Untangling the Skein:
From Substance Dependence to Trust in the Relationship[1]

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Abstract

This clinical case study condenses knowledge from 30 years of working in the world of addictions as an integrative psychotherapist. The theory (the map) is not the territory. By using relational methods, we can transcend the label of "addict" and get to know the human being behind it; this facilitates bond development and internal contact. The client recognizes himself, and is re-integrated, in the mirror that the therapist offers. The relational failures, especially early ones, that have been experienced by the client shape internal processes and the client's relationship with the outside world. The substance takes on a stabilizing and regulating function in the face of emotional pain. A secure psychotherapeutic relationship is required to achieve this same stability and regulation. A conscious and nonreactive countertransference is crucial, as is the managing of the shadows, prejudices, fantasies, and internalized models of help. This way the client can show his vulnerability, have a true and reparative encounter, and overcome his addiction—his life script.

Keywords

Addiction, countertransference, life script, relational methods, relational needs, schizoid process, relationship

One sees well only with the heart. The essential is invisible to the eyes.
—Antoine de Saint-Exupery, *The Little Prince*

Over the course of my career, I have spent 30 years working in the field of addiction, including the last 28 years in Lugo's outpatient Drug Dependency Assistance Unit of the public health system. My strong interest in helping clients has motivated me to receive training in cognitive-behavioral therapy, family therapy, psychodrama, and transactional analysis until I finally reached integrative psychotherapy. Integrative psychotherapy has had an essential influence on my professional and personal development. Integrative psychotherapy is the foundation, the skeleton, that supports the psychotherapeutic work I do and my conception of being a psychotherapist.[2]

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[2] At some points in the narrative (fragments of sessions and relevant therapeutic moments), the first person is used to highlight the intersubjective aspects of the relationship and reflect the relational aspect (so

The presentation of this clinical case condenses part of my knowledge and practice as an integrative psychotherapist in addiction, as well as my reflections and thoughts on the psychotherapeutic relationship. This article conveys the great healing value of the psychotherapeutic relationship, and the importance of the process, beyond any specific technique used. Client and therapist co-create the relationship in each encounter they share. They influence each other, and from there emerges a new experience, a shared language, a unique synthesis. This is reflected in a philosophical principle of IP: "the intersubjective process in psychotherapy is more important than the content of psychotherapy" (Erskine, 2013, p. 8).

The Clinical Case

Manuel[3] is tall, pale, and thin. He seems ethereal, as if he does not occupy space. He has big eyes. He appears very correct, cooperative, and nervous, with a sad countenance. He talks and gives information about himself and his problem, but there is no emotion; there are just words. He says, "I think I need to go to a psychologist. For years I have been dragging around personal problems that were aggravated by alcohol and cocaine." He narrates economic problems, several serious car accidents, a breakup with his partner of 5 years, etc.

Manuel, in this first meeting, continues to talk about himself, his family, and traumatic events. He tells his story as if it were someone else's words and data. He tries hard to give all the information, to be "a good patient," without looking into my eyes. It will take time. He seems so, so distant, disconnected, isolated, and alone.

How easy it would be, without knowing him, to start assigning labels like "addict" and recommending treatment, guidelines, and decision trees. But who is he, what does he need, what does he really want, and how can he be helped? As a psychotherapist, asking yourself these questions leads you not to hurry to intervene, but instead to be extremely careful and respectful of the unique human being in front of you. It is important to take these first steps to co-create a unique psychotherapeutic relationship with each client, to not focus on the consumption, and to widen the field of vision in order to understand the function that this consumption has in his psyche. For rehabilitation from addiction is not just a matter of stopping using, but involves recovering the human being who has fallen by the wayside, even long before he or she started using substances. This relates to another philosophical principle of IP: "humans suffer from relational-disruptions, not psychopathology" (Erskine, 2013, p. 7). Moreover, psychotherapy does not seek symptom relief, but aims to resolve the life script and integrate the parts rejected by the client.

We begin to unravel the tangle of what he brings to each session: the present, the problems of the here and now. He is 29 years old, has a stable job, is asthmatic, started consuming alcohol at 17 years old and cocaine at 18 years old, and wants to solve his addiction. An initial general contract is drawn up, in which it is agreed to address his dependence on cocaine and alcohol and, in the pursuit of abstinence, to explore the role these substances play in his life. This contract would become more concrete at each meeting with a session contract, where the important thing is who he is beyond his addiction.

In sessions with Manuel, I also address how to achieve abstinence, drawing on Prochaska and DiClemente's (1982) transtheoretical model of change and Marlatt's (1993) relapse prevention. I promote awareness of the negative consequences of consumption in all aspects of his life (in his relationships, moods, finances, etc.), as he minimizes the effects of heavy alcohol consumption. I provide health information (e.g., the neurological effects of drinking) and address stimulus control, cravings, etc. Manuel acquires avoidance and self-control strategies and options

important in this case), where the intersubjective process, the co-created psychotherapy, and the involvement beyond empathy were decisive.

[3]This is a pseudonym to protect the privacy of the client.

(including relaxation techniques, identification of internal and external situations that lead to consumption, and learning how to say no). These coping skills allow a patient to handle high-risk situations and increase his or her self-efficacy.

Manuel and I discover a transgenerational script that addresses the meaning and function of drugs in his life (Mauriz Etxabe, 2016). When making his family tree, Manuel talks about his maternal grandfather, with whom he feels identified, as "a party animal..., strong, virile, attractive..." He was an alcoholic, and Manuel says, "men drink alcohol, what image do you project at 3 o'clock in the morning drinking a juice...? I'm going to project a boring image." Manuel speaks about how he identifies drinking with being a more virile man, and how drinking can relieve his profound loneliness. More sessions are required to work through all of this.

He narrates his lack of parental protection. They have never put limits on his nights out or worried about his drunkenness. He interprets this as freedom and values it as something positive, a reflection of the child's loyalty. He will feel this way until the therapeutic bond is stronger. He experiences abstinence as a loss of his freedom, but this is paradoxical; an addict has lost the ability to decide whether to consume or not, so he has lost the freedom of choice.

Consumption also provokes strong sensations that distract him from a feeling of emptiness and death. In his first stage of abstinence, Manuel contacts the emptiness and the anguish he did not want to feel. He eats uncontrollably, and if he drinks or takes drugs, he does it compulsively. He even floods himself with water. I point out this dichotomy—either he acts and feels without limits or he closes and blocks himself off. In his own words, "I get into a tomb," and "I am not alive." I give him permission to feel, express, and take care of himself. For Eric Berne (1973/1974), permission is "a license to give up behavior that the Adult wants to give up, or a release from negative behavior" (p. 410). When Manuel says goodbye, he admits, "this session has helped me a lot."

At the beginning, ambivalence towards consumption is natural. One (the Adult) wants to give up the drug, but abstinence is uncomfortable (for the Child), as one does not yet know what or who to rely on internally and externally. Clients need to rely on the therapeutic relationship for the intrapsychic functions fulfilled by the use of drugs, i.e., stabilization, reparation, regulation, and enhancement.

Manuel comes to all appointments punctual, cooperative, and correct. We are building a bond. I get really interested in his day-to-day life and what is going on inside him. He displays two aspects of his functioning: first, hyper-correct, polite, very responsible, sociable, and complacent, and second, one who consumes, takes risks, and gets into trouble (debts, fines, accidents, etc.).

From the very first session, the attunement to Manuel's *rhythm* (he is deliberate, profound, and quiet) and relational needs seems to be important for him; in particular, he shows a need for security in the relationship. Erskine (2015/2016) defines security as "the visceral experience of having our physical and emotional vulnerabilities protected" (p. 52). He has a very sensitive radar, so I use my verbal (words, metaphors, etc.) and non-verbal (gestures, etc.) expressions carefully. I let him choose the right distance between the chairs (a long one, as he is somewhat scared of contact) and the intensity of light (faint). He doesn't make any eye contact. He describes himself as reserved and "very odd for others," and he doesn't feel easily understood.

The relational need to be accepted by another stable, reliable, and protective person is also important. Erskine (2015/2016) says that "we need to have significant others from whom we gain protection, encouragement, and information" (p. 54). After several months of consuming (abstinence is not stable), Manuel explicitly says that he needs to engage with me to stay abstinent. "With me alone," he says, "it doesn't work." I interpret this as his need to be in a relationship where the other is actively involved and interested in his well-being—exactly what he lacked with his parents. This leads to the fact that every time he has a relapse he anticipates my criticism; he feels that he has let me down and failed me (transferences will be addressed later). That I remain with a look of unconditional acceptance and appreciation, and that I "do not throw

him out" (in Manuel's words), strengthens the bond and is an intrapsychic protection from the great internal criticism.

The lack of adequate emotional care and healthy limits means that Manuel does not know how to take good care of himself: he manages money and food poorly (he either does not eat or eats compulsively), drinks even water without control, and structures his time poorly. From his caregivers, he would have needed limits, information, references, and models to satisfy his relational and evolutionary needs throughout his development. The repeated negligence in the fulfillment of the psychological parental functions created a vacuum in Manuel, leaving him unaware of how to develop in life. He often asks for information, opinions, and above all, readings—he reads a lot about transactional analysis, integrative psychotherapy, etc. I introduce him to theoretical concepts such as Ego States, internal dialogues, and psychological games. These readings and comments help him to "understand himself" and manage his "emotional ups and downs." He often asks if what is happening to him is normal. Sometimes he sees himself reflected in the readings, and this have an impact on him. In sessions, we often explore and address his memories and reflections that have been stimulated by his new knowledge.

Manuel composes music, plays in a band, and writes poetry. When he was younger, Manuel wanted to dedicate himself to these creative pursuits. His mother dismisses them as "his little things" with which he entertains himself. His family convinces him to study a different career than the one he wanted. There was an agreement with someone else, which guaranteed a good and secure economic future for Manuel and his family, but meant that Manuel would not pursue his dreams. The agreement was not fulfilled, and the family experiences it as a great deception and betrayal. I let myself be struck by his story (the relational need to make an impact on another person [Erskine, 2015/2016, p. 56]), showing my compassion for that teenager who gave up his dream to write. He plays it down and is almost proud that it doesn't make him angry. We inquire about what he thinks, and Manuel explains that expressing emotions and feeling them is playing the victim. The psychotherapy starts by a decontamination of the Adult in this regard, paying attention to what the base of that idea could be (prejudice). I also share other situations of emotional expression for him to evaluate if he considered that also playing the victim. The contamination takes place when the Adult takes as truth unfounded beliefs by the Parent or distortions by the Child, and then it rationalizes and justifies those attitudes (James & Jongeward, 1971/1975). This "betrayal" was a traumatic event that marked his life and intensely reinforced his script beliefs about himself ("I am not important"), others ("they are not trustworthy," "they don't take me into account") and about life ("it sucks," "it's sacrifice," "it's sad"). This trauma would be addressed on many occasions to express all the pain and anger it contained.

In each session, I am calmly focused on him, without rushing. I am more interested in what he thinks, in what he feels, than in the data he provides. In this way, it is easier for him to establish real contact by contacting himself (memories, emotions, thoughts, sensations, his body, body tensions, etc.) and me. We create a process of self-discovery and increased awareness.

I assume that in his childhood Manuel did not have this type of encounter, this space to talk about himself and with himself. As well as the heartfelt questions about how he has been doing, what he thinks, and what he feels, we have an involved dialogue with a lot of respect. He shares memories of his family: "in my family we love each other, but we are not very communicative, and we are very introverted;" "we do not hug or kiss each other;" "I clash a lot with my mother;" "she did not read me stories, she would just play a tape and leave." These memories are the tip of the iceberg of many other unconscious procedural memories of relational patterns.

Manuel discovers his history and his experiences when, starting from something that happens in the present, he is asked, "What do you feel? What do you think? How is your body? What you think, feel, and do now, did you think or feel it before? When? How was it?" This is a lot of phenomenological and historical inquiry. At the beginning he has no memories and insists "I was happy" and "I had no trauma." He talks about delays in his development: he started to walk

when he was almost three years old because he was a very chubby baby. He would fall down because he could not bear the weight of his head. Manuel also relates, “I did not stop eating, I ate and slept, I did not cry, I did not fuss.” I interpret this eating and sleeping as an attempt to calm the loneliness of the small child—strategies so similar to the consumption of substances to self-regulate and stabilize. In childhood it was others who gave him food without limits, and now it is he who administers food, alcohol, and cocaine to himself. He speaks ashamedly of his bedwetting until the age of 13, for which his family did not bother to find out what could be wrong with him. There was so much neglect and lack of protection, so many of life’s difficulties to manage in the absence of involved adults. This child must have contained so much emotion and anxiety. I express this to him, and I normalize it. It is a normal reaction to feel so much loneliness. His body keeps all these physiological memories of survival (in the feelings of tension, absence, disconnectedness, and digestive discomfort).

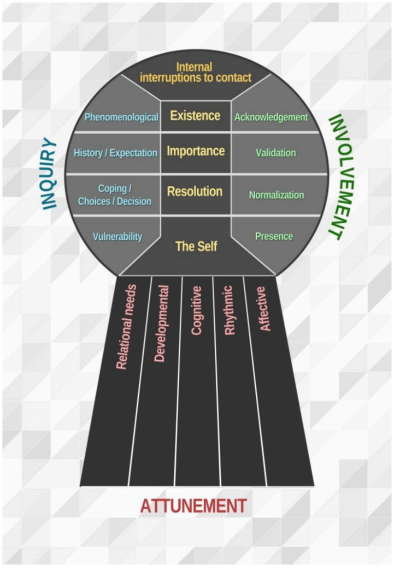
He becomes aware of the lack of adequate care and how he managed to cope with life (his coping systems): he tenses his body so as not to feel the emotion. In one session he contacts sadness; his eyes get wet, but not a tear drops. I inquire, “What happened inside, Manuel? What did you say to yourself? Where did the tears go?” This disruption of internal and external contact will be repeated many times in therapy. His tense body shows itself frequently throughout the process and will be a target of therapy. He speaks of “a very powerful internal command” that tells him “you can’t cry.” His script shows itself. Erskine (2015/2016) defines life scripts as:

> Complex series of unconscious relational patterns based on physiological survival reactions, implicit experiential conclusions, explicit decisions, and/or self-regulating introjections adopted under stress, at any developmental age, that inhibit spontaneity and limit flexibility in problem solving, health maintenance, and in relationship with people. (p. 101)

I value Manuel’s tears as precious diamonds that tell an important story that I care about.

Erskine (2015/2016, p. 53) describes the relational need to feel validated, acknowledged, and important within a relationship. Inquiry, attunement, and involvement, the three pillars of relational methods, represented by Erskine, Moursund, and Trautmann’s (1999/2012) keyhole (see Figure 1), were essential throughout the process and, in this first stage, made it possible to build a psychotherapeutic relationship that was solidly grounded. A secure base was necessary to take the risk of doing the intrapsychic works of regression and body work (through gestures, movements, etc.).

Figure 1. *The "Keyhole" of Relational Methods*



Note. Image from O'Reilly-Knapp, 2016, p. 53.

We are social beings, so we need a relationship—our natural habitat—for our development. Repeated failures in these early relationships are the origin of our intrapsychic mechanisms, such as a life script, that handle pain, emptiness, and loneliness. Therefore, it is in a sufficiently good psychotherapeutic relationship that we can recover. This requires full contact, awareness of thoughts, affects, desires, physical sensations, etc. (internal contact) and the awareness of everything that surrounds us externally (external contact). Full contact in a relationship comes from the constant dance from inside to outside, between self and other. This is how relational needs are satisfied. The satisfaction of relational needs determines the quality of life and one's sense of self. As Erskine et al. (1999/2012) say, "contact with others is the very stuff of one's sense of self and one's ability to function as a human being" (p. 443).

I note how Manuel needs psychotherapeutic involvement beyond empathy. In one session he says, "I am just another story, I am the nine o'clock patient," reflecting his script belief that "I am not important." I take the initiative and propose 90-minute sessions, as one hour does not suit his internal rhythm. I adjust the length of the session to his need. He accepts, demonstrating a relational need for the other to take the initiative (Erskine, 2015/2016, p. 57). Similarly, when Manuel has suicidal ideations during a difficult time (reflecting his distress), I SMS messages like "I care about what happens to you and you can count on me."

The psychotherapeutic work makes Manuel aware of his history of neglect and cumulative trauma, as well as how he has been fragmenting inside. He uses dissociation as his main coping mechanism and is flooded with a deep sense of shame. In this second stage, the approach to his schizoid process and his life script takes center stage.

Human beings are born full of vitality and energy, with a natural curiosity to explore, learn, and grow. At the same time, humans are born vulnerable, with physical and emotional needs that require another person who is committed to our well-being for their own satisfaction. When there are repeated failures in these early relationships, a split into two selves begins to manage those failures: the social self and the vulnerable and vital self. This is inevitable and necessary for the development of the socialization process; it is its basis. The problem arises when the failures are excessive, and the social self becomes nearly the entire identity, as happens to Manuel (he is

very polite, hypercorrect, and unbothersome, he does not say no, and he is very rational, quiet, and sociable).

The child's misunderstandings with parental figures continue to occur, and he develops other parts:

- He introjects external criticism and unconsciously identifies with elements of the other person (attitudes, thoughts, etc.). What used to happen outside between him and his mother, for example, now happens inside. The function of introjection is to give the impression that the relationship is maintained, but at the expense of a loss of Self. He protects his mother by saying, "Mom is good. It is I who am bad."
- And since introjection is not enough either, he develops an even more demanding self-generated criticism—a criticism that protects parental figures more harshly from his anger whenever they fail to tune in to his needs.

Thus, his vulnerable and vital part remains hidden deep inside, out of reach. Hiding is a way of regulating affect, calming down, and self-comforting. These are the characteristics of an isolated attachment (O'Reilly-Knapp, 2001), resulting from repeated experiences of neglect, unreliability, and/or invasiveness with his caregivers. Being vulnerable is perceived as dangerous. Thus, relationship patterns develop based on a social façade: psychological withdrawal, a high internal criticism, and low emotional expressiveness.

In one session Manuel narrates an incident with his mother, in which she "unloaded" her anger with him. He says "she went too far." This report gives rise to a series of inquiries:

"What happened inside?"

"I feel guilty."

"And, what happens next?"

"I leave, I isolate myself."

"Where do you go when you isolate yourself?"

"To an empty place, no thoughts, no feelings, it's a dead part, until I fall asleep." How similar to what he did as a baby! This disconnection is his way to cope with pain. His validation is important; it is his way of surviving and probably the result of many similar disrespectful experiences.

A retroflexion is observed in his tense body (an interrupted gesture that represses what needs to be expressed in order to avoid awareness of psychological discomfort), as he clenches his fist. I point this out and encourage him to exaggerate the gesture and follow the movement when he seems to want to strike. He feels pity and anger, saying "my mother and I don't understand each other." Validating and legitimizing his anger and encouraging him to express it (hitting cushions, breaking papers, etc.) is restorative, as it helps him recover his energy and his body. It gets him out of the freeze.

A traumatic experience is characterized by being at the mercy of an overwhelming situation from which one cannot escape. As the only means of protection, one enters a state of freezing, which, if maintained over time, leads to dissociation and disconnection. All the body's energy, activated to react, has to be slowed down and is not expressed or discharged.

I accompany him in this internal migration to the threshold calmly, quietly, without haste, and with all the respect in the world. I modulate my affectivity so as not to invade him. I stay at the entrance, guarding this sacred place, his refuge, without disturbing him, but letting him know that I am here and that I have not left him alone.

In another session, I ask Manuel to close his eyes and to visualize his baby years, to imagine what it was like at bath time and when he was fed by his mother. He responds, "I don't see her, she tilts my head forward, I see me;" "she treats me like an object;" "I am alone;" "I am cold, my body is tense." He feels anger and sadness. I encourage him to put words to these emotions: "I am not a doll to be manipulated, to decide for me what to think and feel;" "I wanted a son, not me (specifically);" "I never accept myself."

Addressing his self-generated criticism was hard work. Manuel called it Virtue. He studied in a school run by priests, and during his puberty he wanted to be a priest. He still likes to read about theology. Virtue is much more critical of him than his mother's introjections, for it tells him things like "fuck you," "you have airs and graces," and "you think you are superior." It does not allow him to value himself.

So much internal criticism (introjected and self-generated), which he assumes is true, creates intense feelings of guilt and shame every time he shows his vulnerable and vital self. As Erskine (1995) explains, these feelings are composed of a great sadness for not being accepted, repressed anger, fear of abandonment, a sense of death, and an absence of joy. Manuel has a strong core belief that there is something wrong with him. At this stage, the need for self-definition in the relationship (Erskine, 2015/2016, p. 56) takes prominence. So, I celebrate his music, poetry, and accomplishments (the mother always devalued him). I ask for his feedback on the session or therapy, and I value his questioning and his opinions.

The Child is small and physically vulnerable. In a world inhabited by giants and noises, the Child is without words. He perceives himself as inferior and the parents as all-powerful (the power to make him live or die, to satisfy his needs or not). Thus, script decisions represent the Child's best strategy to survive and get his needs met in a world sometimes seen as hostile and even threatening.

In this unconscious life plan, the life script, there are explicit decisions, experiential conclusions, fixated patterns of self-regulation, beliefs about himself and others, and beliefs about the quality of life (Erskine, 2015/2016). Again and again it feels the same way. In relationships we repeat the same thing, and we suffer, but it gives us the security of the predictable and the known. It gives us identity and stability. Erskine (2015/2016), referring to the script, writes:

> This creative strategy is not actually a defense against someone or something as much as it is but a desperate attempt to create self-regulation, compensation, self-protection, or orientation and establish insurance against further stress, psychological shock, or disruptions in relationship. (p. 145)

It is deeply frightening to stop believing the same thing about oneself, others, and the world, to give up behaviors and ways of feeling, to dare to experiment, to flow through life with spontaneity and flexibility, to dare to be intimate, and to be really known. Leaving the script requires courage. As the saying goes, "better the devil you know than the angel you don't."

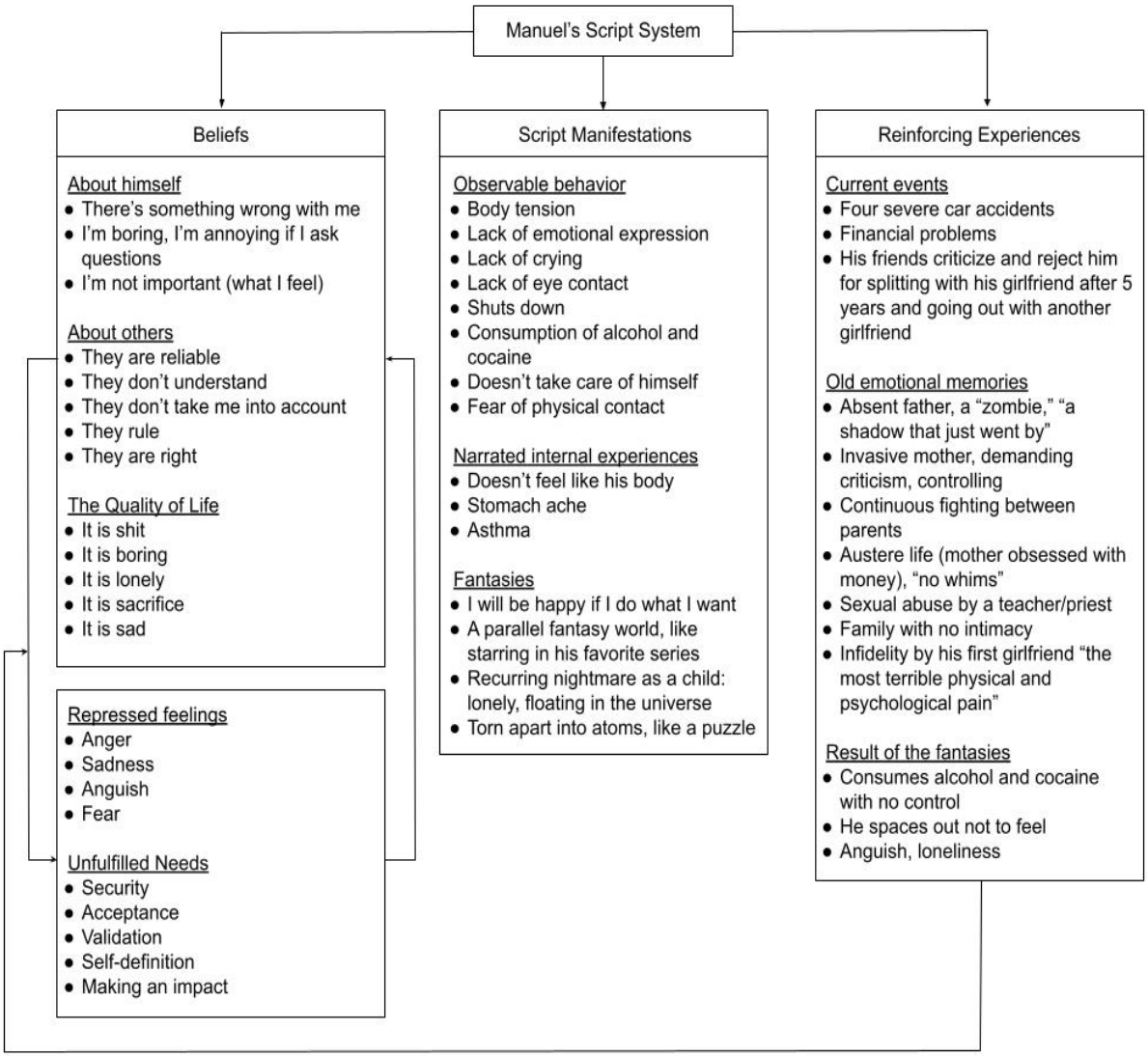
One day, remembering the multiple hospital admissions of his mother when he was a child (between three and ten years old), Manuel is asked to close his eyes and go back to those years. Each time, he was left in the care of different people (grandparents, neighbors, friends, etc.). He contacts his feeling of abandonment and a great loneliness, and he becomes aware that he decided not to show his feelings because "it's no use, nobody pays attention to me." He decides to be good and responsible. I encourage him to talk to this child, to listen to him, to take him into account, and to value him. At the end, he spontaneously gives me a hug of gratitude (one of the few times), he seems happy, and he says he feels alive, "with a high." This moment is important—it shows not only his gratitude, but it also shows the loss of fear, the realization that intimacy is no longer dangerous and the relationship is safe, and his arrival at the experience of secure attachment. Moreover, it satisfies his relational need to express affection (Erskine, 2015/2016, p. 57), just like the day he brought cakes to the session to celebrate his birthday. What a wonderful symbol of the celebration of being and feeling alive!

The work with his script focuses on his script system, that is, how his Script manifests itself in his present life. As Erskine (2015/2016, p. 128) explains, "The script system categorizes human experience into four primary components: script beliefs; behavioral, fantasy, and physiological manifestations; reinforcing experiences; and the intrapsychic process of repressed needs and feelings."

As a child, Manuel had a recurring nightmare that he was floating in the immensity of the dark universe, alone, with the intense sensation of being dead. He often tells me about the

sensation of being dead inside or of being broken into atoms, like pieces of a puzzle. Another day, he gives this example of how he feels inside: “It’s like a spider, when you put a glass on top of it. At first it tries to get out; when it sees that it is not possible, it puts itself into the center and lets itself die.” I am still impressed by his pain and sadness. This is a nihilistic script, which also addresses his thoughts of suicide, or his more or less conscious attempts (he has had four serious car accidents). In those moments, a life contract is made and the escape doors close: he would not do anything either directly or indirectly to go mad or to harm others or himself (a commitment that for a while would be renewed at each session).

Figure 2. *Manuel’s Script System*



Speaking of this internal division he feels, he mentions four parts:

1. One that is resigned, with no hope of being well.
2. A beautiful part, living in fantasy in a parallel world. He tells me how sometimes he walks down the street and feels like the protagonist of his favorite series, and he even hears the soundtrack.
3. Another part that rebels. And, in order not to feel as if he were dead, he drinks and consumes, and therefore he has strong physical sensations.
4. Another part that is the one that functions in the world, fulfills tasks, goes to work, etc.

The bond, the co-created relationship throughout the therapy, is the main way of approaching his script. In this regard, Manuel says of the therapeutic relationship, "it generated trust, it generated serenity... putting a non-deforming mirror in front of me, and getting me to look at myself in it without becoming my worst enemy... giving me security because I know I can count on you." He says he feels "open." Of course, we work on his script beliefs and his decisions, but it is the repeated, constant experience of giving him stability, identity, consistency, and predictability that is decisive for him to think about himself, others, and life in a more positive way. The stable relationship also allows Manuel to recover his body and energy, take care of himself, be aware of his needs, express what he thinks and feels, and have intimacy, hope, the will to live, plans, and dreams. He says, "people are overwhelmed and I am in one of the best moments of my life, feeling things I haven't felt for a long time."

When there is an authentic encounter, psychotherapist and client influence each other; there is an intense unconscious communication. The therapist shapes the client, but the client also shapes and impacts the therapist. A dynamic that reflects this is transference-countertransference.

In integrative psychotherapy, transference is considered in four ways (Erskine, 1991):

1. The means by which the client can describe his or her past, the developmental needs that have been frustrated, and the defenses that were created to compensate for them.
2. The resistance to remember completely, and paradoxically, unconsciously putting childhood experiences into action.
3. The expression of intrapsychic conflict and the desire to achieve satisfaction of relational needs and intimacy in relationships.
4. The expression of the universal psychological effort to organize experience and give it meaning.

On several occasions, I address Manuel's transference. For example, when he has a relapse, he anticipates my criticism, thinking that I will humiliate and reject him because he has disappointed me. He thinks he should leave therapy because he has failed. He feels guilty, and he says to himself, "I am doing wrong." In other words, he reflects the same dynamic that he has with his mother. His mother is invasive, demanding, and critical of him. Initially he is kept in the psychotherapeutic relationship, and I inquire (relational inquiry) to clarify whether he has perceived any criticism from me. Subsequently, I inquire whether anyone in his life acted or would act in that way. When Manuel answers that his mother acted that way, the hypothesis is confirmed (due to what he has been telling about his history)—here is the transference. Finally, I provide normalization (e.g., the relapse is part of the process, it is not over yet, it is a sign that something has happened or that there is something that needs to be addressed) by telling him, "Let's see what happened inside you." In addition, I explain the Prochaska and DiClemente (1982) model, in which relapse is part of the recovery process. Tejero et al. (1993, p. 296) explain, "It has been possible to formulate the hypothesis that the process of change in addictions is practically never linear, but dynamic and spiraling (Prochaska et al., 1992) and that relapses are usually so frequent that they must be integrated as another link in this process of change." Another time, after he believes he has behaved badly with his friend (also a client), he anticipates that when I find out, I will despise him and make therapy more difficult for his friend. He sends a text message saying

that he is leaving therapy. Of course, the therapeutic relationship is not interrupted, and I answer his message with “I am here.” I tell him that he can continue therapy whenever he wishes. He takes more than a month to return.

The fact that I don’t reject him thrills him. The maintenance of my unconditional acceptance and my appreciation for him is so different from what he has experienced! He says, “I feel myself closing up. I don’t want to feel your affection. I never felt that affection.” This is the juxtaposition spoken of by Erskine et al. (1999/2012): “the phenomenon of juxtaposition occurs when there is, for the client, a marked contrast between what is provided in the therapeutic relationship and what was needed and longed for but not provided in previous relationships” (p. 219).

As for the countertransference, it is important for me to be aware of it and not to be reactive, to control the expressiveness and the impulse to lecture him, to tell him explicitly what to do. I do not invade him as his mother does. It is crucial that I also control the desire to seek his approval, and I asked myself if what he elicited in me was something that happened to him when he was in front of another.

Physical contact is another relevant issue. In the face of his pain, imagination—"imagine my hand on your back”—is used, so that he can begin to tolerate the contact without confusion. Physical contact is a primitive, instinctive way of finding comfort and support in difficult moments. In his family they don’t touch, they don’t hug, and they don’t kiss. Outside the intimate context, Manuel does not tolerate physical contact well. He is afraid, for he associates it with sexual invasion; this is a reflection of the trauma of sexual abuse by the director of his school (who was a priest and his teacher). This was abuse by a figure of moral authority and knowledge, in an unequal relationship, by someone who abuses his role and the trust others place in him. How much confusion and lack of protection the adolescent must have felt, at this moment of his life—so important in terms of his body and sexuality. His first time ever talking about it is in therapy. From then on, he is able to talk about it with his parents and partner, and he begins to take ownership of his legitimate anger, sadness, and pain.

To lessen his fear, I set clear and protective boundaries, such as “I will never touch you without your permission.” We begin a process of deconfusion of the Child, in which intimacy and affection won’t be linked to anything sexual.

It is very important for psychotherapists to be aware of the reactions provoked by clients (thoughts, memories, emotions, physical sensations, etc.) so that they do not unconsciously influence their work. It is also important to distinguish if those are personal aspects that have been activated and need to be worked on, or if it has to do with the client, and this material can be used to their advantage in therapy by encouraging inquiries and interventions.

In the psychotherapeutic relationship, affections that have a corporal-physical component (the client can be liked or disliked) arise. Sexual attraction and desire may appear. For Jung (1966/2006), sexual attraction is a symbol of the unification of opposites. And like other aspects, its meaning must be analyzed and managed to ensure the well-being of the client (Little, 2018).

But not everything that happens between client and therapist is transferential. Both are stimulated by images and fantasies about their nature, potentialities, and how this experience of doing therapy is going to be. These fantasies can be positive or negative, and they are influential, even if they are not verbalized.

Finally, I would like to comment on some more ideas about the psychotherapeutic relationship. Like any relationship, it is not static; it is in constant development and is something co-created throughout the therapy process. It is a special relationship: one of unconditional acceptance, asymmetry, professionalism, and respect. In a sense, like many relationships, it is partially inimical to others; it wants exclusivity. There can be two clues that this is happening: if the therapist focuses excessively on the negatives of the client’s relationships (implicitly thinking that no one understands them as he or she does), or if the therapist loses touch with life and lives vicariously through the client. Clients can live interesting lives, and they do unusual and surprising things (with addiction this is quite common).

Conclusions

It is important for the psychotherapist to have the best possible training and to be retrained, updated, and committed to continuing education. It is a duty to the client. But who a therapist is, his/her history, life, hobbies, experiences, ethics, beliefs, and values also have an influence on one's psychotherapeutic practice. Reflecting on all this and becoming aware of it allows us to manage its influence. Beliefs, ideas, and values about what is right, healthy, objective, and normal are especially activated in therapy with addicts. On the one hand, it is important to avoid establishing power relationships and imposing visions of life, values, and ideas. All these ideas and values are debatable. One should seek to work *with* the client and not *on* him (even though it is tempting to think "the client is not always able to recognize what is good for him"). On the other hand, if the psychotherapist's beliefs, ideas, and values are similar to those of the client, there is a danger of taking many things for granted and losing curiosity and the possibility of getting to know the client. However, significantly different values may interfere with therapy and unconditional acceptance, and it may be in the client's best interest to refer him/her to a colleague.

Further, what can be done with therapeutic errors? Are you aware of them? Do you do self-supervision? Do you recognize them? How do you deal with them? Guistolise (1996) points out the importance of incorporating therapeutic errors as an element of the intersubjective process of a deep and quality psychotherapy.

It is also interesting to explore the motivation that leads us to choose the work of a psychotherapist, a work dealing with the dark side of life and with people who suffer, are unhappy, and who have lived through traumatic situations. I find it intriguing to think about the secondary benefits of being a psychotherapist (perhaps it makes the therapist feel better, less unhappy, and more fortunate).

In addition, it is important to analyze which models of help from our Western culture are being internalized by the psychotherapist as he or she forms an identity and the therapeutic relationship. Maybe the model of the doctor, in its negative version of the great healer, the one who cures everything. Or the model of the priest in its worst version, who denies any kind of doubt, who imposes dogmas, and who is all-powerful. Keep in mind the need to control the "furor curandis," to accept that there are different psychotherapeutic models, and to accept that one has limitations, as does the client. The client is the one who sets the goals of the therapy and how far he/she wants to go. It is important to listen to the client attentively, even when he/she criticizes, and to value these criticisms with humility and honesty (seeing if he/she is right). Therefore, the psychotherapeutic model IS NOT the client, thus it is important to avoid confusing the map with the territory.

The inspiring myth of Chiron the wounded healer symbolizes the awareness of illness, which humanizes the therapist and places them in an equal relationship with the client, in which both are imperfect. The therapist also has things to heal and address in their own personal psychotherapy. If he/she faces his/her shadows and wounds, he/she will stimulate the client to face his/her own as well. This idea is reflected in St. Augustine's phrase "nothing human is alien to me" or the greeting Namaste, which means "the divine light in me honors the divine light in you." As a philosophical principle of integrative psychotherapy says, "we are all equally valuable" (Erskine, 2013, p. 2).

The work of a psychotherapist is wonderful and honorable, but it also has negative aspects. A lot of time is spent in a solitary activity, and it is an asymmetrical relationship in which we care for the other. It is essential to practice self-care, maintain one's own psychotherapy and clinical supervision, seek symmetrical relationships, enjoy life and hobbies, etc. We need a kit of resources that minimizes the emotional impact of our work and increases our resilience. Taking care of oneself is taking care of the client, and living enriches the psychotherapist as a human being. After all, he or she is the instrument of therapy.

Manuel initially undergoes therapy at the Assistance Unit; he stops and resumes it two years later in private practice (he decides that he can afford it, and he believes that he has already taken too much advantage of the public resource). I accept this, since a change of context can be favorable for the psychotherapeutic process.

The consumptions have disappeared, he is currently abstinent. He feels better and better about himself, and he accepts himself. He is finally studying the career he wanted, and he has already finished it. He takes care of himself, he attends Antigym classes (a kind of bodywork that claims to enable "participants to better understand and (re)claim ownership of their bodies" [Antigym, n.d.]), he has energy, his presence is greater, and he has recovered his body—he feels it. In his relationships he has greater intimacy and commitment, both with his partner and with his family (with his mother, he has had very intimate conversations about the past and the present). He expresses what he feels and needs. He has plans for the future and seeks and fights for what he desires. All aspects of his Self (behavior, cognition, affect, and physiology) are more conscious and integrated (not fragmented). In short, he functions with much more freedom from his life script and schizoid process.

Currently he has taken another break from therapy. He recently sent me a message sharing that he has just published a collection of poems. I welcome it. I don't know if there will be a third time in therapy with me, as there are still issues to be addressed. But I am sure that I will be there if he decides to do so.

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