



Chapter 13

Relational Theory and Integrative Perspectives in Clinical Practice

You must bring out of each word its practical cash-value, set it at work within the stream of our experience. . . . Theories thus become instruments. . . . Pragmatism unstiffens our theories, limbers them up.

—William James, *Pragmatism*

The broader psychodynamic tradition encompasses a range of theoretical models and therapeutic languages, as we have seen, and practitioners continue to make pragmatic use of concepts and methods from a variety of sources. In the first part of this chapter, I review concepts of therapeutic action set forth in the contemporary relational schools of thought and show how comparative perspectives enlarge ways of working over the course of intervention. In doing so, I focus on Stephen Mitchell's formulations of therapeutic action in his framing of the relational paradigm and review earlier case reports in order to illustrate orienting perspectives and approaches to treatment. In the second section, I return to the pluralist point of view introduced at the start of the book and review the ways in which comparative perspectives strengthen integrative practice in psychosocial intervention.

Relational Perspectives and Psychosocial Intervention

Concepts of therapeutic action set forth in the relational schools of thought outlined in the preceding chapter center on the crucial role of the helping relationship and the functions of interpersonal interaction and experiential learning in efforts to help clients deepen understandings of self, others, and life experience; strengthen coping capacities; and negotiate problems in living. Theorists recognize the influence of common elements believed to foster change and growth across the foundational schools of thought, including the sustaining functions of the helping relationship, the setting of the intervention, conceptual schemes that provide explanations of what is the matter and what carries the potential to help, and the core activities of the therapeutic process (Frank & Frank, 1991; Wampold, 2007; see Borden, 2008a, in press, for a review of common factors in psychosocial intervention).

160 Contemporary Psychodynamic Theory and Practice

From the perspective of relational psychoanalysis, however, formulations of curative factors emphasize the constancy of care in the therapeutic holding environment (Winnicott, 1963/1965b); attunement, empathic responsiveness, and selfobject transference experience (Kohut, 1977, 1984); experiential learning through interpersonal interactions (Sullivan, 1940, 1954; Wachtel, 1993, 2008); interpretive procedures that deepen understandings of self, others, interpersonal behavior, and life experience (Wachtel, 1993, 2008); reinforcement, modeling, and identification (Strupp & Binder, 1984; Wachtel, 1997, 2008); and use of tasks to generate action and strengthen development of crucial skills in living (Borden, 2008b; Wachtel, 1997, 2008). Relational thinkers challenge classical conceptions of transference, resistance, and the analytic frame, rejecting the principles of neutrality, abstinence, and anonymity. They emphasize the importance of “corrective emotional experience” (Alexander & French, 1946), “new relational experience” (Frank, 1999), and Fairbairn’s (1958) conception of “an actual relationship with a reliable and beneficent parental figure” (p. 377).

The therapeutic relationship itself serves as a facilitating medium for change and provides crucial sources of experiencing and learning in efforts to reinstate arrested developmental processes, modify internalized representations of self and others, develop interpersonal skills, and improve social functioning (Borden 1998, 1999, 2008b). Enactments of maladaptive behavior over the course of intervention deepen understandings of dysfunctional modes of interaction and guide efforts to develop more effective ways of negotiating interpersonal life. Emerging lines of inquiry in neuroscience and cognitive psychology explore the ways in which the interactive experience of intervention alters associational networks and fosters the development of new linkages and patterns of behavior (Kandel, 2005, 2006; Schore, 2003a, 2003b; Westen & Gabbard, 2002a, 2002b).

Although practitioners emphasize the importance of establishing a clear, circumscribed focus in their formulations of intervention, they assume that the core activities of the therapeutic process carry the potential to foster change and growth across domains of functioning, helping individuals (1) strengthen their ability to process subjective experience; (2) deepen awareness of their own and others’ behavior; (3) develop problem-solving skills and coping capacities; and (4) enlarge their understandings of self, others, and life experience. As reviews of outcome studies show, the process of intervention generally helps clients develop more positive views of their world, communicate more effectively, strengthen interpersonal skills, and expand their social networks (Wampold, 2007). Clinical researchers assume that improved interpersonal functioning increases morale and reduces the difficulties associated with all forms of psychopathology (see Binder, Strupp, & Henry 1995, p. 44; Frank & Frank, 1991; Luborsky & Barrett, 2006; Roth & Fonagy, 2005).

As we have seen, relational formulations of transference and countertransference emphasize the dyadic, reciprocal nature of therapeutic interac-

Relational Theory and Integrative Perspectives in Clinical Practice 161

tions (Aron, 1996; Gill, 1982, 1994, 1995; I. Z. Hoffman, 1998; Mitchell, 1997; Wachtel, 2008). Generally speaking, theorists conceptualize transference reactions as patterns of expectations established over the course of development and life experience. Cognitive representations of self and others and expectations shape interpretations of events, constructions of meaning, and corresponding behaviors in interpersonal situations that have the potential to perpetuate maladaptive patterns.

The clinician's countertransference states constitute sources of experience that deepen understandings of dynamic processes that perpetuate the client's problems in functioning. Contemporary lines of understanding in interpersonal psychoanalysis conceptualize countertransference reactions as role-responsive complements or counterparts to transferential phenomena. The clinician functions as a participant-observer and provides opportunities for recognition, clarification, and revision of maladaptive perceptions and patterns of relating.

In their efforts to extend concepts of mutuality, relational theorists stress that the client and the practitioner both participate in the helping process; as such, each party influences the other in conscious and unconscious ways. Concepts of intervention increasingly take into consideration the personal characteristics and immediate emotional experience of the clinician (see Aron, 1996, p. 125; I. Z. Hoffman, 1998; Mitchell, 1997, 2000; Wachtel, 2008; Wampold, 2007). As Jon Mills (2005) observes, relational thinkers emphasize a "natural, humane, and authentic" manner of engagement in the therapeutic situation; he characterizes practitioners as "more revelatory, interactive, and inclined to disclose accounts of their own experience . . . , enlist and solicit perceptions from the patient about their own subjective comportment, and generally acknowledge how a patient's responsiveness and demeanor is triggered by the purported attitudes, sensibility, and behavior" of the clinician (p. 155). The practitioner's ongoing processing of countertransference states, therapeutic impasses, and the client's experience of the clinician is a radical shift in clinical practice that has increasingly focused attention on the *process* of intervention (see Mills, 2005; Mitchell, 2000; Wachtel, 2008). Relational thinkers who conceptualize treatment from narrative perspectives view the practitioner as a co-participant in the client's efforts to process experience, construct meaning, and elaborate adaptive life stories (see, e.g., Borden, 1992; Howard, 1991; Schafer, 1983, 1992; Spence, 1982). Social constructivist conceptions of therapeutic interaction emphasize the mutual influence of client and practitioner in the interactive field over the course of intervention (I. Z. Hoffman, 1998).

Clinicians are increasingly emphasizing the importance of the therapeutic relationship and interpersonal expertise in conceptions of evidence-based practice. As noted in the preface, converging lines of study in psychotherapy research document the ways in which the client *and* the practitioner influence the process and outcome of treatment, and relational perspectives strengthen conceptualizations of interpersonal experience in

162 Contemporary Psychodynamic Theory and Practice

evidence-based practice (see APA Presidential Task Force on Evidence-Based Practice, 2006; Borden, 2008b; Wampold, 2007).

The theoretical perspectives encompassed in the broader relational paradigm deepen understandings of vulnerabilities and patterns of behavior that have the potential to compromise the establishment of the therapeutic alliance and precipitate strain or rupture over the course of treatment. Relational models of intervention emphasize flexible use of interactive experience in light of the individual, social, and cultural contexts of the client; interpersonal capacities and skills; and the nature of problems in functioning. Reviews of research show that the efficacy of varying treatment approaches appears to lie more in shared features and qualities of relatedness than in technical procedures associated with various schools of thought (Frank & Frank, 1991; Wampold, 2007). Relational perspectives promise to strengthen approaches to assessment, case formulation, treatment planning, and methods of intervention in evidence-based practice (Borden, 2008b).

Social, cultural, political, and economic forces continue to restrict contexts of practice and modes of service delivery across the range of settings. The influence of managed care has challenged clinicians to broaden their conceptions of the therapeutic endeavor and to develop pragmatic, focused modes of intervention in their efforts to address a wider range of vulnerable groups and problems in living. Drawing on relational concepts, practitioners have introduced flexible models of brief treatment that extend the range of client populations and problems in functioning addressed in traditional formulations of short-term intervention (see Binder, 2004; Borden, 1999, 2000, 2008b; Brandell, 2004; E. Goldstein & Noonan, 1999; Messer & Warren, 1995).

Practitioners assume that time-limited approaches carry the potential to strengthen coping strategies, enhance capacities for relationship, and improve social functioning. From the perspective of most relational theories, even very brief periods of intervention may reinstate developmental processes and facilitate personality reorganization (Borden, 1999; Gardner, 1999; Schmidt, 1999; Winnicott, 1971b).

In the broader context of psychosocial intervention, relational formulations strengthen conceptualizations of brief intervention, case management, family and group treatment, environmental intervention, organizational development, advocacy, and social action.

Comparative Perspectives in Relational Understanding

Mitchell (1988) links core concepts from self psychology, object relations theories, and interpersonal psychoanalysis in his integrative approach and describes overlapping conceptions of therapeutic action, change, and growth in his relational model. He focuses our attention on the core domains of the relational matrix: self-organization, internal object representations, and transactional patterns.

Self and Subjectivity

From the perspective of self-organization, the therapeutic situation allows the individual to recover and experience aspects of self that have been hidden, disclaimed, or disavowed. The relationship with the practitioner is inevitably structured along the lines of earlier ways of being and relating. "Anxiety and disappointment are anticipated where they were previously experienced, and various areas of self-experience are hidden" (Mitchell, 1988, p. 289).

The clinician's exploration of problematic areas of experience and participation in new forms of interaction facilitate efforts to encounter, name, and appreciate previously unknown states of self. The individual can be a different kind of person in his or her experience of the clinician and others than he or she could previously allow him- or herself to be.

It will be useful to consider this domain of experience in light of earlier clinical illustrations. Mary, whose case was presented in chapter 8, told the clinician in the assessment interview that she *never* experienced feelings, viewing emotion as "disgusting" and "dangerous." Over the course of her psychotherapy, however, she came to identify and accept a range of feelings, recognizing her experience of emotion as a source of aliveness and a mode of knowing. Robert, discussed in chapters 6 and 10, developed capacities to process his experience of vulnerability, fear, and uncertainty, which he had previously managed through splitting, projective identification, and aggressive behavior. Martha, presented in chapter 8, came to recognize core experiences of need and desire that she had repudiated in her adaptive, reactive ways of being and relating.

The Inner World of Others

From the perspective of object relations thought, early relationships are internalized, structured, and preserved as powerful presences. Contemporary experience is processed through working models of self and others and modes of interactive experience. "Areas of deprivation, constriction, and intrusion result in attachments to these qualities in [other people] as the form through which contact is made, as vehicles for maintaining a sense of connectedness and relation," explains Mitchell (1988, p. 290).

In this domain of experience, change entails reorganization of core internal structures. The clinician is inevitably experienced as a familiar other in the transference. Over time, through empathic attunement and responsiveness, interpretive efforts, and experiential learning in the give-and-take of the therapeutic process, the practitioner becomes a different, responsive other. The gradual internalization of this experience facilitates efforts to release reflexive ties to past forms of relation. The intrapsychic domain of the relational matrix is thereby transformed. The individual experiences him- or herself as "a different sort of person, . . . residing in a profoundly different human environment" (Mitchell, 1988, p. 290).

164 Contemporary Psychodynamic Theory and Practice

Anne viewed expressions of her most fundamental needs and desires as betrayals of her parents. As we saw in discussion of her case in chapter 7, she experienced extended periods of fear, anxiety, and dissociation as she challenged the constraints of her inner world of others through new forms of behavior. Robert, too, identified with the internalized presences of his parents, and he felt a deep sense of loss as he suspended aggressive modes of behavior that he associated with his father and learned how to process his experience of vulnerability in interaction with others. Loren, presented in chapter 7, had developed strong ties to internalized representations of abusive figures from her past, and she would experience diffuse periods of anxiety and loss as she worked through the effects of earlier trauma and neglect.

The Interpersonal Field

From the perspective of interpersonal theory, “anxiety about anxiety” has forced the individual into constricted, repetitive patterns of interaction. “It is the ritualized action that delimits the experience of both self and other” (Mitchell, 1988, p. 290). The clinician facilitates efforts to identify and process these patterns of interaction, encouraging the individual to “try something different,” to explore different interpersonal situations where richer experiences of self and other are possible (Mitchell, 1988, p. 290). Such shifts in transactional patterns occur in the give-and-take of the therapeutic process as well as in relational life in the outer world.

In spite of her fears, Martha came to learn how to assert her needs and bring her core self to bear in ways of relating and acting that reflected her deepest concerns. Robert, too, strengthened his ability to communicate more effectively in interactions with coworkers, expand patterns of activity in day-to-day functioning, and engage opportunities for friendship.

Mitchell (1988) reflects: “Operating with old illusions and stereotyped patterns reduces anxiety and provides security not simply because the illusions and patterns are *familiar*, but because they are *familial* and preserve a sense of loyalty and connection. Bad-object ties are adhesive and repetitive not simply because they are familial but also because they are familiar and minimize anxiety. . . . The maintenance of a coherent sense of self and the preservation of secure patterns of interaction are inextricably linked to securing connections with others” (p. 291).

The Process of Intervention

The pluralist perspective described in the first chapter enlarges conceptions of therapeutic action in psychosocial intervention. By way of illustration, I return to the case of Robert and explore the ways in which comparative approaches enrich ways of working in the clinical situation. To review, the client had been suspended from his job and initiated psychotherapy in

Relational Theory and Integrative Perspectives in Clinical Practice 165

efforts to address ongoing patterns of strain, rupture, and loss in relational life. As we will see, the relational schools of thought provide different understandings of essential concerns, core activities, and change processes in therapeutic intervention.

Self Psychology. The perspective of self psychology focuses our attention on Robert's loss of cohesion in his sense of self and disruptions in relational life that perpetuate his experience of vulnerability, demoralization, and fragmentation. We recognize the crucial functions of attunement and responsiveness in therapeutic interactions and the importance of processing experience from his point of view, and communicating empathic understanding and acceptance of subjective states. We consider emerging patterns of transference (mirroring, idealization, twinship) that carry the potential to reinstate development and foster growth.

Object Relations Perspectives. Object relations perspectives focus our attention on the ways in which Robert's internal models of self and others and modes of interactive experience influence his perceptions of relationships in contemporary life and shape patterns of behavior in the therapeutic situation. We center on defensive operations that perpetuate problems in functioning (splitting, projective identification) and view patterns of strain and rupture in therapeutic interactions as sources of experiential learning in efforts to identify maladaptive behavior and help Robert develop more adaptive ways of being and relating. The core conditions of the helping relationship, internalization of positive experience, and identification with the clinician carry the potential to help him renegotiate ties to internalized presences of caretaking figures and strengthen capacities to establish constructive relationships and modes of interaction.

Interpersonal Perspectives. Interpersonal perspectives focus our attention on the domains of internal and external experience which Robert avoids as a result of his experience of fear; defensive operations; and vicious circles of thought, feeling, and action that perpetuate his problems in functioning. In working from an interpersonal approach, we press for concrete detail in efforts to understand what actually happens between Robert and others in the context of particular circumstances and settings, exploring the ways in which earlier conditions of care in family life have shaped ways of being and relating. In the role of participant-observer, we expect to process patterns of interaction in the sessions, exploring his experience of the helping relationship, defensive strategies, and potential enactments in therapeutic interaction. The task of treatment, from this perspective, is to help Robert disrupt vicious circles of thought, feeling, and behavior and strengthen capacities for constructive ways of being, relating, and living.

166 Contemporary Psychodynamic Theory and Practice

The orienting perspectives of self psychology, object relations theory, and interpersonal thought provide different conceptions of therapeutic action, change, and growth. As Mitchell frames the therapeutic situation, the client attempts to preserve old and familiar ways of being, relating, and living while searching for something new and different. The client re-creates earlier relational worlds in the interactive experience of the therapeutic process, engaging the clinician through long-standing patterns of behavior. His conceptions of the therapeutic action emphasize the dialectical nature of stability and change as the client attempts to perpetuate comfortable ways of being *and* establish new ways of living.

Critical Pluralism and the Therapeutic Endeavor

According to the conceptions of critical pluralism introduced in the opening chapter of the book, the clinician's understanding of the major therapeutic systems in the broader psychoanalytic tradition provides conceptual foundations for the use of different ideas and strategies in integrative practice. Pluralist perspectives preserve the integrity of the core theoretical systems and make the multiplicity of different approaches a defining feature of clinical practice. The assumption is that all theories have inherent strengths and limits, and thinkers emphasize the crucial role of ongoing dialogue across different schools of thought in efforts to identify common elements, clarify differences, and consider the relative merits of various perspectives. The clinician draws on multiple theoretical models, therapeutic languages, and modes of intervention in efforts to address the particular needs of the clinical situation.

While pluralist perspectives enlarge the scope of understanding and strengthen critical thinking over the course of intervention, they place considerable demands on the clinician in the give-and-take of day-to-day practice. The clinician must consider multiple therapeutic models and negotiate ongoing tensions between a particular approach and alternate modes of intervention. In doing so, the practitioner must consider higher-level theoretical constructs *and* remain focused on the practical application of ideas and procedures in the concrete particularity of the clinical situation, tacking back and forth between ideas and experience.

Movement from one orientation to another is guided by the nature of the client's problems in functioning; vulnerabilities, capacities, and strengths; the immediate focal concerns of intervention; and the ways in which the individual makes use of different approaches over the course of treatment. Following the pragmatic orientation of pluralist perspectives, the clinician judges the validity of concepts and methods on the basis of their *effectiveness* in the context of the individual case (for an expanded account of pluralist perspectives, see Borden, in press).

Relational Theory and Integrative Perspectives in Clinical Practice 167

In following pluralist lines of understanding, we realize that we cannot reduce the complexity of the clinical situation to any single rendering of human difficulty or particular form of therapeutic practice. We realize that no theory mirrors reality and that no single perspective, however encompassing, can possibly meet all our needs over the course of intervention. Different perspectives allow practitioners to approach problems from a range of positions and to shift points of entry in light of particular vulnerabilities, tasks, and circumstances.

The critical root of theory, *theoria*, means “to behold from changing points of view.” At its best, theory enlarges the field of observation, offering ways of seeing and understanding, and helping us expand the range of options and consider courses of action that carry the potential to help. As James would remind us, we cannot make the big claim from a fixed point of view. In his pragmatic stance, the question is not “Is it true?” but rather “How would our work be better if we were to believe it?” What is the use of a truth?

Concluding Comments

We have explored conceptions of self, relational life, growth, and therapeutic action across the range of theoretical perspectives in contemporary psychoanalytic thought. Pluralism has been a defining feature of the broader psychodynamic tradition from the very beginning, as we have seen, and psychoanalysis remains an evolving field of understanding and experience, engaging work in a wide range of disciplines. Psychodynamic perspectives continue to shape conceptions of self, relationship, and social life, enlarging notions of health, well-being, and the common good, and they provide orienting perspectives in divergent modes of psychosocial intervention.

In the course of our clinical training and practice, as I observed in the opening chapter, we must come to terms with fundamental tensions between purer conceptions of the therapeutic endeavor and more pragmatic versions of what we do as we carry out our work. From the pluralist perspective I have described, we master multiple theoretical models, therapeutic languages, and methods of intervention, sorting out the strengths and limits of various perspectives. In doing so, we locate ourselves in the broader therapeutic landscape and establish a clinical sensibility and therapeutic style that is distinctly our own.