

An Integrative Relational Point of View

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This article, part of a special section on the Relational Foundations of Psychotherapy, describes a particular relational approach called cyclical psychodynamics. Cyclical psychodynamics is rooted both in the relational perspective in psychoanalysis and in an integrative melding of psychodynamic, cognitive-behavioral, systemic, and experiential points of view. Central to its theoretical structure is a focus on the vicious and virtuous circles that perpetuate (or contribute to changing) personality patterns that may have originated in childhood but that persist because they often generate the very feedback from others that is necessary to keep them going. As a consequence of this latter focus, the relational foundation of cyclical psychodynamic therapy addresses in equal and dynamically reciprocal fashion both the therapeutic relationship in the consulting room and the key relationships *outside* the consulting room that play an essential role in the maintenance or change of the problematic patterns the person has come to therapy to work on.

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I work from a point of view (which I call cyclical psychodynamics) that is grounded both in the relational version of psychoanalytic thought (Wachtel, 2008) and in long-standing efforts to integrate psychodynamic thought and practice with the contributions of cognitive behavioral, systemic, and humanistic-experiential therapists (Wachtel & Wachtel, 1986; Wachtel, 1977a, 1987, 1997, 2011). This simultaneous participation in both the relational movement and the psychotherapy integration movement probably accounts for one of the major ways in which I differ from many other relational thinkers, not only within the psychoanalytic world but in the broader field of psychotherapy and psychotherapy research. While, like other relationalists, I see the therapeutic relationship as an extremely important element in the process of therapeutic change, and draw on both clinical observations and systematic research (Norcross, 2002, 2010) pointing to its importance, I am nonetheless of the view that therapy can be harmed as much by paying *too much* attention to the relationship between therapist and patient as too little. As I will elaborate below, my work is as concerned with the relationships *outside* the consulting room as it is with those inside. Most of all, perhaps, I am concerned with how attention to each helps illuminate the other.

The transference-countertransference enactments that are so central in the thinking of most contemporary relational analysts are indeed important, both as sources of understanding the patient's difficulties and way of life and as a medium for therapeutic reworking of problematic patterns. But in my experience, it is often only with the additional perspective of viewing and experiencing the interaction through the prism of what one has learned about the patient's daily interactions *with others* that what is happening in the room really becomes clear. Conversely, it is often

only with the understanding and experience of what is happening in the room that one fully understands what is happening with the patient's wife, daughter, father, boss, friend, and so forth.

As I shall elaborate below, the cyclical psychodynamic point of view, and the integrative relational therapy which derives from it, aims *both* to achieve corrective emotional experiences via the therapeutic relationship *and* to foster new ways of interacting with others outside the consulting room that permit the patient's ongoing life experiences to themselves be a key therapeutic agent. In this sense, the importance of the relationship is not only as a therapeutic agent in its own right but also as a means of gaining the patient's cooperation and active participation in experiences outside the session, where, after all, most of the patient's life is lived. It is only in the context of a relationship of trust and confidence that the patient can dare to engage in the kinds of new (and therefore likely frightening or intimidating) experiences outside the room that are perhaps the most powerful therapeutic experience of all.

Psychotherapy and the Social Context

Psychotherapy is often discussed as if it were an autonomous, purely theory- or research-driven enterprise, guided solely by empirical studies or its own internal logic and splendidly immune to the social forces around it. That, ironically, is itself a reflection of those very social forces—at least in America, the specific social context from within which I write. The dominant American myths of autonomy and self-reliance have at their core a denial of the powerful shaping role of social forces and institutions both in the choices and actions of individuals and in the ideas that occur to us either individually or collectively. These myths continue to impede social progress in our country, leading, for example, to powerful strands in our political life that blame the poor for their poverty, that deride government assistance to those in need as crippling or infantilizing, and that generally fail to understand the degree to which our fates are intertwined and our lives lived within the

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promptings and constraints of culture, class, and social context. In the sphere of psychoanalysis, they contributed to a picture of change in which the importance of the relationship as a direct therapeutic influence in its own right was derided and the therapist was cautioned to abjure giving any kind of direct advice or assistance, instructed to leave it to the patient to make his own decisions and take his own initiatives,¹ and directed to refrain from too much encouragement, support, or sympathy (“gratification”), lest the patient’s autonomy be undermined by well-meaning, but ultimately harmful, assistance. As Aron and Starr (2013) have put it, these ways of working and thinking “dovetailed with the American valuation of self-reliance and the heroic image of the lone cowboy riding off into the sunset. . . . If you improved because of interpersonal influence or reliance on your relationship with your therapist, you were not helped to be as autonomous as you might be” (pp. 2–3).

These attitudes were not the exclusive property of psychoanalysis. Rogers’s client-centered therapy (Rogers, 1951) presented a similar picture with a more human face. The Rogerian therapist was warmer, more engaged, more affirming than the so-called “classical” analyst (see Lohser & Newton, 1996, for a valuable discussion of how far in fact the practices that came to be called “classical” analysis actually strayed from Freud’s own practices). But in their own way, Rogerians too subscribed to the myth of autonomy and self-reliance and to the idea that if the therapist refrained from giving advice or assisting too directly, the client’s true self would spontaneously emerge.

Behavioral and cognitive–behavioral therapists have been much less reluctant to give advice or to provide direct structured assistance. But, reflecting what Schon (1983) has called technical rationality, there has been a tendency to highlight almost exclusively the impact of specific techniques and to downplay the role of the relationship (Duncan, Miller, Wampold, & Hubble, 2010). In recent years, this imbalance has begun to shift, as important voices in the cognitive–behavioral realm have explored in valuable ways the contribution of the relationship to effective cognitive–behavioral therapy (Gilbert & Leahy, 2007). This newer trend in cognitive–behavioral thought brings it into closer alignment with the cyclical psychodynamic view described in this article.

The Relational Turn

What has been called the relational turn in psychoanalysis was, in important ways, a challenge to both the myth of autonomy and the downplaying of the therapeutic impact of the relationship. From the point of view of relational psychoanalysis, the analyst is not a mere observer or reflector on the patient’s behavior or experience but is an active participant, a cocreator of what transpires in the room. Challenging the radical individualism underlying the practices of their predecessors, relational analysts emphasized that every human being lives his or her life embedded in a web or matrix of relationships. The impact of the therapist on the patient’s experience of self and vision of life’s options is not something that can be avoided; it must be acknowledged as inevitable—and, indeed, embraced as desirable. As Stephen Mitchell, probably the most influential architect of the relational turn in psychoanalysis, put it, “Personal autonomy is not something that antedates interaction with others, but an emergent property of

interactive processes, not something that can be sheltered from influence, but something that grows *through* influence” (Mitchell, 1997, p. 21).

The relational point of view in psychoanalysis refers not to a single tightly constructed theory but to a broad umbrella of ideas and perspectives, not all of which are necessarily shared by all relationalists (Wachtel, 2008). But there is sufficient coherence among them that the concept of a relational point of view is nonetheless a meaningful one and identifies a comprehensible thread in psychoanalytic thought. Especially central in the writings that launched the relational tradition in psychoanalysis was a concern with epistemology. Relational writers were critical of the objectivist assumptions of what was, at the time of the origins of the relational movement, mainstream psychoanalytic epistemology. Analysts of that era seemed to implicitly assume that if they could just “get out of the way,” the real or true transference and real or true underlying personality dynamics would emerge. Relationalists, in contrast, emphasized that it was impossible to see “the patient” divorced from the context of observation and that the analyst *inevitably* contributed to what emerged in the session, *could not* just get out of the way; what was observed was a *coconstruction*.

This did not mean, as some critics misunderstood, that the very idea of personality structure or individuality was being jettisoned (see Wachtel, 2008, for further discussion of this misunderstanding). It did mean, however, that epistemologically it was fallacious to think that that structure could be seen best by eliminating the therapist’s “distorting” role in what transpired. In attempting to understand another person, one sees portions or facets of a complex whole, and it is almost certainly the case that no therapist sees the entire configuration. If we are functioning well as therapists, we see enough to be helpful and enough to enable the patient to feel understood. But we always see what we see “in our fashion,” shaped by our own proclivities and by the particular circumstances of observation we have created—for example, how we structure the sessions and the therapeutic relationship and how we *act* in that relationship. Moreover, it is not just when we *step outside* the traditional psychoanalytic or therapeutic stance that we are “doing something” that affects what transpires; when we are silent, respond to a question with a question, or just “interpret,” we are doing something just as much, whether acknowledged as such or not (Wachtel, 1997, 2008, 2011; Gill, 1983, 1984; Mitchell, 1997; Hoffman, 1998). Indeed, in some therapeutic contexts, being silent or not answering a question can be an especially provocative act, about as far from “neutral” as one can imagine. What we see is not arbitrary, not made up, unlikely to be completely different from what another person in it would see; but it is *still* seeing it from our particular vantage point. That cannot be eliminated.

Closely related to these epistemological concerns was an emphasis on constructivism. In one sense, the constructivism is *part of* the epistemology; it holds that we *construct* the perceptions and understandings we achieve, that we do not just grasp “reality” in an unfiltered way. But I depict the constructivism as an element of

¹ For purposes of clarity and consistency, I will use the male pronouns “he” and “his” when referring in the abstract to “the patient” or “the client” and the female pronouns “she,” “her,” and “hers” when referring to “the therapist.”

relational thinking that is *not just* epistemological because it is also part of the *clinical or relational attitude* of many relational analysts. They approach their patients not as an observer who is “neutrally” commenting on truths or realities that are evident to the therapist but hidden from the patient (cf. Renik, 1993), but as a collaborator, laboring to grasp or construct a picture out of fragments. They assume as well that the *object* of their pursuit, the patient’s mental state and psychological experience, is itself constructed and is continually being put together and refashioned, rather than a set of fixed hidden contents that are already fully formed and lying in wait to be discovered, like the artifacts uncovered in an archaeological dig. Donnel Stern’s (1997) concept of unformulated experience better captures this new psychoanalytic approach to the unconscious than does the older notion of a buried and “timeless”—and already fully formed—secret. The patient is not simply self-deceiving, unable to see what is plain as day to the analyst; rather, the patient, like the analyst, is attempting to make sense of a configuration that is constantly shifting, as the very process of exploration and meaning-making in which they are both engaged continually changes the experiences from which meaning is made.

A similarly constructivist vision, it is important to note, is shared by a significant, and perhaps growing, number of cognitive and cognitive-behavioral therapists. Arnkoff and Glass (1992) write particularly clearly about the differences between the “rationalist” version of cognitive therapy that for so long dominated the practice of CBT and the more constructivist versions that have gained increasing influence in recent years: “Whereas rationalist cognitive theories assume that the therapist can know the true state of affairs through logic or sensory observation, constructivist theories posit that each person creates his or her reality. Therefore, a constructivist therapist cannot presume to know ‘the’ truth and simply pass it on to the client” (p. 699).

Few relational analysts seem to be aware of this strong constructivist strand in cognitive and cognitive-behavioral therapy, and constructivist cognitive therapists seem equally unacquainted with the foundation of constructivism at the heart of relational psychoanalysis. This mutual lack of awareness contributes to a problematic hardening of the boundaries between therapists of different nominal orientations (psychoanalytic/relational on the one hand and cognitive or cognitive-behavioral on the other) who in fact have much more in common than they realize. It is especially unfortunate because although sharing a robust constructivism, the two versions of constructivist therapy differ sufficiently that each could benefit from being introduced to alternative applications of and styles of implementing a constructivist paradigm.

In addition to, and complementing, the constructivist foundations of the relational turn, a number of other rubrics have been used to articulate the key defining features of the relational paradigm. Among these have been the two-person point of view; postmodernism and perspectivism; the concept of intersubjectivity; the conceptualization of the analytic relationship as mutual, reciprocal, and collaborative; and a range of ideas deriving from feminist thought. Most of these are substantially overlapping, offering slightly different angles on a common theme, but each introduces a somewhat different perspective and illuminates slightly different aspects of what is new about relational thinking in the psychoanalytic context. For an excellent discussion of these

various dimensions of relational thought and their overlaps and divergences, see Aron (1996).

Integrative Relational Psychotherapy

The cyclical psychodynamic point of view that is the central focus of this article originated independently of the relational turn just described. Its initial formulations (Wachtel, 1977a) preceded by several years the first articulations of a unified relational paradigm in psychoanalysis (Greenberg & Mitchell, 1983; Mitchell, 1988) and were directed toward a different project. Whereas the originators of relational theory confined themselves to articulating the commonalities of a subset of perspectives *within* psychoanalysis (interpersonal theory, self psychology, and object relations theory), cyclical psychodynamic theory was addressed to a broader integrative aim—bringing together the differing, but complementary, strengths of psychoanalysis and of therapeutic methods that had evolved from roots entirely *outside* of the psychoanalytic point of view. This broader aim required a more radical reexamination of the assumptions that had dominated psychoanalytic thought and a more comprehensive reformulation, and it gives cyclical psychodynamics, to this day, a somewhat different character than other versions of relational thought. But as both cyclical psychodynamic theory and relational theory evolved, it became apparent over time that, notwithstanding its differing origins and distinctive features, cyclical psychodynamics shared many features with other relational perspectives and was a branch of the same tree (Wachtel, 2008).

The theoretical framework that emerged from the broader integrative efforts of the cyclical psychodynamic project was one that retained many features of the psychodynamic point of view with which I began, but that reworked that point of view, sometimes quite extensively, to accommodate the new methods and new observations that accrued once I began to look beyond the boundaries of my original perspective. The process, I realize in retrospect, was of the sort described by Messer (1992) and Stricker and Gold (1996) as *assimilative integration*, a concept that highlights that integrative efforts inevitably reflect one’s starting point. Had I begun from a behavioral point of view and integrated into it more psychodynamic methods and observations, my formulations would almost certainly have looked somewhat different.

But in considering whether cyclical psychodynamics is just a standard psychodynamic point of view with just an occasional piece from another theory plugged into it, it is essential to bear in mind that every act of assimilation is necessarily accompanied by a process of accommodation (Flavell, 1963). The very act of incorporating new perceptions, ideas, or experiences into an already existing schema *changes* that schema (Wachtel, 1981; Wachtel, 2005). In the case of cyclical psychodynamics, it is evident both how fundamental features of the psychoanalytic point of view have been retained and how they have been reworked to the point where something new has emerged.

A key feature of the cyclical psychodynamic point of view is an emphasis on understanding personality dynamics and development in terms of self-fulfilling prophecies and vicious and virtuous circles. Both systematic research (Wachtel, 1994; Wachtel, Kruk, & McKinney, 2005) and observations in the clinical setting and in everyday life highlight the ways in which the affects and actions that derive from people’s inner states elicit responses from others

that feed back to either maintain or modify those inner states (see also Wachtel, 2009, 2010a, 2014). Although this process can account for change as well as persistence (and indeed, is at the heart of the new feedback loops that successful therapy generates), all too often the result is the ironic maintenance of the very patterns that are at the root of the patient's difficulties.

This emphasis on vicious circles originated in the effort to reconcile the "internal" focus of psychoanalysis and the "external" focus of behavior therapy (Wachtel, 1977a). Especially at the time that my integrative efforts began, psychoanalytic formulations tended to focus on the ways that the experiences of everyday life reflected dynamics laid down early in childhood, playing themselves out like a script that was in its fundamental form already written. Little attention was paid to the ways that continuing experiences consistent with that script were essential to its maintenance or to the ways in which new experiences could modify it; the essential forces were seen as "internal" and already in place. In contrast to this emphasis on the past and on the "internal," behavior therapists, especially in the era in which the cyclical psychodynamic perspective first took shape, tended to highlight the situations and contingencies that shaped behavior in the present (Mischel, 1968). I was impressed with the overall body of evidence in support of both points of view and of the clinical utility of each, but in attempting to combine their complementary strengths into a synergistic therapeutic approach that was also theoretically coherent, these seemingly different conceptualizations presented a major obstacle. Attention to the vicious and virtuous circles alluded to above was the key to reconciling the seeming contradictions. It illuminated the ways in which these two sources of stability or change were not *competing* influences simply dividing up the total variance (Wachtel, 1977b), but were coconspirators, as it were, operating in tandem and part of a continuing series of feedback loops in which, to a very significant degree, *each created the other* over and over again. The ways in which our internal states and structures are manifested in daily life evoke responses from others that feed back to either maintain or change those inner states. As a consequence, notwithstanding the continuities that can be discerned between early experiences and the personality characteristics of later years, the individual's personality is not "set" in the oedipal or preoedipal years but is the product of the reciprocal interplay between *already existing* psychological structures and *new* experiences that those structures contribute significantly to bringing about.

In the time since the cyclical psychodynamic point of view was first formulated, both psychoanalysis and behavior therapy have changed substantially. The evolution and increasing influence of the relational point of view in the former and the development first of *cognitive* behavior therapy and then of third-wave and constructivist versions of CBT (Hayes, Follette, & Linehan, 2004; Mahoney, 2003; Neimeyer & Mahoney, 1995; Neimeyer, 2009) have rendered as overly simplistic the earlier characterizations of psychoanalysis as almost exclusively directed to the past and the "internal" or behavior therapy as exclusively concerned with environmental cues and contingencies in the present. Large differences remain, of course, between these two orientations; this is part of what makes the effort at integration still worthwhile—if they were really the same, there would be little purpose in combining their different strengths and emphases. But—the politics of our field notwithstanding—there is in truth a much less stark

opposition or incompatibility between the two paradigms than is commonly believed by proponents of each. Thus, the current relevance of the vicious circle analysis is no longer so much that it reconciles and integrates two seemingly antithetical visions (though it remains a particularly useful scheme for grounding integrative efforts) as that it simply describes well the actual dynamics of how personality evolves and is maintained—how, for example, the "inner world" of wishes, fantasies, affects, and self- and object-representations and the "outer world" of overt behavior and social reality mutually shape and maintain each other; how patterns of attachment are maintained over time by similar processes; and how social patterns too can persist even when they are antithetical to human thriving (Wachtel, 1983, 1994, 1997, 1999, 2008, 2010a).

How Does the Relationship Contribute to Therapeutic Success?: The Corrective Emotional Experience and Beyond

By now, there is an enormous body of evidence supporting the powerful role of the therapeutic relationship and therapeutic alliance in the outcome of psychotherapy (Norcross, 2002, 2010). The research supporting this conclusion has had great utility, calling to our attention crucial findings and considerations that are often ignored in the present climate of promoting specific "brands" of therapy that essentially compete for market share just like brands in any other business and whose proponents often show the same tendency to stack the evidence to exaggerate their unique value (Duncan et al., 2010; Rosen & Davison, 2003; Wachtel, 2010b). But in highlighting the importance of the relationship, it is important not to rest content with just showing what "proportion of the variance" it accounts for. Although it is of great value to demonstrate empirically the critical impact of relationship factors in therapeutic change, we need as well to specify more clearly *just how* the relationship has its impact.²

One of the earliest important formulations of this impact was Alexander and French's (1946) articulation of the concept of the corrective emotional experience. Their innovations were met with great resistance in the psychoanalytic community, which at the time regarded an emphasis on the direct therapeutic influence of the relationship as detracting from the presumed special transformative power of the traditional psychoanalytic method and as problematically blurring the boundaries between "psychoanalysis proper" and "psychotherapy" (Aron & Starr, 2013). But the basic soundness of Alexander and French's conceptualization has been retrospectively demonstrated, if only indirectly and without acknowledgment, via the repeated adaptation of their idea by almost every psychoanalytic school in recent decades. Thus, we have seen discussions of new relational experience, new object experience, transmuting internalization, and a host of similar formulations that largely replicate Alexander's idea while presenting it with an artfully different name that is intended to avoid the stigma the term had accrued in that community (see, e.g., Wachtel & DeMichele, 1998). Shared by all of these formulations is the idea that the experience of a relationship and mode of interacting with the therapist that differs in personally significant ways from the prob-

² For a comprehensive review of formulations in this regard and the evidence that bears on them, see Norcross, 2002.

lematic aspects of the patient's relationship with his or her parents growing up can be a powerful mutative element in its own right. Whatever quibbles one might have with the particular way that Alexander articulated and implemented his seminal idea—many have objected to the manipulative or authoritarian strains they saw in his specific techniques and formulations—I find Alexander's terminology still the most straightforward and illuminating. For the relationship to be *corrective* (that is, to genuinely promote therapeutic change), it needs to be an *emotional experience*—that is, that it not be dryly intellectual or overly didactic. A more contemporary version of this point is offered by a range of writers who emphasize that the mutative effects of the relationship tend to operate on an implicit or procedural level rather than on the verbal or declarative level common to the strategy of "interpretation" (Stern, 1997; Lyons-Ruth, 1998; Renn, 2012). As highlighted by Lyons-Ruth, some of the most central elements in meaningful therapeutic change resemble learning to ski or ride a bike or to "get" a joke more than the syllogistic lessons in rationality and irrationality of the rationalist cognitive therapist or the explicit interpretations or insights emphasized by more traditional psychoanalysts.

Still requiring further investigation is the question of whether the contribution to therapeutic change of the direct relationship in the consulting room is primarily a function of its being *different* from the relationships of the patient's childhood (as implied by Alexander) or whether it is simply a matter of the relationship being a *good* relationship or *facilitative* relationship. Of course, the two are related, in that the logic of Alexander's point of view suggests that it is the very difference from the relationship with the parents that *makes it* a good or facilitative therapeutic relationship. If the patient's difficulties can be traced to harsh or authoritarian or domineering parenting, then a gentle therapeutic relationship, in which the therapist refrains from taking stands and encourages the patient to discover his own point of view will be both different and facilitative. But if the patient suffered from parenting that was lax or inattentive or failed to provide sufficient structure or guidance, then the same therapeutic relationship that was facilitative in the first case can be experienced as "more of the same" in the second and not be very helpful. Instead, greater input from the therapist, more active and explicit helping and structuring might be called for.

This view is somewhat different from those offered by those therapists that emphasize a more singular view of what kind of therapeutic stance and what kind of therapeutic relationship is helpful. Whereas Alexander's view of what is therapeutic is *contingent*, varying depending on what came before, the guidelines offered by a range of other influential thinkers in our field point to a more *general* therapeutic stance that is seen as useful for virtually *all* patients. Thus, for Rogers (1951), a therapeutic stance that evidences empathy, congruence, unconditional positive regard, and genuineness is *almost always* what is likely to be a corrective emotional experience, and it seems implicit in Rogers's view as I understand it, that that is the case *whatever* the conditions were of the client's upbringing. Somewhat related views of the optimal therapeutic relationship may be seen in a range of object relations and self-psychological conceptualizations of the sort that Mitchell (1988) discusses under such rubrics as developmental-arrest theories or replacement therapies, generally approaches that essentially aim to cure via nurturance and being a "good object." At the

heart of these approaches, as Mitchell discusses them, is the assumption that the patient is, at core, still a helpless baby who most of all needs nurturance. As Mitchell puts it, these theorists

view the patient as an infantile self in an adult body, fixed in developmental time and awaiting interpersonal conditions that will make further development possible. In this view, what was missed is still missing and needs to be provided essentially in the form in which it was missed the first time around. (p. 170)

Depending on the specific vocabulary used, the aim may be to provide "holding" and avoid "impinging" on the vulnerable baby within (Winnicott, 1965), to promote the transmuting internalization of good self-objects (Kohut, 1977), or "to undergo a process of emotional development in the setting of an actual relationship with a reliable and beneficent parental figure" (Fairbairn, 1958).³ In a similar vein, Guntrip (1971), an influential object relations thinker in his own right and a synthesizer of the ideas of Winnicott and Fairbairn (both of whom were his therapists), depicts the aim of therapy as

the provision of the possibility of a genuine, reliable, understanding, and respecting, caring personal relationship in which a human being whose true self has been crushed by the manipulative techniques of those who only wanted to make him "not be a nuisance" to them, can begin at least to feel his own true feelings, and think his own spontaneous thoughts, and find himself to be real. (Guntrip, 1971, p. 182)

It is important to be clear that even for these theorists, establishing a relationship that promotes therapeutic change is not a simple matter of being "nice" (or beneficent or warm or holding). Rogers, for example, recognizes that sometimes the therapist does have negative feelings or cannot so readily show unconditional positive regard, and he argues that in such instances genuineness must be given priority until the therapist can work her way toward true regard; therapy cannot proceed on a foundation of falseness or deception. More dramatically, Winnicott (1949) famously wrote about "hate" in the countertransference, clearly not a simple-minded advocacy of pure loving-kindness. Moreover, all of these advocates of nurturance, beneficence, holding, or unconditional positive regard clearly stand for a differentiated understanding of the specifics of the particular patient's experience. In that sense, what they advocate is not one size fits all, an invariant therapeutic stance applied in similar fashion to all patients.

Nonetheless, there are clear differences between the more *general* stances just discussed and what I have called the "contingent" stance of Alexander. The concept of the corrective emotional experience implies that for some patients, being unintrusive can be more of a problem than a therapeutic aid. In a related vein, in the formulations of Sullivan (e.g., 1953) there are patients for whom a gentle warmly supportive approach can be the very antithesis of what the patient needs. In discussing the treatment of paranoid patients, for example, Sullivan warns that a therapeutic stance that is too warm or empathically embracing can be countertherapeutic,

³ Fairbairn, it may be noted, was one of the earliest advocates of the relationship as a curative agent in its own right, arguing in the same paper that "the actual relationship existing between the patient and the analyst as persons must be regarded as in itself constituting a therapeutic factor of prime importance" (p. 377).

further arousing the patient's suspicions rather than being experienced as helpful or well-intentioned, whereas a tougher and more distant stance has a greater chance of diminishing the patient's anxieties and eventually getting through.

One way of framing these various differences is whether there is basically just one way to be a "good object" or whether there are many, contingent on what the "bad objects" have been in the patient's life. We may debate this question from a variety of theoretical vantage points, but ultimately careful research is required to achieve a clearer—and, most likely, more differentiated—answer to this question.

The Relationship as Catalyst

As important as the direct experience of the therapeutic relationship is in its own right in promoting change (whether via a corrective emotional experience or via the provision of a new good object or empathic resonator with the patient's experience), the relationship is at least as important as a *catalyst*, as a means of promoting the patient's engagement in new and corrective experiences *outside* the consulting room. Life, after all, is mostly lived in other contexts and in relation to other people, and if therapy is to be regarded as successful, it is in *those* contexts that change must occur (Wachtel, 2008). One *error* of relational thinking, in my view, has been overestimating the impact of the emotional exchange in the room as a therapeutic agent in its own right and as the primary means of investigating and articulating the patient's internal life and patterns of relating. This is by no means to deny the value or importance of attending to what transpires in the room or of offering oneself as a new potentially transformative object. Rather, my aim is to place our understanding of the value of these relationship events in the context of a still larger set of therapeutic processes. Much of what enables change that will genuinely infuse the patient's life entails experiences *in* that life—that is, in the experiential context in which most of his suffering or dissatisfaction occurs and in which new emotional meanings and interactional patterns must be established and maintained.

Acknowledging this importance of experiences outside the consulting room does not necessarily diminish the importance of the therapeutic relationship. Rather, it contextualizes it and expands our understanding of the *ways* in which the relationship promotes therapeutic change. Much of the skill of the good psychotherapist is manifested in relational events and transactions that build sufficient trust and confidence that the patient will dare to try out new ways of interacting with the important others in his life or will dare to confront the sources of anxiety that have been at the heart of his difficulties (whether they be directly identifiable external stimuli in phobic disorders, the abandoning of certain ritualized behaviors in obsessional and compulsive disorders, or the less readily identifiable anxieties that account for a wide range of inhibitions, avoidances, and maladaptive relational patterns). That skill is manifested as well in the gentle guidance and modeling (usually more often implicit than explicit) that helps the patient to confront difficult challenges more effectively, in ways that help establish new patterns that work better in his life—e.g., enabling him to express anger, love, need, or self-confidence in a manner that elicits desired rather than feared responses from others and that leave him feeling good about himself rather than frustrated or humiliated. In this way of understanding the therapeutic process,

the agenda and methods of psychodynamic, behavioral, and systemic approaches can be seen to converge (Wachtel, 1997).

In the synergies I am pointing to, the relationship remains critical; what happens *inside* the room can profoundly affect what happens *outside* the room. But if the therapist is too narrowly focused on the former alone, the crucial latter realm, where the therapy's value for the patient is ultimately tested, can be given short shrift. Put differently, even though the therapeutic alliance accounts for an impressively large chunk of the variance compared with other factors studied, including therapist theoretical orientation or the use of specific techniques (Norcross, 2002, 2010; Duncan et al., 2010), its direct impact still constitutes only a relatively small percentage of the whole. To maximize the potential for change resulting from a well established and well-maintained therapeutic alliance, we need to be aware that much of the therapeutic value of what happens in the relationship is in its impact on promoting the necessary new behaviors and experiences *outside* the consulting room that carry much of the weight of therapeutic change and that must be carefully attended to in their own right if the therapy is to be of maximal benefit to the patient or client.

The Therapeutic Relationship and Therapeutic Communication

It has been my conviction for many years now that a good deal of the difference between therapeutic interactions that are truly facilitative and those that fail to promote the change the patient desires lies in the insufficiently studied realm of therapeutic communication; that is, in the ways that subtle differences in the wording or phrasing used to convey what might seem at first glance to be the same content can have a powerfully different impact on whether change is promoted or impeded (Wachtel, 2011). Much of teaching and supervision of therapy focuses on the *content* of what the patient is saying or of what the therapist should focus on, whether this is discussed in terms of correctly identifying the patient's emotional dynamics, his conflicts or developmental level, his irrational cognitions, his problematic behaviors, or any other factor highlighted by one or another theoretical orientation. Much less attention is generally paid to *how* to address these issues, what exactly the therapist should *say*. It is often implicitly assumed that if the patient is accurately understood, then what to say will follow easily and almost automatically. My students have taught me over the years that that is rarely the case.

Often their understanding of the patient is quite accurate, but they are still left uncertain about what to do or say. When I have addressed myself directly to their concerns, when I have said something on the order of "How about saying to her something like such and such?" they were greatly relieved and felt they had learned something important. Similarly, when I have attended to the specific way they had communicated their understanding and perception, and suggested an alternative way of conveying the same content—addressing, in the language I have developed to discuss this set of issues, not just the "focal message" but the "metamessage"—the emotional meaning that can convey approval, disapproval, encouragement, impatience, or a host of other relational meanings all consistent with the same focal message—they have conveyed to me that that has been among the most important learning experiences in their training.

As I have noted elsewhere (Wachtel, 2011),

It is striking how often in the literature basic details are omitted regarding what the therapist actually says, with the consequence that the full implications of what is said remain unexamined. Even many seemingly concrete and communicative reports, whether in the literature or in supervisory sessions, can be seen, on closer inspection, to leave a crucial ambiguity about what was actually said and, hence, to be considerably less useful or revealing than they might first appear. When a supervisee reports, for example, "I told the patient that I thought his forgetting was related to his anger at his wife," his actual comment could have varied anywhere from "You were angry at your wife, and you tried to hide it by forgetting" to "You've told me about a number of things your wife did that I would imagine made you angry; perhaps you forgot because you were trying so hard not to be angry at her." The tone and meaning of these two ways of "telling him his forgetting was related to his anger at his wife," the metames- sages they convey, diverge quite substantially. Unless one examines the actual comments in their concrete detail, one's appreciation of what transpired will be incomplete and potentially quite misleading. (p. 7, italics in original)

The compilation and close examination of numerous examples, in the attempt to spell out detailed clinical guidelines and to tease out general principles of effective therapeutic communication, has been an absorbing task. I look forward to researchers examining in the crucible of systematic research which of the examples I have offered and the principles I have spelled out (e.g., in Wachtel, 2011) are solidly grounded and which need to be modified or refined. It is ultimately through our communications (largely verbal in "the talking cure," but inevitably nonverbal as well) that the therapeutic relationship is established and its effects, whether positive or negative, are achieved. The exact ways that relationships are established and proceed to deepen, detour, or deteriorate over time (or undergo a roller coaster ride of ups and downs) can seem mysterious and ephemeral, and it can be tempting to limit one's research efforts to simply determining how much variance the relationship accounts for. But ultimately relationships are made up of a back and forth series of concrete acts and exchanges and a multitude of messages that serve or do not serve the therapeutic intent. The better we understand the structure and meaning of those messages—both the metames- sages they convey about how the therapist views the patient and the ways they do or do not promote new actions and experiences in the patient's daily life with others—the better able we will be to help our patients live life more effectively and satisfyingly.

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