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The Therapist's Implicit Relational Stance

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Every therapeutic theory and technique rests on an implicit relational stance — a pre-reflective, embodied way of being with clients that is communicated non-verbally and registered by the client's unconscious before any technique is applied. This article explores how to identify and work with one's own implicit stance, and why it matters more than any theoretical orientation or method.

KEY THEMES

— What the implicit relational stance is and why it matters

— Medical model vs intersubjective paradigm as implicit stances

— The therapist's habitual position and its shadow

— How clients unconsciously scan and test the therapist's stance

— Making the implicit explicit in supervision

Two Paradigms, Two Implicit Stances

Every therapeutic theory and technique rests on an implicit relational stance. This stance is not chosen consciously — it is the pre-reflective, embodied ground from which all conscious therapeutic activity proceeds. It is the way the therapist is perceived by the client's unconscious, quite independently of what the therapist intends or believes.

We can contrast two paradigmatic implicit stances. In the first — the objectivist, medical-model stance — the therapist's implicit position is: 'I can perceive your reality accurately and objectively; I know what you need; my job is to apply my knowledge to your problem.' The therapist takes a quasi-scientific expert position, perceiving and understanding from a third-person perspective.

In the second — the intersubjective relational stance — the therapist's implicit position is: 'My subjectivity is always already involved; my perceptions are shaped by my own history and context; I can only hope to meet you through my own humanity.' What matters is not only the therapist's thinking and doing, but also their being — their involuntary, right-brain relational capacities and communications.

The Therapist's Habitual Position

The therapist's habitual position is the characteristic way they tend to inhabit the therapeutic space — the default constellation of their relational modalities, their characteristic emotional availability, their typical way of managing uncertainty and conflict.

Every therapist has such a habitual position, formed through the combination of their own personal history, their training, and the cumulative effect of years of therapeutic work. This position is largely automatic and outside of awareness — it is simply 'how I do therapy', the taken-for-granted background of practice.

The habitual position is not a problem — it is inevitable. Every therapist needs a settled enough position from which to work. The problem arises when the habitual position becomes so fixed that it cannot flex in response to the client's needs, or when the therapist's identification with their habitual position is so strong that they cannot recognise when they have been pulled out of it by the client's enactment.

Clients Scan for the Therapist's Stance

Clients unconsciously scan and test for the robustness of the therapist's position from the very first moment they call — and the working alliance critically depends on the perceived outcome of these tests. This is not because clients realistically perceive and evaluate the therapist's habitual position; on the contrary, they 'read' it subliminally through the lens of their own preconceptions and woundedness, through the transference.

This is why it becomes important for the therapist to not take too fixed and 'standard' a position: precisely because it's impossible to know where our position 'lands' in a given client, we want to give some room to allowing ourselves to be constructed by the client's unconscious.

Making the implicit stance explicit — first to oneself, then potentially in the supervisory relationship — is the beginning of developing a more flexible and responsive therapeutic presence. The goal is not to eliminate the habitual position but to hold it with more spaciousness, more awareness of its shadow aspects, and more capacity to move within and around it in response to what the therapeutic relationship requires.

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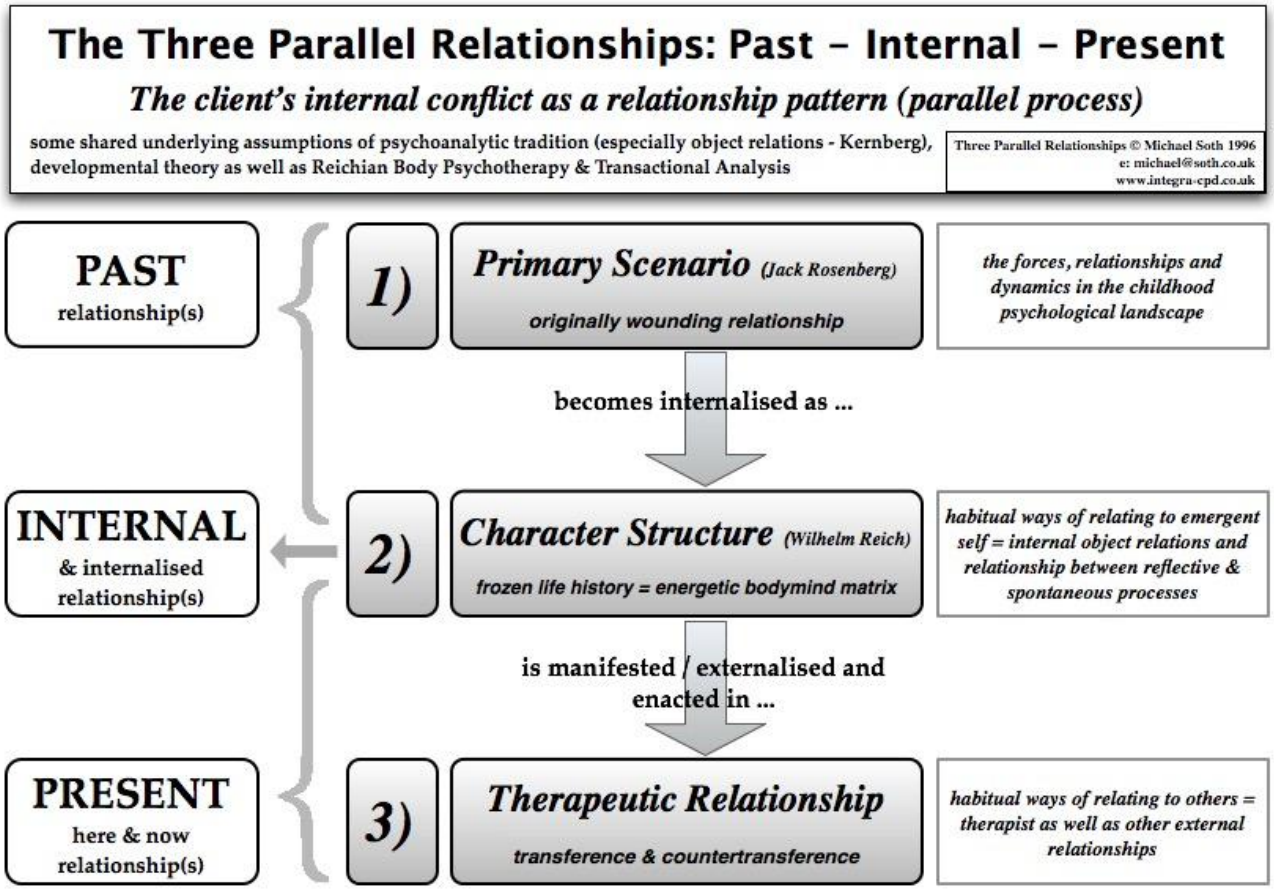
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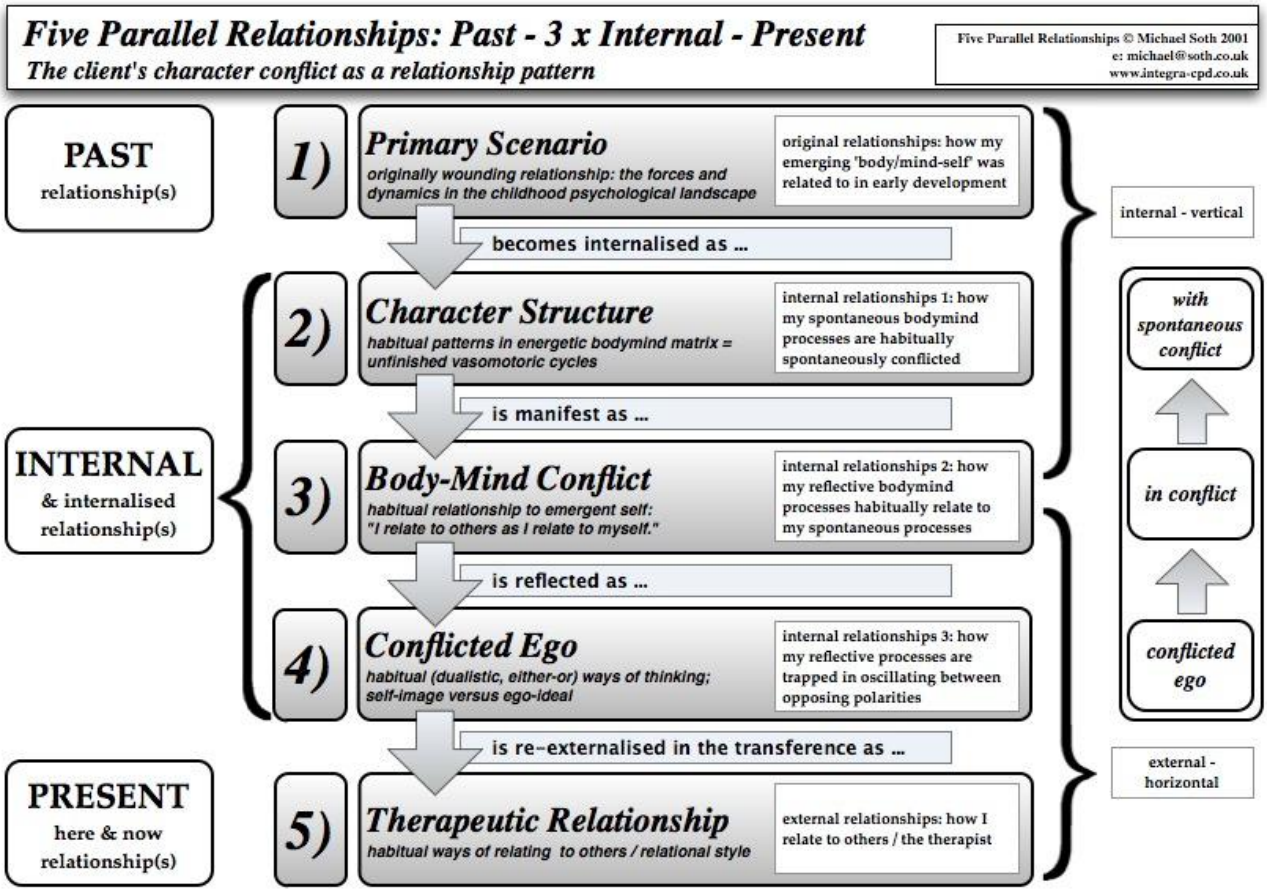
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The Three Parallel Relationships · Michael Soth, 1996



Five Parallel Relationships · Michael Soth, 2001

DIAGRAM · 1996 · MICHAEL SOTH

Three Parallel Relationships: Past - Internal - Present

The client's internal conflict as a relationship pattern (parallel process)

PAST	**1 · Primary Scenario** Originally wounding relationship	Forces & dynamics in the childhood psychological landscape
	becomes internalised as...	
INTERNAL	**2 · Character Structure** Frozen life history = energetic bodymind matrix	Habitual ways of relating to emergent self = internal object relations
	is manifested / externalised and enacted in...	
PRESENT	**3 · Therapeutic Relationship** Transference & countertransference	Habitual ways of relating to others = therapist & other external relationships

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Five Parallel Relationships: Past - 3x Internal - Present

The client's character conflict as a relationship pattern

PAST	**1 · Primary Scenario** Originally wounding relationship *becomes internalised as...*	Original relationships in early development
INTERNAL	**2 · Character Structure** Habitual patterns in energetic bodymind matrix *is manifest as...*	Internal relationships 1: spontaneous bodymind processes habitually conflicted
	3 · Body-Mind Conflict Habitual relationship to emergent self *is reflected as...*	Internal relationships 2: how reflective processes relate to spontaneous processes
	4 · Conflicted Ego Habitual (either-or) ways of thinking; self-image vs ego-ideal *is re-externalised in transference as...*	Internal relationships 3: reflective processes oscillating between opposing polarities
PRESENT	**5 · Therapeutic Relationship** Transference & countertransference	External relationships: how I relate to others / the therapist

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