

# UNTANGLING THE SKEIN: FROM SUBSTANCE DEPENDENCE TO TRUST IN THE RELATIONSHIP

## DESENREDANDO EL OVILLO: DE LA DEPENDENCIA A LAS SUSTANCIAS A LA CONFIANZA EN LA RELACIÓN

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### Abstract

*In this clinical case, some of knowledge acquired after 30 years of working in the world of addictions as an integrative psychotherapist is condensed. The theory (the map) is not the territory. By using relational methods can transcend the label of "addict" and get to know the human being behind it; is facilitated bond development and internal contact. The client recognizes himself, and is re-integrated, in the mirror that is offered. The relational failures experienced, especially early ones, shape the internal processes and the relationship with the outside world. The substance takes on the function of stabilizing, regulating...in the face of emotional pain. And a secure psychotherapeutic relationship is required to obtain this same thing. A conscious and non-reactive countertransference is crucial, and the managing of the shadows, prejudices, fantasies, internalized models of help. This way the client can show his vulnerability, and 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

### Resumen

*En este caso clínico se condensa parte del saber adquirido tras 30 años de trabajo en el mundo de las adicciones como psicoterapeuta integrativa. La teoría (el mapa) no es el territorio. Utilizando los métodos relacionales se trasciende la etiqueta de "adicto" y se conoce al ser humano que hay detrás; se facilita el desarrollo del vínculo y del contacto interno. El cliente se reconoce, y se reintegra, en el espejo que se ofrece. Los fallos relacionales experimentados, sobre todo tempranos, modelan los procesos internos y la relación con el exterior. La sustancia toma la función de estabilizar, regular ante el dolor emocional. Y el cliente precisa una relación psicoterapéutica segura donde obtener esto mismo. Una contratransferencia consciente y no-reactiva resulta decisiva, así como el manejo de las sombras, prejuicios, fantasías y modelos de ayuda interiorizados. Así el cliente podrá mostrar su vulnerabilidad, y celebrar un encuentro verdadero y reparador. Y superar su adicción, su guion de vida.*

**Palabras clave:** adicción, contratransferencia, guion de vida, métodos relacionales, necesidades relacionales, proceso esquizoide, relación

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*One sees well only with the heart. The essential is invisible to the eyes*  
--(Saint-Exupery, *The little Prince*).

Thirty years working in the field of addictions, the last 28 years in the Drug Dependency Assistance Unit of CRE (outpatient unit of reference in the field of Mental Health of the public health of the health area of Lugo for the treatment of abuse and/or addiction problems, subsidized by the Government of the Autonomous Community of Galicia) together with the interest in helping clients have stimulated a continuous training (cognitive-behavioral, family therapy, psychodrama, transactional analysis, etc.) until reaching the Integrative Psychotherapy (IP). This has had an essential influence on the author's professional and personal development. IP is the foundation, the skeleton, that supports the psychotherapeutic work she does and her conception of being a psychotherapist.

The presentation of this clinical case condenses part of my knowledge and practice as an integrative psychotherapist in addictions, as well as my reflections and thoughts on the psychotherapeutic relationship.

This article aims to convey 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, a new experience emerges, a shared language, a unique synthesis. As reflected in the philosophical principle of IP 'the intersubjective process in psychotherapy is more important than the content of psychotherapy' (Erskine, 2013, p. 8).

Tall, pale, thin. Seems not to occupy space, ethereal, big eyes. He appears very correct, cooperative, nervous, with a sad countenance. He talks, gives information about himself, and his problem, there is no emotion; there are words. He says '*I think I need to go to a psychologist for years I have been dragging personal problems that were aggravated by alcohol and cocaine*', and narrates economic problems, several serious car accidents, breakup with partner of 5 years, etc.

Manuel, in this first meeting, continues to talk about himself, his family, 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 the eyes. It will take time. He seems so, so distant, disconnected, isolated, alone.

How easy it would be to start putting labels, '*addict*', without knowing him and start 'treatment, guidelines, decision trees'. But who is he, what does he need, what does he really want, how can he be helped? As a psychotherapist, asking yourself these questions leads you not to be in a hurry to intervene, to be extremely careful and respectful of the human being in front of you, of his uniqueness. As well as to value the importance of 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 and to be interested in 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 appears in another philosophical principle of PI '*humans suffer disturbance-relational, not psychopathology*' (Erskine, 2013, p. 7). Moreover, psychotherapy does not seek symptom relief, but the resolution of the life script, the integration of the parts rejected by the client.

We begin to unravel the tangle by 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 to explore the role these substances play in his life in order to achieve abstinence. This contract would become more concrete at each meeting with a session contract, where the important thing is who he was beyond his addiction.

How to achieve abstinence is addressed, from the Transtheoretical Model of Change of Prochaska and DiClemente (1982) and of Relapse Prevention of Marlatt (1993, cited in Casas and Gossop 1993): promoting awareness of all the negative consequences of consumption in all aspects of him and his life (in his relationships, moods, economy, etc.), e.g., minimizes the effects of heavy alcohol consumption. Health information is provided (e.g., brain effects of drinking). Stimulus control, craving, etc., is addressed. He acquires avoidance and self-control strategies and options (relaxation techniques, identification of internal and external situations that favor consumption, skills to know how to say no, etc.). These coping skills allow him/her to handle SAR (high-risk situations) and increase his/her self-efficacy.

Addressing the meaning and function of drugs in his life, a transgenerational script is discovered (Mauriz-Etxabe, A., 2016). When making his family tree, he talks about his maternal grandfather with whom he feels identified: '*a party animal..., strong, virile, attractive...*'. He was an alcoholic, '*men drink alcohol, what image do you give at 3 o'clock in the morning drinking a juice...? I'm going to give an image of boring*'. He also speaks about the relief he finds for his profound loneliness, all of this would take three sessions.

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, that will be maintained until the therapeutic bond is stronger. He experienced abstinence as a loss of his freedom. However, it is paradoxical, since an addict has lost the ability to decide whether to consume or not, he has lost the freedom of choice. Consumption also provokes strong sensations that distract him from a feeling of emptiness, of death.

In this first stage, when he is abstinent, he contacts the emptiness, the anguish he did not want to feel. He eats uncontrollably, if he drinks or takes drugs, he does it compulsively, even water, he floods himself. The disjunctive is pointed out, either he acts and feels without limits or he closes himself and blocks himself '*I get into a tomb*', '*I am not alive*'. Permission is given to feel, express and take care of oneself.

For Eric Berne (1973/1974) permission is ‘a license to abandon the behavior that the Adult wants to abandon, or a release from negative behavior’ (p. 410). He says goodbye saying, ‘*this session has helped me a lot*’.

At the beginning, ambivalence towards consumption is natural. One wants to give up the drug (the Adult) but abstinence is uncomfortable (for the Child), there is not yet what or who to rely on internally and externally. He needs to rely on the therapeutic relationship for the intrapsychic functions that he had put on the use of drugs, i.e. stabilization, reparation, regulation and enhancement.

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

From the very first session, the attunement to his *rythm* (he is paused, profound, silent) and relational needs (RN) seems to be important for him, in particular, his *need for security in the relationship*. Erskine defines it (2015/2016) as ‘the visceral experience of having our physical and emotional vulnerabilities protected’ (p.52). He has a very sensitive radar, I use my verbal (words, metaphors, etc.) and non-verbal (gestures, etc.) expression carefully, I let him choose the right distance between the chairs (a long one, as he is somewhat scared of contact) the intensity of light (faint). He doesn’t make any eye contact. He describes himself as reserved, ‘very odd for others’, 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 get protection, encouragement, and information’ (p.54). After several months, and consumptions (abstinence is not stable), he explicitly asks that he needs to engage with me to stay abstinent ‘*with me alone, it doesn’t work*’. This is what we do because I interpret it as his need to be in a relationship where the other is really involved and interested in his well-being, has an active role, just 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, failed me (transfers to be addressed later). That I remain with a look of unconditional acceptance, of appreciation and ‘*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 he 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 without control, even water, and structures his time poorly. He would have needed from his caregivers limits, information, references, 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 of how to develop in life. He often asks for information, opinion, and above all, readings, he reads a lot

about transactional analysis, integrative psychotherapy, etc. Theoretical concepts such as Ego States, internal dialogues, psychological games, etc. are also brought to him. 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 and they have an impact on him, what has stimulated him (memories, reflections) is explored and addressed in the sessions.

Manuel composes music, plays in a band, writes poetry, he wanted to dedicate himself to it. For his mother they are '*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 forget his dreams. The agreement was not fulfilled and they experience it as a great deception and betrayal. I let myself be struck by his story, (the relational need to make an impact in 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), also by sharing other situations of emotional expression for him to evaluate if he considered that he was also playing the victim, etc. 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*'). Trauma that would be addressed on many occasions to express all the pain and anger contained.

In each session I am focused on him, without rushing, calmly, 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 contact himself (memories, emotions, thoughts, sensations, his body, body tensions) and me, to establish real contact. Creating a process of self-discovery and increased awareness.

I assume that in his childhood he did not have this type of encounter, this space to talk about him and with him. As well as the heartfelt questions about how he has been doing, what he thinks, what he feels, in an involved dialogue and with a lot of respect ("in my family we love each other, but we are not very communicative, very introverted among us"; "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.

He discovers his history, 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? And then, what you think, feel, and do now, Did you think or feel it before? When? How was it?* A lot of phenomenological and historical inquiry. At the beginning he had no memories and insisted “I was happy”; “I had no trauma”. He talks about delays in his development: he started to walk when he was almost 3 years old, because he was a very chubby baby and could not bear the weight of his head and fell down, ‘I did not stop eating, I ate and slept, I did not cry, I did not fuss’. Eating and sleeping to calm the loneliness of the small child, strategies so similar to the consumption of substances to self-regulate, to stabilize. In childhood it was others who gave him food without limits, now it is he who administers it to himself (food, alcohol, cocaine). He speaks ashamedly of his bedwetting until the age of 13, for which they did not bother to find out what could be wrong with him. How much neglect and lack of protection. How many difficulties to manage in life in the absence of adults involved. How much emotion this child must have contained. And how much anxiety all this must have caused him. I express this to him, I normalize it. It is a normal reaction to so much loneliness. His body keeps all these physiological memories of survival (by the feelings of tension, digestive discomfort, or absent, disconnected).

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 comes out, I inquire, *What happened inside, Manuel? What did you say to yourself? Where did the tears that came out 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 does not let him cry, and that tells him ‘you can’t cry’. His Script will be showing itself. Erskine (2015/2016) defines Life Script as:

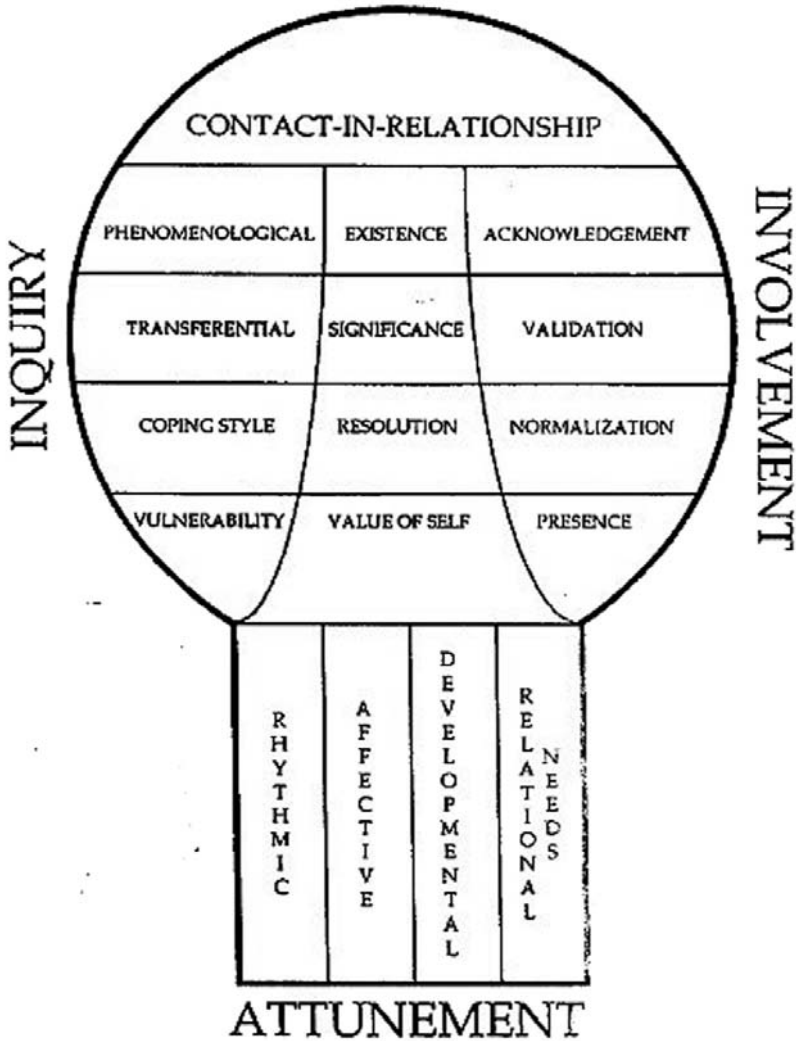
A complex series of unconscious relational patterns based on physiological survival reactions, implicit experiential conclusions, explicit decisions, and/or self-regulatory introjections adopted under stress, at any stage of evolutionary development, that inhibit spontaneity and limit flexibility in problem solving, health maintenance, and relating to others (p. 101).

I value his tears as precious diamonds that tell an important story I’m interested in, that I care about. As Erskine (2015/2016, p.53) describes, the relational need to feel validated, acknowledged and important within a relationship.

The use of relational methods, the Keyhole of Erskine et al. (1999/2012), with its 3 pillars: inquiry, attunement and involvement, (see figure 1) was essential throughout the process and, in this first stage, made it possible to build a psychotherapeutic relationship that was solidly grounded, a secure base from which to be able to take the risk to do the intrapsychic works of regression and body work (through gestures, movements), etc.

Figure 1. *Keyhole* (taken from Erskine et al., 1999/2012).

## METHODS OF PSYCHOTHERAPY



We are mammals, social beings, we need a relationship for our development, it is our natural habitat. Repeated failures in these early relationships are the origin of our building intrapsychic mechanisms such as the Script to 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 or not of relational needs determines the quality of life and one's sense of self. Erskine et al. (1999/2012) says "contact with others is precisely the basis of the notion we have of our own Self and on which our ability to function as human beings is based" (p. 443).

I note how he needs psychotherapeutic involvement beyond empathy. In one session he says 'I am just another story, I am the 9 o'clock patient', reflecting his script belief «I am not important». I take the initiative and propose 90-minute sessions, as one hour does not suit his internal rhythm, so I adjust the length of the session to his need. He accepts (relational need for the other to take the initiative; Erskine, 2015/2016, p. 57). Just as in a difficult time with suicidal ideation (reflecting his distress) I send «sms» symbolizing «I care about what happens to you and you can count on me».

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

Human beings are born full of vitality, energy, a sense of being alive, with a natural curiosity to explore, learn, grow and at the same time vulnerable, with physical and emotional needs, which require another committed to our well-being for their satisfaction. When in these early relationships there are repeated failures, a split into two selves begins, to manage those 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 is when it is excessive, and the Social Self becomes almost the identity, as it happens to Manuel (he is very polite, hypercorrect, does not say no, very rational, does not bother, quiet, very sociable).

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

- He introjects the external criticism, 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, "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 and of 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, the relationship patterns based on a social façade, the psychological withdrawal, a high internal criticism and low emotional expressiveness, are developed.

In one session he narrates an incident with his mother, she ‘unloads’ her anger with him, and says ‘she went too far’. This fact gives rise to a series of inquiries: ‘*What happened inside?*’ - ‘*I feel guilty*’. ‘*And, what happens next?*’, - ‘*I leave, I isolate myself*’. And it goes on, ‘*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, getting inside; and his validation is important, it is his way of surviving and probably the result of many similar disrespectful experiences.

Aretroflexion 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. It is pointed out and he is encouraged to exaggerate it and follow the movement when he seems to want to strike. He feels pity and anger, says ‘*my mother and I don’t understand each other*’. Validating, legitimizing his anger and encouraging him to express it (hitting cushions, breaking papers...) was restorative. Recovering his energy, his body. Getting out of the freeze.

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

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

In another session he is asked to close his eyes and to visualize his baby years, to imagine what it was like at bath time, when he was fed by his mother ‘*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. He called it *Virtue*. He studied in a school run by priests, during his puberty he wanted to be a priest, he likes to read about theology. *Virtue* is much more critical of him than his mother’s introjections, it tells him things like: ‘*fuck you*’, ‘*you have airs and graces*’, ‘*you think you are superior*’; and it does not allow him to value himself.

So much internal criticism (introjected and self-generated), which he assumes as true, creates intense feelings of guilt and shame (which is composed of a great sadness for not being accepted, of much anger that he represses, of fear of aban-

donment, with a sense of death, no joy, enjoyment. Erskine, 1995) every time he shows his vulnerable and vital self. He 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, his accomplishments (the mother always devalued him), ask for his feedback on the session or therapy, and value his questioning, his opinions.

The child is small and physically vulnerable (in a world inhabited by giants, noises, 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 in a world sometimes seen as hostile and even as a threat. Strategies to stay alive and get his needs met as best he can.

In this unconscious life plan, the life script, there are explicit decisions, experiential conclusions, fixated patterns of self-regulation, beliefs about who he is, others, and about the quality of life. Erskine (2015/2016) describes the *life script*:

As an unconscious life plan, based on decisions made by the person at any given stage of his development, which inhibits his spontaneity and hinders his flexibility in the way of solving problems and living the relationships. (pp. 102-106)

Again and again it feels the same way. In relationships we repeat the same, we suffer, but it gives us the security of the predictable, of the known, it gives us identity, stability. Erskine (2015/2016) referring to the Script says:

This creative strategy is not so much a defense against someone or something, but a desperate attempt to generate self-regulation, compensation, self-protection or orientation, and to establish an insurance against eventual situations of further stress, psychological shock or new disturbances in the relationship. (p.145)

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

One day, remembering the multiple hospital admissions of his mother when he was a child (between 3 and 10 years old), he 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...) he contacts his feeling of abandonment and a great loneliness, 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, responsible. He is encouraged to put the man he is today to talk to this child, to listen to him, to take him into account, to value him. At the end, he spontaneously gives a hug of gratitude (one of the few times), he feels happy, he says he feels alive, '*with a high*'. This fact is relevant, it is not only gratitude, it symbolizes the loss of fear,

intimacy is no longer dangerous, the relationship is safe, he has the experience of secure attachment. And on the other hand it satisfies her 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 alive, of feeling alive!

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

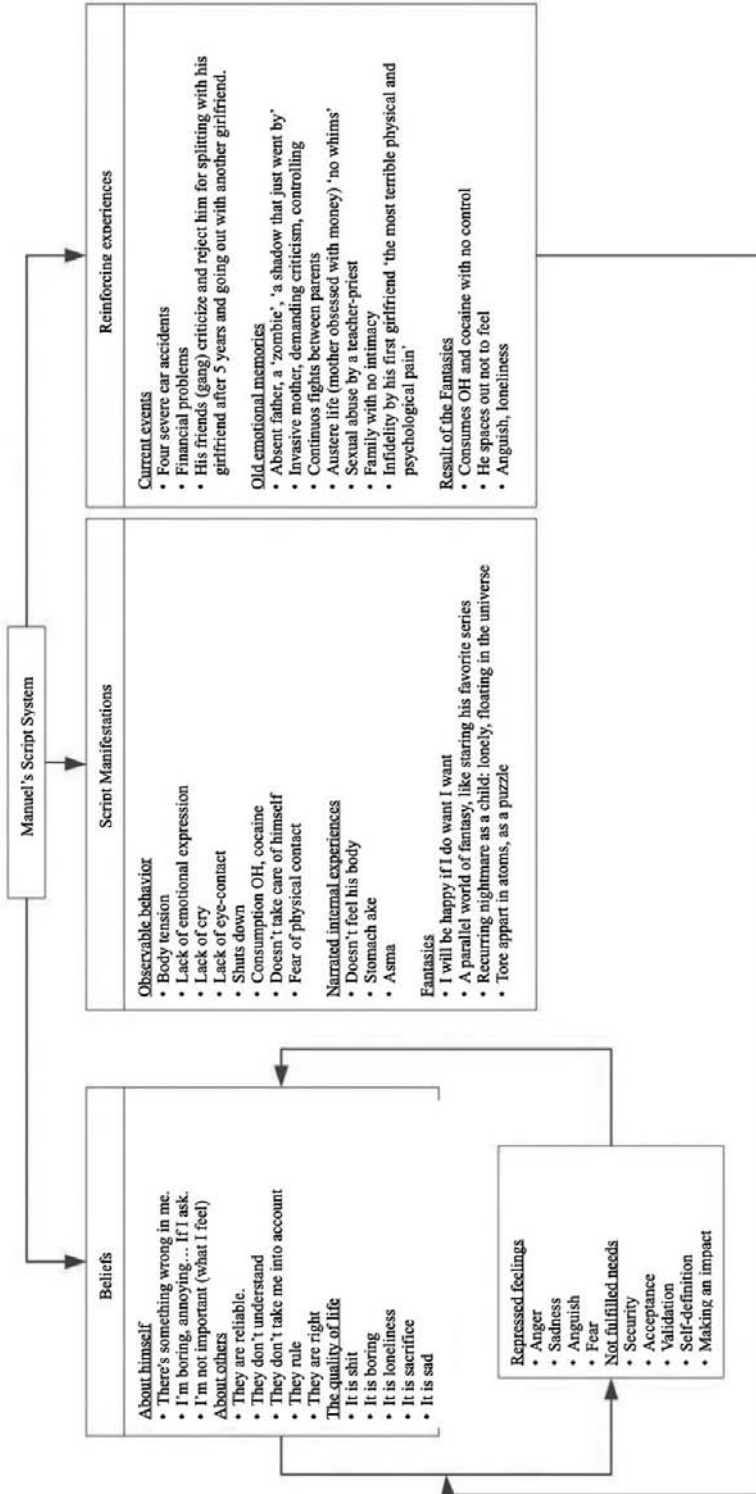
As a child he had a recurring nightmare, he was floating in the immensity of the dark universe, alone, with the intense sensation of being dead. He often tells about the sensation of being dead inside or of being broken into atoms, like pieces of a puzzle. Another day he gives this example of how he 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 in the center and lets itself die*'. I am still impressed by his pain, his sadness. 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 doors of escape are closed: he would not do anything either directly or indirectly to go mad, to harm others or himself (a commitment that for a while would be renewed at each session).

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

1. Without hope of being well, resigned.
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 even hears the music.
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 the tasks, goes to work, etc.

The bond, the co-created relationship throughout the therapy was 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*' and of him he says he feels '*open*'. Of course, his script beliefs, his decisions, were worked on, but it was the repeated, constant experience, giving him stability, identity, consistency and predictability that was decisive for him to think about himself, about others, about life in a more positive way. And also to recover his body and energy, to take care of himself, to be aware of his needs, to express what he thinks and feels; to have intimacy, to have hope, will to live, plans, 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*'.

Figure 2. Manuel's Script System



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 the therapist, 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, an unconscious putting into action of childhood experiences.
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 his transference is addressed. For example, when he had a relapse, he anticipated my criticism, thinking that I was going to humiliate and reject him because he had disappointed me. So he thinks he should leave therapy because he has failed, he feels guilty, he says to himself '*I am doing wrong*', i.e., he reflects the same dynamic as with his mother. His mother is invasive, demanding and critical of him. Initially he is kept in the psychotherapeutic relationship, and inquiries are made (relational inquiry) to clarify whether he has perceived any criticism from the therapist. Subsequently, an inquiry is made as to 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 normalization is provided (the relapse is part of the process, it is not over yet, it is a sign that something has happened, that there is something that needs to be addressed) by telling him '*let's see what happened inside you*'. In addition, the Prochaska and DiClemente (1982) model is explained, where relapse is part of the recovery process. Citing Tejero et al. (1993):

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. (p. 296)

Or when, as a result of a behavior he considers that he has behaved badly with his friend (also a client), he anticipates that when I finds 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, therapy is not interrupted and his message is answered '*I am here*', and 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, that I maintain my unconditional acceptance, 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.*' Here is shown the juxtaposition spoken of by Erskine et al. (1999/2012) 'intense emotional responses...the phenomenon of juxtaposition occurs when there is for the client a stark contrast between what is provided in the therapeutic relationship and what they needed and longed for, but did not get in previous relationships' (p. 219).

As for the countertransference, it was important to be aware of it and not to be reactive, to control the expressiveness, or the impulse to tell him explicitly what to do, to lecture him. So as not to invade him as his mother did. And also to 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 was another relevant issue. In the face of his pain, the imagination - '*imagine my hand on your back*' - was used, so that he could begin to tolerate the contact without the confusion it caused him. Physical contact is a primitive, instinctive way of finding comfort, support in difficult moments. In his family they don't touch, they don't hug, they don't kiss. Outside the intimate context, he does not tolerate physical contact well. He is afraid, he associates it with sexual invasion, as a reflection of the trauma of sexual abuse by the director of his school (priest and his teacher). An abuse by a figure of reference, of moral authority, a reference of knowledge, in a relationship of inequality, by someone who abuses his role and his trust. 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. He never talked about it, the first time was in therapy. From then on, he was able to talk about it with his parents and partner. Thus, beginning to take ownership of his legitimate anger, sadness and pain.

Clear and protective boundaries were set to lessen his fear, such as '*I will never touch you without your permission*'. A process of deconfusion of the Child began, in which intimacy and affection wouldn'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) 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, interventions, etc.

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

But not everything that happens between client and therapist is transference. Both are stimulated by images, fantasies about their nature, potentialities, about how this experience of doing therapy is going to be. These fantasies can be positive

or negative, and they influence, 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, it is something co-created throughout the therapy process. It is a special relationship, one of unconditional acceptance, asymmetrical, professional, respectful. And 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 them. Clients can live interesting lives, and do unusual and surprising things (in addictions this is quite common).

### Conclusions

It is important for the psychotherapist to have the best possible training, to be retrained, updated and committed to continuing education. It is a duty to the client. But also who he/she is, his/her history, life, hobbies, experiences, ethics, beliefs and values, has an influence. Reflecting on all this and becoming aware of it will allow you to manage its influence. Beliefs, ideas, values about what is right, healthy, objective, normal, are especially activated in therapy with addicts. On one hand, it is important to avoid establishing power relationships, and imposing visions of life, values, ideas. Seeking to work with the client not on him (*'the client is not always able to recognize what is good for him'* one may think). All these ideas, values are debatable. On the other hand, if these beliefs, ideas and values of the psychotherapist 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, if they are different or very different, they may interfere with therapy and unconditional acceptance, and it may be in the client's best interest to refer him/her to a colleague.

And, 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 to choose the work of a psychotherapist, a work dealing with the dark side of life, with people who suffer, are unhappy, who have lived through traumatic situations, etc., and to wonder about the secondary benefits of being a psychotherapist (perhaps, it makes the therapist feel better, less unhappy, more fortunate).

In addition, it is important to analyze which *models of help from our Western culture* are being internalized. 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, who is all-powerful. Keep in mind to control the "furor curandis", to accept that there are

different psychotherapeutic models, and to accept that one has limitations, following the client. The client is the one who sets the goals of the therapy, how far he/she wants to go. And to listen to him/her attentively, also when he/she criticizes, valuing these criticisms with humility and honesty (seeing if he/she is right). Therefore, the psychotherapeutic model IS NOT the person of the client, thus it is important to avoid confusing the map with the territory.

The myth of Chiron the wounded healer is inspiring, symbolizing the awareness of illness, which humanizes and places the therapist in a relationship of equality with the client in which both are human, imperfect. The therapist also has aspects to heal, to address in a personal psychotherapy and 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 the philosophical principle of IP 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, it is an asymmetrical relationship, caring for the other. So self-care, maintaining one's own psychotherapy and clinical supervision, seeking symmetrical relationships, enjoying life, hobbies, etc., is essential. To have a kit of resources that minimize the emotional impact 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 considers that he can afford it, that he has already taken too much advantage of the public resource). This is accepted, 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, 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 sessions, he has energy, his presence is greater, he has recovered his body, he feels it. In his relationships he has greater intimacy and commitment, with his partner, with his family (he has had very intimate conversations with his mother, talking 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, physiology) are more conscious and integrated (not fragmented). In short, he functions much freer 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 what I am sure of is that I will be there if he decides to do so.



### A note from the author

1. In the narrative at some points (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 important in this clinical case, where the intersubjective process, the co-created psychotherapy, the involvement beyond empathy, were decisive.
2. The author would like to thank Richard Erskine for his great and valuable contribution to psychotherapy and for developing Integrative Psychotherapy, Amaia Mauriz-Etxabe for her wisdom and humanity, her trainers and colleagues for all they have taught her, and especially to all her clients for their trust and encouragement.

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