1988

Understanding the Therapeutic Relationship as a Personal Relationship

Barbara A. Winstead
Old Dominion University

Valerian J. Derlega
Old Dominion University

Robin J. Lewis
Old Dominion University

Stephen T. Margulis
Grand Valley State University

Invited overview

UNDERSTANDING THE THERAPEUTIC RELATIONSHIP AS A PERSONAL RELATIONSHIP

Barbara A. Winstead, Valerian J. Derlega, Robin J. Lewis
Old Dominion University

Stephen T. Margulis
Grand Valley State College

Theories of personal relationships are reviewed to help us understand the therapeutic relationship as a personal relationship: Chambliss's (1965) theory of friendship which focuses on impression management; Kelley & Thibaut's (1978) theory of interdependence and Rusbult's (1980a) investment model of relationship satisfaction and commitment which focus on social exchange processes; and Levinger's (Levinger & Snoek, 1972) incremental exchange theory which focuses on developmental changes in a relationship. Taking these theories into consideration enables us to view psychotherapy as a personal relationship and suggests avenues for research and hypothesis testing. Conversely, the unique characteristics of therapy as a personal but asymmetric relationship also suggest implications for the development of concepts and research on other types of personal relationships.

Most persons will be involved in one or more personal relationships at various times in their lives, including a friendship and love relationship. Considerable attention has been given to understanding how people are attracted to and behave in the *early stages* of these relationships (e.g. Berscheid & Walster, 1978; Byrne, 1971). However, only recently has full attention been given to long-term personal relationships and their characteristics and the effects of

We wish to thank Steve Duck and Frances Haemmerlie (who acted as the Journal's anonymous reviewers) for their comments on an earlier version of this paper. Correspondence about this paper should be addressed to either Barbara A. Winstead, Valerian J. Derlega or Robin J. Lewis at the Department of Psychology, Old Dominion University, Norfolk, VA 23508, USA, or Stephen T. Margulis, Facilities Management Program, Seidman School of Business, Grand Valley State College, Allendale, MI 49401, USA.

Journal of Social and Personal Relationships (SAGE, London, Newbury Park, Beverly Hills and New Delhi), Vol. 5 (1988), 109–125

sustained, close relationships on the behaviour of the participants (e.g. Chelune et al., 1984; Hinde, 1981; Kelley, 1979; Levinger, 1980).

Psychotherapy involves a special example of a personal relationship. Processes that characterize friendships and love relationships, including interdependence, commitment and caring (Chelune et al., 1984), may also be found in psychotherapy. Furthermore, self-disclosure is a salient part of psychotherapy as it is in close personal relationships, although the usual rules of psychotherapeutic practice prescribe that it is primarily the patient's role to self-disclose and not the therapist's role (Derlega et al., 1987).

There are, however, critical differences between the psychotherapeutic relationship and other personal relationships. The asymmetry of patient–therapist disclosure is in sharp contrast with the mutual or reciprocal self-disclosure that occurs in most friendships or love relationships (Altman & Taylor, 1973; Levinger & Snoek, 1972). The patient is also expected to bear the financial costs of coming to therapy in return for the eventual removal of symptoms or the re-evaluation of the self. Psychotherapy may be described as both a personal and an impersonal relationship (Strupp & Binder, 1984), and it is the juxtaposition of these characteristics that makes it a fascinating area of study for relationship researchers.

In this article we will briefly review three major social psychological orientations to personal relationships, represented by Chambliss's (1965) theory of friendship which focuses on impression management; Kelley & Thibaut's (Kelley, 1979; Kelley & Thibaut, 1978; Thibaut & Kelley, 1959) theory of interdependence and Rusbult's (1980a, 1980b; 1983) investment model of relationship satisfaction and commitment which focus on social exchange processes; and Levinger's (Levinger, 1980; Levinger & Snoek, 1972) incremental exchange theory which focuses on developmental changes in a relationship. Taking each of these theories into consideration will help us understand psychotherapy as a personal relationship and suggest avenues for research and hypothesis testing.

Our intention is neither to construe the psychotherapeutic relationship as a friendship nor to construe friendship as a psychotherapeutic relationship, although we acknowledge that there may be similarities between the two. We assume the psychotherapeutic relationship is one that is not to date thoroughly understood and that examining it through the lens provided by theories developed

to deal with other sorts of personal relationship may clarify what the psychotherapeutic relationship is and is not. This analysis will also shed light on the strengths and weaknesses of the social psychological theories of relationships inasmuch as these will account for some aspects of the therapeutic relationship and not others. Where components of the therapeutic relationship cannot be accounted for by current theories, examination of psychotherapy may lead to useful modifications or additions to these theories. In particular, the unique characteristics of therapy as a personal but asymmetric relationship may suggest implications for the development of concepts and research on other asymmetric, personal relationships.

A word of caution is necessary about our analysis. There is little systematic research that pertains to therapy as a personal relationship, and we have been forced to speculate often about interactions between patients and clinicians based on our own clinical experience and/or informal observation. Furthermore, while we are aware that various approaches to psychotherapy, e.g. psychodynamic, behavioural and client-centred, will have different implications for the patient–therapist relationship, we do not intend in this article to explore these issues in depth. We make the assumption that individual psychotherapy from any approach requires a personal relationship that will be subject to the processes described in social psychological theories of relationships. The value of this approach rests on its heuristic capacity to generate hypotheses.

Chambliss's theory of impression management

Chambliss's (1965) theory addresses how the outcomes of relatively 'early' social interactions, based on concerns about self-presentation, affect the continuation of a relationship. A key assumption is that, in any specific social interaction and whatever its goals, people seek information about one another and attempt to convey personal images to one another of the kind of person they want the other to think they are. This impression need not correspond to how people see themselves nor with how they want most others to judge them. Moreover, the impression of the person which the other receives may be fairly close to or far from the image that the person intended to present.

Three major events unfold as persons express or 'present' themselves in social interactions. According to Chambliss, 'When the actor perceives that his intended impression and the audience's

impression do correspond, we want to say that the actor has been *effective* in his presentation of self' (Chambliss, 1965: 371). When there is a discrepancy between the person's perception of what he or she wants others to think and the other's impression, then the person's presentation of self has been 'ineffective'.

As the interaction continues, the other not only is deciding what the actor is like but also is evaluating the self that the actor has presented. When people perceive that the selves they present are reacted to positively by others, then the interaction has been *successful.* If the other reacts negatively to the self that is being conveyed, then the interaction is unsuccessful. Finally, people bring to encounters their image of the person they think they are. In the interaction the actor comes to understand how the other perceives him or her. If people perceive that they are seen by others as they see themselves, then the interaction is called *validating.*

As people seek acceptance for their self-concept, they will search out social relationships that are perceived, in Chambliss's terms, as effective, successful and validating. An interaction represents some combination of these variables. If people convey one image to another but see themselves in different terms, the interaction could be effective but not validating. Moreover, people may find that they are regarded favourably (that is, are successful), but still find the interaction has been ineffective and non-validating.

An individual who is well-adjusted ought in most circumstances find that a relationship can be effective, successful and validating. A person who is experiencing low self-esteem or personal problems, on the other hand, may find that he or she wishes to present an image to others that is *not* congruent with the self-image. In this case, a relationship in which the other has a positive impression (a successful relationship) may not be a validating one; or a relationship in which the person presents his or her true thoughts/feelings (a validating relationship) may not be a successful one. This is the situation that is likely to occur in therapy. Although the patient is there to seek help for personal problems, he or she may fear that in doing so he or she may give the therapist an unfavourable impression.

Although Chambliss (1965) does not address this issue, validation necessarily requires that people be willing to divulge personal information about themselves to others (i.e. to self-disclose) if others are to see them as they see themselves. In therapy, however, patients may choose to present themselves so that the therapist

will have a 'favourable' impression of them. Patients may present an image which they think will earn them approval and respect from the therapist, but an image that does not correspond with how patients see themselves. Thus, the interaction goals of success (earning a favourable evaluation) and validation (being understood by the therapist as one really is) can operate at cross purposes.

Chambliss suggests conditions which could result in premature termination of therapy. Suppose a therapist uncovers an unacceptable (to the patient) and unrecognized problem and focuses on it too prematurely for the patient. The patient might regard these interactions as non-validating, ineffective and possibly unsuccessful. For Chambliss these are grounds for discontinuing interaction with the other.

Chambliss's analysis of validation is consistent with the proposition that patients may disclose (hence, validate) some negative aspects of self (e.g. promiscuity, which may validate a male patient's view of his sexual attractiveness and manliness) while hiding others (e.g. adolescent homosexual thoughts or experiences, which threaten the patient's sense of manliness) (Derlega & Chaikin, 1977). In our example the patient may be motivated by fear of losing the therapist's positive regard through a discrediting disclosure and is sustained by the successfulness and effectiveness of other self-disclosures and, possibly, by validating other aspects of self.

It also may be the case that people enter psychotherapy with prior beliefs about therapy, for example, that therapists are both supportive and non-critical about clients' faults, which could result in successful encounters and, perhaps, that therapists are omniscient — they can know more about the patient than the patient does. The impact of this belief on effectiveness and validation is equivocal. If the patient believes that he or she has managed to hide critical characteristics from the therapist (hence, is effective), this might undermine therapist credibility and the therapeutic relationship if the prior belief in and need for therapist omniscience resisted change. By contrast, a skilled diagnostician, who can 'read' and astutely interpret patient behaviours, may reinforce a patient's belief about therapist omniscience. These patients might believe they will discover hidden personal characteristics. This may make validating encounters based on current self-knowledge less important.

Social exchange theories: Kelley & Thibaut and Rusbult

Interpersonal relationships can be considered as social exchanges in which the development of relationships depends on the rewards and costs that are experienced. Akin to the operation of an economic marketplace, individuals may attempt to 'buy' the best relationship they can get (Brehm, 1985).

Kelley and Thibaut's (Kelley, 1979; Kelley & Thibaut, 1978; Thibaut & Kelley, 1959) theory of interdependence describes how outcomes (that is, rewards and costs incurred in interactions) affect relationship satisfaction and motivation to continue in or leave the relationship. A fundamental assumption is that persons try to obtain the most profitable outcomes for themselves in social relationships by increasing the rewards and decreasing the costs incurred in social encounters. Persons try to obtain behaviours from others that will satisfy their own needs; these behaviours may be termed 'rewards'. 'Costs', on the other hand, include any unpleasant aspects of an interaction (for instance, loss of esteem, rejection). The outcomes experienced in a relationship are the net result of rewards minus costs.

The formation and continuation of a relationship will depend on the individual's awareness of the possible outcomes in a relationship as well as its alternatives. Early encounters may be used by the individuals to sample and forecast the possible outcomes in a relationship. Similar assessment processes may be expected to occur at each step in the relationship, though these processes probably occur more frequently in the early stages, when greater uncertainty exists about the stability of the relationship.

Expectancies and experiences with prior relationships will affect how satisfied individuals are with the outcomes in a relationship. According to Thibaut & Kelley (1959), comparison level (CL) represents a standard for evaluating one's degree of satisfaction with a relationship on the basis of past and present experiences in social encounters as well as on comparisons with what kinds of successful relations other people have or are believed to have, especially other people who are seen as similar to oneself. The comparison level represents a level of outcomes that is experienced as neutral in value. A person is satisfied with a relationship to the extent that outcomes are above the CL. Thus, satisfaction is a function of outcomes minus CL.

Comparison levels may be affected by ideal or desired social relationships as much as by actual past and present experiences with

relationships. Persons may overestimate the levels of outcomes to be achieved in relationships, based on exposure to mass media or stories that they read or hear about.

Although a person may be satisfied with the level of outcomes in a relationship, he or she may not continue in it. The comparison level for alternatives (CLalt) is the standard used by a person to determine whether to leave or remain in the relationship. It is the lowest level of outcomes a participant will accept in light of available alternative relationships. If outcomes fall below the CLalt, the person should leave the relationship. The comparison level for alternatives refers to the best single alternative available. According to Thibaut & Kelley (1959: 22), it is 'the reward-cost positions experienced or believed to exist in the most satisfactory of the other relationships'. The alternative relationships against which the present one is evaluated in determining the CLalt may include other dyads, membership in a group, or perhaps being alone.

The term 'dependency' is used by Thibaut & Kelley (1959) to refer to the person's likelihood of leaving a relationship. The more likely a person is to leave a relationship, based on the belief that other relationships can aid in achieving important outcomes, the less dependent the person is on that relationship. Thus dependency is a function of outcomes minus the comparison level for alternatives. Persons will leave a relationship if outcomes are lower than the comparison level for alternatives.

Rusbult (e.g. Rusbult, 1980a, 1980b, 1983) has contributed to the theory of interdependence by developing the concept of investment. Investments represent resources that a person has put into a relationship that would be lost if the relationship ended. It can represent the time, energy, effort or money put into making the relationship work. Because of these investments, the person who has made them should feel a commitment to the relationship. According to Rusbult, the person may be 'committed' to (or dependent on) the relationship as a function of outcomes plus investments minus comparison level for alternatives. A person who has made considerable investments in forming a relationship may feel 'trapped' because of the high investments, even though attraction to and satisfaction with the relationship are low (Rusbult, 1980a)

Rewards and costs in therapy. In applying social exchange concepts to therapy, it is worthwhile considering the rewards and costs experienced by patients and therapist. Most of the rewards for patients, at least early in therapy, may be in the expectations for

improvement and in the fact that someone is listening and is apparently concerned about him or her. The obvious costs are, of course, in terms of the financial expenditure and in the time and effort associated with going to therapy.

In addition, a major cost for patients, at least initially, is labelling oneself as having a problem which may make it difficult to begin therapy. Therapists may be able to reduce this concern initially by telling the patient that his or her problems are 'normal' and treatable. Some patients may feel that they are 'crazy', and the negative label and stigma will have to be challenged before the therapeutic relationship can continue.

There is also the cost for a patient of making oneself vulnerable and presenting negative aspects of self. The implicit requirement that the patient must make changes may also be a cost. Some patients may leave therapy because they are not ready to accept the cost of changing.

Even when patients have been able to make self-disclosures in initial phases of therapy, they may reach an impasse. Patients may decide not to share some critical information which makes them feel uncomfortable and upset. Patients may prefer to avoid the unpleasantness (including fear of rejection or discomfort) represented by talking about new material that enters an area not previously discussed. In ongoing therapy, the rewards may be relatively constant, and the costs may have been decreasing over the course of therapy (because of increased comfort in dealing with already exposed issues), but the exploration of new issues may expose the patient to new costs.

Money is symbolic of how some things may operate as both rewards and costs in therapy. Money represents many things to patients, including payment of a fee and commitment to the therapy process. However, payment for a professional relationship may also make the therapy seem burdensome because it negates the feeling that the patient is cared for. ('I pay you, you don't really care for me.') On the other hand, money can have reward properties. It can give the patient a sense of control over therapy. ('I pay you, you have to listen to me.')

For therapists, rewards can accrue from earning money and from a sense of work well done. However, patients can be demanding and call at all hours of the day and night, which represents a cost to the therapist as does the non-payment of fees, and the fear of a lawsuit from a disgruntled patient (Fisher, 1985).

Patients' expectations about therapy. Patients have expectations that therapy will provide relief, particularly after exhausting other relationships such as those with family or friends. Depending on how knowledgeable patients are about therapy, they may have different expectations about therapy. Some patients, in line with a medical model, may expect to get a prescription or an easy answer for their problems and hope for quick improvement. Others who know more about the process of therapy know that progress takes time. Media presentations of therapy (for instance, the Bob Newhart Show on television where he played a clinical psychologist, and the psychiatrist in the stage play *Equus*) may shape expectations about the relationship between therapist and patient and outcomes that should occur. Therapists in these fictionalized portrayals are shown as more involved with their patients (or perhaps even with one patient) than would ordinarily be the case. A therapist may in reality see twenty to thirty patients a week, whereas the media image shows therapists spending large amounts of time with a patient and perhaps being preoccupied with that patient. The comparison level set by media therapists may make real therapy seem less personal or less intense than it 'should be'.

According to interdependence theory, satisfaction with a relationship is a function of the discrepancy between the value of outcomes in the relationship and the individual's expectations about what should happen (that is, his or her comparison level or CL). Thus, patients who have unrealistically high expectations concerning the quality of therapy may be predicted to have considerable dissatisfaction with the relationship. Perhaps, as the therapy unfolds and if expectations become more realistic (so that the comparison level is lowered), satisfaction with therapy increases.

Patient's alternatives to therapy. In predicting whether or not patients choose therapy or decide to continue therapy, the concept of comparison level for alternatives is useful. Patients may have other possible relationships that could provide some emotional support, such as talking with a confidant. However, choosing therapy or continuing therapy implies that the individual's best available alternative (or CLalt) is below the level of outcomes that can be found in the therapy relationship.

It might be expected that if, as a result of therapy, patients are better able to function in other relationships, the rewards associated with these other relationships may increase and their costs decrease. The value of outcomes in the best alternative relationship

[CLalt] may thus increase and the patient's commitment to therapy may decrease — even if the outcome values earned in therapy remain the same.

Patients' investment in the therapy. Rusbult's (1980a, 1980b, 1983) concept of investment has appeal for predicting patients' commitment to psychotherapy. The investment in therapy may be represented by the time and money that have already been spent. Starting again with another therapist or quitting altogether may be unattractive given all the investment that has been made. On the other hand, it is probably easier for patients to quit fairly early in the therapy because the investment of resources into the relationship is small (and the outcome values might be low at this stage, too).

The presence of high investments in the therapy may make patients feel trapped even if the relationship is unsatisfactory. Patients may have difficulty terminating the relationship even if it is not being therapeutic. Occasionally termination with a therapist must occur prematurely (e.g. patient or therapist moves). Because of his or her investments in the therapy, the patient may find the idea of continuing in therapy with someone else unnattractive. To help the patient accept the situation, the therapist might tell the patient who is considering seeing another therapist: 'Yes, you may have to begin again with another therapist, but you have gotten a lot out of therapy already.' This approach emphasizes that the investments are counterbalanced by the rewards that have already accumulated in the therapy, and it may make it easier for the patient to end the relationship and, if advised, transfer to another therapist.

Levinger's theory of relationship development

Levinger (e.g. Levinger & Snoek, 1972; Levinger, 1980) has constructed a theoretical framework called the incremental exchange theory of relationship development. The theory explores the determinants of attraction at varying levels of relatedness and suggests how social interactions at a particular level influence transitions or movements between levels. The original theory (Levinger & Snoek, 1972) focused on levels of relationship development, but a later version (Levinger, 1980) extended it to include development and deterioration of relationships. It will be used to examine different stages in the therapeutic relationships.

According to Levinger and Snoek, we can conceptualize four levels of relatedness: Zero Contact, Unilateral Awareness, Surface Contact, and Mutuality. Level 0 involves Zero Contact. The persons

have no contact or awareness of each other. On the dimension of interpersonal relatedness, three levels of relationship may develop. A relationship begins with Unilateral Awareness, when one person becomes aware of the other. The person evaluates the other, but no significant interaction occurs. Though we may be attracted to someone, the decision to affiliate or actually interact may be affected by other considerations, including the other person's, availability as well as outcomes that can be obtained in alternative relationships.

At the next level, Surface Contact, the initial interactions involved between the two people are determined largely by fulfilling role expectations governing appropriate behaviour and by concern about self-presentation. Surface contacts, then, are largely confined to taking on roles considered appropriate to the situation; for instance, interactions between a shopper and clerk fit certain rules governing such interactions. As Levinger & Snoek (1972) note, in surface contact 'there is little concern about maintaining *this* particular relationship with *this* particular person' (p. 7).

The person's attraction to the relationship with the other at surface contact is based on self-centred criteria. The person determines satisfaction on the basis of the outcomes (that is, the rewards and costs) experienced in the relationship in comparison to what is expected in general and relative to what is available in other relationships. The imagined qualities attributed to the other by the person before any interaction occurs may also affect attraction to the other and satisfaction with the relationship at this level.

At the next stage of mutuality, according to Levinger & Snoek (1972), 'the partners have shared knowledge about one another, assume some responsibility for each other's outcomes, and at least begin to regulate their associations upon a mutually agreed basis' (p. 8). Hence, the behaviour of each influences the other. The partners are more spontaneous in their interactions and a sense of 'we-ness' emerges. That is, the pair has become interdependent and, consequently, they must co-ordinate their behaviour in order to maximize their outcomes. Mutuality can be represented by a continuum of the degree of overlap or intersection of the persons' life space.

This model of interpersonal relatedness describes how people come closer together. In a subsequent paper Levinger (1980) outlines the major phases of a long-term relationship as it builds up, continues and is maintained, and then diminishes and breaks off.

The model assumes an ABCDE sequence of relationship development: A is initial attraction; B is building the relationship; C stands for continuation of the relationship; D, for deterioration or decline; and E for ending, such as death, in relationships that do not deteriorate.

Levinger notes that between the phases of the building of a relationship and the continuation of one, a transition event occurs that he calls commitment. Commitment is 'the avowal of an intent to maintain a relationship over some period of time . . . ' (Levinger, 1980: 531). Commitments vary in strength and vary according to the type and length of relationship they concern. This greater or lesser degree of commitment to a relationship over an interval of time is crucial to maintaining and continuing a relationship. In some relationships it is based on an explicit pledge, such as marital vows or perhaps by setting up barriers around the relationship such as scheduling a time to meet when no other appointments are allowed. In therapy, commitment may involve a decision by the patient to stay in therapy or by the therapist to work with a patient.

Deterioration or the worsening of a relationship is likely to be brought on by either a drop or projected drop in rewarding outcomes and with an increase in negative outcomes. Changes in how the partners relate to one another or perhaps changes in partners' values about what they want in the relationship may initiate the downward spiral. The decision to dissolve a relationship, that is, the progression from deterioration to an ending, maybe brought on by the existence of an alternative relationship (CLalt) which promises more favourable outcomes or a judgement that the relationship is unsatisfactory and irreconcilable. The deterioration of a relationship can be associated with a decrease in the following relationship characteristics: the diversity, duration and frequency of interaction; openness of communication; intensity and type (positive or negative) of expressed emotions; behavioural accommodations and trust; and communality of outcomes and plans.

Stages in the therapeutic relationship. In psychotherapy, patients usually come to treatment at Levinger's stage of unilateral awareness. Patients may not know anything about the therapist except what they have learned from whoever referred them to the therapist, or they may have just selected the therapist out of a phone book or by seeing their name on a building directory. It is worth noting that some models of therapy discourage therapists from accepting patients where there has been any previous relationship, even at the

level of surface contact. The assumption here is that roles individuals have assumed with one another in the past will interfere with the development of a therapeutic relationship that requires different roles.

In surface contact, therapist and patient establish their appropriate roles vis-a-vis one another. Unlike the initial stage of most personal relationships where both partners are evaluating the other as a potential friend or lover, in the therapeutic relationship the patient is evaluative ('Is this a good therapist for me?'), whereas the therapist evaluates intellectually, ('What is the diagnosis; what sort of intervention would be most beneficial?'). The therapist tries not to let emotional responses (for instance, liking versus not liking the patient) interfere with his or her behaviour. In this way, therapy, despite its highly personal nature, is more like other professional or business relationships where the service provider tries to keep personal reactions to clients under control.

There may be development of a relationship in therapy beyond surface contact, but the therapist and the patient will still be affected by their respective roles. The therapist continues to maintain a professional relationship, of the 'therapist' interacting with the 'patient', but the patient may want to dissolve these role structures. The patient may accept these roles cognitively but not emotionally. Having disclosed much that is personal and affectively charged, the patient may expect the therapist to treat the relationship as a mutual one in which the therapist also discloses.

Deterioration as a stage in therapy. How do the patient and therapist cope with deterioration as an issue in their relationship? Although the patient and also the therapist may not be thinking about it, therapy is intended to end; its goal is termination. That end may be viewed as a potentially negative experience by patients, but it is not (or shouldn't be) so viewed by therapists. In premature termination, as in cases where the therapist and patient agree they are not making any progress, Levinger's analysis of the negative features in a relationship that encourage deterioration may be more useful. The goal of the relationship in therapy, in fact, is to end the relationship or the need for the relationship, which is a goal different from other relationships. In positive termination, the patient and therapist may feel sadness and a sense of loss, but the relationship has not gone bad in some way. Also, the therapist may leave the door open for the patient to come back. ('If you need this kind of work in the future, you can get back in touch again.') This is a

task-oriented set. Therapists may also encourage the patient to keep in touch to see how they are doing.

Mutuality as a relationship stage in therapy. Levinger notes that mutuality involves the development of a sense of 'we-ness'. The relationship is based on mutually shared information, joint construction of unique norms that govern the pair's behaviour towards one another, mutual responsibility for enhancing and protecting the relationship, co-ordination of outcomes that benefits both persons and reflects mutual equity, and mutual affection and emotional investment in the relationship.

In long-term therapy, if a patient feels the therapist knows, trusts and empathizes with him or her, that patient may develop a sense of 'we-ness'. The therapist may also feel a sense of involvement and investment, but he or she must remain aware of the limitations of the therapeutic relationship. There is a 'we-ness' in the patient's life more than in the therapist's life. Psychoanalysts talk about therapeutic alliances between the therapist and patient (Greenson, 1965), but it is an alliance against a common enemy, the patient's pathology. The distinction between forming a relationship to defeat the patient's pathology versus forming a relationship for its own sake is easier for the therapist to appreciate than for the patient who will, especially in initial phases of the therapy, identify with his or her pathology.

Levinger's concept of mutuality emphasizes the development of interdependence. It goes beyond what occurs in a relationship governed by role prescriptions or what occurs between passing strangers. In forming an ordinary relationship, participants may want to establish an interdependence that helps to make the relationship satisfying and perhaps long-lasting. However, the goal of therapy is to avoid interdependence; that is, to avoid the patient needing the therapist over the long run and of the therapist needing the patient. The inexperienced therapist may have problems of interdependence in trying to help the patient (for instance, helping them directly to solve a problem, telling them what to do, doing things for them, getting involved with their day-to-day concerns) as opposed to getting the patient to recognize their own ways of taking care of themselves (for instance, solving their own problems, boosting their own self-esteem).

Implications of psychotherapy as a form of relationship for social psychological theories of relationship development

Most social psychological theories of relationship development focus on friendships and love relationships. These relationships may be considered *symmetrical* for the following reasons: The partners are mutually (though not necessarily equally) dependent. They serve to satisfy one another's important needs as central individuals in each other's social networks (Margulis et al., 1984). They exchange self-disclosures and, hence, are both vulnerable to being exploited by one another (Derlega & Chaikin, 1977: 109–10). They are attracted to one another.

Psychotherapeutic relationships are, however, *asymmetrical*, for the following reasons: They lack the mutuality of symmetrical relationships but otherwise share characteristics with symmetrical relationships. There are bonds of sentiment and self-disclosure, but these bonds and the resulting attraction to one other person are usually expressed unilaterally (i.e. from patient to therapist). Attraction can become a therapeutic tool, but it is not a therapeutic end. A therapeutic relationship is often a long-term relationship, though not as long-term as true friendships and successful marriages, yet far longer than the fleeting but intimate friendships of passing strangers (Derlega & Chaikin, 1977). Unlike a symmetrical relationship, therapy has characteristics of a business relationship, with mutual expectations about outcomes, such as fees for service to the therapist and symptomatic relief and/or personality change for the patient (Watkins, 1965). Moreover, although the therapist has concern for, cares for and is committed to the patient, he or she is equally committed to terminating their relationship when the patient is ready. As the introduction states, therapy is a form of relationship which juxtaposes personal with impersonal relational characteristics.

Because therapeutic relationships share characteristics with symmetrical relationships, many of the concepts in current theories, such as those summarized here, apply to the therapeutic relationships. However, these theories do not fully address the consequences of juxtaposing personal and impersonal elements in relationships and, therefore, are incomplete as theories of relationship development. Investigating and explicating asymmetric relationships will expand current theories of social relationships.

Research on the patient–therapist relationship

A primary purpose of this article is to suggest hypotheses that can be confirmed or disconfirmed by research. The methodologies used by social psychologists to test the theories presented here can often be adapted for use in a clinical setting. For example, questionnaires operationalizing theoretical concepts can be administered to patients and therapists who volunteer to participate. There may be resistance by therapists and patients to participating in research and this cannot be easily overcome; certainly patients must never be coerced into participation even when their therapists are willing. Confidentiality also takes on an added dimension when not only the subjects' individual responses but also the fact of their participation, since that labels them as a patient in psychotherapy, must be guarded. Still, clinical psychologists recognize the utility of empirical research and are capable of conducting this research in a sound and ethical manner.

Our analysis also suggests that we need to understand more about asymmetric relationships. Parent–child, teacher–student, employer–employee relationships are ones that can be fruitfully studied. Discovering the similarities among various asymmetric relationships will permit psychologists to develop models of asymmetric relationships in general; and an examination of how asymmetric relationships are and are not compatible with current theories of personal relationships will be useful in improving these theories and making them more complete.

REFERENCES

Altman, I. & Taylor, D.A. (1973) *Social Penetration: The Development of Interpersonal Relationships*. New York: Holt, Rinehart, & Winston.

Berscheid, E. & Walster, E.H. (1978) *Interpersonal attraction* (2nd ed.) Reading, MA: Addison-Wesley.

Brehm, S.S. (1985) *Intimate Relationships*. New York: Random House.

Byrne, D. (1971) *The Attraction Paradigm*. New York: Academic Press.

Chambliss, W.J. (1965) 'The Selection of Friends', *Social Forces* 43: 370–80.

Chelune, G.J., Robison, J.T. & Kommor, M.J. (1984) 'A Cognitive Model of Intimate Relationships', in V.J. Derlega (ed.), *Communication, Intimacy, and Close Relationships*. Orlando, FL: Academic Press.

Derlega, V.J. & Chaikin. A.L. (1977) 'Privacy and Self-Disclosure', *Journal of Social Issues* 33(3): 102–15.

Derlega, V.J., Margulis, S.T. & Winstead, B.A. (1987) 'A Social-Psychological

Analysis of Self-Disclosure in Psychotherapy', *Journal of Social and Clinical Psychology* 5: 205–15.

Fisher, K. (1985) 'Court Protects Talk within Therapy Session', *APA Monitor* (October): 32.

Greenson, R. (1965) 'The Working Alliance and Transference Neurosis', *Psychoanalytic Quarterly* 34: 158–81.

Hinde, R.A. (1981) 'The Nature and Study of Personal Relationships', in S.W. Duck & R. Gilmour (eds), *Personal Relationships 1: Studying Personal Relationships*. London: Academic Press.

Kelley, H.H. (1979) *Personal Relationships: Their Structures and Processes*. Hillsdale, NJ: Erlbaum.

Kelley, H.H. & Thibaut, J.W. (1978) *Interpersonal Relations: A Theory of Interdependence*. New York: John Wiley & Sons.

Levinger, G. (1980) 'Towards the Analysis of Close Relationships', *Journal of Experimental Social Psychology* 16: 510–44.

Levinger, G. & Snoek, J.D. (1972) *Attraction in Relationships: A New Look at Interpersonal Attraction*. Morristown, NJ: General Learning Press.

Margulis, S.T., Derlega, V.J. & Winstead, B.A. (1984) 'Implications of Social Psychological Concepts for a Theory of Loneliness', in V.J. Derlega (ed.), *Communication, Intimacy, and Close Relationships*. Orlando, FL: Academic Press.

Rusbult, C.E. (1980a) 'Commitment and Satisfaction in Romantic Associations: A Test of the Investment Model', *Journal of Experimental Social Psychology* 16: 172–80.

Rusbult, C.E. (1980b) 'Satisfaction and Commitment in Friendships', *Representative Research in Social Psychology* 11: 96–105.

Rusbult, C.E. (1983) 'A Longitudinal Test of the Investment Model: The Development (and Deterioration) of Satisfaction and Commitment in Heterosexual Involvement', *Journal of Personality and Social Psychology* 45: 101–7.

Strupp, H.H. & Binder, J.L. (1984) *Psychotherapy in a New Key: A Guide to Time-Limited Dynamic Psychotherapy*. New York: Basic Books.

Thibaut, J.W. & Kelley, H.H. (1959) *The Social Psychology of Groups*. New York: John Wiley & Sons.

Watkins, J.G. (1965) 'Psychotherapeutic Methods', in B.B. Wolman (ed.), *Handbook of Clinical Psychology*. New York: McGraw-Hill.