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Psychotherapy and the Art of Being Human

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Abstract

This article is the third in a series on symbiosis and transference (see White, 1996, 1998). It examines the basic underpinnings of relationship-based psychotherapy, in which two people meet in a specific setting with specific "rules" about how they are permitted to relate.

The Importance of Transference

This article follows on a previous one (White, 1998) that examined transference, especially how attachment is established and how transactional symbiosis can be discouraged. The investigation of these processes, along with clinical observation and a considerable body of evidence cited in the literature, demonstrates the usefulness of transference in the psychotherapy setting and the importance of the therapeutic relationship to successful therapy outcome.

In her eloquent summary, Clarkson (1992) cited many sources that reported on the importance of the therapeutic relationship, including Yalom: "It is the relationship that heals. Every therapist observes over and over in clinical work that the encounter itself is healing for the patient in a way that transcends the therapist's theoretical orientation" (Yalom, cited in Clarkson, 1992, p. 57). Among those who subscribed to the importance of the therapeutic relationship are Berne, Rogers, and Perls. This article further investigates the nature of the therapeutic relationship.

Techniques in Therapy

As just mentioned, Rogers was a great exponent of the value of the therapeutic relationship. He wrote, "I hypothesize that personal growth is facilitated when the counselor is what he *is,* when in the relationship with his client he is genuine and without 'front' or facade, openly being the feelings and attitudes which at the moment are flowing in him" (Rogers & Stevens, 1967, p. 90). He also wrote, "I believe the quality of my encounter is more important in the long run than is my scholarly knowledge, my professional training, my counseling orientation, or the techniques I use in the interview" (pp. 89-90).

Another individual who noted this difference between relationship encounter and professional training or techniques was Reich (1933/1972): "It was not until a patient told me, some months after the termination of an unsuccessful analysis, that he had never trusted me, that I learned to appreciate the danger of the negative transference. That patient had recalled beautifully for a year and a half in a good positive transference" (p. 25). Reich's comment shows that clients can do excellent technique work (i.e., recalling) while at the same time there is a counterproductive therapeutic relationship (i.e., lack of trust). Thus we can separate the relationship and the technique used in therapy (see Figure 1).

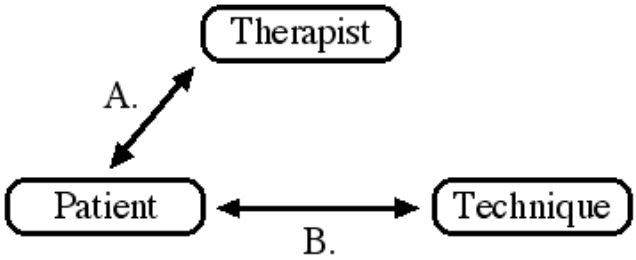

Figure 1
Technique/Transference Dichotomy

It is important to be clear about what is a "technique" and what is meant by the "therapist." For example, there is no such thing as a technique in itself, this is a misnomer. A technique involves the performance of a repetitive set of behaviors with the guidance of a therapist, possibly with the use of equipment such as an empty chair, a bioenergetics stool, biofeedback machinery, and so forth. Thus Figure 1 illustrates the client having a relationship with the therapist who is instructing him or her in a repetitive set of behaviors--a technique.

In addition, we have the "therapist" part of Figure 1, which is harder to define. The three writers mentioned earlier--Rogers, Yalom, and Reich--referred to the genuineness of the therapist, the therapist as a "real" person rather than as merely a clinician interacting with a client. Transactional analysis suggests an additional important component: intimacy. James and Jongeward (1971) wrote that intimacy "occurs in those rare moments of human contact that arouse feelings of tenderness, empathy and affection" (p. 59). Woollams and Brown (1978) offered that "intimacy involves the sharing of feelings, thoughts, or experiences in a relationship of openness, honesty and trust.... The intimate experience may be physical or emotional, pleasant or unpleasant, real or imagined" (p. 84). Further clarity is provided when intimacy is seen primarily as a function of the Free or Natural Child; for example, Berne (1964) wrote, "Intimacy is essentially a function of the natural Child" (p. 160), and Woollams and Brown (1978) asserted, "The Free Child is always involved during intimacy" (p. 84).

In transactional analysis terms, it is now clearer what is meant by the many writers who talk about contact between the client and the therapist. The suggestion is that when there is Free Child-to-Free Child contact between the two, the therapeutic relationship gains its curative

powers. This contention was supported by Berne (1964) when he wrote, "Fortunately, the rewards of game-free intimacy, which is or should be the most perfect form of human living, are so great that even precariously balanced personalities can safely and joyfully relinquish their games if an appropriate partner can be found for a better relationship" (pp. 55-56). In addition, James and Jongeward (1971) said, "Recovering the capacity for intimacy is a major goal of TA and is one of the marks of an autonomous person. Winners risk genuine intimacy" (pp. 62-63).

This description of intimacy and the Free Child must, however, be viewed as only one part of the therapeutic alliance. Obviously, healthy intimacy can only occur when all the other ego states of both individuals are aware of what is going on and such contact is safe, protected, and so forth. In a healthy therapeutic relationship, transactions occur between all ego states, particularly between the therapist's Nurturing Parent and the client's Child.

In fact, without the Free Child, intimacy as described here will not involve a feeling of contact between the two individuals--that feeling of the therapist's humanness as perceived by the client that allows the transference to significantly assist the healing process. Thus, these Free Child-to-Free Child transactions are especially important in comparison to other possible transactions between therapist and client.

It is easy to be confused about what we are discussing here. The Free Child, intimacy, humanness, or genuineness that I am referring to is a specific kind, the profound kind. Berne, as mentioned previously, indicated the difficulty with attaining intimacy. Rogers also wrote, "I have tried to describe this first element [genuineness] at some length because I regard it as highly important, perhaps the most crucial of the conditions I will describe, and because it is neither easy to grasp nor to achieve" (Rogers & Stevens, 1967, p. 92). He went on to highlight this in his discussion of empathy:

> I suspect that each of us has discovered that this kind of understanding is extremely rare. We neither receive it nor offer it with any great frequency. Instead we offer another type of understanding which is very different, such as "I understand what is wrong with you" or "I understand what makes you act that way." These are the types of understanding which we usually offer and receive--an evaluative understanding from the outside. It is not surprising that we shy away from true understanding. If I am truly open to the way life is experienced by another person ... then I run the risk of seeing life in his way, of being changed myself, and we all resist change. (p. 93)

This is further described by Kahn (1991): "In spite of the amount of time and energy Rogers devoted to writing about genuineness (he wrote about it in article after article), he seemed to find this attribute hard to describe and illustrate. But it seems clear that intuitively he knew what he meant" (p. 40).

Indeed, being human, being intimate, or being genuine at the level described here is hard--perhaps even impossible--to write about and describe. It may only be possible to feel and experience. All we can do is acknowledge the challenge and the limitations of such efforts.

Finally, consider this quotation from Rogers (Rogers & Stevens, 1967):

> Recently I had occasion to listen to some recorded interviews by a young counselor of elementary school children. She was very warm and positive in her attitude towards her clients, yet she was definitely ineffective. She seemed to be responding warmly only to the superficial aspects of each child and so the contacts were chatty, social and friendly, but it was clear she was not reaching the real person of the child. Yet in a number of ways she rated reasonably high on each of the conditions I have described. (p. 97)

I contend that therapists have the same difficulty in being who they really are. However, in transactional analysis, being "human" is theoretically quite easy. It involves a large quantity of Free Child. One can simply refer to the literature and see what Free Child is and be that. However, if one feels he or she is doing it easily, then he or she is probably not doing it at all. I agree with Berne that the attainment of true intimacy, and Rogers's true genuineness, is difficult and rare. Such is the nature of "humanness" described in this article.

Thus, in Figure 1, relationship A is defined as described above and is meant to indicate the therapist as a person who is genuine and therefore at some time shows his or her Free Child in some form. So we have the client/therapist relationship, or the transference and countertransference. There is always one of these; it is impossible not to have one. It can be clinical, warm and nurturing, cold and distant, and so on. This is the common ground for all therapies, and the quality of this relationship derives from the personalities, needs, goals, scripts, and wants of both therapist and client.

Relationship B in Figure 1 occurs when the therapist is doing his or her job: being a professional who is applying a technique to assist the client in his or her growth. The client must in some form relate to this aspect of the therapist and what he or she is doing. The list of potential techniques is long: hypnosis, dream work, two-chair work, game analysis, psychosurgery, and so on. Regardless of what technique is employed, the client will have some feelings, thoughts, and reactions toward the therapist and the technique itself. Techniques can be painful, pleasant, fast, slow, boring, exciting, complicated, easy, dramatic, subtle, and so forth. This, of course, impacts on the client and will effect his or her thoughts and feelings.

Relationships A and B are not mutually exclusive, but they do affect each other. The client/therapist relationship (A) will determine how the client goes about using the technique in which the therapist is guiding him or her (B). For instance, wishing to impress the therapist, the client may do good technique work, which will please many a therapist and lead him or her to believe the treatment is progressing well. However, this may not be the case because the client's goal is to use the technique to impress the therapist rather than to change. So, the therapeutic relationship affects how the client uses the technique. Other examples may be the client using the technique quickly, slowly, badly, humorously, agonizingly, begrudgingly, and so on. In each case, the transference relationship affects the tone of the technique work. It is not what is being done, but how it is being done; in this sense, the content of the technique is irrelevant.

Relationship B can also affect relationship A. It tells the client what the therapist thinks is OK

for achieving change. It gives the client permission to do things to himself or herself. For instance, if we use two-chair work, the client returns to the original scene, experiences the incident again, and hopefully makes a redecision. This usually is painful to some degree. Thus, the therapist is communicating that it is OK to inflict pain on oneself, at least in some circumstances. Perhaps a more dramatic: example of this is electroconvulsive therapy. Irrespective of its effects, this technique communicates to the client that it is OK to shock the body violently, at least in the pursuit of health.

In addition, if the therapist uses a "shocking" technique (or any other), then this permission may be generalized to other areas of the client's life, such as family relationships, work, or leisure. Techniques that are fun or nurturing, that involve medication, and so on also communicate a variety of permissions to clients about how to live their lives. This suggests that the "how" of what we request of our clients is as important, if not more important, than the "what" of what we request.

Another way in which the two relationships (A & B) interplay is that we may be giving our techniques more credit than they deserve. This relates mainly to regressive techniques or techniques in which the client regresses or becomes emotional (i.e., cathects the Child ego state). It is plausible to assume that when an individual is in Child more so than during normal functioning, then he or she is in a hypnotically suggestible state. English (1977) wrote about this when she discussed the Child ego state and its relation to hypnotic states. Kovel (1978) suggested that in hypnotism the client's mature discriminations are excluded and "childish dependence upon the hypnotist is encouraged" (p. 273). Van Pelt (1952) also noted that when people are emotional, they are more suggestible, as indeed they are when their field of consciousness is limited and attention is concentrated. All these features may be present when an individual is "deeply" in the Child ego state. Finally, Wolberg (1948) stated that the more impressive the therapist is in terms of stature, strength, education, experience, and so on (i.e., potency and protection), the more suggestible the client will be (i.e., accept permissions). Obviously, the link between hypnotic suggestion and transference deserves more attention and research.

If this is the case, then the mechanics of change may be due more to what the client hears the therapist say and imply during the use of a technique rather than to what the client experiences in participating in the technique. When a client is introduced to a technique, he or she learns what is supposed to happen by what the therapist says, by the direction of the questioning, by watching other group members participate in it, and so on. The therapist leads the client through it; that is what he or she is being paid for. For instance, in desensitization the client is encouraged by the therapist to go further than he or she would normally with regard to contact with or experience of a stimulus about which he or she is phobic. When the fear is too much, the client moves away and assesses the situation. Then the process is repeated, with the client each time confronting the phobic object more and more. The theory is that the Child becomes desensitized as a result of repetitively "meeting" the stimulus and experiencing no harm. Thus he or she slowly learns that the stimulus is not dangerous, and gradually his or her fear diminishes.

However, this may not be the case, or at least only half the case. When a client is introduced to

a technique, the therapist is saying, "This technique can do you good. This technique can help you to feel better." If the therapist did not think this, he or she would not use the technique. In addition, often the therapist will say such things and be there with the client, stroking him or her and offering encouragement for overcoming the phobia. Thus it may be relationship A that facilitates the change rather than relationship B: It may be the therapist's permissions and encouragement (suggestions) when the client is highly suggestible (in the Child ego state) that leads to the change rather than repeated contact with the fearsome stimulus.

Techniqueless Therapy

To reiterate, I am suggesting that the effect of therapy is not so much based on what clients do via techniques as on how they participate in them in relation to their feelings for the therapist and the suggestions that the therapist makes. Given this, the technique itself is largely irrelevant. We could have the client reciting poetry as the technique.

It should be noted that the questions being posited here are somewhat rhetorical. The notion of a techniqueless therapy is an interesting one, indeed. A techniqueless therapy might be defined by exclusion--that is, as a therapy that uses no therapeutic techniques. However, whether this is achievable is questionable. In the research at our institute we have not achieved it--yet. Further clarification of the definition of a techniqueless therapy and the problems inherent in the defining process are given in a later section of this article. Also, while it may seem that this article is an attack on therapeutic techniques, it also acknowledges their usefulness and effectiveness. I use them every day in my work with clients and believe them to be of much assistance and are not trivial, which is the next point at hand in the pursuit of a techniqueless therapy.

If we take the techniques away, we are left with the therapist and client together for 50 minutes. How are they going to get on? To answer this question, consider Figure 2, which is derived from what Goulding and Goulding (1979) called the "wall of trivia" (p. 124).

Figure 2 shows one role that techniques can play in psychotherapy: They can get in the way. As with all "walls of trivia," they make it "safe" for the two individuals involved by keeping them from having contact or closeness. Therapeutic techniques can be a distraction that inhibits Free Child-to-Free Child contact and allows people to keep a safe distance from each other. If we remove the technique, we are left with two people who can actually truly meet one another (Free Child intimacy can occur). Thus we have a techniqueless therapy, which in some sense becomes an extended version of the famous Berne (1964/1976, p. 13) intimacy experiment.

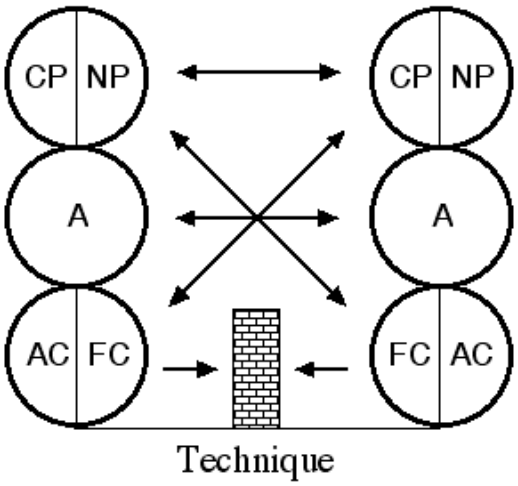

Figure 2
Technique Wall of Trivia

Training Therapists

I have observed training and therapists over 16 years in many different countries, and I am sure that there are some therapists who do not do what I describe here. However, I believe that the following observations are generally accurate.

Therapists are usually trained in technique-based therapies. They are trained to be informative, encouraging, stroking, empathic, and unconditional in their positive regard for the client. Few are trained to be true to the client in the sense of communicating what the therapist feels about the client--that is, to be human in the sense of Free Child-to-Free Child contact, to share whatever feelings are engendered by the client's behavior.

Many therapists encourage clients by stroking them for healthy behavior, positive changes, and likable qualities, and this can be a Free Child transaction. However, inevitably clients do things the therapist does not like. If the therapist comments on these, he or she is giving the client negative conditional strokes. Not many therapists will do this in a Free Child manner; in fact, there is little training on how to give such negative conditional strokes. And few would view such comments as unconditional positive regard, being empathetic, encouraging change, and so forth--the usual therapeutic activities.

Consider the following scenario. A therapist has been working with a client for a number of weeks, and the client, who is isolated, steadfastly does nothing about it. Finally the therapist feels a reaction: his Free Child feels like saying "Get a life!" However, there is a whole range of possible responses:

1. Get a life!

2. I'm angry at you.
3. I don't like your isolation and inaction.
4. I feel my own resistance to your persistent inability to interact with others.
5. Your lack of social skills may lead others to have some difficulty with you.
6. I suggest a contract to talk to two new people at work this week.

All of these communicate the same thing. Number 1 is unsocialized Free Child. Number 6 is highly socialized and has less Free Child and more conforming Child and Adult. A techniqueless therapy involves stating the six possible responses to the client and the client back to the therapist.

Is number 1 more real? It was the first thing the therapist felt like saying, so in that sense the therapist would have been most honest with the client--saying what he or she really felt, which is what we ask our clients to do. However, it is likely that most therapists would say numbers 4, 5, or 6 instead.

At our institute we have conducted research into this area and discovered that initially group members use the higher numbered statements. However, after five or six weeks, members become more comfortable with saying and hearing the less socialized Free Child comments. There is clearly a practice effect that leads to more unsocialized Free Child transactions between group members, which facilitates communication in that members are clear about where they and others stand. Group members learn about difficulties in their communications as they are told openly about them by other group members.

The six statements just cited are examples of negative conditional strokes. Not many therapists can say that each session they give a client a negative conditional stroke. However, by not doing this one is being "dishonest" or not real. Techniques can be used at times to create a wall of trivia, so that the therapist does not have to be real in this way. If there is no wall of trivia the therapist's and client's Free Child ego states can see each other more clearly and thus are more likely to react to each other. It is harder to pretend that this undersocialized human-to-human part of the therapy is not there or not relevant.

Techniqueless Therapy--An Oxymoron

Is it possible to have a psychotherapy that has no techniques--at least part of the time? The problem is that a techniqueless therapy can become a new technique in itself, a type of metatechnique. This is where gestalt therapy often stumbles. For example, Clarkson (1992) quoted Perls as saying:

> A Gestalt therapist does not use techniques; he applies *himself in* and *to* a situation with whatever professional skill and life experience he has accumulated and integrated. There are as many styles as there are therapists and clients who discover themselves and each other and together they invent their relationship. (p. 57)

Himself merely become the new technique, which is *applied* to the therapy, as Perls said, and

can be added to the wall of trivia.

Writings on gestalt therapy are littered with this inconsistency. Polster and Polster (1973) discussed the same subject in a section titled "Therapist Is His Own Instrument" (p. 18). If the therapist is an instrument, then the genuine Free Child humanness is lost. The Polsters go on to say, "The therapist also plays from his own feelings, like the artist, using his own psychological state as an instrument of therapy" (p. 18). The suggestion is that the therapist is being clinical in using the self as an instrument (technique) and thus the gains from the possible contact (Free Child-to-Free Child transactions) are lost.

Shepherd (1972/1974) wrote:

> The therapist's capacity for I-thou, here-and-now relationships is a basic requisite and is developed through extensive integration of learning and experience. Probably the most effective application of Gestalt techniques (or any other therapeutic techniques) comes with personal therapeutic experiences gained in professional training workshops and work with competent therapists and supervisors. (p. 264)

This is another example of how the relationship becomes a technique that is refined and polished. Certainly training and supervision are productive and permit one to develop as a therapist. At the same time, they hinder the therapist in being Natural or Free Child in his or her transactions as a therapist. As Berne (1964) and others noted, the Free Child is spontaneous, unprogrammed, and untrained. How can one have trained spontaneity?--an oxymoron.

There appears to be an assumption that because gestalt therapy is experiential and here and now that it is "real" and Free Child. However, I suggest that the experiential and here and now of gestalt therapy probably have become another technique that inhibits Free Child-to-Free Child contact. They have become another brick in the wall of trivia.

As soon as we think and talk about relating in a real and Free Child sense, it becomes harder to do. As soon as one considers not doing a technique, then that becomes the technique. Gestalt therapy is certainly not techniqueless as was previously suggested. If a client comes to therapy and the therapist does something--even if that is doing nothing--so a technique has occurred. However, this does not mean that the technique wall of trivia has to occur. It would seem plausible that a therapist and a client could have Free Child-to-Free Child contact.

There exists a paradox or oxymoron with regard to this possibility, however. The more naive the therapist, the more likely he or she is to have straight Free Child transactions with the client. The more training and experience the therapist has, the harder this is to do. The more one learns how to do Free Child in therapy, the harder it is to do it authentically.

Being Human and a Psychotherapist

How is it possible to be a psychotherapist and still have genuineness, realness, and Free Child human contact with a client? To date, the research at our training institute indicates three

important factors.

The first is what the gestaltists have emphasized for a long time: awareness. The therapist must be aware of his or her Free Child reactions, thoughts, feelings, fantasies, dark side, and so forth.

The second involves self-honesty. This is less important for trainee therapists because it is harder for them to fake being Free Child in the consulting room. However, once one has gained experience in being human with a client, it gets well known. After doing it 30, 40, or many more times, one learns to know it well and can fake it quite easily. Only the therapist will know when he or she is saying what he or she feels and thinks to the client when it is not really the case or only half the story. This is not meant to suggest that the therapist is being purposely deceitful, as will be explained later; most often the faking is out of awareness.

Third, the psychotherapist needs to develop the ability to split the therapist part that employs therapeutic techniques from the genuine human part of himself or herself. This is crucial. Integrating the two parts usually means that the human part is lost as a subset of the therapist part, just as it is presented in the gestalt literature mentioned earlier.

For example, consider my personal attempt at this (presented in a modified form in White, 1993). The psychotherapist lives a strange work life indeed. I have an office in Perth, Western Australia, where I work five days a week. People come to see me for help, the majority of whom I have never met before (therapist part). Yet in the briefest period of time, perhaps just an hour, they have told me things that they may never have told anyone before. I hear people's deepest fears, loves, hates, despairs, and so on. I hear about fantasies, thoughts of violence, rape, murder, humiliation, sex, degradation, love, affection, wants, and needs. I hear incredible reports of what people have done to others, what others have done to them, and what people have done to themselves--things I would never have thought possible. I am in my office confronted with all of this and the tremendously varied range of emotions that go along with such discussions (human part).

I am traumatized every day I work, but I refuse to become disaffected by the reports I hear from my clients, by seeing the torment on their faces and understanding the emotions that must be going through their bodies. In my chair sits not one, but two, people: Tony White, registered psychologist number 745, and Tony White, the human who thinks, feels, and reacts as a human to these extremes of emotions (human part).

In my dealings with these strangers who come for my help, I have three golden rules. The first is that I will not exclude my Child, or the human part of myself, from my transactions with my clients. The second is that I will not treat anyone whom I dislike because I do not believe to do so would be fair to the client or myself. The third is that I will not tell lies or falsehoods to clients (human part). They are giving me their deepest trust, so I will be straight in my dealings with them. If I like someone I will say so; if I dislike someone, I will say that also. If I have an emotional reaction to the client--whether it be fear, anger, joy, sadness, or whatever--I will express this. Often this creates an empathy rarely experienced in life; on the other hand, often it is traumatic both to express and to be confronted with such statements. Such can also be the

work life of a psychotherapist (human part).

While such intense emotions can occur in psychotherapy, the relationship between client and psychotherapist is a very defined one. Comprehensive lists of what constitute professional practices and ethical guidelines are restrictive and make the therapeutic relationship unique. Psychotherapist and client are not friends, acquaintances, siblings, parent and child, spouses, or teacher and student. They are client and therapist, and the relationship must be professional (therapist part).

The therapist part does this last aspect and deals with clients in a professional manner. He or she makes the diagnoses and treatment plans and uses the techniques. The human part is the human that was mentioned in my own example. These two parts must be split by the therapist in himself or herself both cognitively and emotionally.

This is another problem for gestalt therapy. As mentioned earlier, if ones does not separate the two parts, then the human part usually becomes incorporated as a subset of the therapist. Clearly gestaltists do not separate the two parts, at least theoretically. I suggest that such therapists are not being themselves but being therapists that use the self (human part) as one technique in their repertoire.

Finally, it should be noted that the type of therapy or relating being described here is intense and draining for the therapist. The danger of burnout is apparent. One needs, therefore, to weave it cautiously into the current therapy that one is doing.

Why does the human part becomes a subset of the therapist part? My observation is that there is a natural, ever-present pull for the human part to become a technique of the therapist part because it is easier and emotionally "safer." An experienced therapist has been human or made Free Child contact with a client many times before. It is thus easier to do it again without thinking. It is easier to do habitually because it takes less effort, and humans are naturally habitual creatures. It is like learning to drive a car. Initially one is very aware of his or her thoughts and feelings (Child) about driving. After some time, it becomes more habitual so the thoughts and feelings are hardly recognized. This change is natural, almost inevitable. The same applies to learning to be a therapist. Initially, one concentrates hard and has more feelings and reactions to doing the work. These could then be communicated to the client. With more practice it becomes more habitual and harder to stay in touch with one's feelings and reactions.

Second, to tell someone that you are angry at him or her or what you like or do not like about him or her is emotionally taxing. Each time one does this, one is having a minicatharsis (e.g., the expression of emotion is cathartic), and after such experiences one usually feels drained. This is illustrated by the feeling graph (see White, 1996). There is, therefore, a natural tendency for the therapist to avoid such catharsis and to let the feeling reactions pass by rather than showing them.

Third, if you as the therapist are hungry, suffering from a headache, or just tired, it is much easier to do things as they have been done many times before.

Fourth, therapists hear many unpleasant things, and it is natural for the human part to become hardened, that is, more. clinical. In our work with emergency personnel, we found that regular exposure to trauma leads to decreasing use of the Free Child and increasing use of the Adult and Critical Parent ego states (White & Weeks, 1994).

In conclusion, we have observed that if being human in therapy becomes easy, then the human part probably has become a technique of the therapist part. The more times you are human in this way, the harder it is to do it genuinely.

The split does one other thing of importance. It provides a reference point. Since there is a natural tendency for the human part to slowly, subtly, unconsciously become a subset of the therapist part, it is difficult to remain aware of it. However, if one has split the two parts, then he or she can maintain a sense of what is not human--that is, the therapist part. This can remind one what not to be when being human, thus allowing more renewed insight into what to be when being human.

Conclusion

The assertions in this article are all based on the assumption that being human--or genuine as Rogers called it--or having Free Child intimacy with a client is therapeutic. Research appears to confirm this. This article also has a Parent value system. If one acknowledges transferential and countertransferential feelings in the therapy setting, then the therapist being human is assumed to be a good thing. For the therapist to address the therapeutic relationship with a client, he or she has an obligation to be human in it as well.

It seems hard to imagine a therapy without techniques. However, we must remember that techniques are a "thing" people use and that how they use them is influenced by the client's perception of the therapist. The degree of this influence is debatable, although I suggest that it is considerable.

Finally, this article questions if a therapist can actually be natural Free Child with a client. Gestalt therapy claims this is possible, but this article refutes this claim and offers an alternative way of attempting to achieve this difficult goal.

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References

Berne, E. (1964). *Games people play: The psychology of human relationships*. London: Penguin.

Berne, E. (1976). The intimacy experiment. *Transactional Analysis Bulletin: Selected articles*

from volumes 1 through 9. San Francisco: TA Press. (Original work published 1964)

Clarkson, P. (1992). *Transactional analysis psychotherapy. An integrated approach*. London: Routledge.

English, F. (1977). What shall I do tomorrow?: Reconceptualizing transactional analysis. In G. Barnes (Ed.), *Transactional analysis after Eric Berne: Teachings and practices of three TA schools* (pp. 287-347). New York: Harper's College Press.

Goulding, M. M., & Goulding, R. L. (1979). *Changing lives through redecision therapy*. New York: Brunner/Mazel.

James, M., & Jongeward, D. (1971). *Born to win: Transactional analysis with gestalt experiments*. New York: Addison-Wesley.

Kahn, M. (1991). *Between therapist and client: The new relationship*. New York: Freeman.

Kovel, J. (1978). *A complete guide to therapy: From psychoanalysis to behavior modification*. Ringwood, Australia: Penguin.

Polster, E., Polster, M. (1973). *Gestalt therapy integrated: Contours of theory and practice*. New York: Vintage.

Reich, W. (1972). *Character analysis* (3rd ed., enlarged) (V. R. Carfagno, Trans.). New York: Farrar, Straus, Giroux. (Original work published 1933)

Rogers, C. R. & Stevens, B. (1967). *Person to person: The problem of being human*. Lafayette, CA: Real People Press.

Shepherd, I. L. (1974). Limitations and cautions in the gestalt approach. In J. Fagan & I. L. Shepherd (Eds.), *Gestalt therapy now: Theory, techniques, applications* (pp. 264-269). Ringwood, Australia: Penguin. (Original work published 1972)

Simkin, J. S. (1972). *Mini-lectures in gestalt therapy*. Albany, CA: Wordpress.

Van Pelt, S. J. (1952). *Hypnotism and the power within*. London: Skeffington & Son.

White, T. (1993). *Psychotherapy and the art of being human*. Perth: TA Books.

White, T. (1996). Character feelings. *Transactional Analysis Journal, 26,* 167-174.

White, T. (1998). Transference, attachment, and the transactional symbiosis. *Transactional Analysis Journal*, *28,* 121-126.

White, T., & Weeks, C. (1994). *Ambulance service support programme* (2nd ed.). Perth: TA Books.

Wolberg, L. R. (1948). *Medical hypnosis: The principles of hypnotherapy*. New York: Grune & Stratton.

Woollams, S., & Brown, M. (1978). *Transactional analysis*. Michigan: Huron Valley Institute.

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