1999) it can work against the need for self definition. Self definition demands careful introspection which can be hindered by the introjection of an idealized other. Idealization of the therapist by the client is not uncommon and is an important dynamic to work through. If the therapist colludes with and reinforces being idealized to meet their own needs, the scope of therapy becomes limited and compromised. The therapist needs to keep in mind that idealization by the client is not about the therapist, but about the clients need for intrapsychic protection.

In a similar vein, the need to feel validated can influence the therapist’s response to gifts offered by clients. It can be important to graciously accept gifts from clients, within the guidelines of your professional body, from the perspective of the client’s need to express love. However, a strong need to feel loved and appreciated may lead to the covert encouragement of gift giving to the therapist and the neglect of inquiry exploring the psychological significance of the gift.

We can get powerful validation from our clients in many different ways. We see the changes people make in their lives; maybe they are less self loathing, maybe they are taking risks that were unthinkable before. Some of the most powerful validation I’ve received as a therapist has come from things clients have said. For example, a client once said to me “ Of all the people in my life who might die, only my mother’s death would affect me more than yours” - which was a very sweet (and a bit sad), but was certainly a validation of the work we’d done and met my need to make an impact.

Need for acceptance by a stable, dependable and protective other: Encouragement, information and support that help create safety and protection from one’s own exaggerations, escalations, and intrapsychic conflicts. (This relates to the need to be able to look up to and rely on parents, teachers, elders, and mentors to gain protection, encouragement, and information from them.)

If our archaic needs are brought into session we may indeed look to our client to provide acceptance and re-assurance. I am reminded of a therapist in training who was awed by a client who was powerful and healthy, and craved acceptance from the client. There was a sense for the therapist of wanting to bask in the aura of the client, which interfered with her ability to address and work with the narcissistic defenses the client presented. The therapist struggled with feeling inadequate and one down in comparison to the client. In a classic role reversal, the therapist craved acceptance from the client to soothe her own longings for an “ideal” other who was stable and dependable.

This dynamic might be called an idealizing counter transference which could develop for the therapist while working with a client who is perceived to be one

up in terms power, status, talent, wealth or some other factor. These feelings need to be dealt with in the therapist's own supervision or therapy since they will interfere with effective attunement to the client's underlying vulnerabilities.

There are certain circumstances where it might be therapeutic for the therapist to disclose feelings of idealization, in the form of admiration of a client. An example of this is when the therapist is responding to the client's need for validation and affirmation, or if the client has difficulty acknowledging and valuing their own areas of real competency and power. It might also be useful feedback for a client when they have little insight into the positive impact they have on others around them, or the positive impression they make.

Need for mutuality or confirmation of personal experience: *(This is the need to be in the presence of someone who is similar to you – someone who understands because he or she has been there too. This person can understand your phenomenological experience without explanation.)*

Sometimes we will have a client with whom we have an experience in common, perhaps who has an experience that nobody else in our life can relate to. There may be a parallel process as we treat someone who is going through something we are also struggling with. For example, one of my clients was dealing with her mother's failing health at the same time my own mother was in decline. Just a few words now and then about my feelings of sadness, loss and helplessness regarding my own mother conveyed an understanding of what my client was going through and provided validation of her experience.

In responding to any mutual experiences with a client, we need to stay attuned to what the client's relational needs are at that particular time. They may be at a point in their relationship with us when they don't want to know anything about our inner world. Also, we can never assume that because a client has had a similar experience to us they will have had the same response to that experience. For example, as a gay therapist working with a gay client, I would never assume my client's internal experience of being a gay person in this world would overlap my own. I must patiently and conscientiously inquire again and again into my client's phenomenology in order to understand the world through his/her eyes.

In a negative way, therapists may talk too much about their own personal experiences and unconsciously look to the client to satisfy their need for mutuality. The decision to reveal aspects of the therapist's feelings and experiences must be based on what the client's needs are in terms of knowing about those shared experiences. Disclosing a little bit and observing the client's response will quickly help us gauge whether it is a therapeutic miss or an opportunity to strengthen the relationship.

Need for self-definition: acknowledgment and acceptance of one's own uniqueness. *(This need is in some ways the inverse of the need for mutuality. It relates to a need to have the other person recognize, accept and respect our uniqueness.)*

Clients teach us all the time about aspects of ourselves, of alternate values systems and of different ways of being in the world. In this way, they contribute to and enhance our developing sense of self. I know, personally, that listening to my client's stories over the years has helped me mature and develop a clearer sense of purpose and meaning in my life. I look at this as a byproduct of therapeutic involvement that benefits the therapist.

One therapeutic outcome we hope for our clients is a stronger sense of self definition in their relationships. By this, I mean the client having better awareness of their own inner thoughts, feelings, hopes, fears, physical sensations and so on while relating to others. If the therapist has a strong sense of self in this way it can be a very positive force to bring into the therapy process. I see it as part of involvement – in order to share clear honest information when you process “I – thou” relationship issues, you need to know what your own thoughts, feelings and reactions are and be able to communicate them clearly.

Self definition in therapy for both therapist and client can be achieved through such things as therapeutic contracts, and an invitation by the therapist for the client to disagree with them. The therapist's clear sense of self is an important tool as we assist clients in dealing with their sometimes distorted views of us and the world, and helps us be clearer about our own boundaries and limits. Role modeling can be a potent tool when clients see us able to connect easily with our own inner experience and share those experiences in a clear and responsible way.

Avoiding expressing self definition can lead to confluence in relationships with clients where we don't assert our differences from them (Perls, Hefferline, Goodman, 951). Asserting differences are important in transactions such as confronting a client's script bound belief system or self-destructive patterns of thinking or behaving.

Some other aspects of the therapists need for self definition which may hinder therapy include giving inappropriate or premature advice based on the therapist's world view, or being rigidly tied to a particular theoretical viewpoint or approach. Similarly, a therapist's unconscious need to self define may cause them to be overly confronting or oppositional with clients leading to failures in empathic attunement.

Need to make an impact on the other: influencing and effecting a change. (This relates to the need to experience some potency in affecting or influencing another person in some way. That may be to influence their way of thinking, change a behavior, or to elicit an emotional reaction from the other.)

We want to make an impact, and it feels good and is validating to us if we can make an impact. To need to make an impact can lead to therapeutic errors such as trying too hard and pushing our agenda, or trying to connect at a level of intimacy the client is not yet ready to tolerate. In other words, we may miss the current relational needs of our clients by becoming too focused on change rather than inquiring and connecting .

It is common for less experienced therapists to be discouraged and feel inadequate because a client seems stuck and not changing. This relates sometimes to unrealistic expectations of change, but can also relate to the therapist's need to make an impact not being met. It is important to have the capacity to tolerate the feeling that we are not having an impact (often for a very long time) and be okay with it, and accept the fact this relational need may never be met at all by some clients.

Clients may leave therapy without acknowledging or being aware of the impact we have had on them until much later. I am always touched, and often surprised, when someone contacts me several years after they have finished therapy and tells me how significant the work was to them.

To have the other person initiate: *(The need to have the other person reach out and initiate contact. Any relationship where we always have to take the first step, always initiate, always be the one to approach will eventually become frustrating and dissatisfying.)*

If we are unable to initiate interpersonal contact, if we aren't able to take the risk to reach out and connect in a deep emotional way then we aren't ready to practice a relational therapy. It is important to be aware of the dynamics of initiating since sometimes it is clinically astute to wait until the client initiates reaching out to us. This is particularly important when the client needs the safety of having total control over how, when, and where they make contact and deepen the intimacy of their relationship with us. This is an area where clinical judgment comes into play in terms of when and how the therapist should initiate, and how much should be left to the client. If we need the client to initiate because of our own issues, whether that be fear of rejection, fear of intruding into the clients psyche, theoretical orientation or some other reason, our ability to work deeply with clients can be seriously limited

The presence of the therapist's need to have the other initiate might be felt as a longing for the client to reach out to them, and a disappointment when they don't. For example, a colleague remarked on his longing for certain ex-clients or supervisees to stay in touch, perhaps just with a Christmas card. On a personal level, when I return from vacation and a client doesn't ask "how are you?" or "how was your holiday?" I'm aware of a mild disappointment. In saying this, I'm not suggesting the client should initiate, just that therapists be mindful of their own need in this regard and not make it an expectation of clients or withdraw when it's not met.

Need to express love: *(We all have the desire to express love and caring towards another, and to have this accepted and valued by the other. Love may be expressed in many ways such as gratitude, giving affection, gift giving, doing something for the other).*

Here is an opportunity to role model for clients how to appropriately express caring and the capacity to be loving. It is also an expression of our involvement and willingness to be impacted by our clients.

The therapist's expression of affection, caring or of being loving can be a potent validation and antidote to feelings of worthlessness and self loathing in clients. This can be a healing and corrective emotional experience for clients at a point in therapy where there is trust and potency invested in the therapist.

Timing, attunement and therapeutic judgment all come into play in expressing these sentiments. When your heart opens as you witness the vulnerability and despair of the hurt child in your client, showing this openly may be threatening or overwhelming – it may be premature if your client is not ready to receive it. The expression of caring needs to be titrated and delivered in a way that is fully attuned to the capacity of the client to receive and assimilate these feelings. In this way, expressing love is no different than any other form of self disclosure on the part of the therapist – attunement to the client's need is the first priority.

The therapist might suppress expressing caring or affection for a variety of reasons such as fear it might be misinterpreted as seduction or an invitation to stay dependent. Actions can speak louder than words sometimes, so expressing love through our dependability, presence and concern is often enough. For other clients, the caring and communicative hug at the end of a significant piece of work will be more meaningful.

On the negative side, unmet needs to express love can lead to the therapist misinterpreting or reacting inappropriately to the client's transference feelings, possibly adding a romantic or erotic undertone to the relationship. These dynamics need to be addressed in the therapist's own supervision or therapy.

Conclusion:

The issue of the therapist's relational needs being met through the psychotherapeutic process has not been widely addressed in the literature. We need to provide the information, permission and constructs necessary to support therapists in achieving full awareness of their own relational needs within the context of the therapeutic relationship.

Taking this issue "out of the closet" in individual or group supervision can be beneficial both in addressing feelings such as confusion and shame experienced by the therapist and gaining clarity on appropriate boundaries. This would be especially important for therapists with the script belief of "I don't need" where there may be significant denial of their relational needs being part of the intersubjective field with their client. Sharing, in supervision or with our own therapist, the ways we get our relational needs met through our work with clients helps normalize the existence of this dynamic and support the positive aspects of it. Transparency with colleagues creates the opportunity for feedback if the therapist's needs are being met inappropriately through their clients. This helps identify blind spots, confronts denial, and works towards protecting our clients from the potentially destructive aspects that can occur. If an error has been made it can usually be repaired if acknowledged, owned and worked through with the client, often strengthening the relationship in the process (Guistolise, 1997).

Through heightened awareness of how we get our own relational needs met, we become more conscious and consistent in attuning to our own process. This enhances our clarity around appropriate boundaries and clarity in how we need to be with the client to create optimal conditions for their emotional growth.

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