A Novel Instrument to Capture the Specific Qualities of a Therapy Relationship: Introducing the *Fuente Interpersonal Relationship Assessment* (FIRA)

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"It is a space of relations, a space that is subtle like the ancient concept of the aether or subtle body. This space must be entered, experienced, and properly exited from. Entrance often depends upon the sacrifice of interpretation, […] which opens one to the imagination of the heart, for now one can see with the heart, with an eye unknown to the sensuous eye …"

Nathan Schwartz-Salant (1991, pg. 363)

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1 Preface

Like many works in the field of psychotherapy research, the present study is grounded in personal experience. As the thesis developed, I discovered that one of its implicit aims was to provide me with an explanation for a phenomenon that I was encountering but had no good theory for: the centrality of the therapy relationship in the clinical setting.

By the end of my first year of working with patients, I distinctly noticed that the therapy relationship was the single-greatest contributing factor in making therapeutic progress. This was not altogether unexpected, as I had read enough theoretical literature to understand that the role of the relationship had been emphasized by many authors—practically everyone from Sigmund Freud and Carl Rogers to Jeffrey Young. What startled me, however, was that I could find no comprehensive or systematic method to describe what the specific rapport with a patient amounted to.

Even discussions with other clinicians about the topic, including the nature of their own therapy relationships, yielded little insight. Many therapists found that they had only few attributes at their disposal for describing therapy relationships—aside from relatively generic labels such as "good," "productive," "involving," or "challenging." Psychoanalytically informed colleagues would detail the transference and countertransference aspects of the therapeutic encounter; humanistically oriented clinicians would exemplify the manner in which they explored the "felt sense" with their patients. Still, I could not locate very many viable descriptors for the therapy relationship itself—attributes that would mirror the unique characteristics of the "here and now" with a specific person.

I felt that there was a discrepancy between the almost universal agreement among clinicians that the therapy relationship was key—and the language they had available to describe the nuances of the rapport. This sentiment inspired me to search for existing methods aiming to provide therapists with qualitative language to characterize the dynamics in the consulting room. The approaches that I found—most of them—are assembled and reviewed in this thesis. However, it appeared to me that they fell short in establishing a good vocabulary for capturing the immediacy of the atmosphere with a patient. In terms of their implementation, they relied on questionnaires, often for both patient and therapist, and I did appreciate the dependable methodology that came with that approach. But I sensed that more could be done, and that something was missing.

After some hesitation, I decided to embark on what seemed like an audacious quest. It became my goal to make a contribution to the field—in the form of a novel tool designed to assess the therapy relationship in a qualitative sense: the FIRA. The FIRA is a questionnaire-based system aiming to capture the specificity of the therapeutic rapport and to highlight any areas in which the patient's experience of the relationship differs from the therapist's. As the present study will reveal, these benefits can be put to direct use in ongoing therapies, especially in more long-term commitments.

To develop the FIRA in its current form, much help from colleagues was required. I also needed to find a definition of the therapy relationship that could integrate the phenomena

I was experiencing in my clinical work. Without the work of Nathan Schwartz-Salant, this thesis would not exist. Schwartz-Salant thinks of the relationship as an "interactive field" in which transformational processes occur—a liminal space with unique characteristics. This perspective was eye-opening to me. And if Schwartz-Salant states that his "idea of an interactive field is heavily indebted to Jung's study" (Schwartz-Salant, 1998, pg. 24), then I am all the more indebted to both authors.

The FIRA is, undoubtedly, at an early stage of development. However, I do believe it is ready for deployment in its current form. At the very least, I hope that its existence will inspire other clinicians to take the therapy relationship even more seriously than before, and to pay even greater attention to the minute atmospheric shifts when being with a patient. Over the course of writing this thesis, my idea of therapy was deeply altered. And if the FIRA—or this study—can stimulate even a small change in someone else's psychotherapeutic practice, it will have been worth all the effort of compiling this work.

2 Introduction

The primary aim of the present thesis is to demonstrate that psychotherapy, in theory and practice, can only benefit from additional means to put the therapy relationship at the center of attention—to reflect upon the unique characteristics of a specific therapeutic rapport as it changes over the course of treatment, and to utilize the relationship as a shared space in which transformational processes can unfold. The study will first examine existing tools that strive to assess the quality of a therapy relationship, and it will show that these mainly generate quantitative information, thereby "grading" the relationship and determining the extent of its contribution to therapeutic outcome. Then, the thesis will incorporate a particular definition of the therapy relationship—by turning to the work of Nathan Schwartz-Salant. The Jungian writes: "Rather than seeing a relationship as something two people did to one another, or as a kind of partnership, I began to see a relationship as […] a field that both people engaged and which […] moved and molded their processes, both individually and together, as if these processes were mere waves upon a larger sea" (Schwartz-Salant, 1998, pg. viii). To some readers, this account of the therapy relationship might sound a bit mysterious at this stage, but as the present study progresses, it will become clearer exactly what Schwartz-Salant wants to convey. As a next step, the thesis integrates a concept stemming from the estranged discipline of western astrology—or, more precisely, from psychological astrology as practiced and taught by psychoanalyst and astrologer Liz Greene. Her characterization of the composite, which captures the archetypal qualities of the relationship between two people, shows remarkable resemblance to Schwartz-Salant's thoughts on the therapy relationship as an "interactive field" (Schwartz-Salant, 1988, pg. 53). Both authors consider the relationship to represent a "third area" or "third factor" that is conducive to personal transformation and growth (Schwartz-Salant, 2017a, pg. 15; Greene, 1999, pg. 10). Finally, the thesis uses this theoretical framework to develop a novel assessment tool designed to examine therapy relationships in a qualitative sense: The Fuente Interpersonal Relationship Assessment, or "FIRA." This instrument facilitates archetypal patterns to establish "what the

relationships feels like" when clinician and patient meet in the consultation room. The FIRA gauges the therapy relationship and provides a language to describe relational experiences in an atmospheric sense—for both patient and therapist. In doing so, the FIRA can help shed light on aspects of the therapeutic encounter that might otherwise go by unnoticed. It also supports therapists in focusing on the archetypal transformation process happening in the shared space between themselves and their patients—in the enigmatic container that we call "relationship."

The following summaries provide further information on the contents of each of the present study's central chapters. They are meant to provide a quick overview; therefore, any duplicate references have been omitted. However, all quotations—however short—will be repeated, contextualized, and properly and consistently referenced in the actual chapters. Interested readers are therefore kindly asked to turn to the respective chapter when looking for a particular source.

2.1 Chapter Three: The Therapy Relationship

This chapter investigates the nature, terminology, and clinical significance of the therapy relationship—against the backdrop of different psychotherapeutic convictions. In doing so, it attempts to demonstrate that the therapy relationship plays a cornerstone role in many different schools of thought of psychotherapy. Starting with historical context, the chapter discusses the way in which Sigmund Freud identifies the therapy relationship as a critical aspect of his analytic work. Freud's stance is then expanded by Carl Rogers, who articulates the essential qualities of the relationship through the triad of congruence, unconditional positive regard, and empathic understanding. These three qualities, which, according to Rogers, a competent clinician should all possess, have become widely accepted across therapeutic orientations—in spite of their obvious humanistic origins. The present study also addresses the idea of congruence, which, as it argues, must be distinguished from the notion of being merely aligned or synchronized with the patient. Instead, congruence should be understood to encapsulate a therapist's inner consistency and transparency, which allows for authenticity without running the risk of entering into a state of naive overidentification with the patient. Next, the thesis takes a closer look at Jeffrey Young's schema therapy, which places even greater emphasis on the therapy relationship, especially through techniques such as empathic confrontation and the notion of limited reparenting. Young's belief that practically all patients exhibit some form of characterological particularity highlights the universality of relational dynamics as both a diagnostic and healing factor. In Young's perspective, the therapy relationship is not merely seen as a supportive container but as an active agent in restructuring maladaptive schemas through emotionally corrective experiences.

A terminological issue addressed in the chapter is the issue of absent definitions for the concepts of the "therapy relationship" and the therapeutic "alliance." As the thesis demonstrates, different authors use the terms in different ways. Referencing the works of Flückiger, Wampold, Imel, Di Malta, and others, the chapter shows that these terms are often used interchangeably, inconsistently, or only defined contextually, even within the same publication. This ambiguity is presented not as a purely semantic issue but as one

that affects both research methodology and clinical application. While a more precise and differentiated use of the terms would be desirable, this is not the case. Hence, the chapter details the reasons why the choice was made to favor the notion of the "therapy relationship" as the primary term used throughout the thesis.

As the purpose of the present study is to introduce a new means of characterizing therapy relationships, other means of assessing its qualities are examined. Overall, ten established tools are presented in some detail—including a discussion of the instruments' respective items. Featured among these tools are the Helping Alliance Questionnaire (HAQ), the Working Alliance Inventory (WAI), the Agnew Relationship Measure (ARM), the Relational Depth Frequency Scale (RDFS), and the Scale to Assess the Therapeutic Relationship (STAR). Each is examined in terms of its theoretical underpinnings, structure, and clinical relevance. While many of these tools offer valuable insights into a therapy relationship, the thesis points out the degree to which they tend to regard the therapeutic rapport primarily as a means to predict outcome—rather than attending to the intrinsic quality of a therapy relationship. The HAQ and WAI are presented as historically influential yet limited by this outcome-orientation. The ARM offers a more differentiated picture by incorporating emotional dimensions and allowing bidirectional assessment, by both therapist and patient. The RDFS shifts its focus toward qualitative moments of a sense of connectedness between therapist and patient but turns out to be rather constrained in its purpose. The STAR stands out thanks to its transparent development process and practical usability across various settings, in spite of its origins in the context of community psychiatry. Overall, while the instruments reviewed in this chapter have many strengths, they largely fall short regarding a qualitative assessment of the therapy relationship. All too often, their results are dominated by therapeutic outcome and the sense that the relationship is graded or even benchmarked against others. In the scope of the thesis, this sentiment is also inspiration for the development of a novel tool closing the gap between the universally attested relevance of the therapy relationship and the absence of proper assessment tools examining its variable quality in a sense of "what the rapport feels like."

2.2 Chapter Four: The Relationship in Jungian Theory

This chapter lays the conceptual groundwork for the novel method of assessing therapy relationships later put forward. The core question this chapter attempts to answer concerns the very nature of the human relationship, especially in the context of psychotherapy. The discussion begins with a guided tour through the term's diverse use cases—ranging from the sense of kinship and diplomatic alliances to mathematical correlations and linguistic structures—to demonstrate that common-language definitions lack the precision required to develop the thesis further. A consultation of standard dictionaries reveals multiple entries—interrelatedness, social bonds, transactional dealings—but none of these capture the intersubjective field between therapist and patient, the "what is feels like" atmospheric quality. The chapter finds that neither are the standard definitions of what constitutes a relationship viable, nor can the already available instruments crafted to evaluate the therapeutic rapport be helpful in establishing a working concept. Thus, the chapter turns to Nathan Schwartz-Salant's adaptation of the Carl Jung's theoretical

framework, which thinks of the therapeutic encounter as a dynamic "third area" and a "space between" therapist and patient within which archetypal processes unfold.

To contextualize Schwartz-Salant's perspective on the relationship, the chapter revisits Carl Jung's work "The Psychology of the Transference," in which Jung employs alchemical symbolism—particularly the first ten woodcuts of the Rosarium Philosophorum—as a metaphor for processes of integration and transformation in psychotherapy. Jung's examination of the Rosarium's woodcuts begins with the "Mercurial Fountain," in which unconscious elements first emerge. Then, it proceeds through the incestuous union of "King and Queen," the stark confrontation with the "Naked Truth," and the sense of disconnection and soullessness of the nigredo phase—which stretches over multiple woodcuts. Further transformations follow. The chapter reviews Jung's thoughts on the first ten of the Rosarium's images and includes some of his interpretations, in combination with Nathan Schwartz-Salant's ideas. In a nutshell, the Rosarium illustrates the undercurrents present in the consulting room when deeper change is poised to happen: projective identification is associated to rising vapors that cloud both cognitive and emotional consciousness; the conjunctio stage unites oppositional elements in a mutually created space that is neither wholly personal nor purely archetypal; the nigredo's despairing stillness precedes the soul's ascent to the heavens above and back to its transcendent source; and, finally, the soul's return and the birth of the hermaphrodite—who represents a shared "subtle body" among therapist and patient—indicate that no fewer than three selves have undergone change: the patient's, the therapist's, and their shared self. This process of individuation becomes more fully fleshed out in woodcuts Eleven through Twenty, which are not discussed by Jung. Here, Schwartz-Salant extends Jung's analysis.

Schwartz-Salant's commentary on the woodcuts enriches Jung's original work by translating each alchemical phase into interpersonal experiences observable in the consulting room. Schwartz-Salant introduces his concept of the "interactive field," an entity that depends upon therapist and patient but cannot be reduced to transference and countertransference phenomena. At the conjunctio stage, for example, Schwartz-Salant describes a Bionian "container-contained" quality. To access this domain, which appears to be located beyond space and time, both clinician and patient use imaginal sight—and enter a space where the need to live through their shared experience dominates over the inclination to interpret the emerging relational dynamics. During the succeeding nigredo, both participants feel despair and depression. This phase, albeit difficult, is equally necessary for the transformative forces of the archetypal process to become realized. Between Jung and Schwartz-Salant, certain interpretations of the Rosarium vary, but these differences pale in comparison to the wealth of ideas they agree upon.

The primary objective of this chapter is to combine Jung's analysis of the Rosarium with Schwartz-Salant's ideas of the "interactive field" between therapist and patient, the "space between" them, their shared "subtle body," and the therapy relationship as a "third entity." The notion of the therapy relationship representing a "third area" or "third thing" is of special relevance as it will enable the present study to connect Schwartz-Salant's ideas to the symbolic system of astrology—which is covered by the next chapter. In the larger

context of this thesis, chapter Four shows that the therapy relationship is best conceived as a living, emergent thing—and that it cannot be reduced to concepts such as the "alliance." What is instead required is a model that integrates the therapy relationship's intrinsic dynamism and archetypal depth. Nathan Schwartz-Salant's notion of the relationship representing a "third area" thus becomes the key reference point in the development of a novel tool to assess the therapy relationship in a qualitative sense.

2.3 Chapter Five: The Relationship in Astrology

Chapter Five represents the central methodological step within the present thesis: the proposition that the astrological concept of the "composite"—a symbolic chart representing a relationship as an entity in its own right—can serve as a conceptual basis for characterizing therapy relationships. The chapter builds upon Nathan Schwartz-Salant's idea of the therapy relationship as a dynamic "third area" or "third entity." This "third" emerges from the space between therapist and patient and entails an archetypal dimension that is not reducible to either participant or the sum of the two of them. While Schwartz-Salant's language is deeply rooted in the Jungian tradition, this chapter, by introducing the idea of the composite, adds a symbolic framework that can describe the relational field in a highly nuanced manner. The thesis decisively frames astrology, specifically psychological astrology, not as a belief system but as a symbolic system grounded in archetypal patterns. These patterns may then be adapted to characterize interpersonal relationships—including the therapy relationship. The chapter clarifies that the present study does not intend to advocate the practice of astrology or to determine the extent to which astrology correlates with empirical findings. Rather, the thesis considers astrology as a unified system of archetypal patterns—comparable to mythology or alchemy—that can offer clinicians a vocabulary for recognizing and articulating relational experiences with their patients.

By incorporating authors such as Liz Greene, Howard Sasportas, and Fritz Riemann, the chapter then outlines the foundational structure of psychological astrology—predominantly "planets," "signs," and "houses," with a focus on the descriptive potential of the 12 core archetypes featured in psychological astrology. For context, the chapter also includes Carl Jung's writings on astrology, synchronicity, and the archetypes. Although Jung rarely addresses astrology in his formal publications, the thesis demonstrates that he indeed sees it as a symbolic system—a system that reflects the same archetypal dynamics that he believes constitute the collective unconscious. Through the concept of synchronicity—meaningful coincidences that are not causally linked—Jung defines astrology as a mode of comprehension not informed by causal rationality. Rather, it exhibits striking similarities to alchemy. Jung's letters reveal his sustained interest in astrology as a symbolic system and—especially the more involving clinical cases—as a tool that can facilitate more substantial work with a patient. In Nathan Schwartz-Salant's opus, the author's mentions of astrology are comparably fewer in count. Although Schwartz-Salant refers to astrology multiple times, the context is largely that of his personal journey to psychotherapy. However, his concept of the "interactive field" parallels the astrological composite in several ways. Both concepts involve the notion that archetypal material will be brought to the fore—and that there is an autonomous influence on both therapist and patient. Schwartz-

Salant's many references to the numinous, imaginal sight, and to the field as a subtle body are highly compatible with the manner in which Liz Greene describes the composite: as an energy field with its own dynamics and of a unique, archetypal structure.

The chapter finally details the composite as a symbolic construct; technically, the composite chart is a horoscope based on the midpoints between the planetary placements of two natal charts. Crucially, it does not represent either person in the relationship, but the relationship per se as a third entity. The relationship is thus seen as something that is more than the sum of its parts and has its own identity, emotional needs, values, conflicts, defenses, aspirations, and potential areas of transformation. Greene describes this third entity as something that not only influences both individuals but also operates autonomously, drawing out individual themes, personal challenges, and one's potential for individuation and growth. Importantly, the composite is not constituted by what both participants bring to the relationship; instead, it emerges from the space between them. The obvious parallels between Greene's and Schwartz-Salant's thoughts are closely examined: Both authors refer to the field "between two people;" both emphasize that this space manifests dynamics that go beyond its participants; and both argue that the relationship itself has a developmental purpose. Just as Schwartz-Salant references Maria Prophetissa's axiom—"Out of the One comes the Two, out of the Two comes the Three, and out of the Three comes the Fourth as the One"—Greene notes that the composite as the "third" has a distinct nature and destiny. Much like a child born of two parents, the composite carries forward something unique, which in therapy may take the form of shared themes, transference patterns, or archetypal encounters. The composite does not predict success or failure but characterizes the qualitative atmosphere unfolding in the relational field. Toward the end of the chapter, the 12 most important archetypal principles found in psychological astrology are briefly introduced in preparation for their deployment in chapter Six. Greene's summaries of the planets' respective meaning will, in the next chapter, be used to develop a novel tool to characterize relationships. As Greene writes, the astrological Sun reflects purpose, the Moon emotional needs, Mercury communication style, Venus values, Mars will, Jupiter expansion, Saturn defense, Chiron vulnerability, Uranus innovation, Neptune idealism, and Pluto survival instincts. Each of these archetypal energies can manifest in the therapy relationship, colored by their respective signs and houses. The thesis makes a point of emphasizing the moral neutrality of these archetypes—none are inherently good or evil—and stresses that the composite does not evaluate a relationship in a quantitative sense but describes its qualitative nature. All of these aspects will be considered in the design of the study's new instrument. The astrological composite is a rich, structured, symbolic reference point that can inspire a new approach for describing therapy relationships. By treating the relationship as a third entity and by applying archetypal categories drawn from astrology, it becomes possible to make nuanced qualitative statements about the "interactive field," as discussed by Schwartz-Salant. This approach provides a descriptive framework that is infused with the timeless descriptive prowess of archetypal patterns—and that simultaneously acknowledges the complexity, uniqueness, and changeability of each therapy relationship.

2.4 Chapter Six: The FIRA Questionnaire

Chapter Six introduces the Fuente Interpersonal Relationship Assessment, or "FIRA" for short, a novel clinical tool designed to characterize the therapy relationship using descriptive principles that were derived from archetypal patterns. Unlike existing instruments that largely focus on assessing whether a particular therapy relationship is conducive to positive treatment outcome, the FIRA emphasizes the qualitative nature of the relational atmosphere itself. Based on the assumption that relational experience in psychotherapy is an emotionally complex and dynamic process, the FIRA seeks to assess the perceived "feel" of the therapy relationship as experienced by both patient and therapist. To this end, it presents a set of 12 archetypal clinical situations, each to be matched to one of 24 emotionally nuanced, archetypally informed descriptors. This design enables the FIRA to create a rich qualitative profile of the therapeutic encounter. The symbolic logic that is operative in the FIRA mirrors a core principle in psychological astrology: just as planets express themselves differently depending on the sign and house in which they are placed, so too can relational dynamics manifest in different form depending on the personality of those involved. This principle becomes evident once a distinct selection of relational situations is matched with archetypal patterns.

The FIRA enables therapists to become aware and reflect upon their own perceptions of the relationship. Also, it provides additional insight into the patient's experience of the atmosphere in the consulting room. In doing so, the FIRA attempts to increase the sense of mutual understanding in the therapy relationship and to facilitate the exploration of unconscious or confusing emotional dynamics that may otherwise remain below the surface. Differences between the therapist's and patient's FIRA responses are not viewed as problematic per se. Rather, such discrepancies are to be expected and can prove clinically useful as they can guide the exploration of such areas that may otherwise lead to misunderstanding or to a reenactment of past conflict. In cases where the FIRA questionnaire suggests that the therapy relationship has reminded patients of past trauma or unmet emotional needs, a discussion of the FIRA's results can help to bring these dire states to the surface and give them a voice. If therapist and patient use the FIRA to integrate previously neglected aspects of their rapport, it can lead to a feeling of containment and eventually to mutual development and growth. The FIRA not only uses archetypal patterns to characterize the qualitative nature of the therapeutic encounter. Its use also facilitates the transformational process illustrated in the alchemical principles depicted in the woodcuts of the Rosarium Philosophorum, which were discussed in the previous chapters.

The FIRA is particularly well fit for use in ongoing therapies, where therapist and patient have already established a sense of relational familiarity. Although not all 12 archetypal situations already have to have occurred in-session by the time the questionnaire is completed, the patient's capacity to imagine themselves within such scenarios becomes a diagnostic resource. This gets much easier once the patient has experienced being with the therapist often enough to have built a dependable rapport. Unlike most other tools that assess the therapy relationship, the FIRA's ambition is not to produce a single score that would predict treatment outcome. Instead, its questionnaires generate snapshots of

the emotional atmosphere in the consulting room, which are then mapped in a two-axes matrix. This matrix is a first indicator of how the patient's experience of the therapy relationship might differ from the therapist's. A deep dive into each of the 12 items and their responses then highlights any areas that are worth discussing—areas in which further integration of oppositional elements may be indicated, with the potential of personal development on both the patient's and therapist's side. The FIRA can help to pinpoint previously unarticulated emotions such as fear, unease, or frustration, employing the therapy relationship for the discovery, integration, and potential transformation of unresolved emotional content. Repeated use of the FIRA mirrors any deeper changes in the relationship that may have occurred and underlines the therapeutic work that has been achieved.

2.5 State of Research

The present study reviews several existing assessment tools that were designed to examine the quality of a therapy relationship, some of which are decades-old (e.g., Luborsky, 1984), while others are still fairly recent (e.g., McGuire-Snieckus et al, 2007. They are all united in chapter Three, and—in most cases—their genesis and history are appropriately discussed. Chapter Three also details the degree to which they, since their inception, have been referenced by other authors and put to clinical use.

The parts of the thesis that review Nathan Schwartz-Salant's extension of Carl Jung's alchemical studies find themselves in a different situation: Gary Tomkins's analysis of the Rosarium Philosophorum aside (Tomkins, n.d.), only few authors have made substantial contributions to this particular field in recent times. The comparison of the astrological composite with Schwartz-Salant's notion of the relationship seems to be novel. While more literature exists in the "in between" area of the esoteric and psychology-oriented domains, it does not qualify for use in scientific discourse. Even though this material could have been employed to extract structurally similar ideas or for the purpose of analysis, it could not be academically referenced. To the best of my knowledge, the use of astrological archetypes to characterize therapy relationships also breaks new ground. Therefore, it appears that the approach taken with the FIRA is indeed a pioneering effort in terms of its theoretical basis, methodology, and objective. The FIRA itself has thus far not been reviewed or otherwise referenced, as this thesis represents the tool's very introduction.

2.6 Goals and Methodology

The main ambition of this thesis is the initial publication of the FIRA. To that end, the study analyzes existing methods that examine the quality of the therapy relationship—which is the FIRA's primary use case. These alternative approaches, and their limitations, are taken as inspiration to propose a new method—and to find a fruitful definition of the therapy relationship. The latter is provided by the work of Nathan Schwartz-Salant. His notion of the human relationship is re-contextualized and expanded by the integration of the concept of the astrological composite—as understood by psychoanalyst and astrologer Liz Greene. The amalgam of these reference points is shown to be an apt springboard for the development of a new approach toward assessing the therapy relationship. This approach not only offers previously unexplored possibilities but also reinforces the central role of

the relationship itself—both for the integration and transformation of the patient's relational experience and for the therapist's. On the basis of this combination of ideas, the foundation for the FIRA questionnaire is established, which is presented in its first form in the present study. In terms of a detailed methodology of the present study, the Preview section as well as the core chapters Three to Six provide substantially more information. Essentially, the thesis represents a literary review in combination with the development of a novel tool to characterize the therapy relationship and to aid the therapeutic process.

3 The Therapy Relationship—And Its Characteristics

In this chapter, I will take a closer look at a factor that practically all psychotherapists consider a cornerstone of their work: the therapy relationship. The idea that the relationship between therapist and patient plays a major role in enabling transformational changes in the patient goes back to Sigmund Freud, who notes that "even the most brilliant results were liable to be suddenly wiped away if my personal relation with the patient was disturbed" (Freud, 1912, pg. 103). While Freud approaches the subject matter from a slightly negative vantage point—suggesting that problems in the rapport between analyst and patient will likely lead to a halt or even a reversal of previous therapeutic achievements—he clearly subscribes to the idea that the relationship is a pivotal enabling factor. Freud, after making the quoted remark, continues by explicitly expressing his deep concern about "the personal emotional relation between doctor and client."

3.1 Clinical Relevance of the Therapy Relationship

Not only psychoanalytic but also humanistic approaches to psychotherapy have long highlighted the importance of the relationship in the therapeutic process. In his book "A Way of Being," which was published as a successor to the acclaimed publication "On Becoming a Person," Carl Rogers extensively discusses the main criteria that need to be fulfilled for therapeutic work to unfold. He writes: "There are three conditions that must be present in order for a climate to be growth-promoting. These conditions apply whether we are speaking of the relationship between therapist and client, parent and child, leader and group, teacher and student, or administrator and staff" (Rogers, 1980, pg. 115). Rogers is taking a wide perspective here, but his statement also entails the fact that he thinks of the interaction between therapist and patient as a "relationship." Rogers continues by noting that the baseline criteria for individual growth apply "in any situation in which the development of the person is a goal. I have described these conditions in previous writings; I present here a brief summary from the point of view of psychotherapy, but the description applies to all of the foregoing relationships." I would like to point out that Rogers, with this thought, much like Freud, openly talks about psychotherapy being rooted in relational aspects between therapist and patient.

Rogers then proceeds to outline the three conditions he believes must be met to further personal growth. While he mentions that they apply to the therapeutic setting and beyond, I will be focusing on the former in the context of the present study. Rogers writes: "The first element could be called genuineness, realness, or congruence. The more the

therapist is himself or herself in the relationship, putting up no professional front or personal facade, the greater is the likelihood that the client will change and grow in a constructive manner" (Rogers, 1980, pg. 115). Two things are worth mentioning here. First, this notion perfectly explains Rogers's idea of congruence, which is sometimes misunderstood to mean the therapist being congruent with the patient. Personally, I find this occasional misunderstanding rather unfortunate because it suggests that there can, or should, be such a thing as a symbiotic rapport between therapist and patient. I have sometimes wondered if this particular misinterpretation of the term "congruence" may have less to do with Rogers's original idea and more with some therapists' inclination to subjugate themselves under their patients, going above and beyond the boundaries of healthy and adequate empathy. This concern is also mirrored by Young et al., when they examine common "therapist pitfalls" (Young et al., 2003, pg. 370-317). The reason I discuss this misunderstanding here is that I believe it to severely impact the therapy relationship, steering it into a direction precisely not conducive to the patient's personal growth. The Rogerian idea of congruence has less to do with achieving congruence with the patient and more with entering into the relationship as authentically as possible. Roger continues by stating that congruence "means that the therapist is openly being the feelings and attitudes that are flowing within at the moment. The term 'transparent' catches the flavor of this condition: the therapist makes himself or herself transparent to the client; the client can see right through what the therapist is in the relationship; the client experiences no holding back on the part of the therapist" (Rogers, 1980, pg. 115). This idea of the therapist being "transparent" is echoed by some contemporary psychoanalysts who tend to identify with the relational school. Claudia Luiz, for instance, has even coined the term "analytic transparency" as an updated version of Freud's concept of analytic neutrality (Luiz, 2020).

The second aspect I would like to emphasize is Rogers's repeated use of the term "relationship" to describe the therapeutic alliance—or something akin to what is today often called the "alliance." After talking about congruence as a key constituent in the therapeutic setting, Rogers goes on to mention "unconditional positive regard" for the patient, by which he means "acceptance," "caring," or "prizing" (Rogers, 1980, pg. 116). Whatever the patient happens to bring to the session, themselves and their ideas, beliefs, and feelings are fully welcomed. Rogers finally talks about "the third facilitative aspect of the relationship" being "empathic understanding," which he characterizes as follows: "This means that the therapist senses accurately the feelings and personal meanings that the client is experiencing and communicates this understanding to the client." On the basis of personal authenticity and unconditional acceptance of the patient on the therapist's side, empathic understanding enables the therapy relationship to reveal new aspects and hidden truths about the patient—first to the therapist by virtue of empathetic attention, and then eventually to the patient. Rogers notes that, when empathetic understanding functions best, "the therapist is so much inside the private world of the other that he or she can clarify not only the meanings of which the client is aware but even those just below the level of awareness. This kind of sensitive, active listening is exceedingly rare in our lives." I believe that not only is Rogers quite right in his assessment, which still holds true today, but also does he perfectly illustrate the essential role the therapy relationship tends to play in successful treatment scenarios.

So central is the therapy relationship to so many schools of thought in psychotherapy that practically all psychotherapeutic approaches have their own nuanced perspective on the subject. It would go beyond the scope of the present study to try to represent all relevant points of view, but I want to mention one more, namely that of Jeffrey Young, who chiefly conceived schema therapy and dramatically enriched the world of behavioral therapy by putting the therapy relationship at the center of his theories and of his therapeutic work. It is in fact thanks to the significance of Young's contribution to the field of contemporary psychotherapy that I have chosen to use the term "therapy relationship" rather than "therapeutic relationship" throughout this study. While Young's work features both terms seemingly interchangeably, the former is clearly dominant. There are subtle differences between the two terms, and I feel that "therapy relationship" is more immediate and makes the relationship less of a tool and more of a mutually shared space between two people who have a common objective. However, I should not that I personally do not take issue with Young's tendency to use the terms synonymously.

The relevance of the therapy relationship is a prominent topic in Young's work. In "Schema Therapy: A Practitioner's Guide" he and colleagues characterize its purpose as follows: "The therapist assesses and treats schemas, coping styles, and modes as they arise in the relationship. The therapist-patient relationship serves as a partial antidote to the patient's schemas" (Young et al., 2003, pg. 46). The authors go on to say that "two features of the therapy relationship are especially important elements of schema therapy: the therapeutic stance of empathic confrontation and the use of limited reparenting" (pg. 47). As they outline their concepts of empathic confrontation and limited reparenting, certain parallels to Carl Rogers's approach become evident; the idea of empathy combined with an authentic rapport and the notion of guiding the patient to emotions they cannot currently integrate is part of both conceptual systems. Young and colleagues write: "Empathic confrontation involves showing empathy for the patients' schemas when they arise toward the therapist, while showing patients that their reactions to the therapist are often distorted or dysfunctional in ways that reflect their schemas and coping styles." It is the potential manifest in the therapy relationship that, according to Young, enables not only empathic confrontation but also limited reparenting, which "involves supplying, within the appropriate bounds of the therapeutic relationship, what patients needed but did not receive from their parents in childhood."

The concept of limited reparenting is central to Young's psychotherapeutic stance, and the term "reparenting" suggests that whatever interactions may unfold over the course of a therapeutic engagement, they will have to be somewhat comparable to the formative nature of parental relationships—even if the reparenting achievable in the therapeutic context is "limited," as indicated by Young. While he sees schema therapy as an extension to traditional cognitive-behavioral therapeutic models, he also conveys that his techniques were originally tailored to be used with certain "patients with characterological problems" (Young et al., 2003, pg. 3). Now what does he mean by this description? Young writes: "These patients have a number of psychological attributes that distinguish them from straightforward Axis 1 cases and make them less suitable candidates for cognitive-behavioral treatment." The issue at hand with patients of this kind, explains Young, is that

"their motivations and approaches to therapy are complicated" because they will not "comply with the treatment protocol" of regular cognitive techniques. The affected patients show specific impairments in their introspective processes and are neither able to "access their cognitions and emotions and report them to the therapist" nor to "observe and record their thoughts and feelings." As a consequence, Young notes, these patients often appear "out of touch with their cognitions and emotions," engaging instead "in cognitive and affective avoidance" (pg. 4). This tendency is a significant stumbling block for any therapeutic progress. Within the field of cognitive-behavioral therapy, Young and his colleagues position schema therapy as an addition that is best fit for the treatment of patients with personality disorders. In this context, the therapy relationship is practically essential. However, Young personally sees schema therapy—as well as his emphasis on the "warmth" of the therapeutic encounter and the transformational potential of the therapy relationship—as a cornerstone to practically all of his clinical work. In a 2017 video interview, Young says: "I don't believe there are very many Axes 1 patients," referring to the supposedly large group of patients for whom schema therapy in principle was not developed. "In reality," he continues, "what we've learned is that the number of Axes 1 patients who don't have personality issues is very small" (Young, 2017, min. 21). When he and his colleagues were developing schema therapy, Young adds, "although we always wanted to know what the Axes 1 disorder was, I would always make it clear that it was a rare patient where you can work on Axes 1 without working on schemas and personality dimensions—because they intersected" (min 22). As a consequence, the relationship as a basis for therapeutic work is of paramount importance with almost every patient in Young's view.

3.2 The Terms "Therapy Relationship" and "Therapeutic Alliance"

The sheer relevance of the therapy relationship—almost irrespective of psychotherapeutic schools of thought—is further underlined by an extensive 2018 meta study undertaken by the University of Zürich's Christoph Flückiger and colleagues. The fundamental achievement of the study is the accumulation and evaluation of 295 independent research projects covering a total of more than 30,000 patients. As its conclusion, the meta study confirms "the robustness of the positive relation between the alliance and outcome" of the respective therapy (Flückiger et al., 2018, pg. 316). Because of its significance, the relationship between therapist and patient is one of the most well-researched aspects to psychotherapy. The study notes: "The accumulated volume of research on the alliance is impressive. It is certainly among the richest bodies of empirical research on psychotherapy process outcome" (pg. 333).

However, as indicated by this quote, Flückiger differentiates between the terms "therapeutic relationship" and "alliance"—a distinction not shared by all authors on the subject matter. Flückiger writes: "The term alliance (sometimes preceded by therapeutic, working, or helping) refers to the holistic collaborative aspects of the therapist–client relationship" (pg. 317). This suggests that the "alliance" is a core facet of the larger relationship but does not entail the same scope. However, the differentiation becomes less clear as Flückiger continues to mirror the genesis of the term. He states that "the theoretical

discourse on the collaborative aspects of the therapeutic relationship has been strongly impacted by the proposal that common, pantheoretical factors responsible for a significant part of the effectiveness of different therapeutic practices." Several psychoanalytic and psychotherapeutic authors are mentioned, among them Rogers, whose contribution to emphasizing the importance of the rapport between therapist and patient is described as "another positive influence on the development of work on the alliance." Flückiger finds that "Rogers's application of empirical methods to the investigation of the therapist's offered facilitative conditions (e.g., empathy, positive regard, genuineness, trustworthiness, etc.)" was "another positive influence. […] This body of work pioneered the methods of investigating relational variables rigorously." The previously made distinction between the therapy relationship and the alliance smears a little bit at this point because of the reference to Rogers, because Rogers spoke about the therapy "relationship." Any yet, the situation around the two terms get even more complicated.

With reference to Elizabeth Zetzel (1956) and Lester Luborsky (1976), Flückiger next discusses what he terms the "new" alliance (Flückiger et al, 2018, pg. 317). "The 'new' alliance concept," he and colleagues write, "emphasized the conscious aspects of the relationship (as opposed to unconscious processes) and the holistic achievement of collaborative 'working together' aspects of the relationship." Against this background, the therapeutic alliance is broken down into two phases, the first of which aims to establish "the client's belief in the therapist as a potent source of help provided through a warm, supporting, and caring relationship." This is then succeeded by the second phase, which has the target of reaching "the client's investment and faith in the therapeutic process itself, a commitment to some of the concepts undergirding the therapy (e.g., nature of the problem and value of the exploratory process), as well as a willing investment of her/himself to share ownership for the therapy process." This division into two phases illustrates some of the theoretical attempts made to specify the meaning of the term "alliance" and to compare and contrast it to that of the therapy "relationship." While these attempts to distinguish the therapy relationship from the therapeutic alliance seem logical at first, the actual use of the terms throughout current literature lacks the same precision and the consistency you may expect. Other authors—and this is especially evident with compendia—use the terms almost or completely interchangeably. One individual who has closely observed this tendency is Gina Di Malta, who finds that "The therapeutic relationship is a broad construct that has been labelled therapeutic alliance, working alliance, helping relationship, and helping alliance" (Di Malta, 2016, pg. 21). But the undifferentiated use of the terms goes beyond a mere re-labeling of one or the other. Di Malta adds that the "therapeutic alliance" is in fact "often used interchangeably with therapeutic relationship." Another set of problems arises from contextual inaccuracies. Much like Flückinger et al. in the earlier quote, several theorists and clinicians refer to thinkers such as Carl Rogers when discussing what would either be the "alliance" or the "relationship," whereas Rogers would exclusively use the latter term. I will provide two further examples of this issue. The first one is represented by Bruce Wampold's and Zac Imel's book "The Great Psychotherapy Debate: The Evidence for What Makes Psychotherapy Work." The second edition, released in 2015, includes what the authors call the "Contextual Model." By virtue of this inclusion, the therapy relationship comes more to the forefront of what makes

psychotherapy effective. Wampold writes: "In the first edition, evidence related to general effects was limited to a discussion of the therapeutic alliance. We have expanded this section to also include how placebos induce powerful expectations, as well as several other therapeutic factors hypothesized to be powerful in the Contextual Model" (Wampold & Imel, 2015, pg. ix). While I believe this shift from the first to the second edition of the publication to be a beneficial one, it also showcases certain terminological problems—in regard to whether it is the "alliance" or the "relationship" that is being examined. In their discussion of the contextual model, the authors refer to the "therapeutic relationship" in a manner similar to their use of the "alliance" (e.g., pgs. 46, 48, 49, 53, 55, 56, 80, & 170). On page 49 of their publication, they employ a combination of both terms when pointing to "interpersonal and social factors" that encompass "the therapeutic context and the therapeutic relationship (e.g., the working alliance)." Here, it is not quite clear if the alliance is part of the larger relationship or a representation thereof.

The interchangeable use of the two terms becomes more evident later in the publication. From page 53 onward, Wampold and Imel explain how an initial "therapeutic bond" ideally leads to the creation of a "real relationship." They describe the latter by stating that "the real relationship between the therapist and the client refers to the fact that in the therapy room, two humans are having an intimate emotional relationship" (pg. 55). In detailing the implications of the contextual model, they characterize the "psychotherapeutic relationship" as "an unusual social relationship" and pose the following important question: "Is this real relationship therapeutic? Or, is it simply an aspect of therapy that is superfluous—necessarily present but not therapeutic?" They immediately offer an answer to this question be referring to the contextual model, according to which "the real relationship will be therapeutic in and of itself, to some extent" (pg. 56). This use of the term "relationship" is however not consistent, as the next few quotes will demonstrate. Rather, the authors appear to have simply switched over to the term "alliance" without much reflection on this change. On page 178, they proclaim that "the alliance is a central construct in the Contextual Model" and "has long been theorized to be a pan-theoretical construct that is critical to the success of all treatments." One page later, they state: "The concept of the alliance between therapist and client originated in the psychoanalytic tradition and was conceptualized as the healthy, affectionate, and trusting feelings toward the therapist […]. Over the years, there has been much confusion about the theoretical bases of the alliance" (pg. 179). Overall, it seems that Wampold's and Imel's work, while influential and of immense scope, is maintaining a level of terminological ambiguity regarding the "relationship" and the "alliance."

The situation is similar in Muran's and Barber's compendium "The Therapeutic Alliance: An Evidence-Based Guide to Practice." In certain chapters, the respective authors explicitly differentiate between the two overlapping terms. On page 8, Robert Hatcher writes that the "alliance is a way to think about how the patient and therapist are working together. Alliance measures assess this working relationship." In his contribution, Hatcher strives to "clarify some nagging issues in clinical theory and research, such as whether alliance is part of the relationship in therapy, how alliance is related to technique, and, more broadly, whether it is still useful to think in alliance terms." He then shows how

certain schools of thought in psychotherapy subscribe to understanding the alliance as a "relationship component" (pg. 21) while others take a different stance. The first group, according to Hatcher, consists of "some clinicians and researchers" and prefers to "divide the relationship between the patient and the therapist into components, with alliance among them." The second group sees "alliance as relationship" and therefore as practically equal terms. Hatcher takes the view that "relational analysts have tended to dismiss the value of thinking in alliance terms. Their focus is on the relationship between patient and therapist, with full acknowledgment of the real mutual effects each has on the other. […] The view held by relational analysts is shared by a number of psychotherapy researchers as well." (pg. 20).

The terminological clarity exercised by Hatcher gets obscured in later chapters. In their contribution titled "The Therapeutic Alliance in Humanistic Psychotherapy," Jeanne Watson and Freda Kalogerakos discuss classic Rogerian axioms such as "unconditional positive regard" and "empathy" (pgs. 193) as well as "congruence" (pg. 194)—all of which suggest the use of the term "relationship" as a container in which these values and conditions can be realized. However, the authors use both terms synonymously. As early as in their introduction, they first mention that "the importance of therapeutic relationship has long been central to the writings of humanistic theorists and practitioners," but a few sentences later, they state that they intend to use their chapter to "briefly examine how the alliance is viewed within each of these approaches before exploring the empirical literature that has emerged to guide humanistic practitioners in their interactions with clients" (pg. 191). At this point, it becomes transparent that the terminological distinctions made by Hatcher are not sustained throughout the compendium. A later chapter by Adam Horvarth et al. is titled "Therapeutic Alliances in Couple Therapy: The Web of Relationships" (pg. 210) and looks at "relational dynamics" (pg. 213). I could provide more examples of terminological opacity or the synonymous use of "relationship" and "alliance," but I think that the overall picture is clear.

Going back to Flückiger's meta study, the interchangeable application of "therapy relationship" and "therapeutic alliance" in current literature—which effectively makes them both umbrella terms with little overarching precision—is a complicating factor that presents itself on the surface level of language. Another issue that permeates the study in a deeper sense becomes apparent when Flückiger et al. provide sample questions for the purpose of evaluating the therapeutic "alliance." They refer to "items such as 'I believe my therapist is genuinely concerned for my welfare,' 'We agree on what is important for me to work on,' and 'My therapist and I respect each other'" to indicate the kind of questions that could be utilized to assess the quality of the alliance (Flückinger et al., 2018, pg. 317. As we will later see, questions of this type are commonly asked to ascertain the quality of the "therapy relationship" by other authors—rather than that of the "alliance." This means that Flückiger's work exhibits a presence of terminological vagueness because of the very subject matter discussed, which is presented in several other contemporary works in an almost identical manner yet using different terminology.

For the purpose and aim of the present thesis, I will predominantly use the term "therapy relationship" to capture the rapport, the mutual presence, the emotional connection, the imaginal field, and moments of profound understanding between two people—including the therapeutic couple. I feel that the term "relationship" is richer in psychoanalytic and psychotherapeutic tradition than that of the "alliance" and is still very commonly used, especially in German literature via the term "Beziehung" (Hermer, 2008, pg. 11). At the same time, this paragraph alone showcases the difficulties of defining what constitutes a relationship. It may indeed be as impossible a task as Rainer Sachse suggests (Sachse, 2016, pg. 9). But I believe that most clinicians would agree that it is still vital to investigate what can indeed be said about the therapy relationship—for instance, by looking at specific relationships, one at a time, and by examining their unique characteristics. And to facilitate exactly that is the aim of the present thesis.

3.3 Established Means of Specifying Relational Qualities

We have now reached the point where we can focus on the following question: "What characterizes a relationship?" Or, in other words and to anchor the examination more firmly in psychotherapeutic discourse: "How can clinicians and patients best describe a specific therapy relationship?" With this study, I intend to present a novel way of characterizing the distinctive qualities of individual therapy relationships. However, before I commence to explore new terrain, it seems appropriate to review any currently existing methods that, in certain respects, share the same goal. As we will discover, many approaches have been put forward to discuss, even to measure, relational dimensions. We will also see that what different authors mean by the "quality" of a relationship varies. Some think of quality as something that can be rated on a scale ranging from "good" to "bad." Others understand the term to mean a description of "how" things are within the relationship. Among the latter group, there are those who have an explorative point of view: both the therapist and the patient are then asked to indicate how they feel about the relationship. But there are also those researchers who take a more diagnostic stance: in those cases, the patient's description of the therapeutic encounter is seen as a reflection of their personal—potentially disturbed—relational capacity and their attachment style. The following methods of specifying the quality of therapy relationships are merely a selection of the wide range of approaches and instruments that are currently available and in circulation. I have tried to make as sensible a selection as I could. Outlining them will later help to position my own efforts in the larger context of the state of research.

3.3.1 HAQ-1—Helping Alliance Questionnaire

The Helping Alliance Questionnaire was published in the form of two major versions, the HAQ-1 and HAQ-2. The HAQ-1 was first developed by Lester Luborsky in the 1970s and represents one of the first tools created to assess the quality of the therapy relationship. Luborsky, in many instances, prefers to use the term "alliance" rather than "relationship." More specifically, he tends to speak of the "helping alliance," which is "achieved through supportive techniques, in collaboration with the patient's readiness to experience the alliance." (Luborsky, 1984, pg. 21). However, the term "relationship" is also a frequent occurrence in this work. Luborsky defines the helping alliance, or the "supportive

relationship" (pg. 28), as the cooperative and trusting bond between therapist and patient, emphasizing the patient's perception of this relationship as critical to successful therapeutic outcomes.

The HAQ-1 is a 11-item questionnaire designed for the patient to complete (Luborsky, 1984, pgs. 239–240). It looks at different dimensions of the therapy relationship and its impact on therapeutic success. Each of the 11 items targets a key aspect of the therapeutic relationship. They aim to assess the patient's feelings about the emotional bond, collaboration, trust, and therapist's competence, providing a multidimensional view of the rapport. The patient is asked to provide answers in the form of rating the degree to which each of the items they feel apply to the therapy relationship, with the scale ranking from +3 to -3 and excluding zero as an option. Since the HAQ-1's inception, Luborsky has demonstrated its respectable predictive validity (Luborsky et al., 1983). This means that higher scores on the questionnaire tend to go hand-in-hand with better therapeutic outcomes, including symptom reduction and patient satisfaction. The HAQ's effectiveness was also confirmed by other clinicians, for instance, by a team of German healthcare professionals who found the HAQ to make reliable predictions of therapeutic success. The team's research findings include the impression that the HAQ was well accepted by both patients and therapists. They believe it to be an important asset that the questionnaire is fast to complete (Bassler et al., 1995, pg. 32).

To provide a better idea of the exact nature of the questionnaire, I will now discuss its contents in more detail (Luborsky, 1984, pgs. 239–240). The first item reads, "I believe the therapist is helping me," while the second directly addresses the therapy per se: "I believe that the treatment is helping me." The patient is then asked to reflect upon any new insights into their condition that they may have acquired on a cognitive level: "I have obtained some new understanding." The next item targets the patient's overall emotional state: "I have been feeling better recently." The fifth item assesses the extent to which the patient "can already see that I will eventually work out the problems I came to treatment for." Question Six looks into whether the patient feels they "can depend upon the therapist." The following item reads, "I feel that my therapist understands me," and intends to determine the patient's sense of being recognized and empathized with—a factor that Luborsky believes to be crucial for establishing an emotional bond in the relationship. The patient is then asked to gauge if "the therapist wants me to achieve my goals." Next, the questionnaire addresses whether the patient feels that they are "working with the therapist in a joint effort," followed by the statements, "I believe we have similar ideas about the nature of my problems," and, "I feel now that I can understand myself and deal with myself on my own (that is, even if the therapist and I were no longer meeting for treatment appointments)." What I personally find interesting is that Luborsky's items cover a wide spectrum of topics, from the idea of being able to depend on the therapist to a more intellectual understanding of agreed-upon targets. It is evident that, based on these items, not only the rapport between therapist and patient is examined but also the patient's perceived progress is taken into consideration. These 11 items are then complemented by two open questions and one final "overall" rating. The first open question, "I feel I improved in the following ways," gives the patient the opportunity to specify where they

believe to have made significant progress. The second, "I feel worse in the following ways," does the opposite. Finally, the patient is invited to "estimate" their "improvement so far" on a scale from one to five, with one being the worst and five the best therapeutic outcome. This grading system is a surprising design choice given that the 11 initial items employ a different rating mechanism.

3.3.2 HAQ-2—Helping Alliance Questionnaire (Revised)

The Helping Alliance Questionnaire, since its inception, underwent a significant revision by Luborsky and colleagues, which led to the eventual publication of the HAQ-2 (Luborsky et al., 1996). One of the HAQ-2's aims was to further improve the original tool's reliability and validity and to adapt it to modern psychometric standards. Two particularly obvious changes are the modification of the introductory text that addresses and instructs the patient, as well as that of the scale, which abandons the somewhat awkward +3 to -3 system and simply implements a scale from one to six. Of the HAQ-1's original 11 items, only five have survived. The focus is now more strongly on the relationship and less on the outcome of the therapy. It also includes a direct question about the quality of the relationship: "A good relationship has formed with my therapist." In stark contrast to the HAQ-1, the revision also incorporates negative statements about the clinician's attitude and competence. Item Four reads: "At times I distrust the therapist's judgement," and item Eight questions whether "The procedures used in my therapy are not well suited to my goals." Item 16 and 19 complete the negatively worded questions. Item 16 states, "The therapist and I sometimes have unprofitable exchanges," while item 19 proclaims that "At times the therapist seems distant." An interesting aspect is the slight ambiguity of item 17, which could be perceived as either a positive or negative statement: "From time to time, we both talk about the same important events in my past." In stark contrast to the original questionnaire, all open questions have been omitted, allowing for a more straightforward scoring and benchmarking of results.

Arguably the most dramatic change is the addition of a "therapist version" of the questionnaire, in which the clinician is also given 19 items to rate. Remarkably, the answers provided by the therapist are not geared to reflect their own feelings about the relationship with the patient. Rather, the therapist takes educated guesses about how the patient may be feeling about their rapport and concerning their therapeutic progress. I think that this orientation is likely due to Luborsky's psychoanalytic background, where what a patient is capable of seeing and experiencing in a relationship is diagnostically relevant and informs what goals should be established to increase the patient's relational and introspective capacity. Still, the unevenness of the set of items for the patient and the therapist is striking, for instance, when examining item One: "The patient feels he/she can depend upon me." Item Nine goes into a similar direction: "The patient likes me as a person." The questionnaire's tendency to have the therapist guess what the patient's stance may be is at its most extreme with item 11, which sounds convoluted as a result: "The patient believes I relate to him/her in ways that slow up the progress of the therapy." However, and perhaps unexpectedly considering the items I just mentioned, there is the occasional question that does examine the therapist's own impressions. Question Six reads: "I believe we have similar ideas about the nature of his/her problems." Item 14 enters the same

territory: “I want very much for the patient to work out his/her problems.” But the bottom line is that the majority of the HAQ-2’s questions for the therapist are architected to investigate the patient’s emotions rather than their own. Overall, while the therapist’s version of the HAQ-2 may have certain controversial aspects, I believe its inclusion is undeniably a positive development.

Having now reviewed both the HAQ-1 and HAQ-2, I would like to point out an aspect that is a consistently prominent feature—namely, the goal-oriented focus of the two tools. Whiles the HAQ-2’s questionnaires do examine to what extent the patient feels safe and understood in the relationship, no less than six items openly or discreetly refer to therapeutic progress. Terms and phrases such as “goals,” “joint effort,” “slow up the progress,” “work out my problems,” and “unprofitable” indicate that a large part of the questionnaire puts its focus on the patient’s perceived effectiveness of the therapy. The reason I am highlighting this point is not because I am taking issue with it. But I do think that, by putting so much emphasis on the therapy’s outcome, the questionnaire loses some of the richness that more well-rounded questions could provide; questions that capture additional quality dimensions attributable to the therapy relationship. The immediacy of the relationship can get out of sight when the patient’s—or, equally, the therapist’s—attention is drawn to a future scenario in which the “here and now” aspects of the relationship are no longer present. When studying the HAQ-1 or HAQ-2, a person not familiar with the idea of modern psychoanalysis or psychotherapy might conclude that the sole purpose of the therapy relationship is to move the patient closer to a set of predefined goals. It is my impression that this strong emphasis on outcome conflicts with elements of many schools of thought in psychoanalysis and psychotherapy, including those that I subscribe to. The therapy relationship, in my view, goes beyond the primary purpose of therapeutic success.

3.3.3 WAI—Working Alliance Inventory

The Working Alliance Inventory was chiefly authored by Adam Horvath based on Edward Bordin’s concept of the “working alliance” in psychoanalysis and psychotherapy (Bordin, 1979). The WAI has a major advantage over other means of assessing the therapy relationship: its questionnaires are freely available on Horvath’s website at wai.profhorvath.com. Horvath hosts three different versions, a longer 36- and two 12-item variants, each of which entails a printable item list for patient and therapist. In addition to that, Horvath provides a version for an “observer” of the therapy relationship as well as screening materials for couples. For the purpose of the present study, I will concentrate on those questionnaires that have been tailored to determine the quality of the patient-therapist relationship.

The original 36-item questionnaire is one of the most widely used tools to ascertain the quality of the therapy relationship aside from the HAQ (Wilmers et al., 2018; Flückiger et al., 2019). The version for the patient asks them to mirror the “ways you might have thought or felt about your therapist.” In contrast to the HAQ, the WAI uses placeholder fields that the patient is supposed to complete by adding the therapist’s name. Another aspect in which the WAI differs from the HAQ is the heavy reliance on items that have been worded in a negative way, meaning that they suggest that the therapy relationship

is troubled. While the original HAQ exclusively employed positive attributes that were to be rated, 14 of 36 of the WAI's items imply bad sentiment, starting as early as with the first item: "I felt uncomfortable with …" Other questions that—in my own judgement—have negative implications are items 3, 7, 9, 10, 11, 12, 15, 20, 27, 29, 31, 33, and 34. They inquire, for instance, whether the patient was "worried about the outcome of the sessions," found what they were "doing in therapy confusing," "disagreed" with the therapist about their aims, felt the therapist "was not totally honest," and were asked to do "things" by the therapist that "did not make sense." While I do think that it makes sense for a questionnaire designed to assess the therapy relationship to be conscious of any potential pitfalls or shortcomings, I wonder if the inclusion of so many negative items is necessary. Personally, I feel that some of them may even have a suggestive quality to them, prompting the patient to feel slightly paranoid and to see the therapy relationship in a more pessimistic light than adequate. However, one could argue that, if the relationship is sound, the introduction of potential negative viewpoints will not change the fundamental perception of it. At any rate, the WAI is certainly unique in this regard.

There is another characteristic of the WAI that I would like to point out, which becomes particularly evident in the more positively worded questions. In this respect, the WAI does not differ significantly from the HAQ: its items are highly goal-oriented with a strong focus on the therapy's outcome and on successful symptom reduction. In the case of Horvath's work, this is a deliberate choice—in the sense that he distinguishes between items tailored to look at the dimensions "goal," "task," and "bond." This is due to Horvath's attempt to base his item lists on Bordin's theoretical ideas and clinical insights (Horvath, n.d.). As a result, the subjective quality aspects of the relationship become less relevant overall. Item Two examines whether the patient and their therapist "agreed about the things I will need to do in therapy to help improve my situation." Item Six inquires if the therapist "perceived accurately what my goals were." Item 14 bluntly reads: "The goals of the sessions were important for me," which is later echoed by question 22, suggesting that the therapist "and I were working towards mutually agreed upon goals," and 30, the therapist "and I collaborated on setting goals for my therapy." Clearly, therapy should be a catalyst for change as well as for personal development and growth, but the heavy emphasis on explicit goals made by the WAI arguably shifts its direction further into a disbalance rather than moving toward a more holistic perspective on the therapy relationship.

Of course, the WAI also includes items that I would consider "neutral"—exhibiting neither a negative nor a strictly goal-oriented characteristic. The patient is asked if they feel understood or liked by the therapist, about the clarity of responsibilities, the subjective importance of the sessions in the patient's life, respect and concern from the therapist, and the existence of mutual trust. These are clearly important dimensions of the therapy relationship. I would like to conclude my review of the WAI by highlighting two questions that seem to investigate a patient's potential dependence, anxiety, or self-respect issues directed toward the therapist. Question 28 reads: "I had the feeling that if I said or did the wrong things," the therapist "would stop working with me." The final item similarly assesses if the therapist "cared about me even when I did things that he/she did not approve of." These, to me, are among the most striking of the WAI's questions because they source

information about the relational quality between therapist and patient in a crucial yet very specific aspect of their rapport. But what is also evident is the absence of other personality dimensions in the WAI. I believe that if one attempted to associate the beforementioned items with a matched selection of Jeffrey Young's schemas, it would become transparent that only a very limited scope of relational themes were captured by the WAI. Many schemas would not find themselves represented in the WAI questionnaire.

Coming to the therapist version of the WAI, it is again dramatically different from the HAQ, but in a manner that I would consider positive. Rather than asking the clinician to estimate what the patient may be experiencing, it is now their own feelings and impressions that count. For instance, instead of asking the therapist if the patient felt understood by them, the WAI uses the item, the patient "and I understood each other." The consequence of this approach is that the patient's and the therapist's perspectives are standing on an equal grounds. I don't necessarily think that this design is "better," since almost all therapies involve elements that introduce a disbalance between the two parties—such as the diagnosis per se or the inclusion of interpretation as a technique. But if I had to choose between the HAQ and the WAI in solely this regard, I would be inclined to regard the WAI as superior.

3.3.4 WAI-S & WAI-SR—Working Alliance Inventory (Short & Short Rev.)

Over time, two different 12-item versions of the WAI have been developed. They, too, are available on Adam Horvath's website (Horvath, n.d.; Wilmers et al, 2008, pg. 343). Prior to their publication, research done by Horvath and colleagues had suggested that 12 items constituted the "minimal length for a stable internal structure for the inventory" (Horvath, n.d.). Horvath's comments on the creation of what is now called the "Short Form" and the "Short Revised" suggest that items used in the first iteration of the 12-item HAQ were not evenly distributed over the three dimensions "bond," "tasks," and "goals," as originally envisaged by Horvath based on Bordin's work (Horvath et al., 1986; Bordin, 1979). Horvath then adjusted the questionnaire to achieve a balance between dimensions, with the result being the "Short Form," or just "Short." The 2006 "Short Revised" questionnaire was developed separately and is viewed by Horvath as "a significantly superior instrument as contrasted to the older" version. It also encompasses a therapist version. I will now briefly discuss the item lists of both the Short (WAI-S) and the Short Revised (WAI-SR) variants of the WAI.

The WAI-S, much like the original WAI, features placeholder fields in which the patient can insert the therapist's name. All but three items include such a placeholder. Item Three, for instance, reads: "I believe … likes me." The WAI-S questionnaire differs from the original in several ways—and not only in a 66 percent reduction in items. The number of negatively worded items have been dramatically reduced—to only two. Whereas almost 38.8 percent of the WAI's items were phrased negatively, with the WAI-S, it is only 16.6 percent. The two items in question focus on more cognitive aspects of the therapy, namely, whether the therapist understands what the patient is trying to accomplish in therapy and whether they have different ideas of what the patient's problems are. My impression is also that the overall "feel" of the questionnaire is less goal-oriented, even if Horvath claims

to have tweaked its items to include the dimensions "Goals" and "Task" just as much as "Bond." The word "goals" appears in only one item. The idea of change being the aim of the therapy is however still present. The idea of personal change being the purpose of therapy as well as the notion that recognizing and working on the patient's "problem" is a core objective are very present. The scale employed in the WAI-S is a 7-point Likert type which the middle value equaling a neutral position called "Sometimes."

The WAI-SR has been architected differently from the WAI-S, and by different contributors (Hatcher & Gillaspy, 2006). As of 2025, it is in widespread use and has provided the basis for several clinical studies and evaluations (e.g., Falkenström et al., 2015; Wilmers et al., 2008). In definite contrast to the original WAI, its questionnaire no longer contains any negatively worded items—making it comparable to the original HAQ in this regard. Eight of the patient-version questionnaire's 12 items utilize a placeholder field for the therapist's name, making this approach consistent among all major WAI variants. The individual questions are either taken from the WAI or have been derived from it, with items 1, 2, 10, and 12 belonging to the "Tasks" dimension, items 4, 6, 8, and 11 to "Goals," and items 3, 5, 7, and 9 to "Bond." Overall, the WAI-SR's questions are geared toward evaluating the extent to which therapeutic progress is made more so than those of the WAI-S. A simple way of highlighting this change is to point out that the words "goal" and "problem" are now each used twice, with the word "change" even appearing three times. Again, I do think that change and the patient's desire to improve are cornerstones in psychotherapeutic practice, but a constant highlighting of therapeutic progress will lead to an only rudimentary idea of the nature of the specific therapy relationship at the center of the process. The WAI-SR uses a 5-point scale, with the middle position referring to "Fairly Often," which I would argue does not represent a neutral value. Whereas the WAI-S offers a "Never" option, the WAI-SR starts with "Seldom" as the lowest score.

One of the WAI-SR's strengths is the existence of a therapist version of the questionnaire. Its items are almost identical to the patient version, only that the roles have been reversed. Some questions ask the therapist to guess the patient's thoughts and feelings, while others look at the therapist's own emotions and reactions to the patient. One typical question for the therapist providing an assessment of the patient's condition is the first item: "As a result of these sessions … is clearer as to how he/she might be able to change." An example for the therapist revealing their own feelings is question Seven: "I appreciate … as a person." It seems to me that the WAI-SR achieves an adequate balance between inviting the therapist to include moments of introspection and asking them to share their observations about the patient. There is only one item in the therapist's questionnaire that does not represent a reversal of the respective item in the patient version. Question Two—addressed to the patient—asks them to gauge, "What I am doing in therapy gives me new ways of looking at my problem." This is completely rephrased for the therapist version with the following item being the result: the patient "and I both feel confident about the usefulness of our current activity in therapy." I would like to conclude my review of the WAI variants by briefly discussing the issue of which of the two 12-item variants is preferrable. To Horvath, the WAI-SR is clearly superior. And indeed, the existence of a therapist version alone is a major advantage of that variant. However, I do think that

the design of the WAI-S's scale reveals a shortcoming of the later WAI-SR, namely, the lack of a "Never" option. Personally, I think that the WAI-SR is the more refined on the two alternatives while the WAI-S provides a somewhat more nuanced idea of the rapport between therapist and patient—in the sense that it is not only the outcome of the therapy that is examined but also the nature of the human connection in effect.

3.3.5 ARM—Agnew Relationship Measure

Before I outline the characteristics and the ambition of the Agnew Relationship Measure (Agnew, 1996) by discussing the items of its questionnaires, it is worth mentioning that one of the main papers on the ARM, chiefly authored by Roxane Agnew-Davies, uses the term "client-therapist alliance" to identify what the ARM was design to capture and rate (Agnew et al., 1998, pg. 155). This is yet another instance where the terms "relationship" and "alliance" are used interchangeably, which represents an issue that was discussed at greater length earlier in the present study. I however do not believe that the resulting overlap between the two terms diminish the value of Agnew-Davies's work or of the ARM more generally.

Agnew-Davies's study is based on "five therapists and 95 clients" (pg. 157.) The ARM instrument was employed to assess the quality of the various therapy relationships among this substantial group of people. The author states that the study "rated their relationship following 1120 psychotherapy sessions." What makes the ARM unique is the use of five dimensions, which should—in theory—generate a more well-rounded picture than, for instance, the WAI with its three dimensions. This comparison can be extended: gone are the categories "Goals" and "Tasks" featured so prominently in the WAI. The only dimension the WAI and ARM have in common is that of "Bond." In addition to "Bond," the ARM relies on "Partnership," "Confidence," "Openness," and "Client Initiative." Upon closer examination, it permeates that the WAI's "Goals" and "Tasks" dimensions are partially represented by, for example, the ARM's "Partnership" category. Agnew Davies writes that the ARM aims to realize a "synthesis" that "incorporates affective elements (e.g. bond), working or task elements (e.g. agreement on tasks and goals), social influence elements (e.g. competence, attractiveness, and trustworthiness), and elements of interpersonal initiative and power." As a result, many achievements by prior attempts to make the therapy relationship systematically measurable are arguably retained. Agnew-Davies underlines this benefit by mentioning that she and the team "sought to examine the structure of the alliance domains covered by previous instruments, but we did this within a single measure."

The domain "Bond" contributes six items to the ARM's 28-item questionnaire. It "concern[s] the friendliness, acceptance, understanding, and support in the relationship" (pg. 160). The "Partnership" dimension makes up four items, which focus on "working jointly on therapeutic tasks." The next category, "Confidence," introduces seven items to the questionnaire and assesses "concern optimism and respect for the therapist's professional competence" (pg. 162). Here, it is important to note that the therapist's version of the questionnaire—the existence of which is one the ARM's advantages—deviates from the version for the patient. The therapist is asked to estimate what the patient's sentiment

might be regarding certain aspects of the therapy relationship: "On the therapist's form these items concerned the therapist's perception of the client's confidence." Over the course of executing the study, Agnew-Davis found that this dimension tends to score quite differently between the two parties. She notes that "These items all loaded highly […] in the analysis of client ratings (as did items of the bond and partnership scales […]) but were separate […] in the analysis of therapist ratings […]. Perhaps clients consider professional competence as integral to the emotional bond, whereas therapists consider the bond and their own competence as separate issues" (pg. 163). The "Openness" dimension adds five items to the questionnaire and looks at "the clients' felt freedom to disclose personal concerns without fear or embarrassment." Finally, the dimension "Client Initiative" and its four items examine "the client's taking responsibility for the direction of the therapy." Agnew-Davies also reports that she and colleagues chose to exclude two of the ARM's original items due to an unexpectedly wide range of how they were being interpreted by patients and therapists. She writes: "Item 18 comprised a single-item component for clients but was linked with the confidence component for therapists; item 28 was linked with item 11 for clients but with the partnership component for therapists." These deviations, she beliefs, could have led to problems with the eventual scoring of the respective relationships: "We considered that if these items have substantially divergent meanings from the two perspectives, then their inclusion in parallel client and therapist forms of a scale would make results difficult to interpret." Indeed, looking at item 18, its removal seems understandable. On the patient's side, this item reads, "My therapist is a persuasive person;" on the therapist's side, "I feel I am a persuasive person" (pg. 172). The exact—or even approximate—meaning of this wording remains obscure. Is persuasiveness an asset or a character flaw in a therapist? It seems to me that different clinicians will have different perspectives on this topic. The omission of item 28 in the study is more complex in its reasoning; the item reads very similar to respective items in other questionnaires that look at the distribution of responsibilities in the therapy relationship: We "are clear about our roles and responsibilities when we meet."

While most items are worded as positive attributions or statements, eight out of the 28 do apply negative reasoning—and, as mirrored by Agnew-Davies, have been intentionally architected as "reversed" questions (e.g., pg. 163). In my view, it is not only the wording of these items that openly demonstrates the ARM's primary weakness. While the overall intention of the assessment is to "rate" or benchmark the quality of a therapy relationship on a scale ranging from "bad" to "good," many of its items provide very intrinsic information on how the patient perceives the therapist. In other words, "quality" in a descriptive sense—"how"—is converted into "quality" in a numerical or statistical sense—"how much." The information provided by the patient will depend on their character traits, attachment style, relational pattern, and life experience. However, the ARM then aims to convert these nuances into something that is quantifiable. Item Four, "I take the lead when I'm with my therapist," undoubtedly illustrates how the patient feels they engage in the therapeutic encounter, but, provided that their self-assessment is correct, it this then a positive factor in therapeutic progress? Item 23, "My therapist expects me to take responsibility rather than be dependent on him/her," and item 25, "I take the lead and my therapist expects it of me," are strikingly similar and exposes the same problem. These items

all belong to the "Client Initiative" dimension, and while Agnew-Davis provides an explanation for their similarities (pg. 163), I personally doubt that their results should be interpreted in the form of one common rating that can indicate if a therapy relationship is resting on solid grounds. To provide another example of an item that may reflect a patient's character, or their issues, more so than serve as an indicator of the therapy relationship's quality, question 22 uses the wording: "My therapist seems bored or impatient with me." One could imagine a patient who experienced severe neglect early in their life to be reenacting it in the therapy relationship. In such a case, it would clearly influence the therapy relationship, but would it do so solely in a negative manner? In other words, is the reenactment of trauma not an essential step in the treatment of a certain group of patients? Item 14 could be a description of severe misalignment between therapist and patient, but it may also be reflective of a paranoid-schizoid patient's distorted view of the therapy relationship: "My therapist tries to influence me in ways that are not beneficial to me." While I think that the ARM, by implementing five dimensions rather than three, has a conceptional advantage over other means of measuring the quality of the therapy relationship, it also seems to me that several of its items could be refined to be less dependent on a patient's condition and character traits.

The fact that the ARM provides a therapist version of the questionnaire can be viewed as a benefit. But the inconsistency and unclear intentionality of certain items found in the patient version are equally present in the items directed to the therapist. Furthermore, while some items are looking for introspection on the therapist's side, others ask them to guess what the patient may be experiencing. Still others inquire about therapeutic aspects shared by both parties. As a consequence, 11 of the 28 therapist's items have been written in the first person singular. Question 19, for example, reads: "I feel supportive," and intends to match, "My therapist is supportive," on the patient's end. Five items use the first person plural and capture what the therapist thinks they and the patient achieve together: "My client and I are willing to work hard together," is an item representative of this design. Lastly, 12 items are apparently meant to yield objective statements about the patient, for instance, item Six: "My client has confidence in me and my techniques." I think that, with the ARM-28, the bottom line is that its benefits are somewhat outnumbered by its shortcomings. Agnew-Davis arrives at a more positive conclusion, by not by much. In her study's final remarks, she admits to "the generality of our findings," calls them "limited," and acknowledges that other means of capturing the quality of the therapy relationship may not be subpar to the ARM: "Is the ARM stronger than previous measures? On grounds of its structure, we think it is, albeit not so dramatically as we had hoped" (pg. 168).

The ARM is not only available in its original, 28-item, form. Two shorter variants have been developed over time—namely, the ARM-12 and the ARM-5 (Cahill et al., 2012). There is also an "mARM" version, which uses 25 items. With the "m" standing for "mobile," this variant exists in both English and German and was created to assess a patient's interactions with therapeutic smartphone applications (von Wulffen et al, 2023). Cahill et al. describe the process of reducing the length of the 28-item questionnaire as follows: "For the ARM-12, results of previous research were used together with conceptual considerations" Cahill et al., 2012, pg. 1). The authors then chose items they felt would best

represent the ARM's different dimensions. However, they appear to have dropped the "Client Initiative" category, and only mention "Bond, Partnership, Confidence, and Openness," detailing that the ARM-12 uses three items from each of these four dimensions. For the even shorter ARM-5, "item-analytic principles were used to select five items to represent overall alliance." It was important to Cahill et al. to produce not only patient but also therapist versions for all ARM variants. They point out that "client and therapist versions were constructed to contain parallel items," aiming to avoid any mismatch and to facilitate simple scoring. As for the significance of the results generated by the ARM-12 and ARM-5, the authors mention the involvement of three studies: "We drew data to assess reliability and validity from three UK trials of brief therapy for depression. Results indicated that the two short ARMs have acceptable psychometric properties and that they converged with each other and with the full ARM." A closer look at the ARM-5 reveals that its five questions include only one negatively worded item and that the patient's confidence in the therapeutic process is a dominant theme, with two items dedicated to it.

3.3.6 RDFS—Relational Depth Frequency Scale

The Relational Depth Frequency Scale is the brainchild of Gina Di Malta and was developed to measure "the quality of contact two persons may experience when one embodies Rogers's person-centered core conditions of empathy, congruence, and unconditional positive regard" (Di Malta, 2016, pg. 10). This is, to many schools of thought in psychotherapy, an important aspect of the therapy relationship—first and foremost to therapists using a relational approach, as indicated by Di Malta's reference to Carl Rogers, which she repeats throughout her work. In the study documenting the creation of the RDFS, Di Malta writes: "Relational depth can be considered an aspect of the therapeutic relationship and originates in the person-centred tradition" (pg. 21). To better characterize what she means by "relational depth," Di Malta proposes the terms "realness, presence, mutuality, client openness and […] a lasting experience of interconnectedness" (pg. 11). While, to Di Malta, relational depth is of immense relevance in therapeutic practice, it should not be viewed as the sole criterion of what elevates a therapeutic rapport. Rather, it is "a component of the therapeutic relationship." One of the assets of Di Malta's contribution is her level of self-disclosure, in which she reports on how she arrived at the subject matter that she would dedicate years of her life to. Di Malta states that her "first interest in relational depth came along with the discovery of a transpersonal dimension in me. I believed these moments of connection were instants of clarity where humans could feel connected to something beyond them" (pg. 138). Perhaps unsurprisingly, one person who played a major role in her story is the beforementioned Carl Rogers, as Di Malta's openness to the transpersonal found a correlation in certain aspects of Roger's theories. In "A Way of Being," Rogers expresses that he regularly encounters a "transcendent phenomenon" in his therapeutic work. He finds that "When I am at my best, as a group facilitator or as a therapist, I discover another characteristic. I find that when I am closest to my inner, intuitive self, when I am somehow in touch with the unknown in me, when perhaps I am in a slightly altered state of consciousness, then whatever I do seems to be full of healing" (Rogers, 1980, pg. 129). Rogers adds that, if these conditions are met, "simply my presence is releasing and helpful to the other." But how is this of relevance for the therapy relationship? Rogers believes that while he may act "in strange and impulsive ways in the relationship"

when in this state, "these strange behaviors turn out to be right, in some odd way: it seems that my inner spirit has reached out and touched the inner spirit of the other." This, then, is of immense consequence to the quality and potential of the therapeutic encounter: "Our relationship transcends itself and becomes a part of something larger. Profound growth and healing and energy are present," writes Rogers. His notion that the therapy relationship is a place that can work as a container or a springboard for experiencing a transcendent interpersonal dimension is echoed by Di Malta in several ways. First, the questionnaire Di Malta created as part of her study features items that can be associated with the idea of being in search of the transcendent in the therapy relationship. Item 16, for instance, reads: "I experienced a meeting that was beyond words" (Di Malta, 2016, pg. 164), referring to a patient's therapy sessions. Second, later in her study, when discussing her findings, she proposes that people who tend more toward regarding spirituality a part of their lives will more readily open up to relationships of greater depth, and possibly to what Carl Jung called the encounter of the numinous (e.g., Jung, 1960, pgs. 159–234). Di Malta states: "One factor associated with higher relational depth frequency was being 'spiritual' (but not religious), as opposed to 'atheist'. This may suggest that spiritual individuals who are not affiliated to a religious group could more readily ascribe a relational quality to their numinous experience" (Di Malta, 2016, pg. 141).

I think that even at this early stage of my review of the Relational Depth Frequency Scale, it is evident that its author aims to capture a facet of the therapy relationship less represented by other means of evaluating the rapport—such as the alternative measuring tools discussed in the present study. However, Di Malta still believes that one of the purposes of using her rating method is to predict therapeutic success. Of course, both patient and therapist would first have to complete their respective versions of the questionnaire, each of which consists of 20 items. In doing so, "a person taking the scale would subjectively estimate the number of occurrences they have experienced relational depth moments over the course of therapy as a unit of time" (pg. 13). Both questionnaires are then scored, with a higher number suggesting greater "overall relational depth" (pg. 162), as Di Malta believes: "the Relational Depth Frequency Scale is relevant in terms of therapeutic outcome and may have implications for psychotherapy practice" (pg. 16). More precisely, she is of the opinion that "One of its uses […] is looking at the impact of frequency of relational depth on outcomes" of therapies. (pg. 135). While the RDFS is arguably less well-rounded that the HAQ, WAI, or ARM, its primary use case is similar if not identical.

One thing the RDFS has in common with the original version of the HAQ or the WAI-SR is that its questionnaires exclusively rely on positively worded items. There is not a single question that reflects open criticism of the therapy relationship—and, as a consequence, no item needs to be scored in "reversed" form. While I think that certainly the WAI-SR, if not also the initial HAQ, benefit from this approach, I am less sure if this is the case with the RDFS, as well. Personally, I almost feel bombarded by the sheer amount of overwhelmingly confident statements about the therapy relationship, but this impression could also be regarded as a somewhat cynical position. I will soon provide examples. Another unique aspect of the two RDFS questionnaires it that they are virtually identical, deviating from one another only in the introductory text. All 20 items of the therapist's questionnaire are

carbon copies of those directed toward the patient. Item One, for both parties, reads, "I experienced an intense connection with him/her," with item Two inquiring if the person "experienced a very profound engagement with" their counterpart (Di Malta, 2016, pg. 165). Later items probe for the regular occurrence of "true mutuality," a deep connection, acceptance, a "clarity of perception," "overall warmth," the feeling of being "intensely present," immersion "in the present moment," a "deep understanding," a "shared experience," deep trust, a connection "on a human level," a "deep sense of encounter," the beforementioned "meeting beyond words," moments in which patient and therapist were "really close to each other," a sense of true acknowledgement, and complete openness (pgs. 165–166). The items of the RDFS, especially when compared to those used by other rating instruments, highlight the fact that the theoretical foundation of the tool is deeply associated with the principles of humanistic psychotherapy.

One of the RDFS's strengths is that one particular side of the therapy relationship, that of perceived depth, is examined at great detail. Another advantage is the level of transparency provided by its author as to how the tool was developed. The RDFS and its creation were part of Di Malta's doctoral work, and not only does she offer valuable insights into the selection process of the questionnaire's 20 items (pgs. 168–170) but also shares with the reader her doubts, fears, and challenges over the course of the study's long execution time (e.g., pg. 138). Lastly, Di Malta has made available a rich theoretical framework for the RDFS, which includes numerous references to philosophers as well as to thinkers in the domains of psychoanalysis, psychotherapy, and beyond. One example of this conceptual wealth is her deliberation of the difference between the idea of time as something chronological or as something structured by moments of meaning (pg. 13). She then spins this thought further and proposes that the repeated encounter of "significant moments," in which one may experience relational depth, should be made visible and emphasized in the therapy relationship—for instance, via the application of the RDFS. However, in spite of the RDFS's benefits, it is so firmly rooted in humanistic convictions and in the legacy of Carl Rogers that its nature is slightly mono-dimensional as a result, particularly when compared to other tools such as the WAI-SR or the STAR.

3.3.7 STAR—Scale to Assess the Therapeutic Relationship

The Scale to Assess the Therapeutic Relationship, which also goes by the attractive-sounding acronym "STAR," was developed to examine the therapy relationship in a particular setting, as its authors point out. They state that "No instrument has been developed specifically for assessing the clinician–patient therapeutic relationship (TR) in community psychiatry" and that they wanted to address this issue (McGuire-Snieckus et al, 2007, pg. 85.). This positioning would suggest that the STAR may only be relevant in the particular setting of community health care. However, a closer look at the tool reveals greater potential and a legitimately wider range of applications. Its items, as we will later see, are open enough to be appropriate for many mental health care contexts, making the STAR a relatively universal instrument for evaluating patient-clinician relationships. It is not surprising that, since its inception, the STAR was adopted in Japan as the first tool to serve this purpose. In a 2019, Matsunaga et al. write: "A good therapeutic relationship between patient and psychiatrist is vital for effective mental health care. However, no instruments

to assess this relationship are available in Japan" (Matsunaga et al., 2007, pg. 1). Matsunaga and a larger Tokyo-based team then changed this situation. The report that they "translated the original version of STAR into Japanese. Back-translation was conducted by a bilingual speaker of Japanese and English. The back-translated scale was confirmed by the author of the original version of STAR" (pg. 3). They effectively used the tool in its unaltered form—merely translated into their local language. The original positioning of the STAR of being tailored to a community healthcare context was abandoned. The Japanese team "conducted a cross-sectional questionnaire survey in an outpatient setting at one psychiatric hospital located in Tokyo and two psychiatric clinics located in Tokyo and Chiba" (pg. 2) and found that the STAR "should be considered as a useful instrument for evaluating the therapeutic relationship in Japanese community mental health settings. Further studies must investigate validity and applicability to various mental health care service settings and professionals." The successful implementation of the tool in Japan already indicates that it carries greater potential than originally envisioned. However, an Indian study also chose the STAR for their purposes—in this case to compare patient satisfaction with their therapy relationship during Covid-19, when health care professionals were restricted to meeting their patients online. Here, the STAR was introduced into yet another different setting, namely that of "a tertiary care general hospital addiction psychiatry set-up" (Ghosh et al., 2022, pg. 458). This project was "the first Indian study to systematically assess telehealth satisfaction, therapeutic relationship, and perceived empathy during teleconsultation in patients" suffering from substance abuse (pg. 460). Among the authors' findings is the fact that the monitored patients "felt higher positive collaboration, positive clinician input, and more favorable therapeutic relationships during an in-person consultation." This preference of in-person over online meetings was apparently caused by patients experiencing less empathy from their therapists. Ghosh et al. note: "Empathy is the foundation of a positive patient–physician relationship. Our finding of a relatively poor perception of physicians' empathy in teleconsultation could be explained by the following: absence or limited nonverbal communication (which is a significant part of the face-to-face conversation), the physical appearance of a therapist, and the online disinhibition effect." While the notion that empathy is most strongly felt in direct, physical meetings is highly interesting and has many possible ramifications, I would like to emphasize that not only the Indian but also the Japanese study underline the inherent capabilities of the STAR approach.

How then was STAR created so that it would become such a useful and easily adaptable tool? The premise was based on the belief of McGuire-Snieckus et al. that "the quality of the therapy relationship been found to predict treatment adherence and outcome across a range of patient diagnoses and treatment settings" (McGuire-Snieckus et al., 2007, pg. 85). Since the authors felt that there was no already established method to assess the therapy relationship in their specific community healthcare context, they chose a highly systematical approach in developing their instrument. While their methodically structured means of progressing to the final set of questionnaires is not unparalleled, it certainly distinguishes the STAR from tools such as the original HAQ or the RDFS, where the items used were generated more intuitively and the selection process was less sophisticated—at least as per their available documentation. The STAR's authors describe their

path as follows: "In stage 1, an item pool was generated. In stage 2, the items from stage 1 were administered to patients and clinicians and then reduced […]. In stage 3, the test–retest reliability of the reduced item pool was tested and the items selected for the final scales. In stage 4, the factorial structure of the scale was tested in a new sample of clinicians and patients" (pg. 86). For the purpose of the present study, I will focus on what McGuire-Snieckus et al. call "Stage 1" because it describes how the STAR's items were generated. This is not only particularly relevant due to the aim of my thesis, which is to establish a novel means of characterizing therapy relationships. It is also the area where the genesis of the STAR, compared to other existing instruments, stands out the most. In Stage One of the STAR's development, the team spoke not only with therapists but also with patients to determine where possible pain points may be located in terms of establishing and maintaining a well-working relationship. They write: "First, semi-structured interviews were conducted with clinicians and patients to explore ideas about the therapeutic relationship in this setting from both perspectives. Ten open-ended questions were asked of the participants. The questions were hypothetical and did not address any specific relationship" (pg. 86). McGuire-Snieckus et al. also provide examples of the questions they approached interviewees with. They asked participants to imagine what an ideal—or a difficult—therapy relationship would look like. How could that relationship be described? What elements would make it either perfect or challenging? What actions could a clinician take to aid the development of a good relationship with their patient? The answers to these questions were collected from 12 therapists and 10 patients, which led to the creation of an initial list of items. The team also considered items used by other instruments. Eventually, a 12-item questionnaire was sketched out, tested, re-adjusted, and finally completed and made available to the mental health community at large. I think that one of the choices McGuire-Snieckus el al. made correctly was to limit the extent to which problems unique to the field of community healthcare would impact the to-be-developed item pool. Instead, those issues were embedded into more neutral, universally applicable questions. For instance, the authors mention that interviewees frequently "reported the clinician's helpfulness in accessing other services and benefits" (pg.88), which is a theme not being reflected in the final selection of items. Importantly, the questionnaire was released in two versions, with the therapist's version deviating significantly from the patient's.

Although the STAR's questionnaire for the patient and the therapist, on the surface of their respective items, have hardly anything in common, they were both designed to entail three different dimensions—which McGuire-Snieckus et al. call "factors." For both patient and clinician, the first factor is termed "Positive Collaboration" and consists of six items. It "reflects a good rapport, a shared understanding of goals and the experience of mutual openness and trust. For clinicians and patients alike, this factor […] might capture the general quality of the relationship, the 'chemistry' between the two people and the overall degree to which the relationship works" (pg. 93). As we will see later, even though factor One is consistent among both versions of the questionnaire, that does not mean that the questions are identical or at least similar; they are not. With factor Two, the discrepancies widen. Not only does this factor encompass different items for therapist and patient, but it is also labeled differently. The only aspect consistent between the two questionnaires

is that this factor comprises three items each. On the therapist's side, the second dimension is titled "Positive Clinician Factor" and examines the degree to which the clinician can put themselves in the patient's shoes. On the patient's side, it is named "Positive Clinician Input," and "reflects to what extent clinicians ([are] perceived by the patient to) encourage, regard, support, listen to and understand the patient." I would like to highlight the comment McGuire-Snieckus et al. have made in parentheses here. In making this annotation, they underline their awareness that tools such as the STAR exist in the ambivalence between the patient's and therapist's perception of the relationship and the actual situation—which, for instance, in cases of severe disturbance, may be tricky to pinpoint. I feel that acknowledging this ambiguity is a crucial step in paying tribute to the limitations of a tool such as the STAR that could otherwise be understood to always reflect objective reality. Another relevant facet of factor Two is that McGuire-Snieckus et al. believe that it is the area covered by this factor where therapists may be able to make the most significant improvements to their techniques in order to further their relational skills. Finally, the third and last factor is also different for therapist and patient. In the clinician's questionnaire, it is called "Emotional Difficulties" and deals with negative emotional reactions to the patient. In the patient's assessment, factor Three stands for "Non-Supportive Clinician Input." On both sides, "this factor reflects problems in the relationship such as the clinician's feeling that they cannot empathize with and are not accepted by the patient, and the patient's perception that the clinician withholds the truth and is impatient and authoritarian." In this description of factor Three, the authors are already paraphrasing some of this dimension's items. One of the patient's items, for instance, reads, "My clinician is impatient with me" (pg. 95). They also state that any problems in the relationship associated with factor Three could be remedied, at least to a certain extent, by involving the extended mental healthcare framework: "While such feelings are clearly not helpful in establishing or maintaining a positive relationship, they are important to identify and could be addressed in ongoing clinical supervision" (pg. 93). Again, contextual comments like this one, which attest to the thoughtfulness and sense of responsibility of the STAR's creators, set this assessment tool apart.

Having discussed the STAR's background, development process, and internal structure, I will now review the individual items of each of the two questionnaires, which employ a 5-point Likert scale ranging from "Never" to "Always," with "Sometimes" serving as a neutral value in the middle of the scale. With both questionnaires, all items are scored positively with the exceptions found in the "Emotional Difficulties" and "Non-Supportive Clinician Input" factors (pg. 95). As one would expect, those are worded negatively. In the patient's questionnaire, item Four reads, "I believe my clinician withholds the truth from me," indicating distrust and perhaps an element of paranoia. As discussed, McGuire-Snieckus et al. leave it open to interpretation as to whether the patient's account should be regarded as a de-facto assessment of the clinician's attitude or as their perception of the relationship. In either case, a high score on this item will indicate a low level of trust in the therapeutic process. The two other negatively worded questions to the patients are: "My clinician is stern with me when I speak about things that are important to me and my situation," and the beforementioned statement, "My clinician is impatient with me." The therapist is asked to provide ratings for the item, "I feel that my patient rejects me as a

clinician," implying a sense of being unappreciated in their role, as well as, "I feel inferior to my patient," and, "It is difficult for me to empathize with or relate to my patient's problems." What I personally appreciate about these items is that they capture a relatively wide range of potential pitfalls in therapy with a mere six questions. The investigation of the root cause of high-scoring negative items can, it seems to me, really lead to significant improvements in therapy—or, in the worst case, to a transfer of a patient to a different therapist, who may be able to establish a better rapport with them. The other, positively worded items cover many essential characteristics of the therapy relationship, such as empathy, trust, honesty, mutual openness, a supportive atmosphere, a sharing of the same goals, and unconditional acceptance (pg. 95). One item found in the patient's questionnaire has, in my judgement, greater depth than many comparable items found in other assessment tools. It reads: "I believe my clinician has an understanding of what my experiences have meant to me." This notion encapsulates not only the experience of empathy but also the feeling of being understood on a biographical and perhaps more existential level. The inclusion of items like these is one the STAR's greatest assets, in combination with the author's transparent account of the tool's genesis. Overall, and despite the somewhat bland acronym representing the Scale to Assess the Therapeutic Relationship, I find it the most convincing of the instruments designed to assess the therapy relationship reviewed in the present study.

3.3.8 CATS—Client Attachment to Therapist Scale

The Client Attachment to Therapist Scale was developed for a purpose that differs significantly from most other assessment tools discussed in the present study. This is not evident at first glance. The CATS's authors do state that their instrument was crafted to "measure the psychotherapy relationship from the perspective of attachment theory" (Mallinckrodt et al., 1995, pg. 307), which suggests an aim similar to that of, for instance, the WAI or the HAQ. However, a closer look at the CATS reveals that it was actually designed to examine the patient's perception of the therapist as a result of their particular attachment style—rather than to offer a more or less "objective" perspective on the quality of the therapy relationship. In other words, the CATS, in contrast to other tools, does not intent to benchmark therapeutic rapport and to assess its quality in the sense that the relationship can be better or worse—and therefore more or less conducive to therapeutic success. Instead, the CATS generates diagnostic information on the patient's condition, determining their contribution to the dynamics of the unfolding therapy relationship.

The creators of the CATS discuss the origins of their instrument at length, detailing their ambition to funnel John Bowlby's theories on human attachment (Bowlby, 1969 & 1973) into a simple-to-administer questionnaire. They utilize the term "working model" to capture the modality by which an individual relates to people with whom they are—at some level—intimate with. The basic idea is that a person's working model is established in childhood and, from then on, continues to drive the individual toward certain attachment experiences. Mallinckrodt et al. describe this effect as follows: "The child's working model of others involves generalized expectations that caregivers will be responsive, helpful, and nurturing versus unresponsive, aloof, and possible harmful" (Mallinckrodt et al., 1995, pg. 307). Later in life, "The attachment system established in childhood continues

to have a major influence on adult social relationships and may be activated by any close, intimate relationship that evokes the potential for love, security, and comfort, including friendship, kinship, romantic partnership, and the therapeutic alliance" (pg. 308). The notion that a patient's working model will unfold in the therapeutic context is foundational for the CATS. Its authors stress this point, explaining the core principle of the CATS assessment: "Similar to a parent or caregiver, the therapist offers emotional availability, a comforting presence, affect regulation, and a secure base from which to explore inner and outer worlds." In consequence, the patient's attachment style becomes evident in the therapy relationship: "In therapy, the client reexperiences a primary attachment, reproducing with the therapist parts of an old and usually unsatisfactory relationship."

The CATS establishes three different "clusters" to distinguish between attachment styles—or "working models." The first is that of "Secure" attachment, which is rooted in the early experience of "caregivers who are generally responsive" (pg. 307). As the working model shows itself early on, children who have a predominantly secure attachment feel free to explore new things in the presence of their caregiver, exhibit "some anxiety upon separation," and are "easily comforted upon reunion." This working model puts the individual in a good position when interacting and relating to others, including their clinician. In the therapy setting, they experience their counselor "as responsive, sensitive, understanding, and emotionally available; feeling hopeful and comforted by the counselor; and feeling encouraged to explore frightening or troubling events" (pg. 310). The second cluster is called "Avoidant/Fearful" and has its roots in "consistently unresponsive and emotionally unavailable" caregivers. In therapy, this attachment style may surface in the form of "suspicion that the therapist is disapproving, dishonest, and likely to be rejecting if displeased; reluctance to make personal disclosures in therapy; and feeling threatened, shameful, and humiliated in the sessions." The CATS's third cluster, which is labeled "Preoccupied/Merger," also is established in childhood through problematic interactions with caregivers and can manifest in the therapy relationship by the patient "longing for more contact and to be 'at one' with the therapist, wishing to expand the relationship beyond the bounds of therapy, and preoccupation with the therapist and the therapist's other clients." The combination of these three clusters constitutes the CATS questionnaire, with 14 items for the "Secure" domain, 12 in the "Avoidant/Fearful" dimension, and 10 in "Preoccupied/Merger"—leading to a total of 36 items (pg. 311). Importantly, there only exists a patient's questionnaire and none for the therapist. This is understandable, since the aim of the CATS is to reflect what the patient introduces into the therapy relationship, applying their working model. The questionnaire "assesses client feelings and attitudes toward the counselor from an attachment perspective," write Mallinckrodt et al. accordingly (pg 308). Whether or not the therapist has an influence on the patient's experience is not captured by the CATS, and neither is their side of the therapy relationship taken into consideration.

Examining the items more closely, there are no surprises. Belonging to the "Secure" cluster, item Two reads: "My counselor is sensitive to my needs" (pg. 311), expressing confidence in the therapist's ability to empathize. Item Two is accompanied by nine further items in the "Secure" category, among them item Five, "My counselor is dependable,"

and item 32, “I know my counselor will understand the things that bother me.” In stark yet expected contrast, the second cluster’s items, representing “Avoidant/Fearful,” consist of statements such as, “I think my counselor disapproves of me,” as well as, “It's hard for me to trust my counselor,” and, “I suspect my counselor probably isn't honest with me.” What’s interesting here is the striking overlap of these items with their negatively phrased counterparts in tools like the STAR or WAI, especially since those pursue a different goal, namely, to rate the quality of the therapy relationship—rather than to mirror the patient’s working model. For example, the item last quoted sounds eerily similar to the STAR’s item Four of its patient’s questionnaire: “I believe my clinician withholds the truth from me” (McGuire-Snieckus et al., 2007, pg. 95). This brings us to the items associated with cluster Three of the CATS: these do not look for openly negative emotions on the patient’s side but for excessively positive ones, allowing for no proper separation from the therapist. Item Seven, for instance, reads: “I wish my counselor could be with me on a daily basis” (Mallinckrodt et al., 1995, pg. 311). Item 16 asks if the patient thinks “about calling my counselor at home,” while item 19 inquires whether the patient wonders if they are “my counselor's favorite client.” Considering the CATS’s authors’ repeated reference to Bowlby, the selection of items used by the CATS is well in line with traditional attachment theory—even though clusters Two and Three do not match the often-cited attachment styles put forward by Mary Ainsworth (Ainsworth et al., 1978).

As mentioned before, the intention behind the CATS differs from that of many other tools that try to examine the therapy relationship. But if the CATS now aims to reveal the patient’s “working model”—which corresponds to their attachment style—what then can this information be used for? Can it aid the therapeutic process? The answer to this question is yes, according to Mallinckrodt et al., who believe that the CATS could be employed to assess the patient’s working model not only once but repeatedly over the course of their therapy—to monitor therapeutic progress and to see if the patient’s attachment style changes over time. Such a shift in the way the patient relates to the clinician would then occur thanks to “corrective emotional experiences” made in the therapeutic encounter (Mallinckrodt et al., 1995, pg. 316). It is certainly an enticing idea that “Perhaps the process of therapeutic change itself could be tracked as changes over the course of therapy in a client's attachment patterns and flexibility of working models” by repeatedly using the CATS. However, it still seems to me that the CATS falls short in one respect: the exclusion of the therapist’s side in the attempt to assess “the therapeutic relationship from an attachment perspective and […] to measure the quality of the clients’ attachment to their therapists” (pg. 308) leads to a tool that arguably delivers relevant diagnostic information but conveys only little about the therapy relationship as an entity created by two human beings who are in close, even in intimate, contact with one another. This point, which signifies my overall impression of the CATS, is probably one of contention. Since its inception, the CATS has been used in several studies—as documented by a 2015 meta study that accumulates data from a total of 16 projects (Mallinckrodt & Jeong, 2015). It was also translated into Greek and has been tested with 153 patients from the wider Athens area (Yotsidi et al., 2018). The meta study’s findings suggest that the instrument can indeed provide some indication on the quality of the therapy relationship, in particular in respect to its outcome. “CATS Secure was strongly positively correlated with total

working alliance, CATS Avoidant was negatively correlated with total working alliance, and CATS Preoccupied was not significantly associated with working alliance," state the meta study's authors (Mallinckrodt & Jeong, 2015, pg. 134). I think that this result was to be expected, anything to the contrary would have put attachment theory in question altogether. Mallinckrodt & Jeong conclude their findings by noting that, in general, the CATS demonstrated that "Pre-therapy client attachment difficulties were associated with poor psychotherapy attachment" (pg. 138), implying that, in a sense, the tool can be used to predict therapeutic outcome, which is also one of the other assessment instruments' aims. Personally, I see the CATS's advantage in its ability to monitor changes in the patient's attachment to the therapist as their work progresses and corrective emotional experience are made. When it comes to predicting therapeutic success, I would clearly turn to an alternative tool.

3.3.9 TES—Therapist Empathy Scale

The Therapist Empathy Scale was created to measure the therapist's capacity of creating a warm, comfortable, and non-judgmental atmosphere for their patients—or in the words of its authors, the TES attempts "to assess affective, cognitive, attitudinal, and attunement aspects of therapist empathy" (Decker et al., 2014, pg. 339). While it does not examine the therapy relationship per se, I chose to include it to find a balance between patient-centric and therapist-centric approaches. With the CATS representing the former, the TES is now a fine example of the latter. Also, as Decker et al. suggest, "Therapist empathy also may facilitate the working alliance" (pg. 350), making their tool at least indirectly relevant for the present thesis. Without a doubt, the therapist's ability to relate to their patients on an emotional level will dramatically impact their relationships. There is hardly any school of thought in modern psychotherapy that would take a different view on the sheer relevance of therapist empathy, as Decker et al. emphasize: "Across psychotherapeutic approaches, therapist empathy has been identified as an important nonspecific factor in treatment" (pg. 340). Agreement on this point may be widespread, but a universally accepted definition of empathy has yet to emerge. This is pointed out by the TES's authors: "Definitions of therapist empathy have varied […], though they generally have emphasized the therapist's ability to understand the client's experience and communicate this understanding to the client." They add that therapist empathy is far from being a simple and straightforward expression. Rather, it is complex in nature and can be understood to be "comprised of several components: affective (relating and responding to the client's emotions with similar emotions), cognitive (the intellectual understanding of client experiences […]) and attitudinal as demonstrated by warmth and acceptance."

The TES only looks at the therapist's self-attested capability to empathize, not on their patients' experience with them. This could be regarded as problematic, but Decker et al. argue that "therapist empathy seems to vary more between therapists than to fluctuate within therapists across the clients they treat" (pg. 340), implying that empathy is a relatively stable characteristic a therapist may have, showing itself relatively independently of whom they are with at a given time. Correspondingly, Decker et al. have found that "most discussions of therapist empathy have focused on therapists' behaviors and experiences rather than their clients' reactions to the therapists per se." The TES's design is

reflective of this stance. The nine items of its questionnaire, all directed toward the clinician, examine the degree to which therapists are "able to accurately understand and articulate their clients' feelings and thoughts in a nonjudgmental, accepting, and genuinely concerned manner, while remaining open to changes or shifts in their clients' experiences during the session" (pg. 349). While the items themselves are not publicly available, Decker el at. provide detailed information on the dimensions of empathy they have tried to capture. The first is that of "Concern" for the patient, which can be expressed "by showing a regard for and interest in the client. The therapist seems engaged and involved with the client and attentive to what the client has said. The therapist's voice has a soft resonance that supports and enhances the client's concerned expressions" (pg. 344). What I find interesting is the authors' emphasis on voice and tonality, rather than on other aspects such as posture or gesturing. This close attention to the therapist's voice is a theme that stretches into the next of the TES's dimensions. The second item deals with "Expressiveness" and refers to the "therapist's voice […] when the therapist speaks with energy and varies the pitch of his or her voice to accommodate the mood or disposition of the client." Item Three also emphasizes the role of the therapist's acoustic tonality. It is labeled "Resonate or capture client feelings" and represents actions that an empathetic therapist would take to react to "the intensity of the client's feelings when he or she speaks with a tone and emphasis that matches the client's emotional state or that pitches words or phrases in a manner that underscores how the client feels." The fourth item rates the clinician's "Warmth," with the description reading: "A therapist demonstrates warmth by speaking in a friendly, cordial, and sincere manner. The therapist is involved with and supportive of the client's efforts to express him- or herself. In some way, the therapist seems kindly disposed toward or fond of the client." The next few items represent a shift in focus in the TES, moving away from the therapist's acoustic presence toward displaying an understanding of their patient on a more intellectual level. The patient's "inner world" and their "cognitive framework", both evident in the patient's speech and demeanor, are viewed as invitations for the therapist to empathetically relate to the patient's emotional states. Decker et al. write: "The therapist is attentive to nuances of meaning and feeling conveyed in a client's statements beyond surface content and shows a genuine understanding of the client's inner world." The authors employ the term "cognitive framework" to highlight that the therapeutic encounter "conveys that the therapist values knowing what the client means." The TES's seventh item encompasses the clinician's ability to give their patient the space they need to fully reveal themselves, even to discover themselves, in the safety of the therapy relationship. The therapist not only reacts with great sensitivity to the patient's emotions but also "provides ample opportunities for the client to explore his or her emotional reactions" (pg. 345). In addition to that, they reflect "how the client feels by appropriately labeling feeling states with words (e.g. anger, sadness, frustration), or metaphors (e.g. "It's as if you are pent up and feel about to explode") to clarify and crystallize for the client what he or she is experiencing emotionally." I think that the line between two different perspectives on what constitutes empathy gets blurred here: is it a character trait and a corresponding ability, as suggested previously—or a result of properly applied therapeutic technique? This question remains unanswered by the TES's authors. What is certain is that patients who have difficulties naming their emotional

conditions require significant help building up a personal repertoire of internalized inner states, which is, for instance, discussed at length in Peter Fonagy's work on mentalization (Fonagy et al., 2002). Item Eight of the TES looks at the therapist's acceptance "of the client's feelings and inner experience," with unconditional openness being of paramount importance (Decker et al., 2014, pg. 345). The TES's creators also mention the relevance of the therapist appearing authentic to the patient, a factor stressed by other authors such as Jeffrey Young as one of the key principles for the therapy relationship to work (e.g., Young, 2017). Decker et al. put it this way: "The therapist's stance is one of genuineness and honesty instead of seemingly feigning concern or appearing inauthentic" (Decker et al., 2014, pg. 345). The TES's final item will likely prompt varying reactions from therapists, depending on the school of thought they subscribe to. It is titled "Responsiveness" and includes reactions to both the patient's verbal and non-verbal cues. Thus far, item Nine will probably not raise any eyebrows. What some clinicians, for example, those representing the more orthodox behavioral tradition, may take issue with is the first part of the notion that "The therapist follows the client's lead in the conversation instead of trying to steer the discussion to the therapist's agenda or interests." Should the therapist let the patient steer the session, or should they impose a basic structure to provide the guidance required? What then should one think of interventions, which are largely designed precisely to disrupt the patient in their vicious cycle? To Decker et al., the answer is the former—to them, the patient ought to be in the lead. Unsurprisingly, their paper first presenting the TES refers to Carl Rogers and his humanistic ideas several times (pgs. 340, 343, & 350) while the behavioral string of psychotherapy is given less, if any, attention.

Decker et al. are convinced of "Roger's [sic] assertion that empathy is necessary for client change and raise questions about how therapist empathy and client outcome are linked" (pg. 350). They position the TES and its primary area of application accordingly. To the authors, their instrument "may have utility in therapy process-outcomes studies to examine the moderating or mediating effects therapist empathy may have on client response to different types of psychotherapeutic treatments" (pg. 351). If now the TES was crafted to predict the success of a particular treatment—by generating information on the therapist's ability to empathize—then this aim is virtually identical with that of many other tools discussed in the present thesis. Many of alternatives already discussed share the goal of delivering a prognosis on the therapeutic result. However, they largely put the therapy relationship at the center of attention, with the therapist's contribution only playing a partial role in the complete picture. In that sense, the TES both differs from and overlaps with most of the other assessment instruments. The patient's side to what Decker et al. call the "working alliance" (pg. 350) or "the bond between client and therapist and their agreement about therapy tasks and goals" is largely absent.

An interesting aspect of Decker et al.'s study introducing the TES can be located in their thoughts on whether therapists may be trained to empathize more. Their view is rather pessimistic, putting forward "questions about the degree to which therapists can be trained to be more empathic with their clients." (pg. 350). While one might presume that extensive training and supervision should lead to "improved therapists' empathic skills," the team's findings do not support this idea. Decker et al. conclude that therapist empathy

as measured by the TES hardly changes over the course of a therapist's training—from the initial training phases to the completion of the program: "no such differences were evident." They give two potential reasons. First, they speculate that training methods may emphasize a future clinician's "technical skills to elicit motivations for change" in the patient, and prioritize this over "fundamental or relational skills." Second, and perhaps surprisingly, "it is possible that therapist empathy may not be particularly sensitive to training efforts depending on the therapists' pre-training foundational level of empathic skills." In other words, Decker et al. believe that individuals with little capacity to empathize will not make great leaps trying to hone their respective skills. "It may be that therapists need a minimum degree of baseline empathic capacity for them to improve their ability in this area," state Decker et al.

3.4 Limitations of Existing Assessment Instruments

Having now discussed a selection of existing instruments designed to assess the therapy relationship, the question may be asked: "Why would we need one more?" As indicated throughout the present study, it is my aim to use its format to develop and test the initial version of a new tool for characterizing therapy relationships. In principle, I think that one could justify this ambition simply by stating that, most of the time, "more is more." However, I do think that the majority of the currently available solutions exhibit certain limitations. This is not because they have been inadequately crafted. Rather, these shortcomings are a consequence of their primary purpose. The objective of wanting to "examine the therapy relationship" can mean many things. Most tools ultimately try to rate therapy relationships on a scale ranging from better to worse—and to highlight which factors have contributed to the final score. The higher the score, the greater the chance of that particular relationship being a "good" one that can help the patient to improve. To me personally—and this will be reflected in the instrument that I will later present—the nuanced characteristics of "how it feels to be with another human being" should be at the center of any qualitative assessment, rather than a rating. Based on this "feeling," the experience of one relationship will significantly differ from that of the next, for instance, in how both individuals handle blunt exchange. It will also be unique in how it creates a starting point for personal growth and for the exploration of new ideas. What is perceived as valuable from the point of view of the relationship will have distinctive traits. And these three dimensions are merely examples of descriptors that can be employed to qualitatively differentiate one specific therapy relationship from others. Every relationship has its own individualities, and being sensitive and respectful to these nuances can help to make the relationship an effective springboard not only for the patient's self-discovery and eventual re-imagining but also for the therapist's own maturation.

3.4.1 Tendency to Benchmark Rather Than Characterize

One aspect that many tools assessing the therapy relationship share is their tendency to view relational quality as something that can, or should, be measured on a scale. Without a doubt, the notion of making something as fluid and multi-faceted as the therapy relationship measurable—in the sense of grading it in linear form—is an enticing proposition. One can imagine that attaching a rating to an entity as complex as the rapport between

two people may provide clinicians with a sense of control: if one learns that a relationship scores highly on the HAQ, WAI, ARM, RDFS, or a similar assessment tool, then the respective therapy must hold great promise. I am conscious of the fact that psychotherapy science is under some obligation to produce evidence that therapy "works." As a result, what happens in the therapeutic setting can be regarded a matter that should be captured and scientifically analyzed as far as possible. However, I think that there also must be room for other perspectives—including the view that the "quality," or the "qualities," of a relationship refer to the fabric of the rapport between two people more so than to a rating in the sense of "better or worse." Some tools, such as the STAR and the CATS, pay significant consideration to the inherent complexity of the human relationship and try to distill it into the inner workings of their instruments. The tool I will put forward in this study will put even more emphasis on this more nuanced way of looking at the therapy relationship, not following the primary goal of delivering a simplistic mono-dimensional rating.

3.4.2 Strong Orientation toward Therapeutic Outcome

Many existing assessment tools are designed to capture therapy relationships in the form of benchmarking them. This is often because they intend to predict the likelihood of therapeutic success, which is not an aim that I would want to question or debate. Again, if psychotherapy science is expected to honor the fundamental scientific principles of empiricism, skepticism, objectivity, transparency, and—as far as possible—reproducibility, then rating tools can help getting closer to meeting this objective. They can indicate under which circumstances therapies may lead to outcomes beneficial to the patients. They can also highlight what therapy modalities will lead to what outcome. However, it seems to me that an exaggerated orientation toward the future—including the positive scenario in which the patient no longer requires treatment—can remove both the therapist and the patient from the immediacy of the therapy relationship. If the "here and now" of the therapeutic encounter is largely replaced by a focus on what criteria ought to be met for the patient to make progress, it will render certain techniques impossible, for instance, Jeffrey Young's "limited reparenting" (Young et al., 2003, pg. 47), the creation of corrective emotional experiences, or deeper mentalization work.

In the next chapter, I will be discussing Nathan Schwartz-Salant's idea of the therapy relationship representing a "third area" or an "imaginal field" between the clinician and the patient (Schwartz-Salant, 1998, pg. 59). Schwartz-Salant does not concern himself with the question of whether a relationship might rank highly on a particular scale. The concept of quality that lies at the core of his thinking is a different one—the "how" rather than the "how good." Consequently, his approach puts the immediacy of the relationship at the center of attention. Being in the relationship then implies that both therapist and patient are unquestionably present, immersing themselves in the energies, thoughts, emotions, and relational themes that are unfolding in real time, in a space of their own.

4 The Therapy Relationship as a "Third Area"

This chapter serves the purpose of laying the conceptual groundwork for the new method to assess a therapy relationship put forward in the present study. The central question

will be a seemingly simple one, namely: "What is a relationship?" What idea of a relationship should we be using to make insightful statements about the nature of the rapport between two people? Of course, the term "relationship" appears in countless contexts in common language, with connotations ranging from the "romantic" connection between lovers to the pollical dimension of two countries having established economic or cultural ties. In mathematics, two variables can be "in relationship" with one another, and the same principle applies to physics, where a relationship may exist between seemingly disparate factors—such mass and energy as per Albert Einstein's theory of general relativity (Einstein & Infeld, 1938). In Linguistics, the use of a choice of words in sentence structure constitutes a relationship between those words that generates meaning. Furthermore, many a discourse discussing "cause and effect" phenomena postulates the existence of a "relationship" between different entities, for instance, in cases of parallel occurrence. These are only some of the most widespread use cases of the term "relationship," which I am mirroring here to underline the need for clarity as to what idea of the relationship this study will be based upon. Unfortunately, defining the notion of the relationship will not be as straightforward as consulting a dictionary. The Merriam-Webster provides us with three dimensions of the term, the first representing "the state of being related of interrelated," which may, for example, be found to exist if someone examines "the relationship between variables" (Merriam-Webster, n.d.). The second dimension is described as "the relation connecting or binding participants in a relationship: such as a) kinship or b) a specific instance or type of kinship." Third, the Merriam-Webster lists "a state of affairs existing between those having relations of dealings" or "a romantic or passionate attachment." It is hardly surprising that the common-language dictionary does not mention any specific criteria for what constitutes a therapy relationship.

My review of different means of characterizing the therapy relationship earlier in this study as well as my discussion of the terms "relationship" and "alliance" have shown that certain assessment tools exhibit more precision than others when it comes to outlining their underlying idea of what constitutes a relationship. In several cases, an explicit definition is absent, leaving the reader to establish the intended scope and meaning of the term on contextual grounds. In others, more than one approach is discussed, thereby reflecting the difficulty of providing a binding definition for a term that enjoys ubiquitous application in common language and as a result is as colorful and as it is wide-ranging. This study will be basing its understanding of the term "relationship" on the works of Nathan Schwartz-Salant because I find it to be exceptional in utilizing the unique characteristics of a relationship for the therapeutic process. Schwartz-Salant's conceptualization of the relationship as a third entity arising "in the space between" analyst and patient (e.g., Schwartz-Salant, 2007, pg. 84) will enable us to arrive at a notion of the relationship as a dynamic field with an ever-changing yet distinct atmosphere. This approach is markedly different from those theoretically supporting concepts that are employed by other contemporary methods developed to assess the therapy relationship. Consequently, the technique I am laying out in this study will diverge from existing relationship assessment methods thanks to this choice of theoretical foundation.

4.1 Carl Jung's Use of Alchemy to Capture Relational Dynamics

While Schwartz-Salant's writings are firmly rooted in the practice of psychoanalysis and intend to turn Jung's theoretical research into clinical method (Schwartz-Salant, 2017b, min. 48), it is not always easy to follow or to discuss his thoughts using universally understood language. For instance, Schwartz-Salant frequently refers to ideas originating from the ancient, long discontinued tradition of alchemy (e.g., Schwartz-Salant, 1988) or incorporates terms such as that of the "subtle body" (e.g., Schwartz-Salant, 2007), which some readers may consider esoteric and incompatible with current scientific discourse. To counteract the adverse effect that his work might have if ingested unprepared, I will first illustrate the author's and clinician's larger frame of reference—which is found in Carl Jung's massive contribution to our contemporary understanding of the human soul, especially in his discussion of the experience of the transference and countertransference phenomena. Here, Jung uses alchemical concepts to detail the fluid and often confusing interactions that take place in the therapeutic setting—exchanges of psychic energy that can go by unseen or may be repressed, and which can range from a therapist having an unexplainable sympathetic reaction to a patient all the way to the unsettling experience of severe projective identification taking hold.

In "The Psychology of the Transference," Jung exclusively examines what he calls the "transference phenomenon" (Jung, 1966, pg. 172). Yet, this term includes both what we today consider transference and countertransference, as we will see looking more deeply into Jung's thoughts. After some consideration, I believe the split into transference—the contribution to the dynamics unfolding in the therapy relationship that stem from the patient—and the countertransference reactions from the clinician are in fact an artificial imposition suggesting that such a division can ever be made. It is probably a consequence from a culture rooted in the belief in individuality to assume that the therapeutic rapport can be broken down into pieces that distinctly belong to either party—the patient or the analyst. From René Descartes's "cogito, ergo sum" (Descartes, 2022) via Immanuel Kant's notion that "the 'I think' must accompany all my representations" (Kant, 2003) to today's celebration of the individual in the western world, we arguably find ourselves in a cultural context that is prone to separating one human being from the next, with someone's skin representing the borderline of where their personality ends. This principle however is not supported by Jung's depiction of the transference phenomenon—nor by Schwartz-Salant's clinical method and theoretical work. Jung begins his discussion of the topic by talking about his conviction that many therapies could not make meaningful progress without focusing on the transference. He writes, "It is probably no exaggeration to say that almost all cases requiring lengthy treatment gravitate round the phenomenon of transference, and that the success or failure of the treatment appears to be bound up with it in a very fundamental way" (Jung, 1966, pg. 164). Jung adds that healthcare professionals should not make the mistake of regarding transference as a temporary obstacle hindering therapeutic effectiveness: "Psychology, therefore, cannot very well overlook or avoid this problem, nor should the psychotherapist pretend that the so-called 'resolution of the transference' is just a matter of course." Jung then explains why he chose alchemy as a point of reference to illustrate the transference phenomena. He is conscious that this choice may

come as a surprise to some: “It may seem strange to the reader that, in order to throw light on the transference, I should turn to something so apparently remote as alchemical symbolism” (Jung, 1966, pg. 165). However, “to give any description of the transference phenomenon is a very difficult and delicate task” (Jung, 1966, pg. 321). Jung found the endeavor of dissecting transference so challenging that he needed to rely on something as rich in metaphoric content as alchemy to illustrate his own findings. He did this because “close connections exist between alchemy and those phenomena which must, for practical reasons, be considered in the psychology of the unconscious” (Jung, 1966, pg. 165). In particular, Jung chose the texts and woodcuts from the alchemical opus “Rosarium Philosophorum” to elucidate how transformational processes that originate from deep interactions between human beings can lead to the integration of neglected parts of their personalities. The Rosarium Philosophorum was conceived in late medieval Europe by anonymous authors and first published in Frankfurt, Germany, in the year 1550. It was made available to contemporary scholars by Joachim Telle (Telle, 1992a), who has translated the Latin texts into German (Telle, 1992b). Jung sees the Rosarium as a “historical document, whose substance derives from centuries of mental effort,” and believes that one of its core concepts, the “coniunctio, corresponds to the central significance of the transference in psychotherapy on the one hand and in the field of normal human relationships on the other” (Jung, 1966, pg. 321). Jung underlines the centrality of the coniunctio concept by detailing that intregrating it in the domain of psychotherapy can lead to progress similar to recent advancements in the field of physics. He writes: “The alchemical image of the coniunctio […] is […] valuable from the psychological point of view: that is to say, it plays the same role in the exploration of the darkness of the psyche as it played in the investigation of the riddle of matter” (Jung, 1966, pg. 169). The unfolding of the coniunctio principle in the domain of science points to its spellbinding capacity, as “it could never have worked so effectively in the material world had it not already possessed the power to fascinate and thus to fix the attention of the investigator along those lines.” The reason why the coniunctio bears such prowess lies in its archetypal nature, whereby “the theoria of alchemy […] is for the most part a projection of unconscious contents, of […] archetypal forms” (Jung, 1966, pg. 321). As readers of the present study will likely be familiar with the term “archetype,” I will only add to Jung’s above statement that it, in the most general sense, refers to a pattern or a structured idea inherent in the human condition, shared by mankind and manifesting itself in many areas of life. Jung also describes the coniunctio as an “a priori image that occupies a prominent place in the history of man's mental development” (Jung, 1996, pg. 169). The inner workings of the coniunctio are then laid out by Jung using the Rosarium Philosophorum as a North Star: “In view of this close connection between picture and psychic content, it does not seem to me out of place to examine a medieval series of pictures […] as an Ariadne thread” (Jung, 1966, pg. 201).

Since much of Nathan Schwartz-Salant’s work references Jung’s depiction of the Rosarium Philosophorum, I will now provide a brief summary of Jung’s highly detailed discussion of the series of woodcuts that reflect alchemical beliefs. While the series consists of 20 woodcuts overall, Jung elected to concentrate on the first ten. This selection is extended by Schwartz-Salant (Schwartz-Salant, 1988, pgs. 60–64; 1998, pgs. 192–208), as we will later see in his analysis of the remaining ten.

4.1.1 The Rosarium Philosophorum: Image One

The first of the Rosarium's woodcuts is called "The Mercurial Fountain." It depicts a complex arrangement of many elements—such as sun and moon, four stars, and fumes rising from the bottom to the top of the image. They are all centered around a circular, self-replenishing fountain filled with mercury. Jung explains that this first of the ten symbolical pictures can be considered "an illustration of the methods and philosophy of alchemy. These are not warranted by the nature of matter as known to the old masters; they can only derive from the unconscious psyche" (Jung, 1966, pg. 208). This connection between the alchemical process, as illustrated in the Rosarium, and the psyche, via a deeper archetypal development, is crucial in Jung's thinking. Both sides share the quality of being geared toward transformation and the assumption that a union of opposites is the objective at hand. Since the process has archetypal underpinnings, it comes as no surprise that Jung sees Goethe's "Faust" as another manifestation highlighting the same themes. Jung states that, in this opus, "Goethe is really describing the experience of the alchemist who discovers that what he has projected into the retort is his own darkness, his unredeemed state, his passion, his struggles to reach the goal, i.e., to become what he really is, to fulfil his purpose" (pg. 209). In psychotherapy, character transformation and the integration of conflicting or projected parts is commonly regarded as one of the central objectives. The path toward this goal, according to Jung, is mirrored by the Rosarium. In this sense, the mercurial fountain represents the first step leading to the integration and transformation of disparate and dark elements. It all begins by entering the unconscious, which is symbolized by the fountain's contents: "This fluid substance, with all its paradoxical qualities, really signifies the unconscious which has been projected into it. The 'sea' is its static condition, the 'fountain' its activation, and the 'process' its transformation," writes Jung (pgs. 209–210). He adds that the aim of entering the fountain is "the integration of unconscious contents" (pg. 210). Nathan Schwartz-Salant believes that the process is often initiated by projective identification appearing in the therapy relationship, which echoes Jung's desire to use the Rosarium for the examination of the "transference phenomenon" (Jung, 1966, pg. 172). Schwartz-Salant states that the fumes shown in the image, which effectively serve as a connection between the woodcut's lower and upper areas, represent the unfolding of projective identification. However, the fumes also cloud the sun's consciousness and the moon's emotional receptiveness, which prompts a need to exercise great skill to master the tasks required: "The alchemical process had to transform the state of projective identification into a positive one, without undervaluing its dark and negative form. The art, apparently, was to value the obstruction of the sun and moon by the two vapours" (Schwartz-Salant, 1988, pg. 52). Later images of the Rosarium will associate the conditions introduced by projective identification—or intense transference phenomena—with

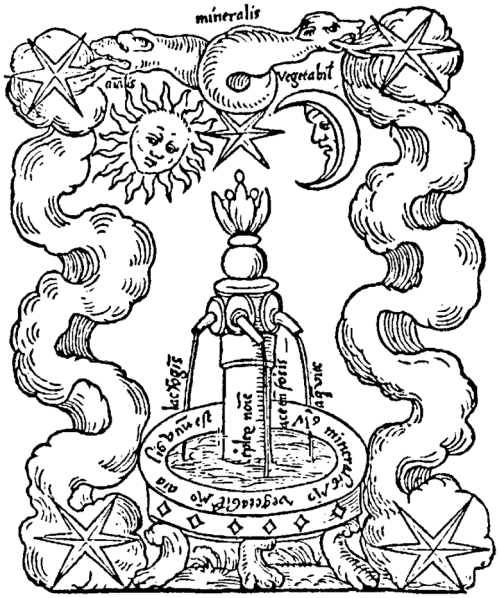

Fig. 1: "The Mercurial Fountain"

an enactment of "incestuous" nature between therapist and patient, as per Jung's and Schwartz-Salant's interpretations (e.g., Jung, 1966, pg. 215; Schwartz-Salant, 1988, pg. 53). The circular shape of the mercurial fountain is another aspect seen as important by both authors. Jung writes that the fountain is depicted as a "circular sea with no outlet, which perpetually replenishes itself by means of a spring bubbling up in its centre"—an idea that is also employed by medieval philosopher "Nicholas of Cusa as an allegory of God" (Jung, 1966, pg. 210). These qualities of the fountain, and therefore of the unconscious, point to it not solely being personal in nature. Rather, the unconscious reaches into a domain that far exceeds the scope of a human life and touches infinity. The objective, then, can only be to partake in it as genuinely and humbly as possible.

4.1.2 The Rosarium Philosophorum: Image Two

The second illustration is titled "King and Queen." Now the main characters of the Rosarium's plot enter the stage. While the two of them have much more than a mono-dimensional meaning, they also stand for opposites that have yet to be united. Correspondingly, Jung asserts that "The arcanum artis, or coniunctio Solis et Lunae as supreme union of hostile opposites, was not shown in our first picture; but now it is illustrated in considerable detail, as its importance deserves" (Jung, 1966, pg. 211). The union of opposites, which has yet to proceed, serves as a metaphor for the integration of parts in the psyche that are easily externalized due to their challenging nature. This is why Schwartz-Salant again mentions projective identification (Schwartz-Salant, 1988, pg. 52), which tends to occur when certain parts of a human personality are not experienced as belonging to one's self. The parts that "appear through projective identification" can be regarded as "hostile elements," finds Schwartz-Salant. The second woodcut is described by Jung in more detail than most others, and one of the reasons why is that he at this stage develops many of the fundamental ideas making up his commentary on the Rosarium. Interestingly, his description of king and queen includes a reference to the astrological significance of Sun and Moon—which I would like to point out since the present study will later introduce the archetypes found in astrology to describe the lived human experience. Jung states that, in woodcut Two, king and queen are standing "respectively on sun and moon, thus indicating their solar and lunar nature in accordance with the astrological assumption of the importance of the sun's position for man and the moon's for woman" (Jung, 1966, pg. 211). He adds that "the two are fully clothed and reach out to one another with their left hands," an aspect he considers significant: "this can hardly be unintentional since it is contrary to custom. The gesture points to a closely guarded secret." To Jung, the fact that the physical contact initiated by king and queen is left-handed rather than right-handed again points to the unconscious taking the lead: "The left-hand (sinister) side is the dark, the unconscious side. The left is inauspicious and awkward; also it is the side of the heart, from which comes not only love but all the evil thoughts connected with it, the moral

Fig. 2: "King and Queen"

contradictions in human nature that are expressed most clearly in our affective life." The fact that king and queen approach one another via their left hands does not mean their right hands remain idle. They use those for a "compensatory" gesture, believes Jung, as they are "holding a device composed of five (4+1) flowers. The branches in the hands each have two flowers; these four again refer to the four elements of which two—fire and air—are active and two—water and earth—passive, the former being ascribed to the man and the latter to the woman." Here, I want to highlight Jung's reference to the four elements, since I will facilitate their millennia-old relevance in various wisdom traditions later in this study in the form of the four "temperaments"—choleric, melancholic, phlegmatic, and sanguine. However, the fifth flower shown in the woodcut shall not go unmentioned, as it is special: "The fifth flower is distinguished from the four in that it is brought by the dove" (pg. 212). The dove's contribution was an important factor to the alchemists. Their "belief in illumination through the Holy Ghost seems to have been a psychological necessity in view of the ominous darkness of nature's secrets" (pg. 214). Put together, the five flowers constitute a "rosie cross" consisting of a "threefold structure," which "is reminiscent of the Mercurial Fountain, while at the same time it points to the important fact that the 'rose' is the product of three living things: the king, the queen, and between them the dove of the Holy Ghost" (pg. 216). While the rose is not shown in many of the remaining images, it is not coincidental that the series of pictures is called "Rosarium Philosophorum," as the name underlines the importance of the rose cross. In his exploration of the second woodcut, Jung reiterates on the theme of incest, and at considerable length. The incestuous nature of the relationship between king and queen is clearly a complicating factor: "We need only bear in mind one fact: that the desired coniunctio was not a legitimate union but was always—one could almost say, on principle—incestuous" (pg. 215). Jung's insistence on the presence of incest, mirrored by Schwartz-Salant, may explain why, in psychoanalysis and psychotherapy, strong affects such as love may be experienced in the consulting room. They are usually interpreted as transference phenomena that should not be acted out. Love, in a wider sense, is, however, crucial for the transformational process to unfold. Jung writes, "as regards the psychology of this picture, we must stress above all else that it depicts a human encounter where love plays the decisive part" (pg. 217). Schwartz-Salant comments on the "incest energies" that "this inclusion of the bodily-erotic element, through projective identification, is essential to the alchemical work. Through it, further transformation of the interactive field can take place, but not without a careful attention to the duplicity and dangers of projective identification" (Schwartz-Salant, 1988, pg. 53). This last quote unites and exemplifies many key aspects of Schwartz-Salant's thinking. The concept of the "interactive field" that constellates itself between therapist and patient is one that I will examine more closely at a later point in this study. At this moment, I will only highlight the fact that the "field" and the process illustrated by the Rosarium go hand-in-hand. While the theme of incest is present throughout the Rosarium, Jung believes that this points to a core principle of the alchemical union of opposites: "Incest symbolizes union with one's own being, it means individuation or becoming a self, and, because this is so vitally important, it exerts an unholy fascination […]. Incest is simply the union of like with like, which is the next stage in the development of the primitive idea of self-fertilization" (pg. 218). Jung then moves on to directly drawing parallels between the Rosarium's

imagery and the transference phenomenon in psychotherapy. He states, “this psychological situation sums up what we can all see for ourselves if we analyse a transference carefully,” adding that the interaction between therapist and patient can often be understood as a reenactment of earlier relationships: “The conventional meeting” between the two people “is followed by an unconscious ‘familiarization’ of one’s partner, brought about by the projection of archaic, infantile fantasies which were originally vested in members of the patient's own family.” The atmospheric quality brought about by the immediate experience of the reenactment enables the clinician to develop a deeper understanding of the patient’s inner life: “The transference of these fantasies to the doctor draws him into the atmosphere of family intimacy, and although this is the last thing he wants, it nevertheless provides a workable prima materia”—a starting point from where the therapeutic process can commence. While key to the therapy relationship, the transference phenomenon, believes Jung, is far from being exclusive to the therapeutic setting. Rather, it must be regarded “a perfectly natural phenomenon which does not by any means happen only in the consulting-room—it can be seen everywhere and may lead to all sorts of nonsense, like all unrecognized projections.” Because of its ubiquity, the importance of integrating the projected elements is vital, and a properly conducted therapy will give “the patient a priceless opportunity to withdraw his projections, to make good his losses, and to integrate his personality” (pgs. 218–219). To Jung, there is a distinct teleology to the occurrence of transference in the therapy relationship. He is convinced that the “aim and real meaning of the transference” is that “it inevitably leads, whatever method of rapprochement be used, to discussion and understanding and hence to a heightened consciousness, which is a measure of the personality's integration” (pg. 219).

4.1.3 The Rosarium Philosophorum: Image Three

Going by the title “The Naked Truth,” the third woodcut can be summarized as “a litany against narcissism, especially against the pride and arrogance that would lose sight of the greater-than-ego powers at work” (Schwartz-Salant, 1988, pg. 53). Jung describes the imagery as follows: “Man and woman confront one another in unabashed naturalness. Sol says, "O Luna, let me be thy husband," and Luna, "O Sol, I must submit to thee" (Jung, 1966, pg. 236). While the communication between the couple has an evident sexual connotation, the woodcut also depicts a dove, which points to a different direction. Jung writes: “Since the spirit descending from above is stated to be the mediator, the situation acquires another aspect: it is supposed to be a union in the spirit,” rather than a physical union (pg. 238). The reason why Schwartz-Salant, in his commentary on “The Naked Truth,” talks about the abandoning of “narcissistic transference and countertransference resistance” (Schwartz-Salant, 1988, pg. 53) is that we are now at a stage of the therapeutic process where “we can say that the situation has thrown off the conventional husk and developed into a stark encounter with reality, with no false veils or adornments of any kind. Man

Fig. 3: “The Naked Truth”

stands forth as he really is and shows what was hidden under the mask of conventional adaptation" (Jung, 1966, pg. 239). Jung at this point uses his term "shadow" to capture these obscured facets of one's personality; referring to it, he goes on to discuss the consequences of what happens when the analytic couple elects to circumvent the confrontation with their darker sides, the non-integrated sinister areas of their respective psyches. He writes: "The man without a shadow thinks himself harmless precisely because he is ignorant of his shadow. The man who recognizes his shadow knows very well that he is not harmless, for it brings the archaic psyche, the whole world of the archetypes, into direct contact with the conscious mind and saturates it with archaic influences." So acute is the danger of non-integrated shadow elements that the "naked truth" becomes a conditio sine qua non for the process to continue. But there is light at the end of the tunnel, and "once the naked truth has been revealed the discussion can get down to essentials; ego and shadow are no longer divided but are brought together in an—admittedly precarious—unity" (pgs. 239–240). It is that moment when the conditions of the second of the Rosarium's woodcuts are met that the archetypal developments can move on to the next stage.

4.1.4 The Rosarium Philosophorum: Image Four

Step Four of the Rosarium is called "Immersion in the Bath." King and queen, still naked, now enter the fountain from the first image. It is filled with mercury—or Mercurius, who, according to Jung, has a thousand names and "stands for the mysterious psychic substance which nowadays we would call the unconscious psyche" (Jung, 1966, pg. 241). This step of the process suggests that "the rising fountain of the unconscious has reached the king and queen, or rather they have descended into it as into a bath." With the couple now immersed in mercury, the unconscious begins to deeply involve both participants: "Mercurius in his watery form now begins to attack the royal pair from below, just as he had previously descended from above in the shape of the dove." Jung now introduces the figure of the hermaphrodite, which will become increasingly dominant as the Rosarium progresses. Jung begins with an explanation as to why this symbol was a common character in alchemical works: "The alchemist thought in strictly medieval trichotomous terms: anything alive […] consists of corpus, anima, and spiritus" (pgs. 242–244). Consequently, "the link between body and spirit, would be hermaphroditic, i.e., a coniunctio Solis et Lunae. […] The underlying idea of the psyche proves it to be a half bodily, half spiritual substance, […] an hermaphroditic being capable of uniting the opposites, but who is never complete in the individual unless related to another individual" (pg. 244). While the king and queen represent body and spirit, the third of the three alchemical cornerstones, the soul, has yet to become a more prominent character in the Rosarium. One reason why it is crucial lies in its capability to unite the three sides: "The queen stands for the body and the king for the spirit, but that both are unrelated

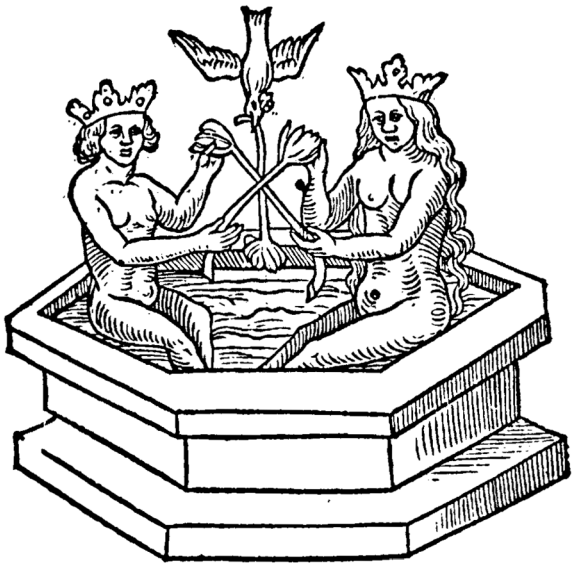

Fig. 4: "Immersion in the Bath"

without the soul, since this is the vinculum which holds them together" (pg. 244). More attention will be paid to the soul from image Six onward. As for woodcut Four, to Schwartz-Salant, the illustrations shows "erotic energies" that are "constellated in the interactive field and serve primarily as a bath of transformation for the unconscious couple" (Schwartz-Salant, 1988, pg. 53). I am including his remarks here as they not only add to Jung's discussion of the woodcut but also hint at the significance of Schwartz-Salant's idea of the "interactive field" between people, a core theme in his thinking, which we will examine more closely in later chapters of this study. Overall, "the psychology of the picture [...] is clearly a descent into the unconscious" (Jung, 1966, pg. 245).

4.1.5 The Rosarium Philosophorum: Image Five

"The Coniunctio" is the name of woodcut Five. On the surface, the image appears to depict a sexual act, and yet "the real meaning of the coniunctio is that it brings to birth something that is one and united" (Jung, 1966, pg. 248). Jung explains this dichotomy as follows: "On a superficial view it looks as if natural instinct had triumphed. But if we examine it more closely we note that the coitus is taking place in the water, the mare tenebrositatis, i.e., the unconscious." As a result, the symbolic meaning of the woodcut triumphs over the "frank eroticism" of the pictures, whereby "union on the biological level is a symbol of the unio oppositorum at its highest" (pg. 250). This marrying of opposites is a central theme in Jung's theories—it is one of the core themes informing works such as the 550-page "Mysterium Coniunctionis: An Inquiry into the Separation and Synthesis of Psychic Opposites in Alchemy" (Jung, 1963). Jung finds that the fifth of the Rosarium's pictures encapsulates the union of opposites in the therapeutic process, and in the transference phenomenon in particular. Jung states that, in woodcut Five, "the main emphasis falls on the unio mystica, as is shown quite clearly by the presence of the uniting symbol in the earlier pictures" (Jung, 1966, pg. 252). Schwartz-Salant uses more current, psychoanalytically informed language to discuss the theme of the coniunctio. He, however, does maintain the fundamental idea of the union of opposites and its relevance at this stage of the process: "Here alternating states of fusion and distance, the opposites whose painful conflict is usually denied and falsified by the deceptions of projective identification, are transcended in a rhythmical harmony" (Schwartz-Salant, 1988, pg. 53). An important challenge in interpreting the woodcut is the complication that the coniunctio, while experienced by therapist and patient, is not a dynamic in which the two of them appear directly, like actors in a play. Rather, it is their "animus" and "anima" that form the union. Jung remains somewhat vague as to the ramifications of this added layer of complexity, but he does point out that "the coniunctio" does not "take place with the personal partner; it is a royal game played out between the active, masculine side of the woman (the animus) and the passive, feminine side of the man (the anima). Although the two

Fig. 5: "The Coniunctio"

figures are always tempting the ego to identify itself with them, a real understanding even on the personal level is possible only if the identification is refused" (Jung, 1966, pg. 261). To emphasize this point, Jung issues a warning regarding the simple and straightforward personal identification with King or Queen: "If we approach this task with psychological views that are too personalistic, we fail to do justice to the fact that we are dealing with an archetype which is anything but personal." Interestingly, the dove is no longer shown in the woodcut. Jung writes that "it is perhaps not without deeper significance that this symbol has disappeared in the pictures of the coniunctio. For at this juncture the meaning of the symbol is fulfilled: the partners have themselves become symbolic" (pg. 252). Schwartz-Salant also points out the dove's absence, extending Jung's thoughts on the shift in the symbolic meaning of the royal couple by again introducing his concept of the "interactive field." Schwartz-Salant writes: "In this woodcut the descending dove, so prominent in the previous pictures, is absent, a sign that its controlling power is now beginning to be integrated into the interactive field" (Schwartz-Salant, 1988, pg. 53). To the present study, the idea of the interactive field, which Schwartz-Salant also sometimes calls a "third area," is of central importance. I will therefore include a few more aspects of Schwartz-Salant's commentary of the themes of the fifth woodcut. Picking up on the role of the absent dove, Schwartz-Salant suggests that the analytic process tends to change once the coniunctio stage has been reached: "Prior to the coniunctio the field was still dominated by fusion or splitting, and the descending dove […] was necessary to avoid the danger that the field degenerate into either a false spiritualisation or a concretistic literalism" (Schwartz-Salant, 1988, pg. 53). These dangers, which hinder any transformational therapeutic work, are now mediated. Schwartz-Salant adds that, in this woodcut and consequently by virtue of experiencing the coniunctio, "one achieves an interactive field in which acting-out, concretising the processes in the third area, is now less of a danger" (pg. 54). This is one of the contexts in which Schwartz-Salant refers to the idea of the "subtle body," a concept that—as we shall later see—is central to many of his publications. He states that, "generally, working in such third areas engages processes that are neither literal nor symbolic but both, a combination the alchemists depicted with the subtle body idea." I can imagine that the reader of the present study will find that this last quote introduces more questions than it provides answers for, because Schwartz-Salant offers no comprehensive explanation of what he means by the "subtle body" in the quote. I however chose to include the passage to indicate that the notion of the subtle body will become a key reference point as we dive more deeply into this author's oeuvre. What else does Schwartz-Salant say about the coniunctio? He proposes that "it is also an event that often occurs unconsciously" and that it "leads to a field whose quality may be described as unifying the opposites container-contained." The latter notion can be seen as a nod to Wilfred Bion and his work on the "container" principle (e.g., Bion, 1984, pg. 90). However, Schwartz-Salant employs his own terminology, including the concept of the "interactive field," to enrich Bion's theories: "This field quality manifests as the analyst's image being introjected by the patient, and the patient's introjected by the analyst. As a result the patient can have the imaginal experience of being contained by the analyst outside of the session" (Schwartz-Salant, 1988, pg. 54). According to Schwartz-Salant, the containment goes far beyond the rapport between therapist and patient in their sessions. Indeed, he

regards the coniunctio experience as "a mutual 'feeling-into' experience that bridges the limitations of space and time." Schwartz-Salant is conscious that some of the language he uses to detail the characteristics of the coniunctio may read similar to that found in literature that would commonly be labeled as esoteric. It is not by accident that he refers to the term "numinosum," which is used by Jung to hint at the existence of a dimension that is beyond comprehension to the human being but still reaches into our lived experience. Schwartz-Salant writes: "The coniunctio field has an acausal dynamic that transmits over a distance, a phenomenon linked in occult literature to communication on the astral plane, something one can grasp as an aspect of information transfer through the unus mundus." Some more scientifically minded readers of the present study may consider these comments by Schwartz-Salant questionable. I have chosen to include them because I feel that they add nuance to his illustration of the coniunctio as an integral aspect to the process of healing and character transformation in psychotherapy. Also, this is an idea that the thesis will pick up in later chapters. Schwartz-Salant concludes his examination of the fifth of the Rosarium's woodcuts by expressing his belief that "the coniunctio is thus a highly prized state; the alchemist's work aimed at creating this field quality in a stable form that would be an elixir transforming baser elements of matter and the human personality." He adds that this stability, while highly desirable, is not easily attained—a fact underlined by the remaining woodcuts, which "deal with issues that paradoxically both destroy this field, yet are also necessary for its eventual stability."

4.1.6 The Rosarium Philosophorum: Image Six

The sixth image of the Rosarium Philosophorum shows "Death," suggesting that "after the coniunctio oppositorum, deathlike stillness reigns. When the opposites unite, all energy ceases: there is no more flow" (Jung, 1966, pg. 257). One of the terms Jung uses to capture this stage is that of the "nigredo," signifying the darkness that comes with it (pg. 258). Death, however, not only means that king and queen are effectively experiencing "the decay of a living creature" (pg. 257). Rather, they have "melted into a single being with two heads" so that "new life can arise." In that sense, woodcut Six symbolizes an "interim stage"—because "no new life can arise, say the alchemists, without the death of the old." For the first time in the Rosarium, the hermaphrodite enters the stage. He has taken over from king and queen, and "one half of the body in the alchemical illustrations is masculine, the other half feminine." Carl Jung points out that, according to the texts accompanying the woodcuts, the goal of the entire transformational process is for a being to come alive that consists of body, soul, and spirit. However, the royal couple, who represented body and spirit, are now decaying, while "the soul (evidently only one soul) parts from them 'in great distress.'" (Jung, 1966, pg. 258). I would like to emphasize the notion that the two royal figures are now characterized as sharing one common soul; this, I believe, corresponds to a sense of "mixing" or "intertwining" of therapist and patient, which has now happened—even though this togetherness is no longer felt as such, in stark difference to the coniuncito stage. Nathan Schwartz-Salant comments that "the death-like state," in the therapeutic setting, "is often experienced by analyst and analysand through depression and despair" (Schwartz-Salant, 1988, pg. 55). Another tough emotion that may surface is that of envy. This is because "unconscious feeling memories of early losses of union are constellated, losses that led to envy-dominated beliefs that union could never again exist."

Schwartz-Salant describes the difficulties of navigating the "Death" stage by outlining that it can be hard to resist interpreting the patient's and also the therapist's feelings from a perspective of clinical diagnosis. It may seem that "failures in the depressive position" of one of the two people involved are coming to the surface and making themselves known. But this use of interpretation as a means of dealing with the situation would be ill-advised. Schwartz-Salant instead recommends focusing on the "interactive field" between therapist and patient, and to remember any "previous qualities of that field." He knows that this is more easily said than done, as "the affects of the nigredo are so strong as to easily repress memories of what previously occurred." But in spite of these hurdles, the clinician is encouraged to think of "previous losses of union, especially in the analytical process preceding the nigredo," and not to be deterred by the inclination to "interpret[…] through the metaphor of parts projected," because this would reduce the experience "to a personal level rather than seen as part of a process of loss of sacred energies." Carl Jung similarly emphasizes the impersonal dimension of the coniunctio and the succeeding nigredo. While both states are lived through on a deeply personal level, they extend into a realm that goes beyond the reach of the individuals involved. Jung writes: "If we approach this task with psychological views that are too personalistic, we fail to do justice to the fact that we are dealing with an archetype which is anything but personal. […] It s hould never be forgotten that it is a symbolical relationship whose goal is complete individuation" (Jung, 1966, pg. 261). Looking at the nigredo more closely, one may wonder why this darkened state has become necessary—why king and queen needed to face death. Jung suggests that, in keeping with the theme of incest showing its presence in earlier woodcuts, the incestuous nature of the coniunctio has its consequences and that "death is a sort of tacit punishment for the sin of incest" (pg. 258). But Jung also points out the royal nature of the two main characters in the Rosarium; in the world of royalty, incest is viewed differently: "Procreation through incest is a royal or divine prerogative whose advantages the ordinary man is forbidden to enjoy" (pg. 264). My understanding of this theme is as follows: The more therapist and patient understand that their experience of oneness and separation in therapy, as illustrated in the Rosarium, has archetypal qualities and goes beyond their personal experience, the less problematic the coniunctio will turn out to be. If they overidentify with their experience—and interpret it as a mere result of their interaction as individuals—the entire process could become dangerous and uncontrollable, with the possibility of a concretization of the unconscious dynamics in the form of physical reenactment. Schwartz-Salant's thoughts seem to be largely compatible with my own reading of Jung's study on the Rosarium. He writes that the "nigredo results from elements of incestuous intertwining through projective identification during the previous coniunctio" (Schwartz-Salant, 1988, pg. 54), implying that the coniunctio process almost inevitably begins with some degree of reenactment of unconscious materials in the

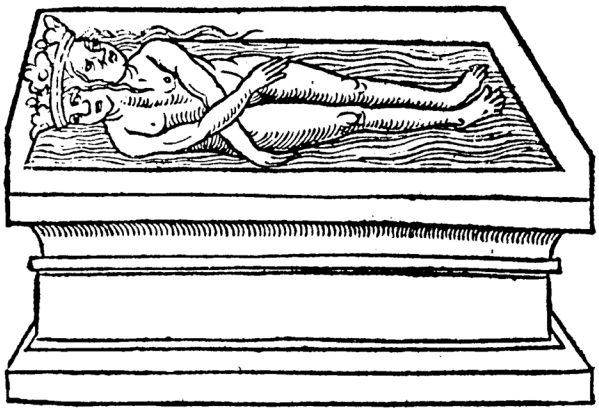

Fig. 6: "Death"

rapport between therapist and patient. Over the course of repeatedly undergoing the process illustrated in the Rosarium, the projected elements are eventually integrated and can be—at least partially—consciously identified. Schwartz-Salant also sees a danger of concretization, or reenactment of unconscious object relationships, in therapy. He states: "Unresolved incest issues in either analyst or analysand, to say nothing of acting-out through psychic merger or physical acts, will destroy the coniunctio" (pg. 55). In this sense, the medieval series of images can serve as "a guide to dealing with transformations in the interactive field," helping both therapist and patient to orient themselves within a process geared toward mutual transformation and growth that can often be utterly confusing—and the nigredo undoubtedly represents one of the more disorienting of stages.

4.1.7 The Rosarium Philosophorum: Image Seven

Woodcut Seven goes by the name "The Ascent of the Soul" and illustrates the next stage of the nigredo and its unsettling darkness. The two bodies, king and queen, who have morphed into a hermaphrodite, continue its decay while a small human-like figure dives upward into the clouds that hover above the mercurial shrine. This small figure, perhaps surprisingly to the alchemical novice, signifies the soul. Carl Jung writes that "the fact that the soul is depicted as a homunculus in our picture indicates that it is on the way to becoming the filius the undivided and hermaphroditic First Man" (Jung, 1966, pg 272). Jung describes the woodcut's larger imagery as such that "out of the decay the soul mounts up to heaven. Only one soul departs from the two, for the two have indeed become one" (pg. 267). He seems to disclose his belief in a certain kind of afterlife by adding that "as in real death, the soul departs from the body and returns to its heavenly source. The One born of the two represents the metamorphosis of both, though it is not yet fully developed and is still a 'conception' only [...]. The 'soul' evidently represents the idea of unity which has still to become a concrete fact and is at present only a potentiality." While Jungs thoughts on image Seven at first seem to indicate a positive step forward, they are much more ambivalent upon closer examination. While they do imply that the coniunctio, the union of opposites, has successfully taken place, we are now in the midst of its aftermath. The union is no longer experienced. Rather, a sense of disconnect unfolds, and of acute disorientation. This feeling of non-linking is now also predominant between therapist and patient. Jung states: "This picture corresponds psychologically to a dark state of [...] collapse and disorientation of consciousness," which "may last a considerable time and it is one of the most difficult transitions the analyst has to deal with, demanding the greatest patience, courage, and faith on the part of both doctor and patient" (pg. 267). Although obviously a challenging stage within the Rosarium, Jung writes that many alchemists considered the nigredo a special and necessary state, even if the reasons for this estimation may initially be elusive when it is being experienced: "It is not immediately

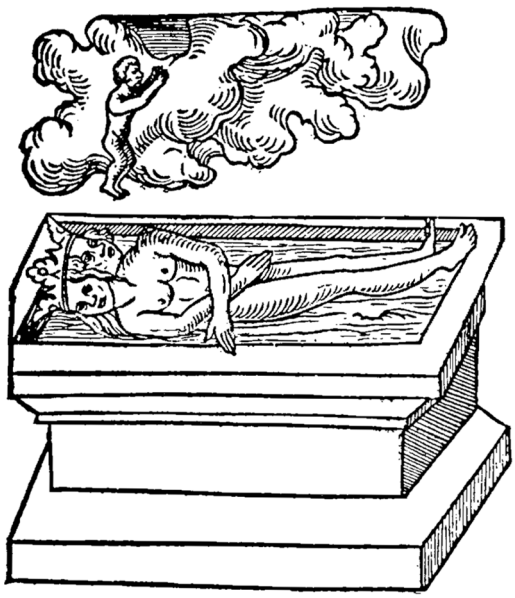

Fig. 7: "The Ascent of the Soul"

apparent why this dark state deserves special praise, since the nigredo is universally held to be of a sombre and melancholy humour reminiscent of death and the grave" (pg. 271). The grounds for why the nigredo is essential will become clearer once we examine Nathan Schwartz-Salant's thoughts on this stage of the process—alchemical or therapeutic in nature—depicted by the Rosarium. However, it is also important to note that Jung and Schwartz-Salant offer different solutions for how to meet the problems presented by this stage of the nigredo. Jung, who wrote his analysis of the Rosarium late in life, has a somewhat more authoritative but probably also well-informed stance. He speaks to the competence required of the clinician, suggesting that "where the doctor fails, the patient will fail too, which is why the doctor should possess a real knowledge of these things and not just opinions, the offscourings of our modern philosophy for everyman" (pg. 256). Based on this—hard to pin down—competence, Jung's approach to dealing with the situation now presenting itself is this: "Faced with the disorientation of the patient, the doctor must hold fast to his own orientation; that is, he must know what the patient's condition means, he must understand what is of value in the dreams, and […] he must approach his task with views and ideas capable of grasping unconscious symbolism" (pg. 270). Jung finds that relying on one's intellect will help little if anything; neither will it prove fruitful to turn to widely available "scientific" methods to meet the demands posed by the nigredo. He asserts that "intellectual or supposedly scientific theories are not adequate to the nature of the unconscious, because they make use of a terminology which has not the slightest affinity with its pregnant symbolism." While Jung's solution is for the clinician to use their experience and apply their knowledge in working with symbolic content, Nathan Schwartz-Salant beliefs that interpretation is a tool inappropriate in reacting to the unfolding nigredo. Schwartz-Salant does agree with Jung, whom he quotes, that "the psychological interpretation of this process leads into regions of inner experience which defy our powers of scientific description" (Jung, 1966, pg. 272). However, he is convinced that, "at this juncture, many projective identification interpretations are possible, but these will only falsify the painful state of a complete absence of linking" (Schwartz-Salant, 1988, pg. 55). In other words, even symbolic interpretations of the therapist's or patient's inner state are misplaced at this point. An illustration provided by Schwartz-Salant discusses the clinician's felt sense of lifelessness: "For example, states of psychic deadness and impotence which the analyst may feel can readily be interpreted by him as an induced effect. But this is off the mark, and takes into the interpersonal relationship archetypal aspects which are truly beyond it" (pgs. 55–56). However, if interpretation is now no longer a valid tool, how then should the therapist proceed in this scenario? According to Schwartz-Salant, this question is beside the point because both therapist and patient are now taking part in a greater archetypal process that cannot be fully grasped or understood. On a conscious level, both therapist and patient must surrender their desire to intellectually contain a development that is informed by archetypal energies. Schwartz-Salant writes: "From a conscious point of view, a person or a couple experiencing the dynamics represented by this woodcut will only know a terrible state of disorientation and loss of any form of inner or outer connection. Yet from a deeper vantage point, this lost connection, the soul, is said to be in the process of being impregnated by a higher form of consciousness" Schwartz-Salant, 1998, pg. 155). Elaborating on this point, Schwartz-Salant

mentions that Jung's deliberation of the Rosarium realizes an important shift in woodcut Seven: "Up to this point in his analysis he had largely employed the model of union or the coniunctio based upon the image of the hieros gamos—a state that can reflect the unconscious relationship between two people" (pg. 55). Schwartz-Salant notes that, in "The Ascent of the Soul," Jung picks up a different facet of meaning to the coniunctio, "namely the unio mystica, the solitary ascent of the soul to God. This is significant: while two people engaged in the interactive field depicted by Figure 7 may experience extreme disorientation, more is happening than meets the eye." In this context, Schwartz-Salant employs a particular way of describing the relationship between clinician and patient, which I want to highlight since later parts of the present study will use this characterization as a conceptional bases. The term I would like to point out is that of the "third area." Schwartz-Salant writes, further addressing the extraction of the soul shown in image Seven, that the consequence of the absence of the common soul is precisely what is felt in the therapy relationship: "Analyst and analysand may experience a severely soulless condition. The third area is characterised here by a total absence of linking." But this feeling of disconnection is not a sign that the treatment has gone into a suboptimal direction or that a reenactment is happening. The nigredo stage's obscureness effectively renders both participants blind to what is truly going on, as the archetypal dimension of the development is beyond comprehension: "While the interpersonal relationship feels soulless, and while the individuals themselves may each feel no inner connection to the unconscious, a mystery is being enacted" (pg. 56). This mystery corresponds with the theme of the unio mystica that Jung's analysis shifted to. To Schwartz-Salant, the soul's ascent to God represents "a state of union with the transcendent self." It is for that reason that the therapeutic process has now entered a phase beyond human control. Rather, "it is a time shrouded in mystery and a sense of analytical failure. What happens here is often unknown, even to the eye of the imagination."

4.1.8 The Rosarium Philosophorum: Image Eight

The eighth of the Rosarium's images is named "Purification." It depicts heavenly waters falling from the cloudy sky, onto the hermaphrodite, who remains motionless within its casket. According to Jung, "The falling dew signals resuscitation and a new light: the ever deeper descent into the unconscious suddenly becomes illumination from above" (Jung, 1966, pg. 281). Jung indicates that the dew may be seen as a signal that the darkness, which must follow the bliss of the coniunctio, is about to abandon its grip on the royal couple turned hermaphrodite. While the soul is still with God, "the falling dew is a portent of the divine birth now at hand" (pg. 273), which requires for the soul to return, changed by its mystical union with the numinous greater power. Jung writes that, "when the soul vanished at death, it was not lost; in that other world it formed the living counterpole to the state of death in this world. Its reappearance from above is already indicated by the dewy moisture" (pg. 281). However, that reappearance has yet to happen. The water, the heavenly dew, has a meaning: once again, Mercurius, representing the idea of the unconscious, is entering the stage. Indeed, the dew "is a synonym for the aqua permanens, hence for Mercurius […]; it is the light, the illumination, that follows the darkness […]. The spirit Mercurius descends in his heavenly form as sapientia and as the fire of the Holy Ghost, to purify the blackness" (pgs. 273–274). At this point of his discussion of image Eight, Jung

refers to Nicholas of Cusa, hinting at the fact that Cusanus was a contemporary of the Rosarium's alchemists (pg. 276). He calls him the "philosopher" of the "union of opposites," whereas the alchemists were "the empiricists" of this "great problem" (pg. 320). One of Cusanus's ideas that Jung chooses to implement suggests that water can be associated with God's wish for humans to use their intellect and understanding, so that they may clean themselves of darker elements. In that sense, "the 'water' is the aqua sapientiae" (pg. 274), a "royal art" and a "God-given gift" (pg. 277), and the "dew falling from heaven" therefore represents "the divine gift of illumination and wisdom" (pg. 274). However, while empirical wisdom was elemental to the alchemists, "the purely intellectual attitude must be abandoned" (pg. 279). Jung elaborates on the consequences that would likely happen if humans were to place to bets solely on scientific effort. He writes: "The alchemists seem to have perceived the danger that the work and its realization may get stuck in one of the conscious functions. Consequently they stress the importance of the theoria, i.e., intellectual understanding as opposed to the practica, which consisted merely of chemical experiments" (pg. 279). Although crucial, the intellect has to be complemented by emotion and intuition. Jung mentions the importance of the notion of "feeling," stating that "the alchemists thought that the opus demanded not only laboratory work, the reading of books, meditation, and patience, but also love" (pg. 280). In this connection, he makes a comparison to psychotherapy, in which both "intellectual understanding and aesteticism" on the one hand and "a feeling relationship to the contents of the unconscious" on the other are required (pg. 279). But in addition to paying close attention to one's emotions, it is also crucial to allow for one's intuitive capacity to shine through: "Intuition gives outlook and insight," writes Jung, mirroring the alchemists' beliefs (pg. 281). Overall, Jung concludes that the eighth woodcut illustrates the necessity for the alchemical process to introduce a stage that would ensure "the removal of the superfluities that always cling to merely natural products, and especially to the symbolic unconscious contents which the alchemist found projected into matter" (pg. 277). Nathan Schwartz-Salant can help us in translating the alchemical ideal more fully into the world of psychotherapy. He agrees with Jung that "the eighth picture, the mundificatio, depicts the process of washing away lingering inflations that attend engaging the third area" (Schwartz-Salant, 1988, pg. 56). He then turns to his concept of the "third area," or the "field," to discuss the implications of the Rosarium's state of cleansing within the developing therapy relationship. To Schwartz-Salant, something greater than the limited scope of the conscious human experience is at work in image Eight, requiring the therapist to pay tribute to the numinous quality of the process. He states: "In the aspect of work on processes in the third area depicted by Figure 8, one is essentially concerned with the patient's creative linking to the numinosum." In other

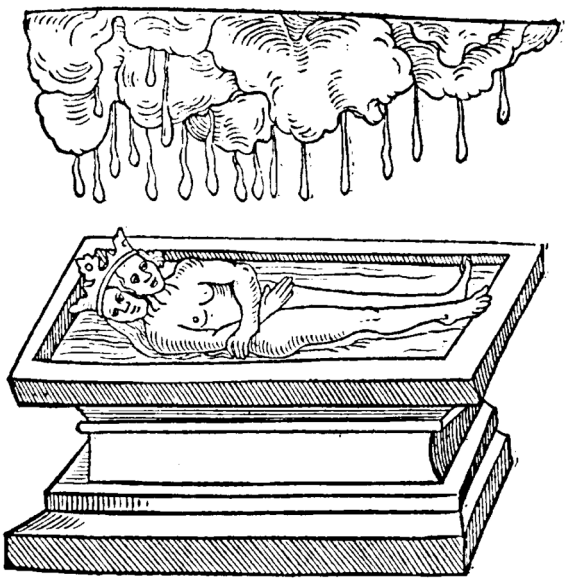

Fig. 8: "Purification"

words, what both the therapist and the patient feel and think—and how they relate to one another—is ruled by an archetypal underpinning. As a result, interpretations of the situation of a reductive sort have little if any purpose and should only be made after some consideration: "In my experience, when engaging the field quality depicted by this figure […] one must remain aware of the field quality and not just speak to the adult personality" with the aim of intellectualizing the experience. Overall, image Eight is a necessary step in the larger process illustrated in the Rosarium. It is a moment of anticipation—of the final relief from the darkness but also of the discovery of the process's deeper purpose. Soon, we will be able to say that "the preceding union of opposites has brought light, as always, out of the darkness of night, and by this light it will be possible to see what the real meaning of that union was" (Jung, 1966, pg. 282).

4.1.9 The Rosarium Philosophorum: Image Nine

As we move on to image Nine, "The Return of the Soul" is finally becoming reality. The soul reappears to "breathe life into the dead body" (Jung, 1966, pg. 283), thereby "reviving the structure that had been forming in death" (Schwartz-Salant, 1988, pg. 56). The notes provided by Nathan Schwartz-Salant on this woodcut are minimal. His sole comment refers to the therapy relationship and how it manifests at this stage of the process illustrated by the Rosarium. He finds that, in this phase, "the field has become relatively stable, and regressions are unlikely to become malignant." Carl Jung's thoughts on woodcut Nine are much more extensive. However, a large section of his elaborations focus on the two birds shown in the image—which Schwartz-Salant completely leaves unconsidered. The reason for this discrepancy is that the two authors refer to different woodcuts. Technically, Schwartz-Salant uses the correct ones. Jung chose to integrate what is effectively the sixteenth woodcut of the full 20-picture series. While Jung concludes his discussion of the Rosarium with image Ten, Schwartz-Salant includes all 20, effectively extending Jung's analysis. Audio recordings of speeches given by Schwartz-Salant (Schwartz-Salant, 1986, min. 58) indicate that he lectured on images Eleven through Twenty as early as the mid-eighties; a more comprehensive presentation is featured in his 1998 publication "The Mystery of Human Relationship" (Schwartz-Salant, 1998, pgs. 192–208). An even more up-to-date discussion of the second half of the Rosarium's woodcuts is provided by Gary Tomkins, a Jungian analyst based in England's Somerset region. Tomkins hosts a detailed analysis of the second half of the Rosarium on his website (Tomkins, n.d.a). However, all of this shall be examined later. Going back to the ninth woodcut and the two birds, Jung writes that it is no coincidence that one of them is pictured standing upright, while the other is immersed in water with only its head sticking out. Apparently, the pair stands for "the double nature of Mercurius, who is both a chthonic and a pneumatic being" (Jung, 1966, pg. 283). This suggests that, while the

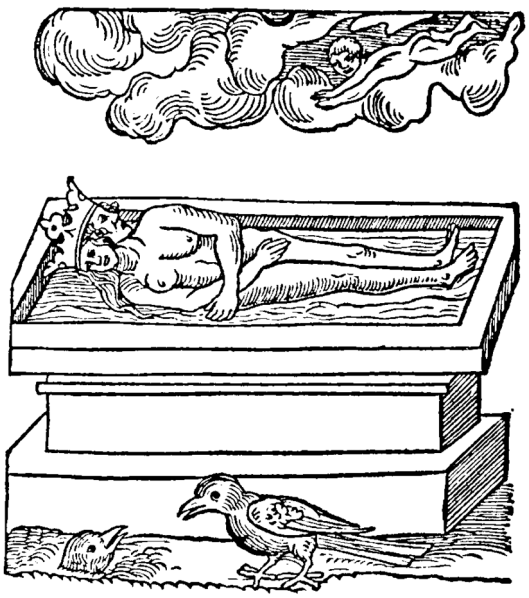

Fig. 9: "The Return of the Soul"

hermaphrodite represents the union of opposites that were once king and queen, "the conflict between them is by no means finally resolved and has not yet disappeared." Rather, the clash of opposites prevails via the duality of the Mercurian birds—a circumstance that implies that these opposites were "banished to the sphere of the unconscious" and must still be considered "unintegrated." The presence of the birds is one of the more subtle aspects of image Nine. It bears implications for question, "What is the meaning of the soul?" (pg. 304) and is certainly crucial in the context of the Rosarium. While Jung does not provide a cut-and-dry definition of the soul, likely because this would not be possible given the nature of the alchemical texts, he does include what amounts to a collection of hints. Jung states that the soul, which, in woodcut Nine "is reunited with the body," can be regarded "the One born of the two, the vinculum common to both. It is therefore the very essence of relationship" (pg. 295). But what qualities does this relational foundation possess, and where is it located? Jung associates the soul with personal human consciousness but also states that it carries an inherent divide between male and female parts, or male or female areas of personal identification. He writes: "The 'soul' which accrues to ego-consciousness […] has a feminine character in the man and a masculine character in the woman. His anima wants to reconcile and unite; her animus tries to discern and discriminate (pg. 304). It must be pointed out, however, that both animus and anima are not directly the intrapsychic representations belonging to therapist and patient. Rather, the animus belongs to the queen in the royal couple with the anima being the king's. The process depicted in the Rosarium "is essentially transcendental," clarifies Jung, adding that "the coniunctio is a hierosgamos of the gods and not a mere love-affair between mortals" (pg. 291). The consequences of this distinction will become clearer when we look more deeply into the work of Nathan Schwartz-Salant on the therapy relationship. What we can, however, already conclude from Jung's thoughts is that the Rosarium's process, and therefore the therapeutic encounter, must be seen as encompassing a dimension that cannot be fully understood by the human intellect. Indeed, one must conclude from the alchemical texts that "not only the coniunctio but the reanimation of the 'body' is an altogether transmundane event, a process occurring in the psychic non-ego" (pg. 291). As Schwartz-Salant puts it, "more is happening than meets the eye" (Schwartz-Salant, 1988, pg. 55). In other words, the largely unconscious nature of the process exceeds the capacity of human consciousness to serve as the container for the development to unfold. Importantly, there are ramifications stemming from the process largely occurring in what Jung calls the "non-ego." Jung writes that the fact that therapist and patient cannot grasp the full scope of their interaction explains "why the process is so easily projected" (Jung, 1966, pg. 291). I find this point highly interesting. Earlier in the present study, I collected several contemporary convictions that the therapy relationship was the single-greatest success factor in therapy. However, what this relationship entailed was largely unclear. Carl Rogers even stated that he often felt that he was doing his best work when not consciously choosing how to engage with his patients, relying instead on his "intuition" (Rogers, 1980, pg. 129). I wonder if the underpinnings of what happens in psychotherapy—and within the therapy relationship in particular—is beyond comprehension for precisely the reasons pointed out by Jung's analysis of the Rosarium. The implication would be that the reasons for a therapy's success are commonly, as Jung puts it, "projected." In this sense, the projection of

"healing" in psychotherapy—or, more specifically, the sense of having achieved the integration of dissociated parts into one's personality—would find different targets outside of the domain of the archetypal and the unconscious. While the patient may project the reason for why they got better onto the clinician, the therapist may attribute the fact that the patient was able to integrate split-off personality aspect to their technique. We could take this thought experiment one step further and wonder about potential consequences of such projection by the therapist. Would they regard their technique as indispensable? Would they, at the same time, be deeply insecure about the validity of this assumption and about their mastery of their methods of choice? I could see this as the potential basis for the endless discussions in psychotherapy science as to what techniques are the best—if not the only "correct" ones, or those that allow for meaningful change in the patient. Maybe therapists would be well advised to consider themselves part of a more comprehensive archetypal development that they will never fully comprehend—rather than finding an intellectual reason for why their patients heal, or rather than fueling their narcissistic desire to think of themselves as "a good clinician." At any rate, both the therapist's and the patient's tendency to project large parts of the transformational process will find a fitting target, as Jung explains: "Experience shows that the carrier of the projection is not just any object but is always one that proves adequate to the nature of the content projected—that is to say, it must offer the content a 'hook' to hang on" (Jung, 1966, pg. 291). In the case of the alchemists, the target of their projection was the matter they were going to transform—and the matter alongside which they themselves were undergoing a transformation.

4.1.10 The Rosarium Philosophorum: Image Ten

Woodcut number Ten, "The New Birth," concludes Carl Jung's analysis of the series. Jung writes: "Our last picture is the tenth in the series, and this is certainly no accident, for the denarius is supposed to be the perfect number" (Jung, 1966, pg. 306). He goes on to detail that, for the alchemists, the numbers One to Four are of special significance, with Ten representing their sum, thereby signifying "the result of the completed work" (pg. 308) as well as "unity on a higher level" (pg. 306). There exists a connection between the number Ten and the "Son of God," or what "the alchemists call […] the filius philosophorum" (pg. 308), and indeed this is what the picture conveys: the hermaphrodite has come to life. It is his birth that had been the goal of the alchemical undertaking all along. The hermaphrodite, "the lapis, understood as the cosmogonic First Man, is the radix ipsius according to the Rosarium: everything has grown from this One and through this One," states Jung accordingly (pg. 309). The figure is winged, which suggests "volatility, i.e. spirituality" (pg. 314). The image also depicts four snakes, which the hermaphrodite all bears: "In one hand it holds a chalice with three snakes in it, or possibly one snake with three heads; in the

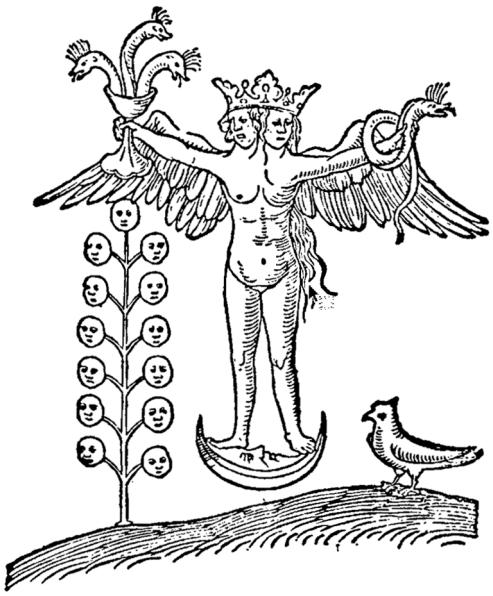

Fig. 10: "The New Birth"

other, a single snake." While the three snakes grouped together in the chalice are "the chthonic equivalent of the Trinity," the fourth represents two things: firstly, the unity of the three […] and, secondly, the 'sinister' serpens Mercurialis with all its subsidiary meanings" (pg. 315). Jung provides nuanced insights into the layered complexity of the four snakes—in essence, they are a transformed continuation of themes present early on in the Rosarium. The two remaining elements in the woodcut are a raven and special kind of tree, which, instead of leaves, carries faces. The raven on the right side of the woodcut, writes Jung without further contextualization, is "a synonym for the devil," while the "sun and moon tree" to the left can be seen as "the conscious equivalent of the unconscious process of development suggested on the opposite side" (pg. 315). Apparently, the raven and the tree are symbols for the conscious and unconscious results from the Rosarium's process. The fact that the hermaphrodite stands on the moon, which "corresponds to the feminine lunar vessel" (Jung, 1966, pg. 315), indicates "that both the positive and negative forms of luna are its foundation" (Schwartz-Salant, 1988, pg. 56). Taking a closer look at the moon's disparate facets, Schwartz-Salant lists qualities that, to some extent, mirror the characteristics of the qualities attributed to the astrological sign Cancer, which is associated with the Moon. I am mentioning this connection because later parts of the present study will employ archetypal patterns from the symbolic system of astrology to describe interpersonal relationships. However, the qualities that Schwartz-Salant associates with the moon in the woodcut are by no means a complete list of the characteristics of the astrological representation. He first turns to the negative connotations of luna and talks about "states of abandonment, envy, depression and despair, which previously were identified with by the ego or by the two people in the relationship" (pg. 56–57). At this stage of the Rosarium—and therefore of the psychotherapeutic process—those negative emotions have "now become integrated" and have formed "part of the foundation of the interactive field," the space between therapist and patient (pg. 57). But not only the Moon's negative connotations apply; "the positive aspects of luna" are equally "fundamental, which is to say that an interactive field exists in which the imagination is stable" and "no longer destroyed" by non-integrated elements or projected aspects of the patient's or therapist's personality. Another way to describe the new development is to say that the "unconscious identification with death" that dominated some of the previous states, "has been overcome" (pg. 56). This all sounds very positive, but Jung warns against expecting too much from the process, since ideal conditions are never fully met: "These images are naturally only anticipations of a wholeness which is, in principle, always just beyond our reach. Also, they do not invariably indicate a subliminal readiness on the part of the patient to realize that wholeness consciously" (Jung, 1966, pg. 319). Still, the integration of "darker" elements— of projected or split-off parts of one's personality—remains a viable goal of the therapeutic process. It is on these grounds that Schwartz-Salant denotes that "in Figure IO one meets a major level of achievement depicted in the Rosarium, the creation of a structure that can also be understood as a shared self between two people." (Schwartz-Salant, 1988, pg. 57). Focusing on the "third area," the space between therapist and patient that is determined by unconscious factors more so than by conscious aspects, Schwartz-Salant speaks of a "third body" existing in the field generated by the therapy relationship (pg. 57). He states: "This is a subtle body or structure that yields wisdom,

knowledge and most crucially, kinship. It has its own autonomy within the third area." This notion of the space between people, which points to the essence of any deeper interpersonal relationship, as well as the idea of the subtle body will be examined more closely later in this study, relying on the guidance of Schwartz-Salant's works.

4.1.11 The Challenges of the Rosarium Philosophorum

Concluding my review of the Rosarium Philosophorum, as interpreted by Carl Jung and Nathan Schwatz-Salant, it seems appropriate to acknowledge the relative strangeness of the alchemical texts to the modern reader. Among the many aspects that make the Rosarium's images and words hard to decode are its inherent paradoxes. Jung discusses at length the alchemical texts' many obvious contradictions, which at times seem to intentionally defy all human logic. Translated into the world of contemporary psychotherapy, the reason for the contradictions corresponds with the unfathomable nature of the unconscious and its "extraordinarily timeless quality" (Jung, 1966, pg. 311). As Jung writes, the unconscious has the distinction that everything it contains "has already happened and is yet unhappened, is already dead and yet unborn." This irritating timeless aspect of the unconscious can derail any student of the Rosarium, as well as of archetypal material in general. It is also a quality that Jung likes to attribute to what he calls the "self"—the goal of one's individual journey of becoming. As Schwartz-Salant explains, the self has a transcendent side that can only stay elusive to the human intellect (Schwartz-Salant, 2017b, min. 16). And for that very reason, some of the more challenging thoughts found in the alchemists' writings come as no surprise to Jung—including the confusing genesis of the Rosarium's hermaphrodite: "It seems to have dawned on the alchemists that this most monstrous of paradoxes was somehow connected with the self, for no man can practise such an art unless it be with God's help, and unless 'he see through himself' (Jung, 1966, pg. 312). The notion that the process of integrating antagonizing opposites, illustrated by the ten woodcuts, relies on the presence of a greater power, and does so more than it depends on human competence, advocates humility on the practitioner's side. As indicated earlier when discussing woodcut Nine, I believe this principle to be applicable in the field of psychotherapy, and Jung's thoughts seem to support my contention. It is more appropriate for clinicians to consider themselves facilitators of the archetypal process illustrated by the Rosarium than to think of themselves as the process's creators. Indeed, Jung quotes the Rosarium's anonymous author as follows: "It is manifest […] that the stone is the master of the philosophers" (pg. 313). This implies that the "stone"—the goal of the process—dictates its very unfolding. The quote continues by emphasizing that "the philosopher is not the master, but rather the minister, of the stone. Consequently, he who attempts through the art and apart from nature to introduce into the matter anything which is not in it naturally, errs, and will bewail his error." My interpretation of this passage is that one should know what to claim authorship, recognition, and responsibility for, and where one's competencies end. This may be especially true for psychotherapists, who work with the fluid and timeless matter that is the unconscious—or with the soul. Overall, I feel that one must agree with Carl Jung that, while the Rosarium's writings and images are often hard to make sense of, the alchemists "performed the inestimable service of having constructed a phenomenology of the unconscious long before the advent of psychology" (Jung, 1966, pg. 289). Jung adds: "The alchemists did not really know what they were

writing about. Whether we know today seems to me not altogether sure." Archetypal processes must remain opaque to some degree, and, according to Jung, there are many of them. "The coniunctio is one of these archetypes," he finds (pg. 292), and maybe all we can do is to try our best to facilitate its prowess even if we can never fully understand it. This, for what it's worth, happens to be my personal goal in practicing psychotherapy.

4.2 Schwartz-Salant's Extension of Jung's Theoretical Framework

Nathan Schwartz-Salant's work dovetails into Carl Jung's largely theoretical opus. Not only does he consider himself a Jungian (e.g., Schwartz-Salant, 1986, min. 66) but he also states that much of his mission is dedicated to applying Jung's findings to the contemporary practice of psychotherapy and psychoanalysis—"into the here and now with people" (Schwartz-Salant, 2017b, min. 21). He, for instance, examines the personality disorders of narcissism and borderline through the lens of Jung's approach (Schwartz-Salant, 1982 & 1989). In a 2017 interview, Schwartz-Salant explains that much of his clinical expertise, built up over decades, is a result of his ambition to turn Jung's concepts into a structured method for the treatment of certain groups of patients. In a sense, he says, his goal was to grow from being a "theoretical" psychoanalyst to an "applied" one—similarly to how a theoretical mathematician might put their efforts into becoming an applied scientist (Schwartz-Salant, 2017b, min. 47). The majority of Schwartz-Salant's publications refers to Jung's work on alchemy as a foundation, especially to Jung's analysis of the Rosarium Philosophorum. However, Schwartz-Salant takes many of Jung's ideas one step further. For the purpose of the present study, the single most relevant of these advancements is Schwartz-Salant's concept of the "third area" between therapist and patient as a "space" in which a complex yet crucial dynamic unfolds. In this light, the therapy relationship can be seen as "a space that is animated, that is alive with meaning, and that contains its own process" (Schwartz-Salant, 1998, pg. iiv). This idea of the therapy relationship as a "third thing" that arises when therapist and patient engage in partially unconscious interaction, will enable us to progress to later chapters of this study, and so will Jung's and Schwartz-Salant's frequent utilization of archetypal patterns. Before we dive more deeply into the nuances of Schwartz-Salant's idea of the therapy relationship, it seems appropriate to contextualize the concept of this "in between world" by examining some of Schwartz-Salant's achievements in extending Carl Jung's system of thought. I will review his discussion of images Eleven to Twenty of the Rosarium Philosophorum, briefly walk through his publications on the treatment of narcissism and the borderline condition, and review his work on the "Fusional Complex"—a phenomenon that, according to the author, corresponds to an underlying archetype not previously mentioned by Jung (Schwartz-Salant, 2007, pg. 14). Furthermore, I will explore Schwartz-Salant's idea of the "subtle body," which has some of its roots in the 1934–39 seminars held by Carl Jung on Friedrich Nietzsche's "Thus Spake Zarathurstra" (Schwartz-Salant, 1986, min. 37; Jung, 1988) but effectively goes far beyond Jung's original scope. The "subtle body," a term used by Schwartz-Salant largely synonymously with that of the "third area," will help us to connect his contribution to Jungian psychoanalysis to our detailed examination of the therapy relationship as a third entity.

4.2.1 Images Eleven through Twenty of the Rosarium Philosophorum

As we shift from Carl Jung's examination of the Rosarium Philosophorum more to Nathan Schwartz-Salant's perspective of the woodcuts, the terminology we encounter will reflect that transition. Nathan Schwartz-Salant frequently refers to notions such as that of the "field" or the "space between" therapist and patient—concepts that will be of significance to later sections of the present study. It is because of that relevance that I will be highlighting Schwartz-Salant's use of these terms as we dive more deeply into his discussion of the Rosarium, with a focus on the remaining images Eleven through Twenty, which Jung excluded from his published material on the series. Apart from Schwartz-Salant, other authors have dealt with this second part of the woodcuts, but not very many. Gary Tomkins is one of them, and I will be including some of his thoughts to provide a rudimentary contemporary contextualization of Schwartz-Salant's ideas.

One quote by Nathan Schwartz-Salant on the Rosarium that can serve as a representation of his tendency to use custom-tailor language and unique terminology in his analysis of the woodcuts suggests that "the Renaissance alchemist created in the Rosarium Philosophorum a treasure of images of field dynamics" (Schwartz-Salant, 1998, pg. 149). Here, the concept of the "field" comes into play, and, in the absence of a terminological definition, we will require more use cases of the term to acquire a solid understanding of what the authors means by it. To Schwartz-Salant, the very point of applying the principles visible in the Rosarium to psychotherapy is that the series of woodcuts demonstrates what happens in the imaginal realm between therapist and patient. He writes: "The series of twenty woodcuts of the most famous alchemical text, the Rosarium Philosophorum […], can be seen as a process of entering a field between two people, experiencing field dynamics, and working with the transformation of the field itself" (pg. 150). The reason why the approach of employing and focusing on field dynamics is such an integral part to working with certain groups of patients has to do with the technique's capacity to bring conflicts to the surface, via a shared experience—conflicts that would otherwise remain inaccessible. For traumatized patients, the field can serve as a container, or as a safe stage waiting for a play to unfold. The aim is to pay attention to the subtle emotional dynamics and to visualize them in your mind's eye, to later enable a transformation of the psychic energies behind the patient's inner stresses. Schwartz-Salant describes this first objective as follows: "The goal is the creation of both an inner-individual and an outer-conjoined field quality which perseveres through any mental, emotional, somatic, or environmental trauma by means of a mind-body union that is so subtle as to be a source of true, imaginal perception." Carl Jung often speaks of "opposites" to capture the nature of his patient's inner conflicts (e.g., Jung, 1966, pg. 211), and Nathan Schwartz-Salant continues and refines this approach. The reason why working with and transforming opposites is of such therapeutic significance has to do with their role in reducing a person's personal suffering stemming from the experience of conflicting aspects of their personality. And indeed, if viewed from the correct perspective, the Rosarium is rich in oppositional figures and symbols. Schwartz-Salant notes that "the way of healing in the Rosarium is through dealing with pairs of opposites, usually represented as sun and moon, or brother and sister, pairs seen as opposing qualities of the subtle body, or within an interactive field" (pg. 154). I would like to underline the fact that Schwartz-Salant again uses the term of the "field" to

communicate his core convictions. The field first enables therapist and patient to enter a space within which opposites can manifest. Then, and based on this mutual experience, a somewhat mysterious process takes hold—a process that allows for the opposites to unite and separate, and for the transformation of the modality by which the patient can handle their conflicting personality aspects. As the patient becomes more conscious of what lies beneath their issues, their suffering is lessened. In this light, the overarching goal of the process illustrated in the Rosarium is that of a "resurrection" of the patient's personality—or, to use Jungian terminology, of their "self." The final woodcut, the twentieth of the series, encapsulates the objective of transforming the patient's self: "The last woodcut of the Rosarium, 'Resurrection,' is thus the crowning achievement of the opus. Whereas in the prevailing Christian belief system the resurrection is an act of faith, in Renaissance alchemy the resurrection is an ongoing, personal and interior experience" (pg. 207). This transformation is achieved by the therapist and patient running through the cycle illustrated by the Rosarium time and again—until the patient's internal representation of their personality has been sufficiently formed. It is on this basis that Nathan Schwartz-Salant finds that "only the experiences of union and death, forged through suffering, vision, and courage, can create the alchemical self" (pg. 208). The patient's ability to be in touch with oppositional aspects within their personality and to sense that they are connected to their self can be regarded as them possessing a new "self-structure." This structure emerges as the process of entering the field, encountering opposites, and transforming them via a shared experience continues over many cycles. This way, "new life" can be "forged in the alchemical fires of coagulating and dissolving old forms of being which, to be transformed, must die, be reborn, and die again" (pg. 209). Unsurprisingly, for the patient to relate to themselves in a new and different manner, their consciousness must undergo a transformation. To Nathan Schwartz-Salant, the resurrection of the patient's self is intertwined with a change in consciousness: "This death-rebirth sequence in the alchemical process of transformation constitutes the continual distillation in which a purified consciousness and self-structure are eventually created." As the patient's consciousness increases and changes, they become aware of new forms of leading their life—and their individuation progresses. The term "individuation" corresponds to one of Jung's fundamental ideas; in essence, it refers to the increased experience of a sense of personal "wholeness, completeness, and perfection" (Jung, 1972, pg. 110). Nathan Schwartz-Salant summarizes the purpose of the therapeutic work mirrored by the Rosarium Philosophorum by including a nod to the Jungian concept. He states that "the goal of the process […] is nothing less than the transcendence of such union death cycles" (Schwartz-Salant, 1998, pg. 143). Again, woodcut Twenty is an apt symbolization: "In this last of the images of the series, the resurrected Christ figure symbolizes the stability and constancy of a self-structure even while, in the background […], dissociative and violent processes still occur. Yet in this goal of the opus, a transformation of consciousness and structure is achieved that is capable of belief in the resurrection, not only the resurrection of a dead self, as in Christ, […] but also the resurrection of one's internal structure in whatever form it must take for continued individuation."

In regard to the analysis of the Rosarium's woodcuts, Schwartz-Salant continues where Jung left off. In principle, it could be argued that the basic objective of the transformation

process is achieved over the course of the first ten images—and Schwartz-Salants attest to that: "The stage depicted by the completion of the first ten woodcuts […] represents the creation of a self-structure that unifies mind and body" (pg. 150). However, the complexity of the first ten woodcuts is enriched and refined by the second half. In other words, work remains to be done even as the first ten woodcuts end. Schwartz-Salant finds that, in the first phase of the process, represented by the first ten images, "the field and a sense of self are often lost to awareness, especially under the impact of passion," necessitating further therapeutic measures. Importantly, he again utilizes the term "field" to address the problem of the need for further treatment. Interestingly, the notion of "passion" influencing the process is one that Schwartz-Salant alludes to several times in his discussion of the Rosarium's woodcuts. While he provides no to-the-point definition of how he uses the term, I take it to refer to a certain kind of emotional dynamics that can unfold in the third area between clinician and patient. One quote that supports this interpretation of Schwartz-Salant's thoughts reads as follows: "Psychoanalysis has seldom focused upon the transference relationship as an enlivened field quality characterized by passion […]. Containing passion and relating to it are essential skills for anyone wishing to deal with the complexities of union states and with associated abandonment issues and their powerful, related emotions" (pg. 188). Integrating passion into the psychotherapeutic treatment on a conscious level is of great relevance to Schwartz-Salant—because excluding it could render the treatment a dishonest endeavor: "Without passion, any relationship risks decay into mechanical behavior and resentment." The inclusion of passion is one of the critical parameters influencing the second phase of the Rosarium. It is designed to further stabilize the union of opposites achieved prior. The second phase is called the "rubedo" progression, in which "the alchemist attempts to bring a kind of life and blood to the 'stone' that now has a deeper continuity and presence amidst intense emotion and body states" (pg. 150). The "stone" again stands for the self, the target of one's individuation. It can be brought to life by undergoing many rounds of walking through the transformation process depicted in the Rosarium, thereby uniting previously unconscious opposites and integrating disparate parts of one's personality. Due to the relevance of the self in the Jungian system of thought and its direct connection to the essential idea of individuation, Nathan Schwartz-Salant emphasizes its role in the context of working with opposites in psychotherapy. The self, according to Schwartz-Salant, exists in two forms: it has an immanent and a transcendent side (pg. 151). Both are relevant in psychotherapy. However, in spite of its central role, the self can never be fully grasped, nor can complete individuation ever be attained: "The issue is not reaching perfection but being on the path of transformation" (pg. 150). Still, the Rosarium Philosophorum's main purpose is to aim for the resurrection of the self in a form as comprehensive as possible, and this is where the second half of the woodcuts come in: "The Rosarium, in its rubedo state, consolidates a self that can live without fusing with others and which experiences a passion for linking—with others and with one's self—that is not disowned from one day to the next in fear of engulfment and contamination" (151). This last quote uses specific clinical language, which may require some explanation. In several of his books, Nathan Schwartz-Salant deals with "mad areas" of the psyche that are dominated by psychotic processes, against which the patient must employ defenses. The presence of these processes makes

it impossible for the individual to feel connected to the affected parts of their psyche, as they are often split off or projected and experienced as foreign energies. As a result, the person's presence suffers from this disconnect—and they have trouble relating to the therapist on a more immediate and intimate level. Narcissistic defenses can also prohibit the mutual entering of the shared space between clinician and patient. The publications discussing these issues in detail are "The Mystery of Human Relationship" (Schwartz-Salant, 1998), "The Fusional Complex and the Unlived Life" (Schwartz-Salant, 2007), and "Narcissism and Character Transformation" (Schwartz-Salant, 1982), among others, all by the same author.

Having now examined why the inclusion of the rubedo sequence into psychotherapeutic practice plays such an important role, we can take a closer look at the individual woodcuts of the Rosarium's second chapter. Image Eleven is titled "Fermentation" and shows striking similarities to woodcut Number Five. As Gary Tomkins notes, "the scene is very much like the lake or sea of woodcut 5," and "the Hermaphrodite has separated into two whole human figures, one male, one female, both of whom are winged" (Tomkins, n.d.a). The royal couple are again engaging in a sexual act, the coniunctio, but now both king and queen have been fitted with angel-like wings. In spite of the similarities between woodcut Five and Eleven, the crucial difference lies within the fact that "a psychic self-structure has been achieved in the tenth woodcut" and, as a result, "the analyst and analysand can now know the rhythm of the coniunctio in which it is a 'third thing' that can be imaginally sensed and related to as if a vision were present" (Schwartz-Salant, 1998, pg. 193). At this stage of his analysis of woodcut Eleven, Nathan Schwartz-Salant already assumes that the reader is familiar with some of his terminology. As detailed earlier, what he means by the "third thing" is the enlivened space between clinician and patient, in which unconscious interactions can manifest. He uses the metaphor of "vision," probably because of the tendency inherent in western culture to rank the human sense of vision higher than others, to capture the intricate dynamics unfolding in the clinical setting. While the image signifies the second encounter of the coniunctio, the quality of the experience is different from the first thanks to both clinician and patient having undergone the coniunctio-nigredo cycle multiple times before. As a result, they both have a better—if implicit—understanding of the larger process in which they partake. One way of describing this change is to say that "the process is far more conscious than it is in the coniunctio of the fifth woodcut" (Schwartz-Salant, 1998, pg. 193). Compared to the earlier phase portrayed in the first ten of the Rosarium's images, "the union state now need not immediately lead to a devastating nigredo," which must no longer be "blindly suffered." This is because therapist and patient have built, and can be aware of, a special kind of

Fig. 11: "Fermentation"

rapport—a togetherness that also leads to a transformation of the patient's inner structure, putting them more in touch with their self. The first stage "of the Rosarium creates a psychic self that is the orienting center for the rubedo phase. Without this experience of the self and its function as a center of one's being, the rubedo stage cannot be successfully entered which, I believe, is an essential part of alchemical wisdom, as revealed in the next four woodcuts." Schwartz-Salant is not fully transparent in this passage regarding his use of the term "self." I take it to mean both, the patient's individual self in the Jungian sense—and a shared self that has emerged in between therapist and patient. Schwartz-Salant refers to the latter as the "subtle body," as the therapy relationship, and as the "interactive field," depending on context. I will examine these concepts in more detail later. Concluding the analysis of woodcut Eleven, the main point is that the arduous earlier therapeutic work has paid off, having led to a more conscious interaction and increased familiarity with the archetypal dynamics. Gary Tomkins believes this familiarity is symbolized by the fact that king and queen, Sol and Luna, are now shown surrounded in a softer-looking landscape compared to image Five (Tomkins, n.d.a). While I think that the changes in landscape are relatively minor, I think that the point Tomkins is making is valid: there is increased "openness […] expressed by the intimacy within the bounds provided by nature, the sea and hills" that constitute a home to the royal couple.

As Schwartz-Salant eloquently puts it, "the twelfth to fifteenth woodcuts of the Rosarium and their accompanying texts accomplish two goals. On the one hand, they illustrate ways in which solar-rational awareness and illumination can be destructive and how, at times, they must be sacrificed. On the other hand, […] states of nigredo are more capable of being conscious to the participants and readily reflected upon" (Schwarz-Salant, 1998, pg. 193). The two points he makes here are further emphasized in his thoughts solely dedicated to woodcut Twelve, with the first playing a particularly important role in Schwartz-Salant's general approach. The twelfth image is called "Illumination" and shows a winged sun drowning in a casket filled with mercury; it signifies the idea of surrendering solar consciousness to the depths of the mercurial unconscious, so that the transformation of oppositional structures may continue. In terms of clinical implications, both the therapist and the patient need to forget what they believe they know about themselves and about their shared relationship. Instead, they must allow for the sense of disconnection typical of the nigredo phase to resurface, as the nigredo is just as essential to the larger development as the coniuncito, the state in which the opposites engage in an initial union.

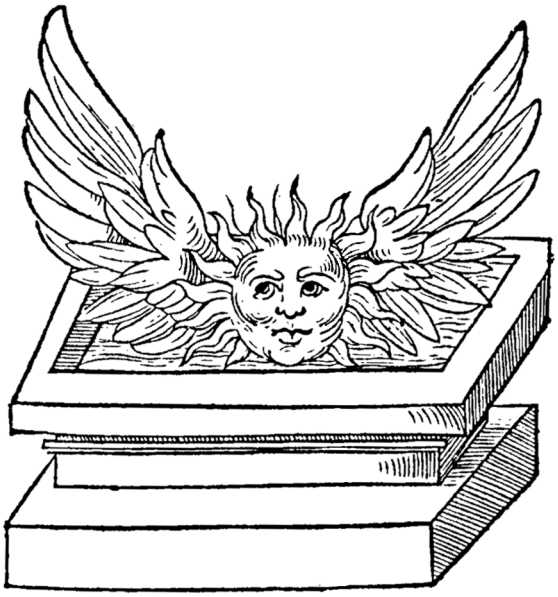

Fig. 12: "Illumination"

Woodcut Thirteen symbolizes the start of the second nigredo sequence in the Rosarium. It is titled "Nourishment." Gary Tomkins offers a concise description of the image's

contents: “Sol and Luna have merged again and lie in a tomb filled with the Mercury of the Philosophers similar to woodcut 6” (Tomkins, n.d.a). The author also highlights how the woodcut differs from its earlier incarnation. He writes: “This time the hermaphrodite figure is winged (albeit with one pair of wings rather than the two pairs shown in woodcut 10). Again one crown is shared implying a single consciousness, a loss of duality.” I find the notion that now consciousness has morphed into something that is shared among therapist and patient important if somewhat hard to flesh out at this point of the Rosarium’s analysis. It makes sense to assume that, at the Nourishment stage, this shared quality is most manifest in the mutual sense of disconnection in the therapy relationship. The single crown and the figure of the hermaphrodite also indicate that the coniunctio has fulfilled its purpose; evidently, it has run its course, with the nigredo now being the imme diate consequence. But while “this is another nigredo experience,” as Tomkins writes, the difficult conditions associated with the nigredo are easier to sustain for both therapist and patient this time around: “Thanks to the spiritual development of the previous cycle (indicated by the wings) the experience is less catastrophic, less total, as consciousness gained in the first […] cycle remains” (Tomkins, n.d). The high relevance of the nigredo, now in its second form, may feel counter-intuitive at first, but Schwartz-Salant insists that it must be considered a conditio sine qua non for the therapeutic undertaking to have a theoretical and practical basis: “The analyst and analysand must consciously sacrifice what they know in service of experiencing once again a deadness and lack of connection, as in the sixth and seventh woodcuts” (pg. 195). The sense of disconnection that is characteristic of the nigredo is hard to endure, especially for therapists who take pride in their capacity for relational intimacy. Therefore, choosing not to employ rational consciousness is a challenge—for instance, in the form of the therapist interpreting the “deadness” dominating the interaction with the patient by attributing the labels of “transference” and “countertransference” to certain aspects of the rapport. Such attempts to interpret the situation by dividing the mutual experience into individual fragments, which are then allocated to either the patient’s or the therapist’s unconscious, may provide quick relief and a sense of control but actually hinder the process. Rather than using interpretation or amplification as methods, the therapist instead should focus on the dynamics unfolding in the clinical setting and aim to identify opposites that surface within the therapy relationship. The therapist must thus use their consciousness in a manner not fully compatible with the usual modi operandi in western culture. Schwartz-Salant emphasizes this point: “The importance of the transformation of consciousness cannot be overemphasized. The modern world highly values achievement and ‘doing’ in distinction to ‘being’” (pg. 195). One way to describe the challenge at hand is to propose that the therapist has to give up what they know and to sustain the sense of confusion—as well as other difficult emotions,

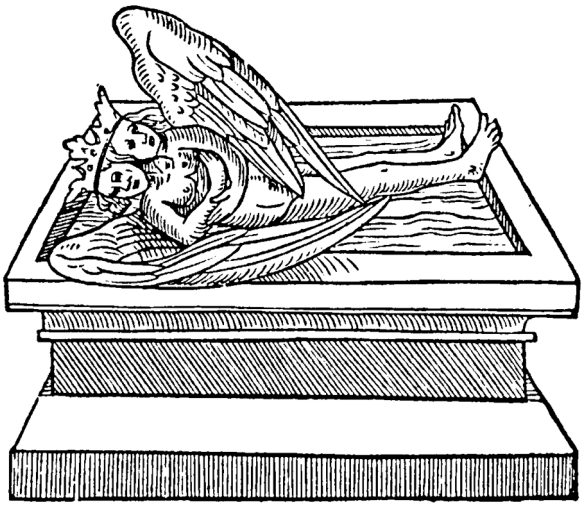

Fig. 13: “Nourishment”

especially those prompted by the nigredo. "For the analyst to possess a genuine state of awareness about his or her analysand's process—an awareness gained, for example, from the transference or dream interpretation—and to sacrifice this consciousness is far from a simple matter," writes Schwartz-Salant. But they can rest assured that they are "giving up something that feels quite precious for a still greater goal," namely the shared transformation process that is happening between therapist and patient. Schwartz-Salant uses the term "interactive field" in this context to capture the area in which the dynamics of the therapy relationship take place. If the therapist manages to surrender their desire to interpret and pays close attention to the quality of the interaction, "the interactive field is further enlivened, and the mystery of relationship is served, a mystery in which the analyst knows that he or she can become the receiver of the analysand's consciousness as readily as he or she is the source of awareness about the analysand." I believe this quote by Schwartz-Salant to be critical in understanding his clinical method—including his idea of the therapy relationship upon which his approach is based. The process illustrated in the Rosarium Philosophorum not only affects the patient but also the therapist; not only one side of the therapeutic couple is undergoing a transformation process but both. Put simply, one could say that, for therapists, there is almost no limit as to what one can learn from one's deep interactions with patients. And I feel that Schwartz-Salant's concepts showcase the humility of acknowledging our own potential for development and growth alongside that of our patients.

Image Fourteen is titled "Fixation" and is a continuation of the Rosarium's second nigredo sequence. It shows "the conjoined body, or hermaphrodite, still [lying] in the tomb, but it has now lost its wings" (Tomkins, n.d.a). Simultaneously, "a female figure rises up to the clouds that have appeared above the tomb, similar to how a young boy rose up in woodcut no 7." Schwartz-Salant's comments on the image are brief as he has already detailed the purpose of the nigredo sequence in his analysis of the prior woodcut. He finds that woodcut Fourteen "indicates the beginning of a new solar life of the hermaphrodite. Consciousness, with its potentially compulsive and soul-killing element is transformed" (Schwartz-Salant, 1998, pg. 196). The inner logic of this woodcut is hard to convey to the contemporary reader due to the particularities of the alchemical language aiming to represent its meaning. The core idea is that Sol, or consciousness, remains in the casket while the lunar forces, represented by the naked woman rising to the skies, have left the dying hermaphrodite behind. The transformation of consciousness continues, as the woodcut's title, "Fixation," effectively "points to the nature of the process Sol is undergoing in the sepulchre" (Tomkins, n.d.a). Tomkins elaborates on Schwartz-Salant's comments regarding the negative effects of consciousness employed in a non-purposeful fashion. The fact that "Sol is being fixed in his transformed state, free from his compulsive,

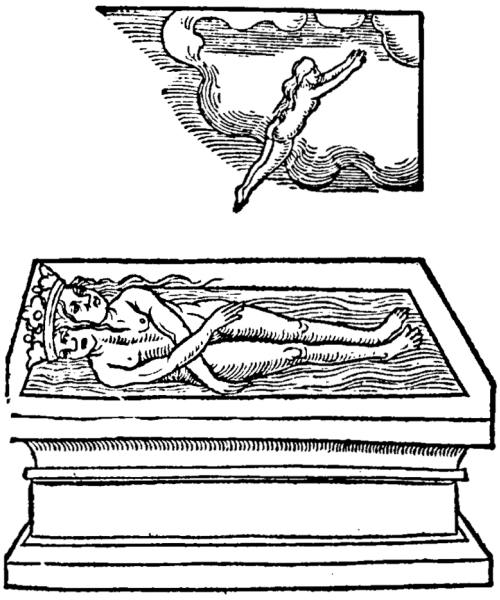

Fig. 14: "Fixation"

soul destroying tendencies, as if by being deprived of light" implies that therapist and patient must have the "willingness to be and stay in the dark." The process cannot be reversed at this stage, and for Sol, "there is no return to his former way of being." To Tomkins, giving up the false sense of control provided by solar consciousness is "a crucial point." Much like Schwartz-Salant, Tomkins is convinced that the sacrifice of techniques such as interpretation may be challenging at first but all the more rewarding further on, because, over the course of the transformation process, both therapist and patient undergo fundamental change: "This process of fixation forms the ground by which consciousness will be able to hold its own amidst change, a consciousness that can withstand, and stand in, the instinctual collective unconscious and not be enmeshed." The idea that the open and dedicated experience of the union of opposites promotes the solidification of the therapist's and patient's selves is picked up on by Schwartz-Salant in his discussion of image Fifteen. While this is not precisely the same point, my understanding is that those two lines of thought to be closely related.

The fifteenth woodcut goes by the title "Multiplication." There exist many parallels to woodcut Seven, and the image "features a descent of rain from heaven" (Schwartz-Salant, 1998, pg. 196). In terms of imagery, the decaying hermaphrodite is being cleansed by the water falling from above. Interestingly, and in spite of the seemingly straightforward nature of the woodcut, Nathan Schwartz-Salant and Gary Tomkins differ drastically as to its meaning and implications. Schwartz-Salant takes the image's title to refer to the multiplication of the "stone," or the therapist's self—which is an idea that he, for instance, highlights in his interview with Laura London (Schwartz-Salant, 2017b, min. 10). The core concept is that therapists who have, over time, built a relatively solid and dependable self-structure will have a catalytic effect on their patients through their presence and via their interactions. As a result, one can identify a "multiplication" that begins with the therapist's self becoming more comprehensively realized and which ends with the patient's self serving as a catalyst for other people yet, far beyond the scope of the therapy relationship. To Schwartz-Salant, "this state of multiplication is not a fanciful wish, but a result of experience, for when a strong self quality exists in a person, it has a 'multiplying' effect on others. In analytic practice, the analyst's self, if it has been forged in the heat of processes such as the Rosarium describes, will have such an effect" (Schwartz-Salant, 1998, pg. 197). However, while Schwartz-Salant, with some conviction, sees the occurrence of "a mystery of transmission," Gary Tomkins elects to disagree. He notes that he is aware that "some authors seem to see Multiplicatio as some mysterious process of transmission the individual acquires and is able to radiate to others" (Tomkins, n.d.a). This comment is obviously a reference to Schwartz-Salant, whose ideas Tomkins frequently echoes. Evidently, this echoing is not the case in the context at hand. Tomkins

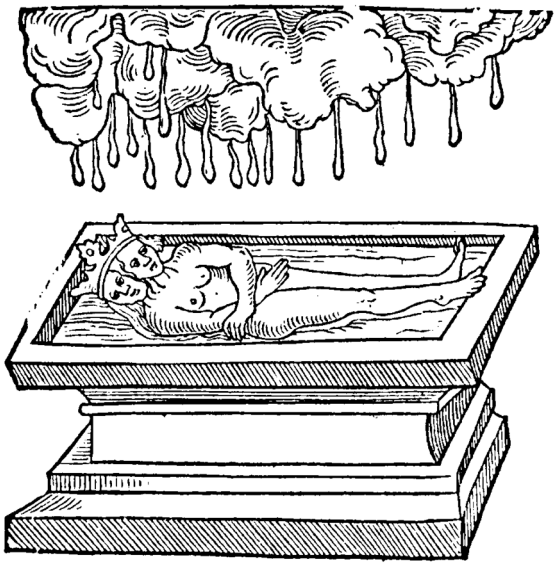

Fig. 15: "Multiplication"

characterizes his alternative interpretation of woodcut number Fifteen with some hesitation: "I would wonder whether the process is more of achieving a degree of Solar clarity that allows for a cleaner reception and perception of others." In other words, Tomkins believes that, if a therapist has undergone the Rosarium's process many times and has learned to suspend their desire to rationally understand what is happening in their interactions with patients, they will be able to see their patients more clearly for who they truly are. Personally, I find both perspectives on woodcut Fifteen intriguing and think that they can perfectly well co-exist with one another. What the two interpretations have in common is the assumption that the therapist's own maturation is dramatically shaped and enhanced by repeatedly acting as a facilitator and participant in the transformation process pictured in the Rosarium.

Woodcut Sixteen is named "Revival" and entails the second return of the soul, this time shown as female. As Tomkins puts it, "the feminine aspect now blessed with heavenly experience, or having been spiritualised, joins with the body and the masculine aspect transformed by the mercurial waters and cleansed by the heavenly dew" (Tomkins, n.d.a). Since we have already examined the differentiation between "solar" and "lunar" principles that the Rosarium entails and which are present in various forms, I will only mention that the king and the sun once again stand for conscious activity while the queen and the moon play the role of emotional receptivity. Of course, there are other facets to be found for both the masculine and feminine representations in the Rosarium. The return of the soul marks the end of the nigredo sequence, and the result is that "a stronger, spiritual quality and a more stable structure are being forged" in this phase of the process. Neither Schwartz-Salant nor Gary Tomkins provide much further notes on the specifics of woodcut Sixteen, presumably because of its similarity to woodcut Nine. However, Schwartz-Salant details some of the larger objectives of the transformation process, now having progressed far into its second half, the rubedo stage: "A major goal of the rubedo stage is the embodiment of the self and a field quality, through which the presence of the body as the vehicle of perception is sought" (Schwartz-Salant, 1998, pg. 197). This quote features several concepts central to Schwartz-Salant's thinking, most of which we will take a closer look at later in this study. The idea of the "self" largely stems from Carl Jung; to Schwartz-Salant, it is one of the self's essential qualities to have an immanent and a transcendent side (e.g., Schwartz-Salant, 2017b, min. 16)., with both being relevant in psychotherapy and in one's personal experience of becoming. Over the course of one's individuation process, the immanent self progressively "incarnates" into that person, and the therapist frequently aids this development as part of the treatment, especially when working with Borderline patients (e.g., Schwartz-Salant, 1989, pg. 28). It is important to point out that the "embodiment" of a shared self, as pictured in the Rosarium, differs in certain respects

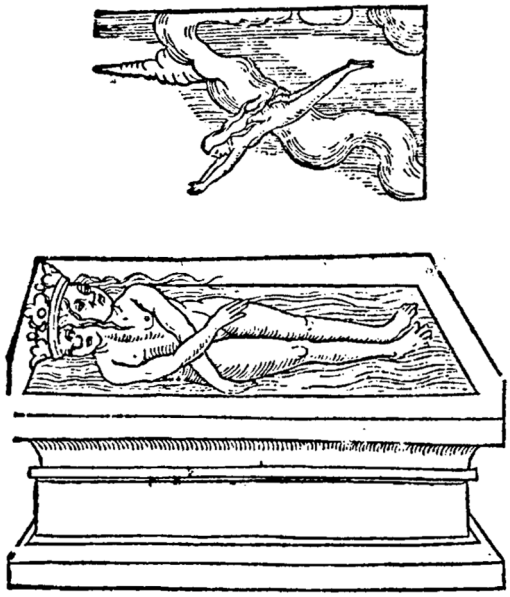

Fig. 16: "Revival"

from the transformation of an individual's self. The second idea that Schwartz-Salant mentions in the above quote is that of the "subtle body." He employs this concept throughout his work to capture the space between therapist and patient in its sensory dimension, which is why he calls the subtle body a "vehicle for perception." We will discuss this latter side to Schwartz-Salant's theories at greater length later. Concluding the analysis of woodcut Sixteen, the increasingly intimate rapport between therapist and patient corresponds to "a stable interactive field that is forming and continuing to 'redden' as it becomes more conscious and allows for both spiritual and imaginal vision" (Schwartz-Salant, 1998, pg. 197).

The seventeenth woodcut goes by the title "Perfection." The image is filled with complex symbolism—so much so that our analysis will not be able to do the woodcut justice. In a nutshell, "the Hermaphrodite has arisen again […], displaying its wings" (Tomkins, n.d.a). The image has a few striking similarities to woodcut Ten but also deviates from it in a number of ways. The hermaphrodite's wings look less like those of an angel and more dragon-inspired, and the tree with the 13 heads now bears heads that resemble the sun rather than the moon. Furthermore, Tomkins correctly notes that "instead of standing on a crescent moon the figure stands on the body of a three-headed snake that appears to be eating itself. To the right a pelican gores its chest to feed its three young and a lion lies (largely obscured) behind the Hermaphrodite." Schwartz-Salant comments that the image "shows what is known as the third conjunction, the result being the hermaphrodite now on the solar hill" (Schwartz-Salant, 1998, pg. 197). In terms of the woodcut's meaning, it once again highlights the union of male and female aspects—this notion is supported not only visually but also by the alchemical texts accompanying the woodcut (pgs. 201–202). Schwartz-Salant states that, at this point, the "masculine, solar life finally recognizes the power of the feminine not only to harm but also to transform. Furthermore, the solar life of the masculine recognizes how vital it is to the transformation of the feminine" (pg. 202). The interplay of these principles is not only crucial within an individual but also the therapy relationship, or the "interactive field" between therapist and patient, as Schwartz-Salant puts forward: "This recognition holds for men and women and also for these powers as opposites within an individual or within an interactive field." The new development pictured in the woodcut has important clinical implications, which Schwartz-Salant details using familiar psychoanalytic language, with the added ingredient of his concept of the field. He writes: "This image represents a field quality which not only overcomes unconscious fusion states that passion can promote but also ends the deceptions of projective identification. Two people can now experience a field in which passion exists, in which paranoid elements no longer dominate, and in which active and passive roles readily change." In other words, the rapport between therapist and patient has now become more fluid, with the interaction being

Fig. 17: "Perfection"

dominated less by psychotic elements or projection. In the language of object relations theory, one might say that the therapeutic process now entails encounters of transference and countertransference in which the roles of who represents what change at greater frequency and with fewer defenses to overcome.

The eighteenth woodcut is comparably straightforward in its imagery but also one of the Rosarium's most mysterious. Gary Tomkins describes the woodcut as follows: "The Green Lion in the background of the previous woodcut is now the focus. The Lion's mouth is wide open, […] devouring the Sun. Liquid drools from the Lion's mouth falling onto the ground below. The liquid is red in the coloured versions of the woodcuts and it is generally presumed to be blood" (Tomkins, n.d.a). According to Schwartz-Salant, the woodcut is called "Mortification of the Celestial Marriage" (Schwartz-Salant, 1998, pg. 203), but Tomkins refers to it by the alternative title "Green Lion Devouring the Sun" (Tomkins, n.d.a).

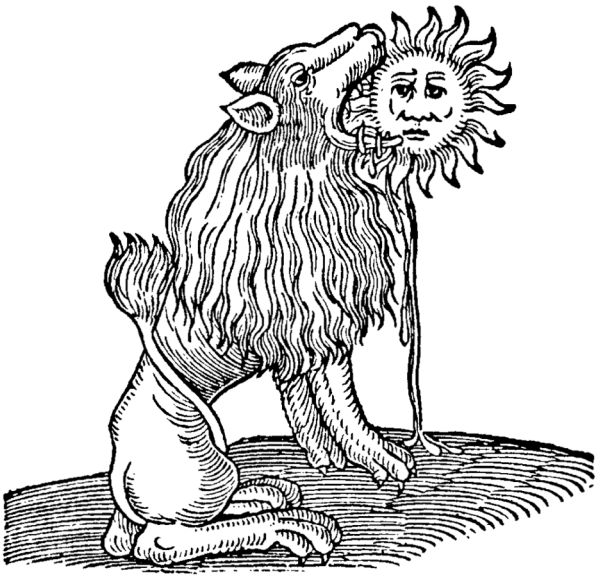

Fig. 18: "Green Lion Devouring the Sun"

Tomkins states that the Lion is a figure so rich in symbolic meaning that it can hardly be adequately analyzed. To Schwartz-Salant, the core idea behind the symbolism corresponds to another change in the field between therapist and patient, as the space between the two people has now stabilized even further. He writes that, as the sun is being killed by the lion, "the solar life of rational and spiritual understanding is again sacrificed in the service of creating a new field structure" (Schwartz-Salant, 1998, pg. 202). Schwartz-Salant adds that the acceptance of "shadow motives for acts that were actually destructive" play a role in this sacrifice of consciousness. The "shadow" representing another essential Jungian idea, Schwartz-Salant provides a concise if implicit explanation of the term by discussing the perceived dangers to a person's ego if shadow elements are allowed to continually make their presence known within the therapy relationship: "To accept the shadow, to acknowledge one's undermining or malevolent behavior can be very dangerous, for the other person can then do actual harm. For example, one is vulnerable to all manner of rejection and scorn, narcissistic injuries and abandonment that threaten the stability of the self." However, at this juncture, the therapy relationship has reached a level at which it can meet such challenges. Both therapist and patient can trust that the field will carry them through the experience of shadow energies becoming manifest and transparent. They can also rest assured that taking the risk of exposure will pay off: "The eighteenth woodcut represents a field quality which is conducive to risk while faith exists that one can survive such attacks as a vital, embodied self." One of the rewards for mutual bravery is the certainty of knowing that the experience in the therapeutic setting can be considered complete and truthful. Schwartz-Salant states that the central notion of the woodcut is "that one would risk one's solar self, knowing that this risk was a way in which the soul and truth were honored." At this stage of the Rosarium,

taking this daunting step of temporarily abandoning rational thought has become a real possibility. Gary Tomkins disagrees with Schwartz-Salant to a certain extent in terms of the meaning of the lion. To Tomkins, the figure represents an aspect of the collective unconscious to which human beings can merely surrender; taking the heroic stance of "overcoming dangers" associated with the lion, to Tomkins, is a misplaced approach. He finds that "the Green Lion is not to be 'faced' or 'overcome' but to be swallowed by. If we do not let go into the Collective Unconscious it remains an 'it' out there, to be related to, rather than lived in, and from" (Tomkins, n.d.a). While I find Tomkins's argument—that Schwartz-Salant is interpreting the dynamics depicted in woodcut Eighteen according to the rules of a heroic tale—sensible, I am not convinced that either approach is false or inappropriate. Rather, both interpretations have their validity, and, depending on a person's character, they will live through the scenario shown in the image with a focus on the inherent personal heroism—or by paying attention to the greater numinous powers that ultimately determine the outcome of the situation.

Woodcut Nineteen is called "Assumption and Coronation." Again, we see the Rosarium Philosophorum shift gears regarding the image's overall presentation. On first encounter, the woodcut's content may be just as surprising as that of previous illustration featuring the Green Lion. As Schwartz-Salant writes, "the soul is depicted as uniting with the Holy Trinity" (Schwartz-Salant, 1998, pg. 203). But this description can only be considered a summary, and Gary Tomkins's discussion of the woodcut offers a more comprehensive overview: "Two bearded mature male figures, dressed in ceremonial robes are seated on thrones either side of a young female. […] The men hold between them a crown they appear to be lowering onto the young woman's head in coronation. Above the crown, the white dove of the Holy Spirit hovers as if in blessing of the ceremony" (Tomkins, n.d.a). As Tomkins mentions, the image marks the return of the dove, which has long been absent from the woodcuts—it was an integral part of the initial set of images of the Rosarium's first half. Image Nineteen clearly marks a festive event that could be interpretated as a rite of passage. Tomkins finds that the woodcut's title nicely summarizes its fundamental theme: "'Assumption' implies a taking something upon oneself and 'Coronation' implies a crowning and taking up of authority and responsibility in the world. Both suggest a recognition by authorities of achievement by the individual, and an investiture of authority and responsibility in that individual." He notes that the fact that the image is centered around a "young girl" may be an attempt to counter the prior woodcut's focus on solar, male, principle. The crowning of the young female, he writes, can be seen as a nod to the lunar side, and thereby "as the compliment to the Green Lion." Interestingly, Schwartz-Salant puts most of his attention on a specific detail of the imagery. He observes that, "the soul is not only crowned by images of larger people," but in some renderings of

Fig. 19: "Assumption and Coronation"

the woodcut, "the crown is far too large for the soul, meaning that the person must recognize that the source of illumination lies outside his or her being" (Schwartz-Salant, 1998, pg. 203). This notion then serves as the gateway to Schwartz-Salant picking up his earlier discussion of the self as both immanent and transcendental. The transition shown in woodcut Nineteen points to the archetypal nature of the larger process, which includes the transcendental domain and, correspondingly, a self "which cannot be embodied, felt within." However, the transcendental self is also "capable of creating an immanent self. These two aspects of self, immanent and transcendent, are symbolically evident in the nineteenth woodcut, along with a lunar, subtle body life." Schwartz-Salant adds that, in spite of the "substantial similarity" that the two sides of the self exhibit, they must not be confused—a distinction that the alchemists were masters in making. It mattered greatly to them to repsect "this difference between immanence and transcendence" (pgs. 203–204) and as a result, "the alchemist never fails to know his place in the Cosmos, and grandiosity no longer tempts or betrays him. In the spiritual life of relationships, the same level of consciousness is essential" (pg. 204). Schwartz-Salant's remark on the importance of maintaining an awareness of both the immanent and transcendental side of the human—and the therapeutic—relationship has several implications. The first is that one must make the effort of trying to understand that, while a person's transcendental self can never be fully grasped, it still needs to manifest as best as possible in immanent form. This is crucial in therapeutic work, where in many cases the individual seeking treatment feels that their realized potential is far from their innate possibilities. This problem may be particularly pronounced when working with patients with characterological disorders. As Schwartz-Salant details in his book on the Borderline personality, many of these patients have an awareness of something that could be called their "transcended self" but fail to identify an immanent self within them. One way to put this dilemma is to say that, for these patients, "immanence […] has never incarnated" (Schwartz-Salant, 1989, pg. 28). This then leads to symptoms such as fragmentation, splitting, or the sense of inner emptiness. The second implication of the above quote is that all relational interaction bears two dimensions: one that Tomkins might call "worldly" (Tomkins, n.d.a) and one that firmly belongs to the archetypal domain.

The final woodcut of the second half of the Rosarium Philosophorum, Number Twenty, is titled "Resurrection." As Schwartz-Salant notes, the image is "different from all of the other woodcuts" because it "portrays the emergence from the grave of a single human being" (Schwartz-Salant, 1998, pg. 206), namely Christ (pg. 204). Christ has just "climbed out of his tomb or sepulchre, […] is haloed and carries a long tall staff with a small cross piece and mounted below it a two tailed pennant displaying a cross. His other hand, with thumb, index and middle fingers extended, makes the sign of the Trinity" (Tomkins, n.d.a). Translating this imagery into clinical language, the obvious question points to what it is that is being resurrected, and the answer is the self: the patient's self, to some extent the therapist's self, and what could be considered the self shared among the two. To Schwartz-Salant, the therapy relationship—the "field of relations" between therapist and patient that he sometimes also calls the "subtle body"—is the container in which the transformation and the final rebirth occur. This space undergoes just as much change as the self belonging to patient or therapist: "A self-structure also exists within the entire process—

for example, the alchemists insist that it takes gold to make gold—but the self is lost and gained as the different qualitative states of the Rosarium are encountered" (Schwartz-Salant, 1998, pg. 207). When the final stage, depicted in woodcut Twenty, is reached, "a new kind of stability is finally achieved, a self that is both immanent and transcendent." One of the prerequisites for the process to complete, however, is to maintain the distinction between the immanent and transcendental sides of the self by embracing what Schwartz-Salant terms a "spiritual" perspective. He writes: "Within the context of a spiritual awareness that knows both an immanent and a transcendent form, the interactive field between people becomes a source of a self that is both shared and individual" (pg. 205). I would like to emphasize that this is yet another instance where Schwartz-Salant refers to the "interactive field," one of his terms designed to capture the space between therapist and patient, and the dynamics of how they relate to one another. Returning our focus to the clinical outcome of the transformation process, Schwartz-Salant comments that the resurrected self will be able to play a central role in the respective individual's life: "The self that is finally created in the Rosarium is not merely a source of identity; it is an ongoing guide—felt in time and space rather than […] intuitively sensed—and it is known as one's final cause" (pg. 207). I feel that the idea of the resurrection of the self is not only a fantastic conclusion to the Rosarium Philosophorum and its interpretation for psychotherapeutic practice; the notion also highlights the value of Schwartz-Salant's contribution to the extended analysis of the alchemical opus. Whereas Carl Jung only focused on the first ten woodcuts, the commentary by Nathan Schwartz-Salant demonstrates that the original work is further enriched by the inclusion of images Eleven through Twenty. And while most essential aspects may have been present in the first half and in Jung's discussion thereof, the sheer relevance of the need to abstain from using certain clinical methods when staying in the here and now with the patient is the actual task at hand, is dramatically emphasized by Schwartz-Salant's thoughts on the rubedo sequence. The Rosarium can be seen as an illustration of the relational dynamics between therapist and patient that, eventually, and after much hard work on all sides, leads to new life. Something has been accomplished within the therapy relationship: first and foremost the creation of a dependable rapport that was able to contain emotional opposites and to facilitate a shared transformation process—and because of this achievement, "Resurrection," the final woodcut's title, "is a marvelous term for this end phase; indeed, it signals a faith kindled and sustained by experience."

Fig. 20: "Resurrection"

4.2.2 Application of Jung's Theories to Treating Character Disorders

Nathan Schwartz-Salant's analysis of images Eleven through Twenty of the Rosarium Philosophorum is not his only work designed to widen the scope of the Jungian system of thought. He also writes at length on the application of Jung's psychology to the treatment of specific groups of patients—specifically those that could be classified as suffering from

narcissistic or borderline personality disorders. In a 2017 interview, he states that his ambition was to put Jung's work to practical use, because he felt that—over the course of his training at Carl Jung's institute in Zürich—he had learned a lot about the human psyche but had yet to discover how this knowledge translated into clinical practice. As a result, he made it his mission to resolve this problem: "My whole professional career has been about bringing Jung into here-and-now work, into the here and now with people," he states in an interview (Schwartz-Salant, 2017b, min. 21). The issue that Schwartz-Salant was facing at the beginning of his career was that Jung did not consider himself "a psychotherapist in the sense of someone who was going to look at personality disorders. Jung was looking at the substructure of these disorders" (min. 47). In consequence, Schwartz-Salant felt that he had to add certain practical aspects to Jung's theoretical framework. As part of his 2017 interview, he explains the challenge that he was facing at the time using an analogy. He recollects that he—in his earlier scientific studies that preceded his time in Zürich—had a Japanese mathematics professor who had invested a large part of his life transforming theoretical knowledge into practical application. This professor, Schwartz-Salant says, had been educated to be a theoretical mathematician and then spent "20 years of his life becoming an applied mathematician. [...] In Zürich, the kind of training I had [...] was more like the pure mathematics, and it took my many decades to bring it into here-and-now reality" (min. 47). Schwartz-Salant adds that this discrepancy was the reason "why you see these books I've written: on narcissism, on borderline personality." But while he clearly generated new conceptual ideas in his publications, he finds that he always wrote his books "from a point of view that has Jung's point in it about the archetypal, about the numinosum" (min. 48). While some of Schwartz-Salant's work also includes references to disorders other than borderline and narcissistic characterological problems, these do represent an area of focus within his oeuvre. One reason for this emphasis may be that "narcissistic structuring and borderline states" share a commonality regarding their etiology: "Both are reactions to what is felt to be an impossible fusion-separation drama. In the narcissistic character, fusion is maintained through controlling the object, while separation is also maintained through the narcissistic defense which wards off all affective involvement. In the borderline disorder the fusion-distance dilemma is resolved in radical shifts towards fusing with an object and, sensing the terror of loss of identity, recoiling into a distant state, with the object now carrying a projection of dread and extreme danger" (Schartz-Salant, 1998, pg. 132). I find the ideas Schwartz-Salant puts forward here to be extremely insightful and indicative of his deep insight into the genesis of a human being's inner conflict that is later diagnosed as a personality disorder. However, it would go beyond the purpose of this study to examine all of the above quote's implications, even though its clinical relevance is evident. Instead, I will now discuss some aspects of Schwartz-Salant's books on narcissism and on borderline states; the core purpose of this elaboration is to further illustrate certain key ideas in his thinking—ideas that further elucidate his concept of the therapy relationship as a third entity.

The book "Narcissism and Character Transformation" (Schwartz-Salant, 1982) is one of the author's earlier works. It reads very much like a treatment manual for Jungian therapists, but like a manual that has been enriched with a vast array of mythological analogies and a substantial collection of clinical vignettes. It includes topics that readers of the

present study will already be familiar with: One chapter looks at the difference between "The Immanent and Transcendent Self" (pgs. 16–18), another compares "Psychoanalytic and Jungian Views of the Self" (pgs. 18–20). The chapter "Archetypal Factors in Transformation" (pgs. 53–60) entails an intriguing case study that captures how Schwartz-Salant employed Jungian techniques to support the development of a young women suffering from a combination of typical symptoms—such as the feeling of having failed to build a longer-lasting counter-sexual relationship with a significant other. Schwartz-Salant refers to notions such as the "alchemical vas hermeticum" to showcase the patient's "transformation" over the course of the process (pg. 54), which highlights his inclusion of alchemical metaphors even back in 1982. Another chapter entailing a number of ideas significant to this study is titled "Seeing through the Body" (pgs. 125–127). Here, Schwartz-Salant discusses what he calls "a new dimension of vision, an imaginal seeing" (pg. 125). The basis for this imaginal sight is the therapy relationship—the space between therapist and patient in which phenomena such as projective identification take place. Schwartz-Salant details how using one's own physical presence can serve as a gateway for establishing a particular perspective on the immediacy of the clinical setting and its dynamics. However, the technique is hard to describe, and there is barely any scientific explanation at hand: "It is difficult to explain this process causally, except in the unscientific sense that something going on in another person 'causes' something to happen in us," writes Schwartz-Salant. Because of these hurdles, he employes an analogy, even though its overtly familiar nature somewhat trivializes the subject matter. He proposes: "Just as it is possible to walk into a room of people and 'pick up' that something is out of order, perhaps dangerous, or that someone is in a complex, so too body consciousness can operate in the here and now." We have already encountered the principle of imaginal sight various times in our review of Nathan Schwartz-Salant's analysis of the Rosarium Philosophorum—and in his instructions on how to employ the Rosarium's clinically. I will therefore focus on thoughts by Schwartz-Salant that add to what we already know. It is also important to remind ourselves that Schwartz-Salant's book on narcissism is among his earlier work, and certain ideas have not been fully fleshed out. The almost strict reliance on the "somatic unconscious" and bodily presence is less prominent in later publications. Still, one quote that highlights the degree of personal involvement of the therapist in the shared interaction with the patient is Schwartz-Salant's analogy of the clinician as a measuring tool: "By being close to our body, with psychic awareness relatively low, we are like a measuring instrument in flowing water or a magnetic field; we can use our own reactions to know when the other person's energy is fading and when it is present." This approach, as Schwartz-Salant details, can be helpful in identifying parts of the patient's personality that are effectively hidden from their consciousness and have yet to be integrated. He writes: "In this state one is often discovering, along with the patient, their split-off parts that begin to feel seen" (pg. 126). The fact that Schwartz-Salant talks about the phenomenon of splitting in this context may suggest that his method is tailored to the treatment of patients with characterological issues or who rely on structural dissociation to manage their lives. Then again, as Jeffrey Young believes, there is the open question of how many patients there really are who do not, to some degree, exhibit Axes Two traits—in addition to Axes One symptoms (Young, 2017, min. 21). Based on this view, Schwartz-Salant's technique

might have a more comprehensive range of applications than those that one would think of. Still, his approach also has distinct, known limitations. The challenge is to believe in the technique, even though it is not compatible with the western world's tendency to prioritize objectivity over subjective truths. "This imaginal seeing is a vague, shadowy vision, not a clear one of solar nature. Trusting it now becomes the cardinal issue," writes the Jungian (Schwartz-Salant, 1982, pg. 126). Another chapter establishing fresh ideas, which are further developed in Schwartz-Salant's later works, is called "Psychic and Somatic Empathy" (pg. 127). In this section, he talks about "being immersed in the field" and provides a concise clinical "example of shared, mutually induced vision" (pg. 128). This is followed by the chapter "The Magical Use of Imagination" (pgs. 131–132), where Schwartz-Salant adds to his discussion of projective identification and raises the problem of how to handle the therapist's potential inductive effects on the patient: "How do I know that I am not inducing what I think I see, and that my patient is not just being suggestible, or perhaps agreeing with me for the sake of maintaining an idealized image?" he asks (pg. 131). The short answer is that experience is key. Concluding this review of "Narcissism and Character Transformation," I would like to point out two more instances where Schwartz-Salant integrates themes that we have familiarized ourselves with via the author's discussion of the Rosarium. On page 165, Schwartz-Salant describes the "archetype of coniunctio" as an "energy field that binds, but one whose goal is an imaginal connection, not a physical one," thereby linking the transformation process illustrated in the alchemical opus with the notion of the interactive field between therapist and patient. And finally, the book's last chapter "Transformation and the Individuation Process" (pgs. 167–170) rounds off the publication with another case study that mirrors its many themes.

"The Borderline Personality: Vision and Healing" (Schwartz-Salant, 1989) refines practically all of Nathan Schwartz-Salant's early ideas, extends them, and adds some new ones. The book's core objective, best articulated in Schwartz-Salant's characterization introducing the final chapter, reads: "In this work, I have employed alchemical symbolism to view borderline conditions as aspects of the archetypal pattern of the coniunctio; in this way borderline conditions are seen to be situated with a larger archetypal pattern that subsumes the personal perspective" (Schwartz-Salant, 1989, pg. 201). Even a cursory glance at the book reveals the fact that the author has adapted the Rosarium Philosophorum to optimally facilitate the treatment of borderline patients. In fact, the fourth of the book's chapters represents an only lightly modified version of Schwartz-Salant's 1988 article "Archetypal Foundations of Projective Identification," which has been elemental in the present study's discussion of the Rosarium's first ten images. In the book's section titled "The Dead or Helpless Self," we again encounter the fundamental distinction between a person's immanent and transcendent self (pgs. 50–54). According to Schwartz-Salant's 2017 interview with Laura London, this is one of the book's cornerstone ideas. He states that, "in my book on the borderline personality, I made it a special point that the borderline personality is someone who often knows the transcendent self but does not have an immanent, in-dwelling self" (Schwartz-Salant, 2017b, min. 48). This specific lack then leads to the sense of inner deadness—a symptom often described by borderline patients as "penetrating emptiness" (e.g., Schwartz-Salant, 1989, pg. 64). Schwartz-Salant concludes that, therefore, "the self within them is dead. But they have this other kind of vision

that comes from transcendence. And I wrote my whole book about that, how that vision in them has to be seen in order to help enliven the self within them" (Schwartz-Salant, 2017b, min 48–49). We have now come full circle and have returned to the idea of imaginal vision, the technique used to bring the transformation process depicted in the Rosarium into the lived experience of the therapy relationship. The concepts of the "interactional field" and the "subtle body" are also integral to "The Borderline Personality: Vision and Healing" (e.g., pgs. 6–7). Regarding the former idea, Schwartz-Salant states that, when working with borderline patients, the "field that we meet […] must be stressed if the therapist is to achieve the goal of embracing the renewing potential within borderline conditions." He associates the field and its use with "the territory of alchemical thought resurrected by the remarkable research of C. G. Jung […]. Jung's approach to alchemical symbolism can be focused upon the interactional field" (pg. 6). The question may then arise where and how the field can be discovered in the treatment room. Schwartz-Salant tries to address this point, thereby offering a working definition of his concept of the subtle body. He writes: "A crucial issue is the locus of these elusive energy fields; the inability to locate them within our normal space-time perception leads to the recovery of the ancient concept of the subtle body. This concept is a mainstay of alchemical thinking and refers to experiences that can be called neither psychical nor mental but partake in both realms" (pg. 6–7). He adds that the subtle body, in his understanding, depends on imagination—because the subtle body is where psychic energies such as those connected to projective identification first manifest. "The subtle body is a realm through which projections pass and transform; while its processes can be perceived by the imagination, they are not usually available for discovery by the rational mode" (pg. 7). We will examine the concept of the subtle body in some more detail later in this study; it is however remarkable how most of Nathan Schwartz-Salant's most important ideas already exist in relatively nuanced form in his 1989 work. Even though it often seems to overlap with the term "field," the term "space," referring to the space between therapist and patient, is equally used throughout the publication. Schwartz-Salant notes that this space is "composed of couples and their relationships" (pg. 107). It is crucial to understand that he is referring to the coniunctio, and the Rosarium in general, when he speaks of "couples;" since we have already studied his analysis of the Rosarium in the present thesis, this should hopefully be evident. The following passage suggests that Schwartz-Salant's "space" may be largely congruent with the "subtle body," which would imply that the "space" and the "subtle body" are the domain in which the "fields" constellate: "This space is a transitional area between the space-time world (where processes are characterized as an interaction of objects) and the collective unconscious—the pleroma […]. This area has a fundamentally different quality from the space-time world. In its pathological form, the pleroma invades the conscious personality as primary-process thinking. But in its creative form, it is the source of healing through one's experience of the numinosum." I would like to emphasize two aspects of this quote. First, it makes explicit in what realm Schwartz-Salant's "space" may be found by therapist and patient. It is not ordinary everyday reality, and neither does it belong purely to the transcendental. The space or subtle body, as per Schwartz-Salant, lives in between the two areas and is not accessible by conventional rational empiricism or insight of a purely mystical nature. Entering this space, according to Schwartz-

Salant, is only possible via imaginal sight, by lowering one's consciousness to allow for the in-between world to emerge. This is more easily said than done, which is why the author provides so many case studies to illustrate his approach. I assume it is also no coincident that Schwartz-Salant coined the technique "imaginal sight" in reference to the Jungian term "active imagination" (e.g., Jung, 1963, pg. 494). Second, the above quote underlines the principal reason why Schwartz-Salant advocates the practice of introducing imaginal sight. The experience of the numinosum is the crucial healing factor, and the shared entry into the in-between realm of the "pleroma" by therapist and patient is key for the individuation process to take hold. Only by embracing the archetypal can transformation become a possibility. With the self representing a union of opposites, it is the field between clinician and patient in which contradictory elements can manifest—and in which they may undergo radical change by being brought to increasing levels of consciousness. Similar to Schwartz-Salant's examination of narcissism, his look at the borderline condition includes numerous clinical vignettes, which contribute to a publication that represents a one-of-a-kind treatment manual for therapists familiar and comfortable with the Jungian school of thought.

4.2.3 Exploration of Previously Undiscovered Archetypes

Among Jungians, Nathan Schwartz-Salant has the distinction of having authored books on archetypal patterns that were previously unmentioned in psychoanalytic or psychotherapeutic literature. The question of what constitutes an archetype in the first place is difficult to answer as positions vary. However, in the context of the present study, I will preliminarily accept Schwartz-Salant's assertion that certain emotions, for instance, rage, can have archetypal characteristics (Schwartz-Salant, 2007, pg. 43). Also, I will support his notion that one of his unique conceptual ideas, the "Fusional Complex," is of archetypal nature (e.g., pgs. 5 & 138) and therefore connected to the numinosum (pg. 11). Aside from the Fusional Complex, to which an entire volume of Schwartz-Salant's oeuvre is dedicated, the "Order-Disorder Paradox" represents another foray into previously unchartered territory. In this section of the present study, I will outline the fundamental principles of the two concepts and, as part of my presentation, point out some of the many insightful references featured in Schwartz-Salant's respective works—to ideas such as the "field," the "space between" therapist and patient, the "subtle body," and the therapy relationship as a "third entity."

Nathan Schwartz-Salant's 2007 publication, "The Black Nightgown: The Fusional Complex and the Unlived Life," looks at a phenomenon not previously discussed in literature, not even in the field of Jungian psychotherapy. The "Fusional Complex" is a term coined by Schwartz-Salant, and it aims to capture a condition that is "not confined to the consulting room" (Schwartz-Salant, 2007, pg. ix) yet of "perplexing nature" (pg. xi) and therefore hard to describe. The basis for identifying the complex in the clinical setting is, perhaps unsurprisingly, the therapy relationship—or, as Schwartz-Salant puts it, the "field," or the "subtle body." We will encounter these two terms quite regularly as we dive more deeply into the subject matter, especially that of the "field." In order to register that a patient is suffering from a Fusional Complex, writes Schwartz-Salant, a special "kind of awareness is required, a non-ordinary form of perception that can perceive the spiritual or psychic

background in a person, or in the field he or she occupies" (pg. 20). He adds that, by introducing this approach, "the analysand's inner reality becomes perceptible, as does the reality of the field." What makes it hard for the analyst—or the "therapist," as Schwartz-Salant uses both terms to refer to the clinician—to consciously experience the reality of the complex's presence is its unsettling qualities. On the one hand, the rapport with the patient is dominated by a "fusional pull;" on the other, the encounter is simultaneously heavily influenced by "a tendency toward distance and non-communication" (pg. 4). In other words, "at once, there is a fused connection and a state of disconnection. Both are true." (pgs. 4–5). The unsettling nature of the "archetypal pattern" (pg. 5) that is the Fusional Complex manifests in various forms in the therapy environment, and Schwartz-Salants includes many case studies in his book to outline some of the complex's many faces. A more general description of what may happen reads as follows: "When the Fusional Complex is activated, separation from an accustomed 'safe territory' of established patterns—or, in an interaction, separation from another person's spoken or unspoken desires or demands—can lead to extreme and destabilizing anxiety, a compensatory rage, and temporarily impaired capacity for reflection and clear thinking" (pg. 6). Schwartz-Salant openly admits to the fact that he, for a long time, reacted to the strange dynamics instituted by the Complex by activating defenses: "For years, I avoided this frightening state," he notes (pg. 7), which is understandable since it can lead to a "sense of weird entanglement that makes our body tighten as to ward off something you couldn't name if asked" (pg. 1). In some cases, the encounter of the Complex can come close to the intensity "of the black hole of psychosis" (pg. 11). What eventually enabled Schwartz-Salant to "explore this anxiety" (pg. 7) was the technique of focusing on his embodied presence as an anchor point: "It was only when I allowed my attention to descend more deeply into my body, and attend to the field with another person, that I could sense that extremely disturbing state was between us." The last quote is significant in the larger context of the present study because it represents one of the instances where Nathan Schwartz-Salant describes the field between clinician and patient—and hints at its central role in the therapeutic endeavor. The author further highlights the centrality of the field concept by characterizing it as the conditio sine qua non for the Fusional Complex to become identifiable in the first place. He believes that "only when the field is seen and engaged" does "experiencing the gap" between the fusional pull and the disconnectedness become possible (pg. 9). The objective of experiencing this discrepancy is key as it is precisely this "huge chasm" that is at the heart of the Complex: "This chasm is a representation of the archetypal core of the Fusional Complex. It is a dreaded, traumatic state, and has been characterized by various analysands as a fear of a 'void,' an 'abyss,' a state of 'nothingness,' a 'white nothing,' a 'bottomless pit,' or a 'sucking demon,'" reports Schwartz-Salant. Against the backdrop of these distressing descriptions of the felt sense constituted by the Fusional Complex, the reader of this study may already wonder what kind of treatment Schwartz-Salant has found to be most effective. But before we focus on treatment modalities, it seems appropriate to take an up-close look at the Complex's primary and secondary features to gain a better understanding of its scope, including the various associated clinical symptoms. Schwartz-Salant lists two aspects as fundamental and therefore as "primary." The first is the beforementioned "simultaneity of fusional drives and noncommunication,"

which can "dominate[…] the field between two people" and create "a fused connection and a state of disconnection" within this field (pg. 14). I would like to point out Schwartz-Salant's use of the term "field" in this context, as it will stretch into later chapters of the present study. Once again, the field between therapist and patient, the relational quality and the dynamics of the rapport, are a cornerstone to Schwartz-Salant's thinking. The same holds true for the second primary feature of the Complex, namely the "disorganizing nature of the archetypal core." This characteristic "infuses the field with a chaotic energy that threatens the subject with a loss of coherence and identity" (pgs. 14–15). One aspect that both primary features of the Fusional Complex share is that they unfold in the domain that is the interactive field. While the patient also suffers from the Complex's symptoms outside of therapy relationship, the Complex only becomes clinically identifiable and treatable on the basis that both the therapist and the patient are open to entering the field. This means that they pay close attention to the atmosphere in the room and the relational quality, with one of the questions in their minds being whether any oppositional forces can be discovered as distinct elements or energies within their interaction. Aside from the two primary features, Schwartz-Salant puts forward nine "auxiliary features" of the Fusional Complex (pg. 15). For the purpose of the present study, I will focus on those that help to flesh out Schwartz-Salant's underlying core concepts—such as the "field" and the "subtle body." One feature corresponds to the "unstable or nonexistent experience of three-dimensional space within the field of the Fusional Complex." This absence of relational dimensionality leads to "projective identification" being "fragmentary or nonexistent as a useful modality," thereby hindering the treatment. Thinking back to the Rosarium and its first two woodcuts, projective identification often serves as an entry point into the therapeutic process; its absence is therefore significant. Another feature of the Complex is what Schwartz-Salant calls a "damaged subtle body and use of substitute skins." Since this description may sound somewhat cryptic, I will quote the full explanation provided by the author. I will, however, not go into detail regarding the clinical relevance of "substitute skins"—partly because this would go beyond the scope of this study and partly due to the fact that, at the time of this writing, I am still working on understanding their nature, their ramifications, and their significance in the clinical setting. Nathan Schwartz-Salant writes: "Through non-ordinary forms of vision, feeling, or kinesthetic experience, one can perceive that a person with a strong Fusional Complex has a torn or otherwise damaged subtly body—the container for the inner life, existing 'in between' mind and body. 'Substitute skins,' such as extreme self-hatred, dissociation, muscular rigidity, and passive fantasy, form as protective containers against inner and outer intrusions." One can tell from this passage that, in Schwartz-Salant's thinking, the subtle body plays a critical role; this role is not limited to the patient and their personal experience but extends to the therapy relationship, in which a shared subtle body arises out of the therapeutic process. This is illustrated in the Rosarium Philosophorum and in Schwartz-Salant's analysis thereof. Another secondary feature of the Fusional Complex is that of "unlived life and humiliation" (pg. 16). While this aspect does not directly relate to Schwartz-Salant's fundamental concepts, the personal tragedy it points to is tangible as the idea of the "unlived life" refers to a person's inability to consciously realize certain aspects of their personality. I am including this facet due to its clinical implications in terms of the patient's suffering. Schwartz-

Salant elaborates on this aspect: “The power of the Fusional Complex creates a wasteland of unlived potential in a person, resulting in his or her strong feelings of humiliation.” In addition to the secondary diagnostic features of the Complex, he lists four ”typical reactions in the analyst” (pg. 17). Three of the four refer to the relational field between clinician and patient. Schwartz-Salant’s description of the first begins with the fact that “the analyst tends to dissociate from the field of relating because being present is confusing and both mentally and physically painful.” The third addresses “psychotic processes in the field,” while the fourth offers guidance on how to correctly diagnose patients affected by the Fusional Complex. “Until one consciously engages the field of the Fusional Complex,” writes Schwartz-Salant, any “narcissistic, schizoid, obsessive-compulsive, dissociative or borderline” traits in the patient will present an “obstacle” that hinders effective treatment. He also discusses potential “anti-therapeutic reactions” by the clinician as well as “other severe forms of resistance” that are triggered by the encounter of the Fusional Complex, and which “may diminish or resolve when the Complex is identified.” Interestingly, this last remark already points to the notion that correctly identifying the Fusional Complex, in Schwartz-Salant’s experience, will often lead to its eventual dissolution. The challenge is that the Complex can “exist along with a variety of less chaotic but still extremely difficult conditions” that appear to be treatment-resistant “until the Fusional Complex […] is perceived in the here and now of the analytic process. This can have a powerful transformative effect” (pgs. 13–14). Healing the Fusional Complex requires the clinician to “learn[…] to ‘lean into’ the field,” so that “the opposites of fusion and distance may become conscious as a sequence of states” (pg. 17). He adds that “something beyond pathology is involved” in the encounter of these opposites—which of course is a reference to both Jung’s idea of healing and the Rosarium’s imagery. The union of opposites is, once again, the winning therapeutic recipe: “When a sense of containment within a higher-dimensional field is further established, the opposites can be glimpsed together. This especially opens to a deeper awareness that the Fusional Complex is more than pathology: it is a potential gateway to a new form of both ego-consciousness and the self” (pg. 18). Again, we touch upon the underlying Jungian belief that it is the felt presence of the numinosum that has the actual healing effect. In this sense, “we believe, with Jung, that the numinosum heals” (pg. 193). But how can Nathan Schwartz-Salant assume that the Fusional Complex is connected to the numinosum? There are two reasons: The first is that engaging the field in the therapeutic setting and realizing the process illustrated in the Rosarium is a technique that aims to let the numinosum enter the consulting room in the form of an ”emotional experience[…] of the sacred” (pg. 11). The second reason stems from the notion that the Fusional Complex in itself is of archetypal nature, and “generally, the nearer we get to the core of any complex, the unknowable archetype per se, the more we experience the numinosum” thanks to the “sacred energy of the archetype.” However, the fact that the patient will likely improve once these conditions are met, can also be explained via Jung’s concept of individuation, which corresponds to an increasing level of self-realization. At the start, the patient will suffer from the Fusional Complex inhibiting “the self’s incarnation into space-time life” (pg. 13). But “when the analyst can see the numinous energy—through a non-ordinary perception […]—the extreme chaos the person experiences can eventually calm down sufficiently to allow the incarnation process of a new self to become

a living reality." And this transformational change, which has emerged out of the therapy relationship in the clinical encounter, then improves the patient's existence and leads to them embracing a "new sense of identity." In conclusion, "The Black Nightgown" is book that lays out many remarkable and unique ideas—and that exemplifies these ideas with many nuanced case studies. Whether one appreciates the combination of the publication's strengths or acknowledges the fact that it successfully extends existing Jungian theories and practices, the book certainly elucidates Schwartz-Salant's core concepts, in particular that of the de-facto starting point of his therapeutic work—the therapy relationship in the form of the "field" that constellates between therapist and patient.

The 2017 work entitled "The Order-Disorder Paradox: Understanding the Hidden Side of Change in Self and Society" is Nathan Schwartz-Salant's last book and attempts to communicate an idea that the author states he began to develop decades before its eventual release (Schwartz-Salant, 2017b, min. 22). Even when it was more fully formed, he lived through "years of reluctance to publish this work" (Schwartz-Salant, 2017a, pg. xi). In a nutshell, the fundamental principle of the Order-Disorder Paradox, which Schwartz-Salant abbreviates via the acronym "ODP," is that "increasing order in a psychic system creates disorder." It is important to note that "disorder" in this context does not refer to a psychiatric illness that could then be diagnosed and clinically treated, such as a "personality disorder" or "post-traumatic stress disorder," as defined by the ICD-10 or DSM-5 (World Health Organization, 2008; American Psychiatric Association, 2013). Rather, the term "disorder" refers to a phenomenon that could also be called "confusion" in the sense that one is encountering psychological states that feel disruptive and seem more opaque than transparent to intellectual understanding. Based on this connotation, the experience of "disorder" can impact an individual in various ways—and may, for instance, cause anxiety or stress. This principle is exemplified via several clinical cases provided by Schwartz-Salant (pgs. 73–90), which we will touch upon later. Laying out the foundational thoughts leading up to the Order-Disorder Paradox, Schwartz-Salant, who was trained as a physicist prior to becoming a Jungian analyst (pgs. xi–xxviii), turns to the concepts known as "entropy" and "negentropy" (pg. 107). The two opposing terms enable him to develop the idea that the "law of energy conservation," which is one of "the principles of thermodynamics" (pg. xxiv), also applies to the human psyche—and, in certain respects, to the therapy relationship as a "conjoined system" (pg. 90). While negentropy corresponds to order perceived by a person's ego, entropy represents various disorderly conditions. This might sound like a perplexing idea, but thanks to a multi-layered presentation, Schwartz-Salant enables even readers not deeply familiar with energy conservation and the first and second law of thermodynamics to follow his core arguments. The core notion that "entropy can be rigorously applied to the psyche itself" (pg. 105) is best explained in the book's innocuously titled chapter Seven, "The Interaction of Order and Disorder in Everyday Life" (pgs. 55–62), which includes a surprising amount of clinically relevant information. Schwartz-Salant first outlines the fundamental principle of the Paradox by stating that "psychic energy, like physical energy, can be characterized as ordered or disordered" (pg. 55). The two forms are polar opposites, even though "in psychic life, order and disorder are not always known in clear, separable forms" (pg. 61). In fact, they often appear mixed, as "in the depth of the psyche, order and disorder usually intertwine." Schwartz-Salant

characterizes order as follows: “The more ordered our energy is, the greater our capacity for clarity, organization, consciousness, and creativity” (pg. 55). However, and this is where the paradoxical comes in, whenever order is generated, the amount of disorder in the psychic system also rises—as per the paradigm of energy conservation. Schwartz-Salant writes: “Every time we create order, or a new orientation emerges into consciousness from the unconscious […], the disorder that will appear in the ego tends to represent itself as anxiety, fears of abandonment, reactive anger, hypervigilance to being emotionally attacked, fear of envy, despair, enfeeblement, or withdrawal.” If a person is in such a state, it is hard for them to function properly, and “problem solving, concentrating, or thinking clearly” is no longer a viable option. Consequently, one tends to forget that, in tandem with the sense of disorder that one feels, there are also elements of order to be found within the same system—within the same frame of reference that is the individual’s life. The encounter of disorder prompts reactions of resistance, which in themselves are challenging and make it “difficult to remember that a creation of order preceded the disorder” or is just about to enter consciousness. Because “order must engender disorder” (pg. 57), there is a necessary side effect, an unintended consequence, to the achievement of establishing structure in one’s existence. “You solve a problem in your life, you’ve created order; the subsequent doubt is disorder. You accomplish something in your work, you’ve created order; the emptiness you then feel is disorder” (pg. 56). The challenge of facing the negative emotions associated with disorder can be so great that the emotional hurdles undermine one’s ability to hold on to one’s successes and trust the progress one has made. It is easy to doubt the validity of those positive aspects due to the hardship felt in dealing with facets of disorder. However, Schwartz-Salant has found that knowledge of the Order-Disorder Paradox can help in such situations. It serves as not only as a theory that one may turn to but also as a “container” (pg. 78) in which both order and disorder can be experienced with all of their positive and negative ramifications. Reflection on the Paradox “can provide containment” (pg. 58), and Schwartz-Salant has found that “it is often helpful for my patients to view their painful reactions to otherwise positive events in terms of order and disorder. […] If […] we learn to recognize the disorder as part of our creation, we become more able to celebrate and enjoy our accomplishments as they should be celebrated an enjoyed” (pg. 56–57). Perhaps the most interesting dimension of the Order-Disorder Paradox is that it can be thought of as a two-way street, with order generating disorder—and disorder hinting at the fact that, in some areas of one’s life, order is about to emerge. In other words, the experience of disorderly states can herald the birth of new order. This idea extends to the individuation process, where a person’s self becomes progressively manifest in their life, and to transformational changes that an individual is just about to make—changes that might lead to the discovery of a new way of being and relating. None of these developments that create new order are necessarily already conscious, as Schwartz-Salant indicates: “Often that process forming in the unconscious is the central archetype, the self, engendering, among other qualities, an altered sense of identity and values, especially of the mystery of relatedness to others and to oneself” (pg. 58). Even when a new order has yet to unfold, disorder may already be felt, prior to the nascent development taking form. This means that, over the course of our own individuation, we must expect to encounter many moments of inner chaos and disorientation, but these do

not suggest that we have failed to make actual progress. Rather, states of disorder validate the order that they accompany—and they can point to areas within our psyche that could be considered our Achilles heels. Awareness of the Order-Disorder Paradox and its presence in our lives can contribute to a better handing of the difficulties associated with disorder. This is illustrated by Schwartz-Salant's case studies (pgs. 73–91): Many patients, believes Schwartz-Salant, find relief in acknowledging that their "situation is both personal and archetypal," with the Paradox offering a "larger, archetypal perspective" (pg. 79) on an individual's current condition. It is this function of supporting patients in understanding momentary disorientation as part of something greater that enables succeeding treatment steps. The new connotation of the idea disorder allows them to appreciate that the complete picture stretches beyond the chaotic state they are momentarily facing. Rounding off this review of "The Order-Disorder Paradox," I will only hint at the many instances in which Schwartz-Salant employs the concepts of the "field," the therapy relationship as a "third" entity, the "in-between realm" between therapist and patient, and the "subtle body"—the book's page 96 alone encompasses all of the quoted terms, and they are a common occurrence beyond that. All of these concepts are of great relevance in the scope of the present thesis, and I will provide further quotes stemming from the publication when discussing Schwartz-Salant's core ideas one by one.

4.3 Schwartz-Salant's Idea of the Therapy Relationship

Much like one would expect from a Jungian analyst, Nathan Schwartz-Salant considers the therapy relationship to be a crucial ingredient, especially when treating patients with personality disorders. We have seen the role of the relationship between therapist and patient exemplified in Schwartz-Salant's extended analysis of the Rosarium Philosophorum, as well as in his books on narcissism and the borderline condition. Also, we have reviewed his innovative concepts of the Fusional Complex and the Order-Disorder Paradox, which are equally connected to therapeutic techniques that put the therapy relationship and the dynamics it contains at the center of attention. However, while the fundamental function of the relationship is clear, Schwartz-Salant's way of describing it—of capturing it—is unique and deviates quite significantly from most other contemporary approaches. In this chapter, I will summarize his various attempts to conceptualize the rapport that emerges in the therapeutic encounter. In the absence of concise definitions, I will present a selection of quotes by Schwartz-Salant to illustrate four key means of describing the therapy relationship. Each of these means are partial answers to the question, "What is the therapy relationship?" Put together, these answers, if incomplete by design, will allow the present study to progress to its final chapters, in which a novel approach toward characterizing the quality of a therapy relationship will be proposed. Schwartz-Salant's four ways to picture the relationship are as follows: the "space between" therapist and patient, the "field" that constellates as an effect of their rapport, the "subtle body" as a container of the interaction, and the relationship as a "third area" going beyond therapist and patient. Three of these concepts are united in this single quote, in which Schwartz-Salant underlines the importance of Jung's ideas in his own thinking: "Jung employed […] alchemical symbolism to illuminate the deeper complexity of transference and counter-transference. In so doing, he essentially laid the groundwork for the notion of a third area as a field between people

and for the use of alchemical symbolism as representative of the transformation of energy patterns within the field" (Schwartz-Salant, 1998, pg. 59). At the heart of all of those concepts lies the idea that it is the therapy relationship where transformational processes can unfold—processes that are of an archetypal nature. Because the relationship's teleology is guarded by the numinous, its dynamics are, at least to a large degree, beyond the control of those who partake in it—despite the relationship's containing function. There is a natural limit to the extent to which the transformation process can be steered by the therapeutic couple. Instead of attempting to exercise control, for instance, by constantly interpreting the emerging dynamics, suggests Schwartz-Salant, one must have "faith in the process" (Schwartz-Salant, 2007, pg. 13). This assertion is likely a reference to Wilfred Bion's notion of having "faith" in the "ultimate reality and truth" that is "signified with O" (Bion, 1970, pg. 31). I want to mention this apparent parallel without too much further discussion since I believe it is correct that "many analysts shy away from Bion's concept of O" (Symington, 1996, pg. 175), and psychotherapists who subscribe to non-analytical schools of thought will hardly react with less reluctance. Still, it is one of the hopes that I have for the present study that it will make a small contribution to the same not holding true for Carl Jung's and Nathan Schwartz-Salant's use of the Rosarium Philosophorum. The rich analogy between the alchemical work and the therapeutic technique of focusing on transference is merely one of the many brilliant concepts developed by the two authors, and they deserve to be read and to be considered. I am therefore proud to feature them in this study.

4.3.1 The Transformational "Space between" Therapist and Patient

The first instance where Nathan Schwartz-Salant refers to the "space between" therapist and patient that I want to showcase is one that has two interesting qualities. First, it includes an implicit in-a-nutshell explanation of the fundamental concept. Second, the quote also provides a preview of Schwartz-Salant's idea of the subtle body, which we will focus on later in this chapter. He writes: "Two people can become aware of a state in which their subtle bodies are interacting. This experience is often felt as a change in the quality of the space between them, which is experienced as energies and more material in nature" (Schwartz-Salant, 1989, pg. 133). Schwartz-Salant add that, when this happens, therapist and patient "are then at the threshold of an awareness of archetypal processes." The connection between the "subtle body" and the "space between" individuals is drawn particularly strongly in Schwartz-Salant's relatively early book on the borderline personality. But even in his later works, there are occasions in which the terms are used almost interchangeably. Returning to the notion of the "space," the author states that, under certain conditions, "the atmosphere or space between" therapist and patient can start to "feel alive, vibrant" (pg. 147). Again, he refers to the subtle body concept. Then, he discusses a special case and reports that "there was a texturing of space in which we both seemed to be inside a field that was also between us." The case study stretches over several pages and is enriched by the motif of the royal couple found in the Rosarium Philosophorum: "My attention was on the imaginal couple between us and also on [the patient …]. There were two separate objects: a couple composed of the patient and myself, and the imaginal couple, whose presence could be sensed and their form imaginally seen in the space between us" (pg. 149). These thoughts might appear to be somewhat cryptic, even if one has

read Schwartz-Salant's analysis of the Rosarium. They all bear wide implications for the clinical setting, but to elaborate on them would go beyond the scope of the present study. Still, the essential point that I would like to make based on these and the following quotations is that the space between therapist and patient—which I will approximate to mean the therapeutic rapport or the therapy relationship—is essential for the treatment to succeed. The main reason for this prominent role is the notion that the relationship, or the space between clinician and patient, serves as the container in which the archetypal transformational process can eventually take place.

The idea of the "space between" therapist and patient is equally present in later works by Schwartz-Salant, such as the 1998 publication "The Mystery of Human Relationship." In this book, he provides several case studies to exemplify the level of interaction with his patients, which is based on the imaginal vision discussed in the context of the Rosarium. In one instance, he writes: "We could thus both feel a connection, a sense of an energized space between us" (Schwartz-Salant, 1998, pg. 134). In another, he states: "At the beginning of one particular session, I allowed my attention to hover within the space between us, and after a few moments, I began to imagine that we were in a violent storm" (pg. 80). The combination of these two quotes demonstrates the "aperspectival" imaginal sight that Schwartz-Salant proposes in his 2007 book on the Fusional Complex. There, he talks extensively about the subtle body concept, essentially using it synonymously with the space between people, or, more precisely, the "in-between realm" that arises in the relationship. "A quality in between" therapist and patient, he writes, can be regarded as an area that is "neither spirit nor physical body" and which "allows for an exchange of energy between man and the universe of relations […]. One can perceive this fabric of relations by focusing upon the interactive field, the in-between realm one can access through aperspectival awareness" (Schwartz-Salant, 2007, pg. 72). Two aspects stand out about this last quotation. First, it demonstrates the extent to which Schwartz-Salant tends to use his core terms almost as if they were synonyms—and this includes the "field," the "space," and the "subtle body." Second, one facet that all of these terms share is that they point to the relational quality between therapist and patient, and while the last quote is quite dense, I believe that it can demonstrate this tendency. Further mentions of the "space between us," exactly as quoted here, can be found on pages 88 and 90 of "The Mystery of Human Relationship." Permutations of the notion of the space between clinician and patient can be located, for example, in Schwartz-Salant's article "Vision, Interpretation, and the Interactive Field" (Schwartz-Salant, 1991). In one case, the author refers to the "felt experience of a 'third space' between analyst and analysand" (pg. 350). Elsewhere, he fleshes out the idea of the space by indicating the level of dynamism it can entail: "As in certain magical rituals where a candle is put out in water, symbolizing a transformation of the water, the interactive space between them might have begun to be felt as alive, not merely an empty space across which the patient's projections somehow pass" (pg. 357). The last quote can be recognized as describing the relationship between therapist and patient as a container that facilitates profound unconscious interaction that is hardly possible otherwise—this principle may be described as follows: "In order to create a container to mine the essential value of the Complex, both people in a relationship must be willing and able to understand the maddening conflicts they experience as qualities of a field they both share—qualities

that are not reducible to individual projections" (Schwartz-Salant, 2007, pg. 66). The mutual experience shared by therapist and patient is not simply "projective identification at work" but something that lives "in the space between us" (pg. 84). In order to open themselves up to the unfolding dynamics of the relationship, the therapist must "lean into the field […]. In a sense, one allows the field, itself extending endlessly but also sensed as 'in between' analyst and analysand, to be one's focus" (pg. 21). Overall, the above quotes enable us to conclude that the idea of the "space between" people is regularly used by Nathan Schwartz-Salant to illustrate the particular nature of the unconscious interaction in the therapy relationship. I would also argue that it may be, at least loosely, equated with the relationship more generally, since both the therapy relationship and the shared space between two individuals are both considered a container for the therapeutic process.

4.3.2 The Therapy Relationship as an "Interactive Field"

The notion of the "field," which constellates in the space between therapist and patient, is almost omnipresent in Schwartz-Salant's work. I will therefore start to examine this concept by turning to Gary Tomkins's reflections on Schwartz-Salant's therapeutic approach. Tomkins, in his discussion of Schwartz-Salant's perspective on the Rosarium Philosophorum, writes: "Working psychotherapeutically in the [second phase of the process illustrated in the Rosarium] involves the therapist not knowing. The therapist needs to let go of theories and perspectives and enter what Schwartz-Salant describes as the interactive field" (Tomkins, n.d.b). This field, Tomkins continues, is a place where neither therapist nor patient believe they know what is happening; rather, "both are open to the experience of the now. Attention can be paid to whatever arises, body sensations, feelings, thoughts, images." Tomkins, like Schwartz-Salant, emphasizes the point that interpretation ceases to have great value in this context: "Things are allowed to be what they are, and the interest is in the experience and the process, not the understanding of it. The move to interpretation is to be avoided as this punctures the interactive-field [sic] created between therapist and client. In this space, attention is paid to what emerges and little attempt is made to attribute this to either party." The centrality of the field concept, including the notion that experiencing the field is more important than interpretation at many stages of the treatment, is evident in much of Schwartz-Salant's oeuvre. Unsurprisingly, this fact has not remained unnoticed by the author himself. In the first chapter of "The Black Nightgown: The Fusional Complex and the Unlived Life," he notes: "In the course of this book I will use phrases such as 'seeing into the field,' 'seeing through the field,' or 'seeing the field.'' (pg. 12). Schwartz-Salant also hints at how the field can be accessed. Its contents "are perceptions that may be achieved with a form of 'non-ordinary perception,' itself a function of a consciousness that is different from the rational, perspectival form of awareness that has ruled our culture for at least the last three hundred years." This different kind of consciousness is detailed in Schwartz-Salant's interview with Laura London (Schwartz-Salant, 2017b, min. 32). In terms of terminological consistency, we again encounter noticeable overlap between the concepts of the "space between people" and the "field," for instance, when Schartz-Salant calls the "interactive field […] the inbetween realm one can access by aperspectival awareness" (pg. 72), thereby using language that is very similar to how he characterizes the "space." But in spite of the apparent interchangeability of these terms, the fundamental principle remains the same, and it represents a

theme that dovetails into the Jungian idea of the archetype. Schwartz-Salant has been following this theme for much of his life: "The archetypes create fields. And the question for me became discovering how these fields operate between people." This urge then led him to writing books on characterological disorders (Schwartz-Salant, 2017b, min. 21). In this connection, Schwartz-Salant uses the plural, "fields," while most of the time he employes the singular to describe the "interactive field between people" (Schwartz-Salant, 1998, pg. 204). He finds that "observing and experiencing the field affords a way of transformation," and when making this remark, he explicitly refers to "the alchemical path" laid out in the Rosarium (pg. 153). One passage that uses both the singular and the plural of the "field" concept reads as follows: "When two people interact, their fields interact, yielding an 'interactive field.'" (Schwartz-Salant, 2007, pg. 197). But while the shared field depends upon the two individuals involved, it is simultaneously of archetypal nature. Schwartz-Salant states that "because two people will create their own particular field, we need to think of the field as their field, endowing it with a personal quality. Yet, the field is far more than an amalgam of each person's subjective states of mind. […] Archetypal dynamics, rather than personal-subjective dynamics, rule its properties." This last quote is not only an insightful description of the "field" per se; it is also rich in implications for this study and for its elemental goals. The thesis aims to introduce a selection of archetypal symbols to characterize a given therapy relationship—thereby accounting for both the personal and the numinous qualities of the therapeutic interaction. In this sense, one can find distinct parallels between Schwartz-Salant's notion of the "field" and the ambition of this study. In both cases, the subjective meets the objective, or as Schwartz-Salant puts it: "The field experience is always a mystery of subjectivity encountering, and discovering, objective field-dynamics" (pg. 205). And the present study turns to objective archetypal symbols, united by a single structural container, to represent and characterize the subjective field that emerges between therapist and patient.

In conjunction with the concept of the "field," Nathan Schwartz-Salant proposes a selection of related ideas that, in researching his work, I have found remarkable. The present study serves as my Magister thesis and as such, its core function is to document a point of transition. However, I would also like this study to mark the stage of my own development as a clinician at the time of this writing. The following quotations by Schwartz-Salant belong to those that I find exceptional—but I also realize that I will have to continue investigating their ramifications for my therapeutic work for the foreseeable future. In these passages, Schwartz-Salant discusses the topoi of healing and growth, both within the therapy relationship. Importantly, he characterizes them as a two-way street: not only the patient benefits from partaking in an archetypal process but also the therapist. "Analyst and patient are together on a path of discovery, with neither having more nor less effectiveness. This may not diminish the patient's need—he feels this acutely—but the analyst too can marvel at how his growth is so tied to that of his patient" (Schwartz-Salant, 1982, pg. 166). On what basis can Schwartz-Salant arrive at this conclusion? The line of argument begins with the notion that, over the course of a treatment, a rapport is created. This togetherness can vary qualitatively, much in correspondence with the different phases illustrated in the Rosarium Philosophorum. At the same token, both participants bring their own themes to the relationship. Schwartz-Salant writes, referring to the field concept:

"The field is affected by the inner life of each person" (Schwartz-Salant, 1998, pg. 153). As the process progresses, the therapy relationship grows stronger. "In the kind of shared energy field I have been describing, what often develops is a transformation of the transference into a sense of kinship" (Schwartz-Salant, 1982, pg. 166). This emerging kinship can be associated with the hermaphrodite in the Rosarium; it is a sense of relatedness that did not exist prior. This change takes place largely because of the presence of numinous factors that reach into the field experience, believes Schwartz-Salant: "By entering a field with its defining and fluid dyadic forms, both people in a sense not only submit to a higher authority but also must trust the other not to misuse his or her power. If they succeed, they will in the process usually feel closer together than ever before. In effect, they will share a mystery; in a small yet significant sense, they will have been initiated together into the mystery of their relationship" (Schwartz-Salant, 1998, pg. 159). As part of this mystery, healing becomes a possibility—albeit the undertaking is far from simple and straightforward: "One has to learn how to enter and exit the field of union; and until one has acquired experience enough in dealing with the area, one either does not enter at all and thus remains narcissistically isolated or one attempts to enter and is immediately swallowed up by the field's magnetic energies and is fused to them. The whole enterprise is extremely painful, old wounds being opened up and salted in the process. But one finds one's way only through repeated excursions into that territory, and through suffering the reopening of festering wounds so that they can, with time, properly heal" (pg. 126). I am including the last two quotes in unabridged form because they indicate the margin of my current level understanding the subject matter. From the experience I have gathered thus far, working with patients often does require the clinician to remember the darkest places they have been. Fears are activated, some of which will be all but familiar. But, with some patients, unconscious elements probably play an even larger role. One gets to encounter new emotional states and a shared inner world that one could not have imagined. The dividing line of where the patient ends and the therapist begins can, in those scenarios, no longer be drawn. Maybe one also becomes aware of the illusional quality of the boundaries between people that are assumed to exist to comply with the demands of everyday life. At any rate, I do believe that events like shared field experiences, and techniques that incorporate them, such as "heart-centered imagination" (Schwartz-Salant, 1990, pg. 158), contribute to mutual healing and growth. I feel that I have experienced some of the numinosity associated with imaginal sight and hope to have only touched the surface.

4.3.3 The Therapy Relationship as a Shared "Subtle Body"

The notion of the subtle body is one of the most challenging concepts in Nathan Schwartz-Salant's work. In some instances, the term seems to mean something comparable to the "field." Schwartz-Salant uses similar language to describe the field, calling it, for instance, "the realm of the subtle body, […] a place where transformation can occur" (Schwartz-Salant, 1998, pg. 158). He also notes that "the dynamics within the field between therapist and patient, or the shared subtle body, can have strong effects on both parties" (pg. 152)—effectively using the terms synonymously. The same is true when Schwartz-Salant asserts that he finds "the field concept to be an excellent representation, in modern terms, for the key alchemical idea of the 'subtle body'" (pg. 23). At other times, the subtle body is portrayed as something that can be grasped within the interactive field (Schwartz-Salant,

2007, pg. 71). Then again, at other times yet, the subtle body appears to be the "container" in which the field can constellate itself (pg. 80). In essence, the subtle body bears a quality that is opaque to the contemporary scientific mindset. It is of a "neither physical nor material […]existence that [… has] a kind of location-non-location in the space between people" (Schwartz-Salant, 2017b, min. 21). Working with the subtle body in the clinical setting involves a particular approach and a special kind of vision: "The subtle body can be experienced imaginally as a kind of energy field that extends outwards from our physical being. It is invisible to ordinary perception but can be seen imaginally" (Schwartz-Salant, 2023, min. 4). Schwartz-Salant explains that the subtle body does not belong to the physical nor the spiritual world but serves as the bridge between the two: "The subtle body […] is both spiritual and physical" and can therefore "manifest itself psychically in terms of dream, phantasy, and body images, and it can manifest physically in terms of body structure" (min. 16). The underlying idea is that "every complex has a body" (min. 15); as a consequence, complexes can express themselves either on a corporal level or in a person's psyche. But "rather than studying one or the other of these opposites, […] there is much to be gained by turning instead, and when possible, to that often-obscure middle realm in which they both partake" (min. 15). To focus on the subtle body, Schwartz-Salant thinks, can have great clinical effect with certain groups of patients: "If one can successfully work through the subtle body realm, there is often a chance to transform not only psychic structure but physical structure, as well" (min. 17). He adds that "this intermediate realm of subtle bodies was the major concern of alchemy" (min. 16), which refers to Carl Jung's and his own work on the Rosarium Philosophorum, as well as to related studies. Having examined the Rosarium's coniunctio and nigredo states, we are ready to proceed to the next quote by Schwartz-Salant, which incorporates both alchemical concepts: "[The subtle body] appears in the context of two people in analysis. Their subtle bodies can interact in states of fusion—or the extreme opposite, in a state of separation that can become extremely afflicted and persecutory in its soullessness" (min 4). Clearly, Schwartz-Salant is referring to the alchemical nigredo state when he describes feelings of disconnection and soullessness. To Schwartz-Salant, Jung's alchemical analyses are of the utmost importance—both personally and professionally. He says: "I became very committed to that aspect of Jung which explored the subtle body, and that's alchemy. Alchemy is all about the subtle body. And so […] I have basically moved my psychological practice towards the 'interactive field with people,' as I called it, and to understanding this level of the union between people" (Schwartz-Salant, 2017b, min. 22). The link between Jung and Schwartz-Salant in terms of alchemy extends beyond the Rosarium Philosophorum. Indeed, the idea of the subtle body can be found in Jung's opus, in particular in Jung's seminars on Nietzsche's "Thus Spake Zarathustra." In the transcript, which has long remained unpublished, Jung calls the notion of the subtle body an "enigma" (Jung, 1988, pg. 445). Still, he elects to take the concept very seriously. Simon Cox, who has analyzed Jung's interpretation of the subtle body idea, finds that Jung takes it to represent "an intermediary vehicle that traverses the troubled waters separating mind from body and conscious from unconscious; a liminal structure possessed of a different kind of 'knowing'" (Cox, 2022, pg. 165). Jung himself describes the concept as follows: "Somewhere our unconscious becomes material, because the body is the living unit, and our conscious and our

unconscious are embedded in it: they contact the body. Somewhere there is a place where the two ends meet and become interlocked" (Jung, 1988, pg. 441). In conclusion, the subtle body is "the place where one cannot say whether it is matter, or what one calls 'psyche.'" As these passages indicate, the subtle body's fundamental quality of existing neither in the psychical nor spiritual world, are acknowledged by both Jung and Schwartz-Salant. To Jung, the consequence of this particularity is that "the subtle body […] necessarily must be beyond space and time. […] The subtle body is said not to consist of matter, or it is matter which is so exceedingly subtle that it cannot be perceived. So it must be a body which does not fill space, a matter which is beyond space, and therefore it would be in no time" (pg. 443). This characteristic of being independent of space and time is precisely what prompts great difficulties in discussing the subtle body, finds Jung. Due to this strange quality, the subtle body "is beyond our grasp per definition" and a "transcendental concept which cannot be expressed in terms of our language or our philosophical views, because they are all inside the categories of time and space," believes Jung.

But regardless of the challenging nature of outlining the subtle body concept, Jung and especially Schwartz-Salant consider it integral to the understanding of alchemy. Not only is the subtle body "a necessary container for the inner life" (Schwartz-Salant, 2007, pg. 71) but also a "fabric of relations" (pg. 72). These relations may enter the consulting room in the form of projective identification but extend to working with unconscious elements in general. The unconscious couple, illustrated in the Rosarium by king and queen, are placeholders for opposites that can exist in many forms and come alive in the clinical setting. These opposites, writes Schwartz-Salant, depend upon the shared subtle body between therapist and patient to come to life: "The unconscious dyad exists in a medium, the subtle body" (Schwartz-Salant, 1998, pg. 152). It is therefore no surprise that the subtle body "is central to alchemical ways of thinking." Over the course of the alchemical opus, depicted in the Rosarium, the relationship between therapist and patient matures—in a sense, three different selves come into play: the therapist's, the patient's, and the shared self (Schwartz-Salant, 1988, pg. 57). All three are on their path toward individuation and growth as they undergo a process of transformation. While the process can be arduous, the reward makes everything worthwhile: by "suffering through numerous sequences of union-death states […], the alchemical process also leads […] to an ongoing awareness and experience of the 'intermediate realm' of the subtle body" (Schwartz-Salant, 1998, pg. 207). This "subtle realm" is a container "in which a self can flourish, a self that combines both spiritual and physical attributes and which draws upon the transcendent as well as one's most intimately personal experiences." Schwartz-Salant's discussion of the subtle body clearly demonstrates the centrality of the concept in his own thinking. However, and perhaps this is by design, the concept remains somewhat vague. Still, I hope to have been able to show that, in Schwartz-Salant work, the subtle body has the important distinction of representing a shared entity between therapist and patient—a mutual reference point and a domain in which deep emotional interactions occur. Whether one may call this shared subtle body a "relationship," or even "the therapy relationship," is probably debatable. Personally, I find this approach toward the idea of the therapy relationship significantly more convincing than other contemporary definitions, many of which primarily

regard the therapy relationship as a means to an end—even if that end is optimal therapeutic outcome.

4.3.4 The Therapy Relationship as a "Third Entity"

Nathan Schwartz-Salant's references to the therapy relationship as a "third area" are less common than those that mention the "field" or the "space between" clinician and patient. In terms of overlap with these alternative concepts, it can get tricky to determine a distinct difference. Occasionally, Schwartz-Salant appears to treat the three ideas as synonyms, for instance, in the following passage, which is part of "The Mystery of Human Relationship" and describes a therapy session. First, the terms "third thing" and "field" are used as if they were identical twins: "We[, the patient and I,] were experiencing a change in the quality of awareness of the texture and space around us, that is, the 'field' or the 'third thing.' We felt as if an 'other' was present with us" (Schwartz-Salant, 1998, pg. 89). Another passage, this time from "Order-Disorder Paradox," reads: "The 'third' can be cognizance of the field between two people" (Schwartz-Salant, 2017a, pg. 96). Coming to the second complication, the earlier quote continues by extending the synonymous use to the "space between" therapist and patient: "The nature of the field was such that we could both experience being inside of and contained by it. At other times, we felt as if we were observing the field, its nature and qualities in the space between us" (pg. 90). Arguably, the confusing situation is worsened by the fact that, on in some instances, the "third area" seems to be used interchangeably with the notion of the "subtle body." One example is Schwartz-Salant's assertion that "such is the nature of alchemical theory and belief: within and through the medium of the pneuma or subtle body, the union experience occurs. Many alchemical drawings indicate this level of a 'third area' with its own life of which two people may partake and by which they may be changed" (pg. 15). In a 1991 publication, Schwartz-Salant equalizes the terms in a similar manner when he discusses "processes in a 'third space' which was often called the subtle body" (Schwartz-Salant, 1991, pg. 348). In spite of this somewhat arbitrary utilization of terms, the notion of the "third area" or "third entity" does bear immense significance in Schwartz-Salant's work. The main point is to clarify that the relationship with a patient is different from the two individuals composing it; it is not the sum of its parts. Rather, it can be thought of a separate entity that one may interact with. Just like one can choose to enter a relationship, one can commit to participate in constituting a "third area" with another person—even though it is clear that doing so will mean walking into unknown territory. This act of willpower is the reason why Schwartz-Salant notes that, when reporting on a particular case, he "consciously began to engage a 'third area' between" himself and the patient (pg. 89). Within this space, relational dynamics come to life—in a process that goes beyond mere reenactment. These dynamics can be characterized as the encounter of unconscious elements, surfacing in the context of an archetypal process, or as imagery seen by employing "aperspectival" vision. Schwartz-Salant writes that in "aperspectival mode, the inner life of another becomes visible as the spirit takes on a concrete form […]. This imagery, when perceived and experienced by both people within the third area, is the source of healing" (Schwartz-Salant, 2007, pg. 72). The thought that the third area, thanks to its numinous dimension, is the locus where healing can happen is logical since it is also this area in which unintegrated opposites are contained and transformed. "We could understand our interaction as

inclusive of a 'third thing', a mythical realm that had been ordering and weaving together the psychotic parts of our psyches" (Schwartz-Salant, 1990, pg. 157), writes Schwartz-Salant about another case. Since we have already examined practically all of the essential themes associated with the "third thing" in the quotes thus far presented, it seems appropriate to introduce a point that is not made by Schwartz-Salant, but which, in my estimation, is highly compatible with his line of thought. Nicolas of Cusa, whose work we have touched upon earlier and who was greatly admired by Carl Jung (e.g. Jung, 1966, pg. 320), put forward not only the idea that God was the personification of the union of opposites (Nicolas of Cusa, 1985, pg. 36, 37, & 62) but also the belief that every finite thing was equally distant from God due to His infinite nature (pg. 86). I wonder if the same principle can be applied to psychotherapy—specifically, to the role of a practitioner's level of expertise. I do not doubt that clinicians should receive proper training, and it appears to me that better and worse therapists exist in this world. But in a sense, regardless of the robustness of one's techniques, in the end, the ultimate healing factor depends upon whether a connection to the numinous has been established. Compared to the relevance of the numinous—the infinite nature of God, in Cusanus's perspective, or the archetypal, in Carl Jung's school of thought—the influence of any one therapist on the outcome of the treatment is probably far smaller than our own narcissism and our desire for control would have us believe. The entity that has the power to unite opposites, to integrate desperate parts, and to heal escapes the limited intellectual and emotional capacity of the humble clinician—and that of the patient, for that matter. Just like God "dwells in inaccessible light" (pg. 101), so far out of reach is the Jungian numinosum. Maybe what is really required of us as therapists is, much like both Bion and Schwartz-Salant suggest (Bion, 1970, pg. 31; Schwartz-Salant, 2007, pg. 13), an act of faith—above anything else.

As we have seen, Nathan Schwartz-Salant uses the term of the "third area" to highlight the idea of the therapy relationship representing an entity that cannot be reduced to the sum of its parts. It is not simply a combination of certain characteristics stemming from the patient, plus a collection of traits from the therapist. Rather, it can be thought of as an entity that, while it does depend upon the existence and the interaction of the therapeutic couple, has a life of its own and entails its unique qualities—qualities that may in fact be new, or even foreign, to both therapist and patient. To Schwartz-Salant, the relational dynamics only really unfold if the therapist chooses to abandon the security of knowing what is happening, for instance, in the form of using interpretation as a technique, rather than committing to the experience of the immediacy of the rapport. This choice between interpretation and engaging the third area is a key point to Schwartz-Salant, and, in the absence of the sense of orientation that interpretation would provide, the hurdle to enter the third area again requires an act of faith. As Schwartz-Salant puts it: "Out of this [therapeutic] dyad a third may arise as either an interpretation […] or as an imaginal 'third thing' that becomes a field through which one experiences the session" (Schwartz-Salant, 1991, pg. 357). A good, brief description of what it means to engage the field and to thereby enter the third area reads as follows: "When we approach an interaction between two people in terms of the field as a 'third area,' we understand relationship not primarily from inwardly reflecting upon sensations, feelings, and cognitions of various kinds, but from observing the ways such data take their organization and meaning from an underlying field."

(Schwartz-Salant, 2007, pg. 198). In other words, what therapist and patient experience in the therapy relationship is seen as inner states and as interpersonal dynamics that are structured by the qualities determined by the current state of the relationship. One way in which Schwartz-Salant conceptualizes the notion of the "third" is via the so-called "Axiom of Maria." The axiom is a common occurrence in Carl Jung's studies, especially those on alchemy (Jung, 1968), and goes back to Maria Prophetissa, an early alchemist who also goes by the name "Maria the Jewess" and supposedly lived almost two millennia ago, as Eisen and Laderman note (Eisen & Laderman, 2007, pg. 265). The two authors indicate that Maria's ideas belong to an "alchemical corpus, dating possibly from the early third century, is attributed to Maria the Jewess, or Maria Hebraea, whose works we learn through the writings of Zosimus of Panopolis, who flourished in Alexandria around 300 CE." Carl Jung regards the Axiom of Maria as "one of the central axioms of alchemy" (Jung, 1968, pg. 46), while Schwartz-Salant finds that "it is a leitmotif throughout two thousand years of alchemical thought" (Schwartz-Salant, 2017a, pg. 96). In Jung's translation, the "saying of Maria Prophetissa" reads: "One becomes two, two becomes three, and out of the third comes the one as the fourth" (Jung, 1968, pg. 46). Schwartz-Salant sometimes also employs a slightly different translation: "Out of the One comes the Two, out of the Two comes the Three, and out of the Three comes the Fourth as the One" (Schwartz-Salant, 2007, pg. 200). In the context of the present study, the axiom plays a role because it is often used by Schwartz-Salant to emphasize the relevance of the "third area" in the therapeutic process. In essence, the One represents the initial therapeutic encounter—for instance, a particular situation that arises in a therapy session. Clinician and patient are interacting and relating in a certain manner, with both experiencing certain inner states. In this one shared scenario, opposites might emerge, such as contrasting inner states that are divided among the therapeutic couple. The patient may feel mania, the therapist sadness (Schwartz-Salant, 1989, pg. 139). Thereby, the Two emerges—in the form of manifesting opposites. In the next step, two different variations of the Three are possible, and "at this point, you have a choice. On the one hand, you can begin to infer 'whose emotion' is primary, either yours or the analysand's. This is the structure of interpretation" (Schwartz-Salant, 2007, pg. 200). The alternative to the use of interpretation is, as we have detailed prior, the option to engage the field as the axiomatic "third." This choice opens up the door to a deeper exploration of the relational dynamics between therapist and patient. The experience may, if repeated over time, exhibit the archetypal temporal structure illustrated in the Rosarium Philosophorum, with distinct coniunctio and nigredo phases (Schwartz-Salant, 1989, pg. 141). However, out of this process, both participants' selves are transformed, in addition to their shared self: the Fourth as the One. Such a "symbolic sense of oneness" can, according to Schwartz-Salant, be seen as "a sacred event, a moment of grace, and perhaps also a result of faith in background sense of oneness." While I consider this characterization of the therapeutic process to be highly fascinating and convincing, the main point of the Axiom of Maria in the context of the present study is the notion that "the 'Three' is the creation of the third thing, the field" (Schwartz-Salant, 1998, pg. 60). It is Schwartz-Salant's "third area," in which relational dynamics can unleash their full potential, and it is this area in which the therapy relationship really comes alive.

5 The Descriptive Potential of the Astrological Composite

Having examined Nathan Schwartz-Salant's perspective on the therapy relationship, we are now ready to begin our search for an appropriate means of describing a specific therapeutic rapport. We have seen that, according to Schwartz-Salant, the relationship can be thought of as a third entity that goes beyond the sum of the parts of those involved. Within the third area, the experience of relational dynamics is connected to an archetypal process that ultimately serves as the single-greatest contributor to healing. However, "with the three being the field experience characterized by an underlying grasp of […] oneness" (Schwartz-Salant, 2017a, pgs. 96–97) arises the question of how we can describe the quality of the field that manifests within the third area. While Schwartz-Salant's work includes many insightful case studies, an attempt to standardize his method of detailing the intricate interactive-field encounters seems impossible. Also, non-Jungian health professionals might find Schwartz-Salant's language so deeply immersed in Jungian tradition that they have trouble connecting with his approach. The reader of the present study may now wonder why its author feels so strongly about "standardization"—that providing a uniform, systematic approach to making qualitative statements about a given relationship is of such relevance. There are two main arguments in favor of attempting this kind of standardization. First, a number of instruments designed to gauge the quality of a therapy relationship already exist, some of which this study has reviewed. Any new method, I feel, should acknowledge that the existence of those established approaches will prompt specific expectations—such as ease of use and direct applicability to ongoing therapies. This principle will likely hold true even if a novel method takes a different approach in terms of emphasis, for instance, focusing less on therapeutic outcome and on shared targets than other approaches. Second, tools that enable clinicians to take a fresh perspective on their therapy relationships are valuable in that they can help to identify new treatment-related possibilities as well as blind spots on the therapist's side. With the therapy relationship playing such a crucial role in the clinical context, I find it somewhat surprising that not more has thus far been done to enable therapists—and patients—to assess their relationships in a simple qualitative way.

To develop our novel descriptive method, the notion of the relationship representing a "third entity" will be elemental, because there exists a method of characterizing relationships as a "third" in qualitative terms—only that is has thus far not entered the psychotherapeutic domain. This method stems from the symbolic system of astrology, which, like Jungian psychology, rests upon an archetypal dimension from which it derives meaning. This study will treat the archetypes inherent in western astrology as "conceptual forms of thought." This is a definition that James Jarrett, the editor of Jung's lectures on Nietzsche's "Thus Spake Zarathustra," calls an "extraordinary description of the archetype" (Jung, 1988, pg. xix). The thesis will consider astrology as a symbolic system with great nuances and immense descriptive potential. It will, however, not elaborate on the objective merit of astrology. Neither will it attempt to weigh in on the value of astrology as a practice. It will proceed on the premise that the astrological archetypes can help us achieve something—namely, talk about relational characteristics. Beyond this purpose, there is no need to take it seriously, even though one is certainly at liberty to do so. While some Jungians,

such as Liz Greene and Christina Becker, openly practice not only psychotherapy but also astrology (e.g., Greene, 2018a, pg. i; Becker, 2025, min. 1), any overlap between these two fields is, at the time of this writing, prohibited or frowned upon in certain countries. As a consequence, the present study must clearly state that it neither promotes nor supports any violation of existing regulations or ethics guidelines. Rather, what it attempts to accomplish in this chapter is the following: It will outline that the idea of the astrological "composite" exhibits striking similarities to Schwartz-Salant's concept of the "third area" as a separate entity—because it "represents the relationship itself as a third factor" (Greene, 1999, pg. 10). This means that the idea of the composite can guide our process of developing a novel method of characterizing relationships that may then be transferred to the field of psychotherapy. Relying chiefly on select works by Jungian analyst and astrologer Liz Greene, we will examine the descriptive power of astrological archetypes so that they can be applied to the therapy relationship in standardized form.

5.1 Psychological Astrology as a Symbolic System

Astrology—or, more precisely, psychological astrology—goes far beyond the scope often associated with it based on newspaper columns pretending to make personalized predictions based on the archetypal quality of an individual's astrological Sun. It is a symbolic system that bears great complexity. In essence, a person's "radix" horoscope involves 12 archetypal patterns, each of which appear on three different layers that involve "planets," "signs," and "houses." The planets can be characterized as "symbols of the powers of the unconscious," as Carl Jung puts it (Jung, 1990, pg. 175), or as a set of "particular psychological drives, urges and motivations" (Sasportas, 2007, pg. 19). In terms of the houses, we can also turn to Howard Sasportas for a short description; at the core, they determine how a planet's energy manifests: "The drive of a planet is expressed through the sign in which the planet is placed." This means that a distinct facet of someone's personality will express itself in their life in a certain coloration, depending on the sign in which a planet is located. The houses are generally less well understood (pg. 13) and indicate the respective context in someone's existence in which a planet, influenced by its sign, makes itself known. In other words, the houses present "the specific areas of everyday life or fields of experience in which all this is occurring" (pg. 19). A to-the-point summary of the three fundamental layers constituting a horoscope is the statement that "the planets show what is happening, the signs how it is happening, and the houses where it is happening." To the present study, two principles are of importance here: First, the idea that an individual's psyche consists of several different energies that may appear to be in harmony or in conflict with one another; second, these energies manifest in characteristic ways. These principles will later be used in this study to develop a descriptive approach to assess therapy relationships. Aside from the authors already quoted, the psychoanalyst Fritz Riemann, probably best known for his analysis of different forms of anxiety (Riemann, 2009) provides a valuable entry point for the application of astrology to counselling and psychotherapy (Riemann, 2004). Unfortunately, this book is not yet available in English. Riemann argues that especially psychoanalysts will find the astrological system of thought—"astrologisches Denken," as he puts it—to be highly compatible with traditional assumptions made by depth psychology (pg. 44). Riemann examines the planets, of which the system

of astrology currently knows ten, with two playing a double role, in some detail (pgs. 155–205). The same is the case with the 12 signs (pgs. 71–154), while the houses get somewhat less attention (pgs. 206–213). Liz Greene discusses the result of the interaction of all these factors in her book "The Astrology of Fate" using the old metaphor of the archetypes representing "gods," thereby hinting at their numinous quality. She writes that "meeting a planet in a sign and house is like entering a temple and meeting the manifestation of an unknown god" (Greene, 1984, pg. 34). The way the archetype manifests in someone's life can vary greatly: "We may meet that deity as a concrete 'outer' experience, or via another person who is the mask through which the god's face peeps; through the body; through an ideology or intellectual vision; through creative work; as a compelling emotion," explains Greene. She also emphasizes the fact that the numinous energies may harmonize or be in conflict with one another, and, as a result, they can be hard to pinpoint: "Often several of these are experienced together, and it becomes difficult to see the unity between what is happening in life outside and what is happening within." Reading these passages, one clearly notices that Greene, herself a Jungian analyst, is following Jung's fundamental idea of projection of inner psychic contents onto objects in the external world. A particular facet of someone's personality can unfold in various ways, much like "the planet bridges the abyss between 'outer' and 'inner' and provides us with our meaningful connection, for the gods live in both worlds at once" (pg. 34). The core principle is that each of the ten "archetypal figures" (Arroyo & Greene, 1991, pg. 17) must express themselves in a person's existence—but the forms in which it can do so are manyfold.

Having outlined some of the basic assumptions inherent in the symbolic system that is western astrology, I need to volunteer a disclaimer: As the author of the present study, I am by no means an expert in astrology. The attempt to take an actual deep dive into the many nuances of this system of thought would therefore likely result in an exercise in futility. I appreciate that this study could potentially benefit from a more comprehensive look at the mechanisms behind the drawings that astrologers produce, and at the ways in which those can be interpreted. The omission of these contents was not made lightly. I do feel that, at this juncture, it is my best option to point the interested reader to the works of Liz Greene, Howard Sasportas, and Fritz Riemann. However, in order to establish a consistent throughline within this thesis, I will provide a cursory look at the 12 archetypes that constitute psychological astrology when discussing the concept of the astrological "composite." The composite is an idea that sees the relationship between two people as something additional—as something separate from them, even though its existence depends upon those who establish it. It regards the relationship as a "third entity has its own psychological dynamics and its own mode of expression" (Greene, 1999, pg. 9). Soon, we will also see that the parallels between Nathan Schwartz-Salant's idea of the relationship and Liz Greene's go much deeper than this quote alone can demonstrate.

5.2 Carl Jung and Nathan Schwartz-Salant on Astrology

Before we progress to a closer examination of the idea of the astrological composite, it makes sense to take a step back and to appreciate the extent to which the symbolic system of astrology is part of the Jungian canon. While Carl Jung only sparingly refers to astrology

in his official publications, his written correspondence contains more than just the odd mention of astrology. In essence, he sees it as a blank page that was filled with rich ideas from the human unconscious—as an area of projection. At the same token, he would turn to astrology to exemplify the notion of synchronicity—of a parallel occurrence of otherwise unrelated events that are united by an underlying symbolic configuration, which then bestows meaning upon both events. Unsurprisingly, the thought of astrology representing a symbolic system is shared by Jung. He believes that "astrology, like the collective unconscious with which psychology is concerned, consists of symbolic configurations: the 'planets' are the gods, symbols of the powers of the unconscious" (Jung, 1990, pg. 318). With its symbols being expressions of the human unconscious, astrology can be thought of a manifestation of the essence of man that would otherwise remain inaccessible, and, in this respect it is similar to many other human endeavors, including various scientific undertakings: "As we all know, science began with the stars, and mankind discovered in them the dominants of the unconscious, the 'gods,' as well as the curious psychological qualities of the zodiac: a complete projected theory of human character" (Jung, 1968, pg. 140). As a consequence from this perspective on astrology as the field, Jung finds it to be comparable to that of alchemy. He adds that "astrology is a primordial experience similar to alchemy. Such projections repeat themselves whenever man tries to explore an empty darkness and involuntarily fills it with living form." The idea of astrology highlighting human expression is important, but I would argue that Jung's concept of synchronicity is even more relevant. I have, when discussing astrology as a symbolic system, often found that people believed the basic assumption to be that there existed a causal relationship between star configurations and certain events in someone's personal life. As a result, the premise of astrology then immediately appears to be absurd. However, this notion of causality is precisely not the axiom in which psychological astrology is rooted. Jung notes that "astrology does not follow the principle of causality, but depends, like all intuitive methods, on acausality" (Jung, 2015, pg. 464). He adds that "there is no psychological exposition of astrology yet, on account of the fact that the empirical foundation in the sense of a science has not yet been laid," due to its incompatibility with modern reasoning. While the mechanisms at work in astrology cannot be grasped with causal thinking, it can be understood via the paradigm of synchronicity, as Jung explains in his Letters: "It seems to me that [astrology] is primarily a question of that parallelism or 'sympathy' which I call synchronicity, an acausal connection expressing relationships that cannot be formulated in terms of causality" (Jung, 1990, pg. 318). Therefore, in a nutshell, "astrology […] concerns the question: what is the psychological condition in which a synchronistic phenomenon may be expected?" Jung's question points to how astrological conditions reach into people's lives—or, more precisely—how they mirror what takes place in their lives at a certain point in space and time. In this light, astrology appears as a domain that allows for an ancient belief to shine through—namely that of a "dependence of character and destiny on certain moments in time" (Jung, 1968, pg. 11). Jung makes it clear that he, for one, subscribes to the idea of fate. But whether one shares his opinion or chooses not to, the principle of synchronicity remains paramount in Jung's opus. It is so central that I would like to include a passage in which Jung sketches out this concept in unabridged form, in part because it serves as an apt characterization of his understanding of astrology. In a letter dated September 6, 1947, he writes: "Since

you want to know my opinion about astrology I can tell you that I've been interested in this particular activity of the human mind for more than 30 years. As I am a psychologist I'm chiefly interested in the particular light the horoscope sheds on certain complications in the character. In cases of difficult psychological diagnosis I usually get a horoscope in order to have a further point of view from an entirely different angle. I must say that I very often found that the astrological data elucidated certain points which I otherwise would have been unable to understand. From such experiences I formed the opinion that astrology is of particular interest to the psychologist, since it contains a sort of psychological experience which we call 'projected'—this means that we find the psychological facts as it were in the constellations. This originally gave rise to the idea that these factors derive from the stars, whereas they are merely in a relation of synchronicity with them" (Jung, 2015, pg. 475). I still maintain that the purpose of the present study is not to determine the degree to which astrology can be regarded as an appropriate, viable tool in any particular context—including psychotherapy. But I do find the above quote remarkable in that it nicely elucidates Jung' conception of synchronicity and the fact that he sees it realized in the domain of astrology. In another letter, Jung states that he has "observed personally quite a number of synchronistic events where I could establish the nature of the underlying archetype" when working with astrology (Jung, 1990, pg. 318). These experiences, he states, are possible because "the archetype itself (nota bene not the archetypal representation!) is psychoid, i.e., transcendental and thus relatively beyond the categories of number, space, and time." To Jung, the archetypes, the numinous, and the principle of synchronicity are intertwined. Together, they make their presence known in alchemy and astrology alike. However, Jung is also aware that not everyone will applaud his interest in these subjects, and he reports that he, in some cases, had to comply with expectations. He, for instance, writes in March 1954: "I am once again preoccupied […] with the question of synchronicity and astrology. I have had to suppress the chapter on astrology altogether in the English edition [of a certain publication] since apparently no one can understand it" (Jung, 1990, pg 162). Freud may have been among those taking a more critical stance. In the two volumes containing Jung's known correspondence, there is only one letter addressed to his mentor that involves the topic of astrology. It is dated June 12, 1911, and reads: "My evenings are taken up very largely with astrology. I make horoscopic calculations in order to find a clue to the core of psychological truth. Some remarkable things have turned up which will certainly appear incredible to you" (Jung, 2015, pg. 24). Jung's optimism is palpable, and he continues by making a prediction—whether it has since become reality, is probably up for debate. Jung continues: "I dare say that we shall one day discover in astrology a good deal of knowledge that has been intuitively projected into the heavens," thereby referring to his idea of projection, which we have encountered earlier. He points to the temporal nature of the horoscope and implicitly touches upon the principle of synchronicity in addition to Freud's term of the libido: "It appears that the signs of the zodiac are character pictures, in other words libido symbols which depict the typical qualities of the libido at a given moment," he tells Freud. Overall, astrology may not represent a cornerstone to Carl Jung's thinking like the archetypes, the numinosum, and synchronicity, but it appears that he does regard all of these areas and ideas as interconnected—due to the qualitative dimension of space and time (Jung, 1990, pgs. 353–354).

Astrology is a symbolic system that can help phenomena of much greater scope to rise to the surface of human consciousness. Consequently, "the fact that astrology […] yields valid results proves that it is not the apparent positions of the stars which work, but rather the times which are measured or determined by arbitrarily named stellar positions. Time thus proves to be a stream of energy filled with qualities and not […] an abstract concept or precondition of knowledge" (pgs. 138–139). Jung's fascination with astrology stays with him well into his "advanced age," as he writes (Jung, 2015, pg. 175). In May 1954—Jung is 78 years old at the time—he notes that "there are many instances of striking analogies between astrological constellations and psychological events or between the horoscope and the characterological disposition." And while it is also true that "astrology has actually nothing to do with the stars but is the 5000-year-old psychology of antiquity and the Middle Ages" (Jung, 2015, pg. 56), it, to Jung, still represents a realm in which one may just encounter the effects of synchronicity.

Nathan Schwartz-Salant also refers directly to astrology and to the archetypal patterns it contains, but since his oeuvre is smaller than Carl Jung's, those mentions are much fewer overall. In his book "The Order-Disorder Paradox," he tells his personal story of how he first got acquainted with psychology and psychotherapy, detailing a specific episode through which he gained the ability to relate to other people on a deeper level. (Schwartz-Salant, 2017a, pgs. ix–xx). Passing that threshold, he explains in his interview with Laura London, let him discover previously undiscovered capabilities such as his "easy facility for astrology" (Schwartz-Salant, 2017b, min. 10). In another context, he examines challenging life events that should be accepted as moments in time when a new order is about to manifest in one's life; the experience of disorder leading up to the inflection point thus represents a period that bears the potential of upcoming personal transformation. The act of recognizing the value of such developmental phases, to Schwartz-Salant, corresponds to a consciousness that does not solely depend on rationality. He writes: "Times to pause and accept feeling hindered in our projects are part of a mythical consciousness as seen in divinatory techniques such as […] astrology" Schwartz-Salant, 2017a, pg. 124). Astrology can therefore serve as an entry point to acknowledging numinous dimensions in one's existence. Taking this thought one step further, Schwartz-Salant discusses the topos of the "unus mundus," a key concept in Carl Jung's work. For readers of the present study not familiar with the term, I would loosely describe it as a combination of Plato's "realm of ideas" and the Jungian notion of the "collective unconscious." Jung says that "the idea of the unus mundus is founded on the assumption that the multiplicity of the empirical world rests on an underlying unity […] Everything divided and different belongs to one and the same world, which is not the world of sense but a postulate […]. The background of our empirical world thus appears to be […] a unus mundus" (Jung, 1963, pgs. 537–538). Schwartz-Salant employs the idea of the unus mundus to put forward his theory of psychic energy conservation, which I will not elaborate on since my objective now is to highlight his references to astrology. Schwartz-Salant states: "The unus mundus—beyond three-dimensional space—is the locus of such conserved psychic information. Divination techniques such as astrology […] attempt to access it through the mythical level of consciousness" (pg. 93). The quote illustrates the association of the unus mundus with the ideas of the numinous and the archetypes, which, as the thesis will demonstrate, all play a crucial

role in psychological astrology. In "The Mystery of Human Relationship," Schwartz-Salant discusses six astrological signs, as well as their polarities, which he calls "astrological opposites" (Schwartz-Salant, 1998, pg. 97). Of course, his use of the term "opposite" in this context is a nod to Carl Jung. Compared to Jung's references to astrology, those made by Schwartz-Salant are lower in number. But the reason why Schwartz-Salant represents the central inspirational author featured in the present study has little to do with his explicit references to astrology, irrespective of their count. This choice is based on the high level of compatibility of his ideas—especially of the concept of the therapy relationship as a third entity—with certain facets of astrology, especially with the astrological composite.

5.3 The Astrological Composite and Its Meaning

We have now examined Nathan Schwartz-Salant's idea of the relationship and explored its roots in Jungian psychology, with a focus on Carl Jung's work on alchemy as a reference point for the analysis of the transference and countertransference phenomena. To both Jung and Schwartz-Salant, the relationship between therapist and patient is the space in which transformative interactions can occur. Schwartz-Salant summarizes his reliance on Jung's concepts as follows: "I have used Jung's work in my attempt to understand the nature of a 'third area' which two people in relationship create and which, in turn, can have a transformative effect on each person's internal structure" (Schwartz-Salant, 1998, pg. vii). This notion of the therapy relationship representing a third entity arising in the space between clinician and patient is not solely found in Schwartz-Salant's approach. Rather, it is also represented in the system of thought of astrology—via the notion of the "composite." To take a closer look at the composite, we will primarily turn to Jungian analyst and astrologer Liz Greene. In a seminar on the astrological perspective on the human relationship, she notes that "Jung refers to alchemical symbolism frequently to describe the dynamics of relationship" (Arroyo & Greene, 1991, pg. 17), thereby acknowledging her own theoretical foundations in the Jungian school of thought. Greene then begins to discuss the dynamics that will unfold in relationships, in a manner that is similar to Schwartz-Salant's description of imaginal sight. She writes: "You can get a sense of the forces that are at work in the relationship because they take the form of images or figures, and you can see them in the space between two people." I would like to point out here that her wording is all but identical to that used by Nathan Schwartz-Salant when he refers to relational interactions taking place in the "space between people" (Schwartz-Salant, 2017b, min. 21). But this parallel is merely our first encounter of similar conceptual patterns among Schwartz-Salant's idea of the relationship and Liz Greene's understanding of astrology. Before we turn more directly to the composite, I should probably first clarify its principal intention. In essence, horoscopes can be calculated for practically anything with a start point—anything that finds its existence in the frame of reference that we call Earth. This applies to human individuals but is extended to animals, countries, and important events. However, the composite is different from these examples. It has the distinction of not having an original "timestamp," an actual time and locus of "birth," as it represents a relationship in whatever form it may take. The composite, simply put, is constituted by "the midpoints or half-sums between each pair of identical planets in the two birth charts" (Greene, 1999, pg. 9)—it results from the birth data of those individuals who are in the

respective relationship. Due to this special nature of the composite, it "represents the relationship itself as a third factor," as Greene notes (pg. 10). She adds that "two people create a third thing between them." Again, the language she uses to characterize the idea of the composite shows similarities to Nathan Schwartz-Salant's. This phenomenon continues when Greene provides a more detailed description of the composite: "When we are looking at a composite chart, we are not exploring what two people activate in each other or feel about each other. We are interpreting the energy field they generate between them. The composite chart is […] a third entity." I find the fact that she talks about an "energy field" generated "between" people striking, as the wording is almost an exact match with Schwartz-Salant's (e.g., Schwartz-Salant, 1982, pg. 165). Also, her description clearly indicates that the relationship, as captured by the composite, cannot be reduced to being a sum of the parts that enable it—much like Schwartz-Salant's imaginal sight and "shared subtle body" experience (Schwartz-Salant, 1998, pg. 152) cannot be limited to transference and countertransference reactions. Greene elaborates on the notion of the energy field, stating that "the composite chart is like an energy field, which affects both people and draws certain things out of each individual as well as imposing its own dynamics on both" (Greene, 1999, pg. 10). Examining this quote, one could draw parallels to Schwartz-Salant's conviction that the numinous aspects found in relationships are beyond the control of those involved (e.g., Schwartz-Salant, 2007, pg. 193). As Greene writes, "working with composites makes us think in terms of something larger than ourselves as individuals" (Greene, 1999, pg. 13). The psychoanalyst and astrologer also believes that, when working analytically, "you become aware that there is a process going on which the ego is not controlling, but with which the ego can cooperate." (Arroyo & Greene, 1991, pg. 29). The core principle that "the composite chart has a distinct nature of its own" means that it "may not look a lot like either of the charts of the two individuals, and may contain configurations which do not appear in the natal charts." Much like a child, which is distinct and, in a sense, separate from its parents (Greene, pg. 10), the composite is "different from either of the two individuals" constituting it (pg. 9). One may be reminded of the "Axiom of Maria" discussed by Schwartz-Salant (Schwartz-Salant, 2007, pg. 200), where the birth of the "Three" is an elemental step in the transformation of the self, which is the ultimate goal of the process unfolding in the relationship. In apparent accordance with the Axiom, Greene finds that "although each individual in a relationship has his or her own independent identity, when we look at the composite chart we are viewing a third entity." She adds: "This third entity has its own psychological dynamics and its own mode of expression." We have now seen that the notion of the relationship representing a "third thing" is a principle we can identify in both Schwartz-Salant's and Liz Greene's work, with Greene highlighting it via the concept of the astrological composite. We may now ask the question: "What is the meaning of the composite?" The answer, in the context of the present study, is two-fold. First, the composite, as discussed, demonstrates the separate nature of a human relationship. While any relationship could not come to life without those to whom it owes its existence, it cannot be reduced or fully explained by referencing the qualities of its founders. Rather, the "relationship as a separate entity" (Greene, 1999, pg. 16) is a third area found in the space between its participants. Second, the composite illustrates the fact that each relationship exhibits certain characteristics and entails its own

teleology. As Liz Greene states, "every relationship creates its own ambience" (pg. 11). She adds that "two people in relationship create an atmosphere around them, not by conscious choice, but because that is simply what happens." This ambience is precisely something the composite describes in a highly specific qualitative manner. Since the present study aims to establish a novel means to characterize the therapy relationship, the notion of the composite can offer guidance in this endeavor. Aside from a relationship's qualitative characteristics, the composite also indicates "its meaning and pattern of destiny" (pg. 12) in terms of the developmental aspirations for those involved. Being in a relationship can facilitate transformational change and bring certain areas of one's life to consciousness; this is a theme that we have previously found to be paramount in Jung's and Schwartz-Salant's thoughts. In Liz Greene's words, "a relationship can push us into having to confront certain areas of life, even if […] we are neither predisposed nor well equipped to cope in that area" (Greene, 1999, pg. 12). Astrological theory assumes that, "when composite planets highlight a composite house, that area of life will be extremely important to the relationship, and both people will be impelled to focus on it, even if the same house is empty in both birth charts." I have already provided a rudimentary explanation of what an "house" signifies, but this is not a key point in the current context. What's important is that the astrological composite characterizes a unique atmosphere between those who constitute the respective relationship; that it describes a "third area" even though "we do not usually think of our relationships as independent entities" (Greene, 1999, pg. 11); and that it is the domain in which transformational processes may take place—processes that encompass an archetypal dimension, connecting one's personal experience with the realm of the numinous.

5.4 Characterizing Relationships Using Astrological Archetypes

There are several reasons why I believe the 12 archetypes found in astrology to be an apt springboard for the development of a systematic approach toward assessing the therapy relationship. Not only are they highly nuanced, but they are also linked to a larger symbolic system that allows for a wide range of potential expressions of each archetypal pattern. As reflected in every horoscope, a planet and its associated archetypal energy will appear in a specific coloration, depending on the sign and house of its placement, in combination with other, minor factors. Therefore, a detailed characterization of a person, event, relationship, or another entity using these archetypal principles reaches a respectable degree of sophistication. Whatever the subject of one's analysis might be, the introduction of archetypal patterns can not only assist in the effort of specifying what is already known. It can also help to get closer to what's yet to be explored—such as unconscious elements. As Carl Jung says, "the psychology of the unconscious is particularly concerned with archetypal symbolism" (Jung, 1990, pg. 177). Another aspect that qualifies astrology as a descriptive method is its moral neutrality: its diagnostic capacity does not result from or depend upon the attribution of positive or negative labels to the characteristics of the subjects it examines. In other words, the archetypal patterns united by a horoscope need not be interpreted as plainly good or evil—and this principle extends to the composite. Liz Greene writes: "The composite won't reveal whether the relationship is 'good' or 'bad' in terms of the chemistry between two people" (Greene, 1999, pg. 12). One of the aims

that I am following with the present study is to develop a method for assessing relationships that is not outcome-oriented. As we have seen when reviewing other tools designed to examine the therapy relationship, they are largely geared toward establishing the degree to which a relationship is conducive to therapeutic success. The consequence is a tendency to benchmark the relationship in question and to make quantitative or quantifiable statements about it. By contrast, the method proposed in this study is more concerned with making qualitive statements.

As indicated earlier, it would go beyond the scope of this thesis to review psychological astrology at greater length. I would point the reader to authors such as Liz Greene, Howard Sasportas, Stephen Arroyo, and Fritz Riemann, many of whom write extensively about the subject matter; to Jungians, Greene's work will likely be particularly insightful thanks to her many references to Jung's opus—including his late "Red Book" (Jung, 2009; Greene, 2018a). Still, I would like to give the reader an indication of how astrology operates as a symbolic system. Liz Greene, in her work on the composite, provides a brief summary of the archetypes involved, which exist in three dimensions: planets, signs, and houses. Greene starts with the symbol of the Sun, which "represents the basic identity" (Arroyo & Greene, 1991, pg. 30), and the Moon, which is more reactive and passive and "needs to belong; it needs other people and needs to be needed." Then, she states: "The composite chart has a core identity which signifies its 'purpose' (the Sun) and a characteristic set of emotional responses and needs (the Moon)" (Greene, 1999, pg. 11). Greene next mentions the planet Mercury, which is only partly congruent with the liquid metal of the same name found in the Rosarium Philosophorum, and to Venus and Mars. Greene finds that the composite "has a mode of communication (Mercury) and a distinctive set of values and ideals (Venus). It has a mode of expressing energy and will (Mars)." This is followed by Greene outlining the remaining faster moving planets and their role in the composite, which "has its own way of growing and expanding (Jupiter) and it has innate limitations and defence mechanisms (Saturn)." The composite also includes Chiron, which does not hold planetary status but is often included in psychological astrology and, in the composite, points to "a specific vulnerability to the collective." This distinct fragility is "due to patterns from the collective background of the relationship." Chiron marks the dividing line between the more personal "inner" and the more collective "outer" planets; the latter move through the signs at comparably slower speeds. Greene, in a next step, notes about the composite that "it reflects certain collective ideals which strive for change and progress (Uranus). It has innate aspirations which reflect certain collective fantasies (Neptune). It has a bottom-line survival instinct which can prove supportive to the relationship's continuity but can also be destructive if the relationship is under threat (Pluto)." These three planets represent the "outer" celestial bodies. After this short discussion of the planets' roles in the composite, Greene focuses on aspects of the composite that involve non-planetary elements, such as the Medium Coeli and the Ascendant. She then concludes her quick tour of the core astrological ingredients by contrasting the planets with the signs and houses they are located in: "The signs in a composite chart describe the basic […] 'temperament' of which the relationship is made; the planets describe the motivating energies; and the houses describe the spheres of life through which the planets express themselves." Once again, the reader hopefully senses that astrology is a complex system that requires deeper

study for a more profound understanding. However, while rudimentary, Greene's discussion of the composite does convey that this astrological concept can be utilized to characterize a relationship in a nuanced fashion. In the next chapter, I will be using the same astrological patterns sketched out by Greene to create a novel method to characterize therapy relationships. Concluding this review of astrology, I will turn to Carl Jung, who also wonders about the nature of a particular relationship—this time, not between people but between the fields of psychology and astrology: "Obviously astrology has much to offer psychology, but what the latter can offer its elder sister is less evident," he notes (Jung, 1990, pg. 177). It is one of the hopes associated with the present study that it might lend some much-needed credibility to the symbolic system of astrology, which has not been held in the highest regard by the scientific community over the last few centuries. As a study that belongs to the larger field of contemporary psychotherapy research, this thesis does attempt to offer astrology a small yet earnest hand on its path toward its eventual rehabilitation in the decades ahead.

6 The Fuente Interpersonal Relationship Assessment (FIRA)

The Fuente Interpersonal Relationship Assessment, or "FIRA" for short, was developed to provide a tool that could serve as a springboard to characterize therapy relationships. As we have seen in our review of existing methods, practically all of them tend to emphasize the question whether a specific relationship is conducive to therapeutic outcome—or not so much. Based on this premise, they then make a quantitative statement about how helpful the relationship might be to the patient. While this approach is useful, it has its limitations, as many qualitative nuances are either missed or not at the center of attention. Here, the FIRA takes a different route. It uses archetypal situations that may manifest in the consulting room, and it inquires about both the patient's and therapist's emotional state in these situations. To be even more precise, the FIRA investigates the patient's and therapist's sense of the atmosphere between them and offers a selection of 24 archetypal patterns that may be employed to describe the nature of the mood in the room.

In doing so, the FIRA enables clinicians to do three things: First, it supports the therapist in analyzing and structuring their own experience of the therapy relationship. Finding the right words to describe one's impressions is not necessarily commonplace in contemporary psychotherapy, depending on a clinician's training and working methods. Psychoanalytically oriented health professionals will refer to transference and countertransference reactions but even this group will rarely emphasize the atmosphere between themselves and the patient—the qualitative aspects of the relationship per se. Second, the FIRA can help the clinician to gauge the extent to which the patient shares their experience of the therapeutic rapport. The expectation is not that both parties will produce the same FIRA results if the treatment is progressing well. Rather, accounting for the differences indicated in the FIRA can help the clinician to better understand the patient. The FIRA can also be an excellent starting point for the exploration of the themes represented by its 12 questions: if a patient recollects a certain situation rather differently from the therapist, a closer look at the discrepancies may not only deepen mutual understanding but also

reveal underlying emotional dynamics that have not been dealt with on a conscious level. Third, the patient—or the therapist, for that matter—may have found specific situations in the clinical setting uncomfortable or even unsettling: they may have reminded them of traumatic events, hurtful relational patterns, or difficult feelings such as guilt, regret, and shame. The FIRA can bring these challenges to light in cases where they have previously been missed. It can also support the therapist in isolating any areas in which the patient's past relational experiences have kept them from more fully embracing the therapy relationship as a springboard for personal transformation and growth. Thus, the FIRA goes beyond merely assessing the therapy relationship for what it is at a given point in time; it aims to support the therapeutic process by facilitating the effort of bringing the emotional interactions between therapist and patient to greater consciousness on both sides.

6.1 Initial Item Development

Even at the early stages of the FIRA's development, the ambition was to design two questionnaires—one for the patient and one for the therapist. Each of them would include 12 items that looked into particular archetypal situations as they might occur in the clinical setting. However, what changed over the course of my conceptual work on the FIRA was the issue of whether these questions should lead to open answers or to a predefined selection of responses. Originally, I felt that open answers were preferable: the person filling out the questionnaire would then, in their own way, characterize their recollection of the atmosphere in the room for each of the 12 archetypal situations. But I soon discovered that this approach was simply too demanding. Not only did colleagues draw my attention to the difficulty of finding the right words to describe their experience of their therapy relationships; I personally also found that I struggled to complete the questionnaire using my own patients and ongoing therapy relationships as a reference. I remember a conversation with a colleague in which we spoke about where in their relationship with a patient they saw room for growth. The question was meant to point to the Sagittarius archetype and its realization in the therapeutic rapport. My colleague's feeling was that they could not name a specific area; rather, they told me of their conviction that, in the absence of a potential for growth, therapy was generally useless. I concluded that I needed to provide options in the form of checkboxes. This step not only simplified the procedure of completing the questionnaire, it also brought structure to an aspect of the FIRA that had previously lacked organization. An important distinction of the 12 responses that were then introduced was that each of them again represented an archetypal pattern—this time not defining the situation in the clinical setting but the nature of the respective mood in the room. As a result, each archetypal situation was matched to a certain archetypal coloration in the space between therapist and patient.

From this point onward, the structure of the FIRA was such that it featured two dimensions in which archetypal patterns were involved: the clinical situations and the corresponding emotions appearing in the therapy relationship. What I appreciated about this design was that it resembled a cornerstone principle in the symbolic system of astrology, namely, that any archetypal energy represented in a horoscope will express itself in a unique way, depending on its coloration stemming from the influence of other archetypal

modalities. Interested readers will recollect my brief examination of the "planets," "signs," and "houses" in astrology, which, in combination, produce the described effects. The topic of what mechanisms constitute western astrology brings us to the question of which sources were used in the development of the questionnaire's items and its checkbox-style answers. In general, the primary author whose works I consulted was Liz Greene, who has written at length about the theory and practice of psychological astrology. Some aspects are given special attention, as Greene has published dedicated works dealing with certain archetypes. Her books on the archetypes represented by the planets Saturn (Greene, 2000), Neptune (Greene, 2011), and Uranus (Greene, 1996) as well as the astrological Sun (Greene, 2023), have been massively instructive in the formulation of the FIRA questionnaire. Howard Sasportas's book on the interpretation of the astrological houses was also crucial (Sasportas, 2007), especially for the creation of the questionnaire's checkbox options. However, I have found that reproducing the larger process of condensing Greene's depiction of the most relevant 12 archetypes and of then applying them to the clinical environment was a highly complex undertaking—in my estimation, it was too complex for all steps to be mirrored in this thesis at "high resolution." If I were to discuss exactly how I arrived at the FIRA's questions and answers, I would have to maintain the same level of detail that I provide in my examination of aspects such as Carl Jung's interpretation of the Rosarium Philosophorum. Therefore, I must again point to the same authors whom I referenced when reviewing astrology as a system of thought. Future work on the FIRA might include a more elaborate discussion of the questionnaire's genesis and reflect its development process at considerably greater length.

6.2 Item Refinement and Decision to Expand to 24 Options

While the questionnaire's 12 items hardly changed during the FIRA's development, the options that are offered as answers in the form of checkboxes were revised and fine-tuned several times. In this endeavor, I received immense support from Ilse Gschwandtner, a counsellor and psychological astrologer based in Linz, Austria. Her decades of experience interpreting astrological patterns have led to a significant overall improvement of the questionnaire. Together, we took multiple rounds of discussing what archetypal emotions might appear in the therapy relationship on an interpersonal level, how they might manifest, and how they could best be characterized. The FIRA in its current form would not exist without Ilse Geschwandtner's contribution.

Another important step in the FIRA's genesis was the decision to expand the number of checkbox options from 12 to 24. In conversations with colleagues, particularly with Marlene Wöss, it became clear that the questionnaire would benefit greatly from the inclusion of a second set of archetypal expressions per answer. Whereas previously, each of the 12 potential answers attempted to cover both the positive and the negative aspects of an archetype, the split into two sections now allows for a more nuanced picture. The result is a trade-off between two factors: One the one hand, participants now have to consider not only 12 but 24 options before making their choice in the form of choosing the best match. While the 24 responses remain identical for all of the questionnaire's items, they are still a lot to take in and reflect upon. Hence, the larger number of options arguably makes it a

harder task to complete the FIRA. On the other hand, the two-set structure enables therapeutic use cases for the FIRA that did not exist previously. If a patient experiences a particular archetypal situation in a troubling manner, this tendency may be explored in therapy. This integration of difficult emotional content can be especially valuable if the therapist was not sufficiently aware of the nature of the patient's feelings prior to administrating the FIRA. Psychoanalytically oriented therapists may also find that using the FIRA aids the process of understanding one's countertransference reactions.

On a personal level, my work on the FIRA has thus far impacted my clinical practice in two respects. First, the iterative process of fine-tuning the questionnaire's answers has helped me to isolate certain blind spots when attempting to identify archetypal patterns in my therapeutic work. The progress that I have made in this regard could be compared to the learning process associated with recognizing some of the less obvious behavioral patterns exhibited by characterological patients. In this context, I must again acknowledge Ilse Gschwandtner's many instructive insights. Second, my therapeutic work profited from my focus on the FIRA's principles. In one case, I was able to arrive at a deeper understanding of a patient's frustration that I had sensed in a session. I had no explanation why they felt frustrated until I, together with the patient and thanks to the FIRA's items, discovered that the patient's emotions resulted from them experiencing an archetypal pattern. We then found that their frustration was something they had encountered many times before, sometimes in a traumatic manner. This let us make sense of the challenging atmosphere that had dominated the consulting room in the affected session. As we became more conscious of the previously unseen level of interaction between us that had prompted the difficult feelings, we were able to transform our relationship and to contain the patient's emotions that were a result of unmet needs.

6.3 Current Revision of the FIRA and German Translation

At the time of this writing, the FIRA is available in preliminary form, as indicated by revision number v.0.6. The version for the patient is called "FIRA-P," while the therapist version goes by the name "FIRA-T." The two only differ slightly, as the wording has been adjusted to reflect the respective person's perspective on the therapy relationship. In terms of the content of the questionnaire's items and checkbox-type responses, they are virtually identical. For this version of the questionnaire, the items were selected and refined as described above. Additionally, a cover page with instructions was formulated. Still a work in progress is the scoring, which is included in its current state on page Six of the questionnaire. Page Six also features guidance on how to score the results. The recommendation is for the scoring to be done exclusively by the therapist—for both the clinician's and the patient's answers to the questionnaire's items. As the FIRA is more widely tested, the scoring will likely be extended and refined.

Included in the present study is also a German-language version of the questionnaire. The translation effort was not as straightforward as one might think. The main hurdle was that emotional attributes are assigned differently in different cultures. Therefore, the attempt was made for the German version to stay true to the purpose of the original. Rather than aiming for a literal translation, the German-language questionnaire aims to achieve

the highest-possible level of congruence with the English-language version—in terms of intentionality and meaning, relative to the larger structural body of the language. This approach seemed preferable and explains the slight deviations in wording between the two variants, which attentive readers with proficiency in both English and German might notice.

6.4 Benefits of Using the FIRA in Ongoing Therapies

An inclusion of the FIRA in psychotherapeutic practice may lead to several benefits, all of which ultimately aid the therapeutic process—either directly or indirectly. The FIRA's design lends itself to assessing the therapy relationship in cases where the process has gone on for a while. It can be considered a prerequisite that the patient was able to familiarize themselves with the therapist and the clinical setting. The questionnaire's items refer to archetypal situations that need not all have already been encountered as such; if the therapist and patient have built a solid-enough rapport, both should be able to put themselves into mutual situations using their imagination, even if they have not experienced a shared moment exactly as sketched out by the FIRA's items. Still, a minimum number of sessions will be required to form a realistic idea of the other person and the therapy relationship.

The FIRA's main ambition is to facilitate the qualitative assessment of a specific therapy relationship. Arguably, the number of tools that were crafted to inspire and support clinicians in gauging their relationships in a structured manner is limited. Therapists subscribing to the analytic or humanistic schools of thought may take a different stance, as they are well versed in registering and recording a patient's transference or the felt sense of being with the patient. But a dedicated focus on the relationship per se is not universally advocated. Here, the FIRA can be of help. It promotes the notion of finding words for archetypal patterns as they manifest in therapy sessions, and it encourages discursive thinking about the therapy relationship. In that sense, it can serve as a reminder for the clinician to pay even closer attention to the atmosphere in the room—and it supports them in doing so.

The FIRA encapsulates Nathan Schwartz-Salant's idea of the therapy relationship representing a third entity that, in many respects, is separate from the patient, the clinician, or the therapeutic couple. Taking an up-close look at the relationship and what happens in the space between those in the consulting room can lead to a stronger sense of relating to one another. Also, it can prove instrumental in laying the groundwork for the unfolding of archetypal transformational processes as outlined by Carl Jung and Nathan Schwartz-Salant in their analysis of alchemical principles.

Another benefit is that the FIRA, in incorporating 12 different archetypal scenarios, aids the analysis of the therapy relationship alongside these dimensions. It eases the discovery of a patient's maladaptive behavior patterns and softly exposes those areas in which their experience of the clinician and the therapy relationship may be distorted. Such discoveries can then become shared points of reference between therapist and patient. They can also become an entry point for transforming a patient's trauma-induced tendency toward reenactment. If a patient, in a specific scenario, experiences the therapy relationship in a

challenging way, their emotional state might be similar in other situations that have had comparable qualities. The archetypal design of the scenarios employed in the FIRA makes it more straightforward to identify areas in which the patient's experience is consistently distorted or in which they are particularly likely to be triggered and driven to reenact.

On the therapist's side, the FIRA can equally support their never-ending quest to pinpoint any personal blind spots they might have—especially in working with the patient in question. The therapist's FIRA results can deviate significantly from the patient's, thereby suggesting that the therapist's experience of the shared relationship differs dramatically from the patient's. Precisely what this discrepancy means will be case-dependent and thus cannot be generalized. But the FIRA will, by virtue of its archetype-based design, indicate those areas where one may find a clue.

Perhaps the FIRA's most important function is that it can facilitate the containment and integration of difficult emotions into the shared space of the therapy relationship. Over the course of a treatment, there may have been situations where the therapist, the patient, or both, were looking for the right words to characterize their experience. In the absence of a language to capture one's emotional states and impressions, it can prove impossible to hold on to them and to bring them to consciousness. The FIRA supports this process: First, it provides the springboard of the 12 archetypal situations, which may serve as a reference base; other events that were part of the actual therapeutic encounter can then be matched with entries is the reference base or contrasted against it. Second, the FIRA's answers, grouped into two sections of checkboxes, can be thought of as a matrix that helps to structure one's thought process and to find appropriate labels for one's emotional states. As a result, if implemented correctly, the FIRA supports the discovery, integration, and transformation of unconscious dynamics in the therapy relationship.

6.5 Current Limitations of the FIRA

The FIRA is a novel tool, and at the time of writing this thesis, it is still under active development. While it is evident that further testing, additional feedback loops, and general refinement are desirable, the FIRA in its current form is certainly usable. The one area that would likely profit the most from additional work is the FIRA's scoring section. As the author of the present study, I will be grateful to receive any inspirational ideas for how it could be taken to the next level. Equally, any other suggestions for how the questionnaire or other aspects of the FIRA could further improved are highly welcome.

7 Discussion

In academic papers, the Discussion section is usually the place where the study's core results are reviewed and scrutinized. Achievements are highlighted and known limitations put forward. Any areas in which further investigation is required are identified. Potential applications of the study's findings are equally exemplified. However, the main results of the present thesis are represented by the conceptualization and operationalization of the FIRA, which are discussed at length in chapter Six. The chapter elaborates on the FIRA's

goals, potential applications, explicit and implicit design choices, theoretical background, and known limitations. It also indicates where further development may prove fruitful.

One of the most prominent issues associated with the FIRA is that the instrument is at an early stage. The questionnaire's items were created based of a "first principles" methodology rather than on extensive collaboration and evaluation. While the genesis of the FIRA was indeed an iterative process, many other tools for the assessment of the therapy relationship were developed in a more elaborate fashion—and using far greater resources. Thus, future versions of the FIRA will clearly benefit from integrating such an approach, in order to test and fine-tune its items as well as their responses. I could imagine the face of the FIRA changing quite substantially as a result.

The scoring section of the FIRA arguably could be improved. Also, the instructions for the clinician on how to best employ the tool could be extended. Such steps would likely simplify the FIRA's integration into ongoing therapies. The FIRA is also not appropriate for use with every patient, as it requires the participant to be in touch with their emotions, to register them, remember how they felt, and be willing to deeply reflect about the therapy relationship. The capacity to accomplish all of this must not be taken for granted. In addition, the FIRA can contribute only little in the context of short-term therapies, as it relies on the existence of a solid-enough rapport, which is usually based on a respectable amount of shared experience between patient and clinician.

Still, I contend that the FIRA, in its current form, is ready to be deployed—much like a young bird that is about to lift its wings for the very first time. It may not instantly reach the highest heights, but there is hope that it will get there. At any rate, as the FIRA's main author, I hope that the instrument—and the present thesis—will motivate other clinicians to double down on the importance they already put on the therapy relationship, as it is the place in which meaningful and lasting change can unfold.

8 Appendix

The following pages contain the FIRA questionnaire in English and German, for both patient and therapist, respectively. The questionnaire's final page always includes a preliminary scoreboard as well as instructions. It is recommended for all scoring to be done by the clinician.

The FIRA questionnaire—both the patient and therapist versions, and in English or German—are available as a free download at https://delafuente.at/fira. Any use of the materials in the context of clinical practice or academic research is highly welcome. However, please note that the FIRA is protected by copyright and may only be modified with the author's prior consent. Any inquiries may be directed to thomas@delafuente.at.

FIRA-P (v. 0.6)
Questionnaire to Assess the Therapy Relationship

This questionnaire aims to capture how you experience your therapy relationship with your clinician. You will be presented with 12 questions. Each will ask you to put yourself in a certain situation with your therapist.

Please imagine how you might feel in the situation described. Then check the response that your “gut feeling” tells you is the closest match.

You have two dozen options to choose from, which are consistent for all 12 questions. The options on the left reflect a more “positive” experience, while those on the right indicate a more “challenging” one. Both types of responses are equally important: answers toward the right can prove especially helpful for adjusting the therapy to your needs.

Should you require further guidance, your therapist will be happy to assist you.

Sample question:

“When my therapist and I discuss my diagnosis or treatment modalities, the atmosphere in the room is …”

Always select the option that feels closest to your experience:

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
☐ h+) Ready to enter dark areas
☐ i+) Letting me grow and discover
☐ j+) Clear-eyed and realistic
☐ k+) Enabling me to see my future
☐ l+) Allowing me to heal old wounds

☐ a-) Aggressive and pushy
☐ b-) Burdensome and slow
☐ c-) Chaotic and jumpy
☐ d-) Emotionally clinging
☐ e-) Full of self-involvement
☐ f-) Complicated and tedious
☐ g-) Directionless and vague
☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

1. When my therapist and I engage in lively exchange, the energy in the room is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
☐ h+) Ready to enter dark areas
☐ i+) Letting me grow and discover
☐ j+) Clear-eyed and realistic
☐ k+) Enabling me to see my future
☐ l+) Allowing me to heal old wounds

☐ a-) Aggressive and pushy
☐ b-) Burdensome and slow
☐ c-) Chaotic and jumpy
☐ d-) Emotionally clinging
☐ e-) Full of self-involvement
☐ f-) Complicated and tedious
☐ g-) Directionless and vague
☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

2. When my therapist and I discuss important values, the atmosphere is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
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☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
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☐ j+) Clear-eyed and realistic
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

3. When we enjoy a moment of playful banter, our rapport is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
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☐ d-) Emotionally clinging
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☐ f-) Complicated and tedious
☐ g-) Directionless and vague
☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

4. When I talk about my family with my therapist, I feel the conversation is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
☐ h+) Ready to enter dark areas
☐ i+) Letting me grow and discover
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☐ g-) Directionless and vague
☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

5. When we discuss my hobbies or my children, our communication is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
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☐ f-) Complicated and tedious
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

6. When I talk about the day-to-day of my job, our exchange is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

7. When we focus on my important relationships, the mood is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
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☐ g-) Directionless and vague
☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

8. When we talk about intimacy or sexuality, those sessions are …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

9. When we explore new ideas together, the atmosphere is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

10. When we talk about what I want to achieve in life, the mood is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

11. When we discuss the ideals I aspire to, those moments are …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
☐ h+) Ready to enter dark areas
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

12. When we dive into topics like religion or spirituality, our rapport is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
☐ h+) Ready to enter dark areas
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☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

Scoring:

Choleric experiences:

# of a+): ___ # of a-): ___
# of e+): ___ # of e-): ___
# of i+): ___ # of i-): ___

Subtotal of +): ___
Subtotal of -): ___
Total (choleric): ___
(insert into distribution matrix)

Melancholic experiences:

# of b+): ___ # of b-): ___
# of f+): ___ # of f-): ___
# of j+): ___ # of j-): ___

Subtotal of +): ___
Subtotal of -): ___
Total (melancholic): ___

Sanguine experiences:

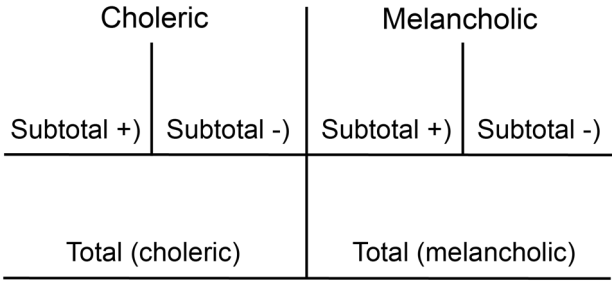
# of c+): ___ # of c-): ___
# of g+): ___ # of g-): ___
# of k+): ___ # of k-): ___

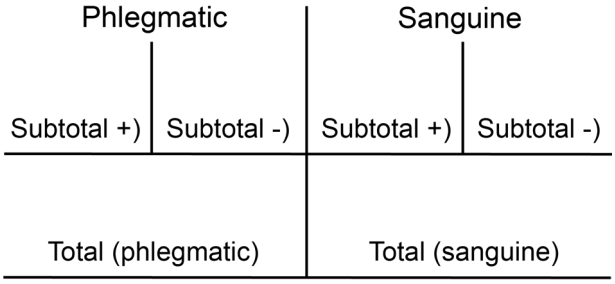
Subtotal of +): ___
Subtotal of -): ___
Total (sanguine): ___

Phlegmatic experiences:

# of d+): ___ # of d-): ___
# of h+): ___ # of h-): ___
# of l+): ___ # of l-): ___

Subtotal of +): ___
Subtotal of -): ___
Total (phlegmatic): ___





Instructions: This sheet will let you evaluate your FIRA results and determine the characteristics of the archetypal experiences you have thus far had in your therapy relationship. The distribution of these experiences among the four traditional "temperaments" will give you a rough idea of the overall "feel" of the therapy relationship. If you compare your results to your therapist's, you will immediately see the degree to which their overall experience deviates from yours. Note that such differences are to be expected and do not imply that the rapport between the two of you is less than optimal. Next, you can examine both the apparent similarities and differences between your results more closely. Look at the individual answers and at how they compare to your therapist's. The questionnaire's items cover sensitive subject matter. When you feel that the time is right to discuss your experiences, sharing your feelings with your therapist will be beneficial for mutual understanding and further treatment outcome.

FIRA-T (v. 0.6)
Questionnaire to Assess the Therapy Relationship

This questionnaire aims to capture how you experience your therapy relationship with a specific patient. You will be presented with 12 questions. Each will ask you to put yourself in a certain situation with your patient.

Please imagine how you might feel in the situation described. Then check the answer that your “gut feeling” tells you is the closest match.

You have two dozen options to choose from, which are consistent for all 12 questions. The options on the left reflect a more “positive” experience, while those on the right indicate a more “challenging” one. Both types of responses are equally important: answers toward the right can prove especially conducive to discovering challenging aspects in the rapport you have with your patient.

Sample question:

“When my patient and I discuss their diagnosis or treatment modalities, the atmosphere in the room is …”

Always select the option that feels closest to your experience:

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
☐ h+) Ready to enter dark areas
☐ i+) Letting me grow and discover
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

1. When my patient and I engage in lively exchange, the energy in the room is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

2. When my patient and I discuss important values, the atmosphere is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

3. When we enjoy a moment of playful banter, our rapport is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
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☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

4. When my patient talks about their family, I the conversation feels …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

5. When we discuss my hobbies or my children, our communication is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

6. When my patient talks about the day-to-day of their job, our exchange is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
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☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
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7. When we focus on my important relationships, the mood is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
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☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

8. When we talk about intimacy or sexuality, those sessions are …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

9. When we explore new ideas together, the atmosphere is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
☐ h+) Ready to enter dark areas
☐ i+) Letting me grow and discover
☐ j+) Clear-eyed and realistic
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☐ f-) Complicated and tedious
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

10. When we talk about what the patient wants to achieve in life, the mood is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
☐ h+) Ready to enter dark areas
☐ i+) Letting me grow and discover
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

11. When we discuss the ideals the patient aspires to, those moments are …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

12. When we dive into topics like religion or spirituality, our rapport is …

☐ a+) Straightforward and direct
☐ b+) Grounded and comforting
☐ c+) Playful and lighthearted
☐ d+) Nurturing and caring
☐ e+) Full of self-expression
☐ f+) Practical and nuanced
☐ g+) Harmonious and accommodating
☐ h+) Ready to enter dark areas
☐ i+) Letting me grow and discover
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☐ h-) Intrusive and unsettling
☐ i-) Superficial and sloppy
☐ j-) Demanding and harsh
☐ k-) Impersonal and detached
☐ l-) Elusive and dreamy

Scoring:

Choleric experiences:

# of a+): ___ # of a-): ___
# of e+): ___ # of e-): ___
# of i+): ___ # of i-): ___

Subtotal of +): ___
Subtotal of -): ___
Total (choleric): ___
(insert into distribution matrix)

Melancholic experiences:

# of b+): ___ # of b-): ___
# of f+): ___ # of f-): ___
# of j+): ___ # of j-): ___

Subtotal of +): ___
Subtotal of -): ___
Total (melancholic): ___

Sanguine experiences:

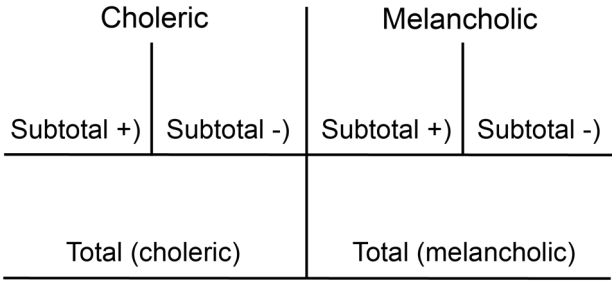
# of c+): ___ # of c-): ___
# of g+): ___ # of g-): ___
# of k+): ___ # of k-): ___

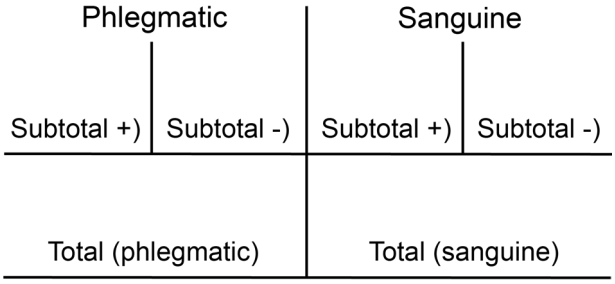
Subtotal of +): ___
Subtotal of -): ___
Total (sanguine): ___

Phlegmatic experiences:

# of d+): ___ # of d-): ___
# of h+): ___ # of h-): ___
# of l+): ___ # of l-): ___

Subtotal of +): ___
Subtotal of -): ___
Total (phlegmatic): ___





Instructions: This sheet will let you evaluate your FIRA results and determine the characteristics of the archetypal experiences you have thus far had in your therapy relationship. Their distribution among the four traditional "temperaments"—choleric, melancholic, sanguine, and phlegmatic—will give you a rough idea of the overall "feel" of the therapy relationship. If you compare your results to your patient's, you will immediately see the degree to which their overall experience differs from yours. Note that such differences are to be expected and do not imply that the rapport between the two of you is less than optimal. Next, you can examine apparent similarities as well as distinct differences—Jungian opposites—between your results more closely. Look at the individual answers and at how they deviate from your patient's. The questionnaire's items cover subject matter that may be sensitive to your patient. If you find the right time and modality to discuss your FIRA results, you may learn more about how your patient felt and why. In the process, you may discover sides to their experience of the therapy relationship that you had not noticed, and which may be instructive in helping them develop and grow.

FIRA-P-DE (v.0.6)
Fragebogen zur therapeutischen Beziehung

Dieser Fragebogen soll erfassen, wie Sie die Interaktion mit Ihrem Therapeuten erleben. Ihnen werden zwölf Fragen gestellt. Jede dieser Fragen lädt Sie dazu ein, sich in eine bestimmte Situation mit Ihrem Therapeuten hineinzuversetzen.

Bitte stellen Sie sich vor, wie Sie sich in der beschriebenen Situation fühlen würden. Wählen Sie dann die Antwort aus, die Ihrem „Bauchgefühl“ am nächsten kommt.

Bei allen zwölf Fragen stehen jeweils 24 Antwortmöglichkeiten zur Auswahl. Die Optionen auf der linken Seite spiegeln eine eher „positive“ Erfahrung wider, während diejenigen auf der rechten Seite eine eher „herausfordernde“ Erfahrung anzeigen. Beide Antwortarten sind gleichermaßen wichtig: Die Optionen in der rechten Spalte können besonders hilfreich sein, um die Therapie an Ihre Bedürfnisse anzupassen.

Sollten Sie weitere Unterstützung benötigen, wenden Sie sich bitte an Ihren Therapeuten.

Beispielfrage:

„Wenn mein Therapeut und ich über meine Diagnose oder Behandlungsmethoden sprechen, ist die Stimmung im Raum …“

Bitte kreuzen Sie diejenige Option an, die Ihrem Gefühl am nächsten kommt:

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

1. Wenn mein Therapeut und ich in lebhaftem Austausch stehen, ist die Energie im Raum …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

2. Wenn mein Therapeut und ich darüber sprechen, was für mich im Leben wertvoll ist, ist die Atmosphäre …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

3. Wenn wir in der Therapie humorvoll miteinander scherzen, ist die Stimmung zwischen uns …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

4. Wenn ich mit meinem Therapeuten über meine Familie spreche, fühlt sich das Gespräch so an …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

5. Wenn wir über meine Hobbys oder meine Kinder sprechen, ist unsere Kommunikation …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

6. Wenn ich über meinen Arbeitsalltag spreche, ist unser Austausch …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

7. Wenn wir uns auf meine wichtigen Beziehungen konzentrieren, ist die Stimmung …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

8. Wenn wir über Intimität oder Sexualität sprechen, sind diese Sitzungen …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

9. Wenn wir gemeinsam neue Möglichkeiten oder Ideen erkunden, ist die Atmosphäre …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

10. Wenn wir darüber sprechen, was ich im Leben erreichen möchte, ist die Stimmung …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

11. Wenn wir über für mich wichtige Ideale sprechen, sind diese Momente …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

12. Wenn wir in Themen wie Religion oder Spiritualität eintauchen, ist unser Verhältnis …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

Auswertung:

Cholerische Beziehungserfahrungen:

Anzahl an a+): ___ a-): ___
Anzahl an e+): ___ e-): ___
Anzahl an i+): ___ i-): ___

Menge an +): ___
Menge an -): ___
Gesamt (cholerisch): ___
(in Übersicht einfügen)

Melancholische Beziehungserfahrungen:

Anzahl an b+): ___ b-): ___
Anzahl an f+): ___ f-): ___
Anzahl an j+): ___ j-): ___

Menge an +): ___
Menge an -): ___
Gesamt (melancholisch): ___

Sanguinische Beziehungserfahrungen:

Anzahl an c+): ___ c-): ___
Anzahl an g+): ___ g-): ___
Anzahl an k+): ___ k-): ___

Menge an +): ___
Menge an -): ___
Gesamt (sanguinisch): ___

Phlegmatische Beziehungserfahrungen:

Anzahl an d+): ___ d-): ___
Anzahl an h+): ___ h-): ___
Anzahl an l+): ___ l-): ___

Menge an +): ___
Menge an -): ___
Gesamt (phlegmatisch): ___

Verteilung archetypischer atmosphärischer Beziehungserfahrungen in der Therapie

Cholerisch		Melancholisch	
Menge +)	Menge -)	Menge +)	Menge -)
Gesamt (cholerisch)		Gesamt (melancholisch)	

Phlegmatisch		Sanguinisch	
Menge +)	Menge -)	Menge +)	Menge -)
Gesamt (phlegmatisch)		Gesamt (sanguinisch)	

Anleitung: Dieses Blatt ermöglicht es Ihnen, Ihre FIRA-Ergebnisse auszuwerten und die Merkmale der archetypischen Erfahrungen zu bestimmen, die Sie bislang innerhalb der therapeutischen Beziehung gemacht haben. Die Verteilung auf die vier traditionellen „Temperamente“ vermittelt Ihnen einen ersten visuellen Eindruck von der therapeutischen Beziehung. Wenn Sie Ihre Ergebnisse mit denen Ihres Therapeuten vergleichen, sehen Sie sofort, inwiefern sich Ihr Gesamterleben voneinander unterscheidet. Beachten Sie bitte, dass solche Unterschiede zu erwarten sind und keineswegs bedeuten, dass das Verhältnis zwischen Ihnen nicht optimal wäre. Im nächsten Schritt können Sie die einzelnen Überlappungen und Unterschiede zwischen Ihnen beiden genauer einsehen. Beachten Sie die einzelnen Antworten und Ihre Abweichungen voneinander. Die im Fragebogen skizzierten Situationen betreffen sensible Inhalte. Wenn Sie das Gefühl haben, dass der Moment für Sie der richtige ist, können Sie Ihre gemeinsamen Erfahrungen mit Ihrem Therapeuten besprechen. Dies wird das wechselseitige Verständnis fördern und Ihrem Therapeuten helfen, den therapeutischen Prozess besser auf Ihre Bedürfnisse abzustimmen.

FIRA-T-DE (v.0.6)
Fragebogen zur therapeutischen Beziehung

Dieser Fragebogen soll erfassen, wie Sie die Interaktion mit Ihrem Patienten erleben. Ihnen werden zwölf Fragen gestellt. Jede dieser Fragen lädt Sie dazu ein, sich in eine bestimmte Situation mit Ihrem Patienten hineinzuversetzen.

Bitte stellen Sie sich vor, wie Sie sich in der beschriebenen Situation fühlen würden. Wählen Sie dann die Antwort aus, die Ihrem „Bauchgefühl“ am nächsten kommt.

Bei allen zwölf Fragen stehen jeweils 24 Antwortmöglichkeiten zur Auswahl. Die Optionen auf der linken Seite spiegeln eine eher „positive“ Erfahrung wider, während diejenigen auf der rechten Seite eine eher „herausfordernde“ Erfahrung anzeigen. Beide Antwortarten sind gleichermaßen wichtig: Die Optionen in der rechten Spalte können besonders hilfreich sein, um herausfordernde Aspekte innerhalb der therapeutischen Beziehung aufzuzeigen.

Beispielfrage:

„Wenn mein Patient und ich über dessen Diagnose oder Behandlungsmethoden sprechen, ist die Stimmung im Raum …“

Bitte kreuzen Sie diejenige Option an, die Ihrem Gefühl <u>am nächsten</u> kommt:

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

1. Wenn mein Patient und ich in lebhaftem Austausch stehen, ist die Energie im Raum …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

2. Wenn mein Patient und ich darüber sprechen, was für ihn im Leben wertvoll ist, ist die Atmosphäre …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

3. Wenn wir in der Therapie humorvoll miteinander scherzen, ist die Stimmung zwischen uns …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

4. Wenn ich mit meinem Patienten über dessen Familie spreche, fühlt sich das Gespräch so an …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

5. Wenn wir über die Hobbys oder die Kinder des Patienten sprechen, ist unsere Kommunikation …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

6. Wenn mein Patient über seinen Arbeitsalltag spricht, ist unser Austausch …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

7. Wenn wir uns auf die wichtigen Beziehungen des Patienten konzentrieren, ist die Stimmung …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

8. Wenn wir über Intimität oder Sexualität sprechen, sind diese Sitzungen …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

9. Wenn wir gemeinsam neue Möglichkeiten oder Ideen erkunden, ist die Atmosphäre …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

10. Wenn wir darüber sprechen, was mein Patient im Leben erreichen möchte, ist die Stimmung …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

11. Wenn wir über für ihn wichtige Ideale sprechen, sind diese Momente …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

12. Wenn wir in Themen wie Religion oder Spiritualität eintauchen, ist unser Verhältnis …

☐ a+) Direkt und offen
☐ b+) Geerdet und beruhigend
☐ c+) Gedanken anregend
☐ d+) Fürsorglich und nährend
☐ e+) Zuversichtlich und fröhlich
☐ f+) Nuanciert und differenziert
☐ g+) Harmonisch und entgegenkommend
☐ h+) Intensiv und voller Tiefgang
☐ i+) Inspirierend und wachstumsfördernd
☐ j+) Nüchtern und sachlich
☐ k+) Ein Blick in eine bessere Zukunft
☐ l+) Empathisch und heilsam

☐ a-) Aggressiv und fordernd
☐ b-) Schwer und langsam
☐ c-) Chaotisch und sprunghaft
☐ d-) Emotional klammernd
☐ e-) Überheblich und arrogant
☐ f-) Kompliziert und verzwickt
☐ g-) Ziellos und unbestimmt
☐ h-) Obszön und verstörend
☐ i-) Oberflächlich und schlampig
☐ j-) Herausfordernd und streng
☐ k-) Unpersönlich und fremdartig
☐ l-) Unverbindlich und verträumt

Auswertung:

Cholerische Beziehungserfahrungen:

Anzahl an a+): ___ a-): ___
Anzahl an e+): ___ e-): ___
Anzahl an i+): ___ i-): ___

Menge an +): ___
Menge an -): ___
Gesamt (cholerisch): ___
(in Übersicht einfügen)

Melancholische Beziehungserfahrungen:

Anzahl an b+): ___ b-): ___
Anzahl an f+): ___ f-): ___
Anzahl an j+): ___ j-): ___

Menge an +): ___
Menge an -): ___
Gesamt (melancholisch): ___

Sanguinische Beziehungserfahrungen:

Anzahl an c+): ___ c-): ___
Anzahl an g+): ___ g-): ___
Anzahl an k+): ___ k-): ___

Menge an +): ___
Menge an -): ___
Gesamt (sanguinisch): ___

Phlegmatische Beziehungserfahrungen:

Anzahl an d+): ___ d-): ___
Anzahl an h+): ___ h-): ___
Anzahl an l+): ___ l-): ___

Menge an +): ___
Menge an -): ___
Gesamt (phlegmatisch): ___

Verteilung archetypischer atmosphärischer Beziehungserfahrungen in der Therapie

Cholerisch		Melancholisch	
Menge +)	Menge -)	Menge +)	Menge -)
Gesamt (cholerisch)		Gesamt (melancholisch)	

Phlegmatisch		Sanguinisch	
Menge +)	Menge -)	Menge +)	Menge -)
Gesamt (phlegmatisch)		Gesamt (sanguinisch)	

Anleitung: Dieses Blatt ermöglicht es Ihnen, Ihre FIRA-Ergebnisse auszuwerten und die Merkmale der archetypischen Erfahrungen zu bestimmen, die Sie bislang innerhalb der therapeutischen Beziehung gemacht haben. Die Verteilung auf die vier traditionellen „Temperamente“ – cholerisch, melancholisch, sanguinisch und phlegmatisch – vermittelt Ihnen einen ersten Eindruck von der therapeutischen Beziehung. Wenn Sie Ihre Ergebnisse mit denen Ihres Patienten vergleichen, sehen Sie sofort, in welchem Ausmaß sich dessen Gesamterleben von Ihrem eigenen unterscheidet. Beachten Sie bitte, dass solche Unterschiede zu erwarten sind und keineswegs bedeuten, das Verhältnis zwischen Ihnen wäre nicht gut. Im nächsten Schritt können Sie die einzelnen Überlappungen – wie auch die Unterschiede (Jung‘sche „Gegensätze“) – zwischen Ihnen beiden genauer einsehen. Beachten Sie die einzelnen Antworten und Ihre Abweichungen voneinander. Die im Fragebogen skizzierten Situationen betreffen Inhalte, die für Ihren Patienten sehr emotional sein können. Wenn Sie den richtigen Zeitpunkt und die passende Form finden, um über die gemeinsamen Erfahrungen zu sprechen, können Sie genauer erfahren, was Ihr Patient empfunden hat – und mit der Zeit auch, warum. Dabei werden Sie vielleicht Aspekte in seiner Wahrnehmung der therapeutischen Beziehung entdecken, die Ihnen bisher entgangen sind und deren Integration hilfreich sein kann, um den Patienten bestmöglich in seiner Entwicklung zu unterstützen und in seinem persönlichen Wachstum zu fördern.

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"Therefore I say to the psychotherapist:
let no day pass without humbly remembering
that everything has still to be learned."

Carl Jung (1966, pg. 255)

Curriculum Vitae

Thomas de la Fuente was born on July 28, 1978. He has lived in Switzerland, Austria, the U.S.A., Sweden, and other countries.

He now resides in Spain and Austria, practicing psychotherapy in Austria and providing psychoanalytically informed counselling in Spain. He also works as a writer and communications advisor.

De la Fuente graduated from Akademisches Gymnasium Linz, Austria, with a focus on the humanities—especially psychology, philosophy, and educational didactics.

In 2007, he received a magister's degree in philosophy from the University of Vienna, cum laude, studying the theory of psychoanalysis at both the University of Vienna and the Medical University of Vienna.

Four years later, he completed his doctorate at the University of Vienna, earning distinction for his dissertation on Erik Erikson's idea of personal identity.

As of 2025, de la Fuente is in the process of completing his studies in psychotherapy sciences at Sigmund Freud Privatuniversität Wien in Vienna, Austria.

"We are a microcosm responding in a mysterious connection—
surely not understood causally—to the macrocosm. Our microcosm
has a center, the self, that holds us together and nurtures us, analogous
to the sun's ordering energy pervading the physical universe."

Nathan Schwartz-Salant (2017a, pg. 69)

"Homo enim Deus est, sed non absolute, quoniam homo.
Humane igitur est Deus. Homo etiam mundus est,
sed non contracte omnia, quoniam homo.
Est igitur homo μικρόκοσμος."

Nicholas of Cusa (In: Jung, 1966, pg. 320)

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Kurzzusammenfassung

Die Arbeit macht es sich zur Aufgabe, ein neuartiges Werkzeug zur Erfassung der emotionalen Beziehungsqualität zwischen Patient und Therapeut zu entwickeln. Dies geschieht vor dem Hintergrund bereits vorhandener Instrumente, die augenscheinlich dasselbe Ziel verfolgen. Eine Analyse dieser Methoden zeigt jedoch, dass sie ein quantitatives Verständnis des klinischen Miteinanders aufweisen – basierend auf der Annahme, eine „gute“ Beziehung führe eher zu therapeutischem Erfolg. Um stattdessen die von Patient und Therapeut wahrgenommene zwischenmenschliche Atmosphäre zu erfassen, zieht die Arbeit eine Definition von Beziehung heran, die dem Werk Nathan Schwartz-Salants entspringt. Der Jungianer versteht Beziehung als Container, innerhalb dessen sich archetypische Prozesse entfalten. Diese Auffassung wird infolge mit dem Konzept des „Composit“ assoziiert, welches dem Denksystem der psychologischen Astrologie nach Liz Greene entstammt und Beziehung als etwas „Drittes“ ansieht, innerhalb dessen sich interpersonelle Dynamiken offenbaren. Eine gemeinsame Bewusstmachung dieser relationalen Dynamiken und deren psychische Integration kann zu persönlichem Wachstum führen. Die Beziehung als „Zwischenraum“, der sich auch im klinischen Setting einstellt, ist der Ansatzpunkt des neuen Messinstruments „FIRA“. Das Werkzeug nutzt Grundprinzipien, die einerseits dem Jung’schen Gedankengut und andererseits dem Denksystem der psychologischen Astrologie immanent sind, um die Atmosphäre zwischen Therapeut und Patient einer genaueren Betrachtung zu unterziehen. Bei bestehender Indikation und richtiger Anwendung kann der FIRA in laufenden Therapien emotionale Integrations- und Transformationsprozesse unterstützen. Er nimmt eine differenzierte Analyse des therapeutischen Miteinanders vor und ermöglicht die Arbeit an Aspekten des Beziehungserlebens des Patienten, die ansonsten womöglich verborgen blieben.

Abstract

The primary aim of the present study is to propose a novel method for assessing the emotional quality of the therapy relationship from both the patient's and the therapist's perspective. This is undertaken against the backdrop of a substantial number of existing tools designed to achieve a similar aim. A closer examination of these instruments reveals that they are largely geared toward producing quantitative results, based on the assumption that a "good" relationship will promote therapeutic outcome. To focus instead on the perceived quality of the relationship, the thesis draws on the work of Nathan Schwartz-Salant, who conceives of the therapy relationship as a transformational container within which an archetypal process unfolds, provided that the necessary preconditions are met. This notion of the relationship as an archetypally structured catalyst is combined with the idea of the astrological "composite," which symbolizes the relationship as a "third" entity that manifests in between therapist and patient. Within this space, interpersonal dynamics—if properly integrated and brought to consciousness—can foster personal growth not only for the patient, but also for the therapist. This "space between" therapist and patient forms the central focus of the FIRA. Methodologically, this new instrument for gauging the therapy relationship employs first principles derived from Jungian theory and astrology to enable a deeper exploration of the atmosphere that emerges within the consulting room. When used appropriately and with suitable patients, the introduction of the FIRA into ongoing therapies can support the process of integrating and transforming areas of the patient's relational experience that might otherwise remain unaddressed.