INSIDE the SESSION

What Really Happens in Psychotherapy

Paul L. Wachtel

1

PSYCHOTHERAPY AT GROUND LEVEL

It is easier—and safer for the therapist's reputation—to write *about* psychotherapy than to depict it directly. From 30,000 feet, the landscape looks orderly and the contours easy to grasp. But on the ground, things became much more uncertain. The experience of doing psychotherapy is, for almost all therapists, an experience that presents many moments (and often more than moments) of uncomfortable and unsettling ambiguity. The neat theories that can feel reassuringly definitive when encountered in classes or textbooks give way to a messy human reality that is much more enigmatic. Any therapist who claims that he or she confidently knows what to do most of the time probably isn't paying close enough attention to what is actually transpiring in the room.

The aim of this book is to present a *ground-level* view of the therapeutic process, complete with the confusion and unpredictability that are an inevitable part of that process. I aim to present in these pages the full transcripts of several sessions, along with a very detailed account of what I was thinking and feeling in the course of the sessions, what my intent was when I said (or did not say) certain things, and what my reflections were afterward regarding what I might have missed and how I might have responded

differently. My aim is to present my work "warts and all" and to reflect on it in a way that I hope will be useful not only to students and beginning therapists but to clinicians with many years of experience as well. We have many presentations of therapy as it "should" be but fewer of how it is as it unfolds in real time, where foresight and hindsight may be widely divergent.

Although my writing on psychotherapy has often included numerous clinical examples, this is the first time that I have organized an entire book around the presentation of complete sessions. This means not just the "interesting" parts; not just the parts that "illustrate" something (one can only illustrate when one has some idea *what is being* illustrated); but the whole mess (or, from a more positive perspective, the whole arc)—the moments of feeling unclear, frustrated, even incompetent, and the moments when the skies clear and the direction in which to move becomes apparent. In combining this ground-level view with a presentation of my theoretical understanding of the process and of the patient, I hope to provide the reader with an educational experience of a sort that is not generally available.

One further feature of this book that may enhance its value for the psychotherapist is that a video of one of the sessions discussed here is available as a DVD (American Psychological Association, 2007) and provides an additional perspective on what is presented here. Psychotherapists who purchase and view the video can compare what is conveyed by the written transcript to what is evident when *watching* and *listening to* the session unfold. There are inevitably affective nuances and nonverbal dimensions of the transaction that are not captured by a transcript. Conversely, there are perspectives to be gained by the greater ease a printed transcript allows in going over the material repeatedly as well as by the examination offered here of the theoretical and clinical considerations that led to my interventions in the session. The two modes of presenting and addressing the session are complementary. Each makes its own unique contribution.

Regardless of whether the reader chooses to complement her experience by a viewing of the video as well, she will have the opportunity, in the pages that follow, to examine where I am the same throughout these three sessions and where I am different. It will be obvious that in certain respects my personal style and particular way of viewing things shapes what transpires in all three sessions, and at the same time, that I am in each instance responding to the unique features of the intersubjective field created by the two quite different individuals who share the room with me. Similarly, it will be evident that *within* each session, and thus even with *the same* patient, my responses and my experience vary considerably from moment to moment depending on the affective climate between us.

AN INTEGRATIVE RELATIONAL POINT OF VIEW

The theoretical perspective that guides the work presented in this book is rooted in more than 30 years of practicing from a point of view that brings together elements of psychoanalytic, cognitive–behavioral, systemic, and experiential approaches. It is rooted as well in my immersion in the significant evolution of psychoanalytic thought in recent years that has culminated in what is now known as the *relational* point of view in psychoanalysis (P. L. Wachtel, 2008). This newer version of psychoanalytic thought and practice is likely to be relatively unfamiliar to those readers who have primarily been trained in the other three orientations that contribute to the synthesis to which I just referred. The teaching of psychodynamic thinking in many training programs is frequently not only cursory, dismissive, and caricatured but often several decades out of date as well (Bornstein, 1988; Hansell, 2004; Redmond & Schulman, 2008; Westen, 1998).

It should be noted that the sessions presented here have enough elements that resemble features of cognitive–behavioral, systemic, and experiential approaches that they may feel more familiar to readers from those traditions than they might have anticipated; but it is my hope that these readers will be open to considering how the sessions also illustrate how new developments in the psychodynamic tradition can seamlessly complement their present approach and enable their work to achieve greater depth and clinical efficacy. To get the most out of this book, the nonpsychoanalytic reader needs to be alert both to the ways that the psychoanalytic aspects of the work are compatible with her own evolving clinical framework and sensibility and to the ways that the psychodynamic component adds something new to the mix, illuminating features of the clinical picture that the reader might otherwise have missed and introducing modes of intervention that valuably complement those already in her repertoire.

This does not mean that I am asking the reader to check her skepticism at the door. The psychoanalytic features of the work, and the theoretical assumptions on which they rest, must be subjected to the same rigorous evaluation as any of the other ideas and methods that constitute the contemporary therapeutic landscape. It is unfortunately true that for many years a large segment of the psychoanalytic community was disturbingly cavalier about the empirical foundations of psychoanalytic ideas (and indeed, there remains a subset of psychoanalytic thinkers with such attitudes today). But it is also true that psychoanalytic ideas and practices have been subjected to rigorous empirical examination to a considerably greater degree than is commonly appreciated and that their empirical foundation is in many respects quite as solid as that of the other theoretical traditions in our field (see, e.g., Blatt, 2008; Leichsenring &

Rabung, 2008; Levy & Ablon, 2009; Mayes, Fonagy, & Target, 2007; Shedler, 2010; Westen, 1998; Westen, Novotny, & Thompson-Brenner, 2004).

Needless to say, my arguments about the value of openness to unfamiliar ideas applies equally to the psychoanalytic portion of the book's readership. The same caricaturing of other theoretical orientations and modes of practice, the same tendentious "otherization," certainly occurs with as much regularity in psychoanalytically oriented training programs as in those of the other orientations. I thus offer this chapter's brief summary of my integrative perspective both to readers from my original home perspective of psychoanalysis, to enable them to see bridges to the vital contributions of innovative therapists of other orientations, and to therapists in the worlds of cognitive–behavioral, systemic, and experiential thinking to enable them to benefit from and to integrate a vital body of ideas and practices that they may have largely ignored up till now. Whatever the reader's home orientation, I hope that you will find both important ways in which what I am describing fits comfortably within your familiar frame of reference and ways in which it *stretches* your thinking. I hope as well that the session transcripts will illustrate how methods from "outside" of the orientation in which you were originally trained can be assimilated coherently into an evolving, increasingly comprehensive frame of reference.

THE CENTRAL ROLE OF ANXIETY

One way in which the version of psychoanalytic thought that guides the approach described here may feel surprisingly familiar and comfortable to cognitive–behavioral therapists is that it places a strong emphasis on the central role of anxiety in the difficulties that bring people to therapy and explicitly incorporates the concept of *exposure* in understanding how that anxiety is overcome (for more detail, see P. L. Wachtel, 1997, 2008). This emphasis on anxiety is consistent with a key reformulation in Freud's own thinking (Freud, 1926), a reformulation whose profound implications for the therapeutic process have generally not been well appreciated or understood in the psychoanalytic community (P. L. Wachtel, 2008). Whereas previously Freud had conceptualized anxiety as a product of repression, which he viewed as the more fundamental phenomenon, in 1926 he stated explicitly that he had been in error and that it was anxiety that underlay repression rather than vice versa. Since he had several times before this (e.g., Freud, 1914/1959) stated that the concept of repression was the "cornerstone" of psychoanalysis, he had, in effect, shifted the very cornerstone of his theory. If, as Freud later put it, "anxiety makes repression and not, as we used to think, the other way round," (Freud, 1933, p. 89) then it is anxiety that lies at the foundation of the entire edifice of psychoanalytic thought and is properly thought of as its cornerstone. This suggests that over-

coming anxiety, even more than undoing repression, is the cornerstone of therapeutic change.

The reader should be aware, however, that although the clinical approach I am presenting in this book is centrally rooted in this reformulation, another implication of the perspective I am introducing is that Freud probably went too far in reversing his previous formulation. From the vantage point of the vicious circle conceptualization I will lay out in what follows (see also E. F. Wachtel & P. L. Wachtel, 1986; P. L. Wachtel, 1987, 1993, 1994, 1997, 1999, 2008), it is more accurate to state that the causal arrows run in *both* directions—anxiety leads to repression, and repression, in turn, leads to a variety of consequences that generate further anxiety.

It must also be noted that for some readers the term *repression* itself, even when removed from its position as cornerstone of the theory, is problematic. The concept of repression is often misunderstood as being primarily, if not exclusively, about experiences that have been "forgotten" but can later be recovered. A range of tendentious studies have "disproved" the concept based on this faulty understanding. A sounder understanding of the concept in the contemporary context would focus on the way the person can misrepresent his own experience. There are *many* possible constructions of what we are feeling or what we are up to (Hoffman, 1998, Neimeyer & Mahoney, 1995), and it is the way those constructions reflect not only what is actually happening but also how we *need* to see ourselves or the events of our lives that is the real focus of the contemporary concept of repression (or—to state the matter in a way more consistent with contemporary terminology—of the broader concept of defense). A more sophisticated understanding of these concepts makes it clear that they in fact converge quite considerably with the findings of research in the areas of social cognition and cognitive neuroscience.

IMPLICATIONS OF THE NEW UNDERSTANDING OF ANXIETY FOR CLINICAL PRACTICE

This fundamental shift in the foundations of the psychoanalytic vision should have resulted in corresponding fundamental shifts in psychoanalytic technique, since the practice of psychoanalysis had long been predicated on the idea that undoing repression was the most central therapeutic aim and the heart of the therapeutic process. But to a very great extent, when it came to therapeutic technique, this momentous shifting of the very cornerstone of the psychoanalytic approach remained an "unnoticed revolution" (P. L. Wachtel, 2008). What should have followed is a focus on how to diminish the *anxiety* that underlay the processes of avoidance and misconstrual that called themselves to the attention of Freud and other early analysts. Patients *did* persistently

avoid noticing or acknowledging certain things about themselves and their relations to others. But that avoidance was not the problem in itself (though, apropos the vicious circle perspective I alluded to above and will elaborate later in this chapter, it further compounded the patient's difficulties in ways that need to be addressed in their own right). Closer to the heart of the problem was the anxiety and other painful affects that *motivated* the avoidance.

It needs to be noted that Freud did in many respects understand this underlying motivational foundation from the very beginning. Central to the idea of what he called "the defense neuropsychoses" (Freud, 1894, 1896) was the assumption that it was to avoid psychic pain that the patient put certain things out of his mind. But Freud's central identity as a *discoverer* of the hidden or not yet understood (see P. L. Wachtel, 2008) led him to emphasize instead the undoing of repression as the heart of the therapeutic process. Thinking of his work as much like that of the archaeologist who digs down beneath the surface to unearth precious clues and nuggets that reveal a hidden world, Freud viewed psychoanalysis most fundamentally as a process of uncovering what had been buried. Freud's central aspiration, as depicted by his biographer Ernest Jones (1961), was not as a therapist or healer but as a discoverer of the lost world of the unconscious mind. But the venue of his research was not the laboratory but the consulting room, and so it was essential to persuade himself that his focus on unearthing the buried contents of the unconscious was also, conveniently, precisely what would be of maximum benefit to his patients.

As I shall elaborate further momentarily, Freud was actually largely correct in assuming that his explorations of the patient's warded-off psychological experiences were curative. But the reason for this therapeutic effect had less to do with the patient attaining insight than with the patient's being *exposed*, in the process of exploring the warded-off thoughts, feelings, and intentions, to stimuli and experiences that had previously been fearfully avoided. Freud's discoveries about the nature of unacknowledged motives and thoughts, his ability to recognize disavowed intentions and the conflicted expression of feelings and attitudes in behavior that at first seemed to be about something quite different, helped to direct generations of therapists toward noticing phenomena and connections that might otherwise have been overlooked. Without his insights into the pervasive avoidance of awareness of certain powerfully important and determinative experiences, our therapeutic efforts would have been limited to surface complaints and to those objects of fear that the patient was already capable of identifying. To my mind, these latter efforts are often too crude to address much of what is presented by the large majority of patients in daily clinical practice—as opposed to patients narrowly culled for controlled trials (see Westen, Novotny, & Thompson-Brenner, 2004)—and it is for this reason that I believe that the methods of cognitive–behavioral therapy, as valuable as they are, need to be complemented by the understanding accrued from psycho-

analytic inquiry. But I also believe that without a clearer understanding of just what *brought about* the improvements that resulted from psychoanalytic confrontations with previously unconscious thoughts or feelings, the therapeutic effort is likely to be inefficient and crude in a *different* way. What needed to be added to the earlier psychoanalytic understanding of the sources of therapeutic change—especially once it was understood that it was anxiety that underlay the patient's difficulties even more fundamentally than repression—was a clearer understanding of how anxiety is overcome. It is to this topic that I turn next.

EXPOSURE AND THE REDUCTION OF ANXIETY: A BROADER VIEW

Taking seriously the revised theory of the relation between anxiety and repression that I have just described implies some important modifications in psychoanalysis as a therapeutic modality, modifications that not only make psychoanalysis more humane and effective but also render it more compatible with developments in other therapeutic orientations. The two most important of these are (a) a confrontation with the question of *what does* lead most effectively to the overcoming of anxiety and (b) a series of shifts in the fundamental attitude of the therapist once her aim is seen to be to help the patient *become less afraid* of his feelings and experiences rather than one of *unmasking* those experiences or bringing to light what the patient has been hiding (from himself as well as from others). As I will elaborate shortly, these modifications in no way entail ignoring that people may misrepresent or hide important aspects of their experience, nor do they imply any less interest in helping people to understand themselves more fully and accurately. They do, however, point to important differences in how that self-understanding is to be pursued and what *other* therapeutic processes need to be linked to and combined with that increased self-understanding in order to be maximally helpful to the patient.

Turning first to the question of what enables people most effectively to overcome anxiety, there is by now a vast body of research suggesting that the most important factor is *exposure* to the experience that has been feared and avoided without the anticipated traumatic consequence. (see, e.g., Craske & Mystkowski, 2006; Deacon & Abromowitz, 2004; Foa, Huppert, Cahill, & Rothbaum, 2006; Foa & Kozak, 1986; Foa & Meadows, 1997; Keane, 1995, 1998; Zinbarg, Barlow, Brown, & Hertz, 1992). This conclusion has been drawn from hundreds, if not thousands of studies, ranging from laboratory investigations using nonclinical populations to controlled clinical trials. Up till now, the emphasis on exposure as a therapeutic process or modality has primarily been evident in the practice of cognitive–behavioral therapy,

particularly in the realm of manualized treatments. But there is a far broader clinical potential for harnessing the impact of exposure in overcoming anxiety.

Treatments that are manualized and specifically targeted for specific symptoms or complaints have their place in the overall landscape of therapeutic approaches, but these narrowly targeted treatments also have significant limitations (see, for example, P. L. Wachtel, 2010a; Westen et al., 2004). A large portion of the patients who come to see therapists have difficulties that are not so readily categorized or targeted, and it will be apparent to the reader that they include the two people—Louise and Melissa—whose sessions are the core of this book. But in fact cognitive–behavioral and/or manualized and narrowly targeted treatments do not exhaust the potential applications of the research demonstrating the impact of exposure in overcoming anxiety. Careful attention to what actually transpires in psychodynamic treatments makes it clear that much of what goes on in these treatments entails a similar process of exposure, although both the modality or context of the exposure and the nature of the stimuli or experiences to which the patient is exposed can be quite different than in most cognitive–behavioral treatments (P. L. Wachtel, 1997).[1]

In cognitive–behavioral treatments, the focus has tended to be on exposure to external situations that are the explicitly identified targets of the patient's fears (bridges, dogs, airplanes, etc.), although increasingly there is also an emphasis on the patient's anxiety response to internal or proprioceptive cues that are part of the arousal pattern in which the patient is caught (e.g., Barlow, Allen, & Choate, 2004; Craske & Barlow, 2008). From this latter vantage point, it is not simply the external stimulus prompting the arousal pattern that must be targeted for exposure but the experience of anxiety itself; the patient must learn to gain some comfort with the internal somatic cues associated with anxious arousal rather than panicking and thereby escalating and perpetuating the problem.

These are causal dynamics that psychodynamic therapists need to (and often do) take into account. But dynamic therapists are usually also engaged in promoting the patient's exposure to still another class of stimuli, whether they are explicitly thinking of what they are doing in terms of exposure or not. The exposures that are most at the center of psychodynamic treatments tend to be to the stimuli associated with the patient's own wishes, thoughts, and representations of self and other.

It has, of course, traditionally been the assumption of psychodynamic therapists that it is the patient's lack of access to these thoughts and feelings

[1]Because most dynamic therapists do not think of what they are doing in terms of exposure, it is probably often the case that the exposure is less efficient than it might be if consideration were given specifically to the dimension of exposure—that is, how most effectively to bring about exposure to the thoughts and feelings the patient has been fearfully avoiding.

that is at the heart of his difficulties, and the therapy is very largely designed to bring them back into focus. The usual way of understanding this process, however, has been centered on ideas like interpretation and the promotion of insight; the patient needs to come to *know* and *understand* these aspects of himself in order to get better. This knowledge, of course, is not supposed to be a merely intellectual understanding, but self-*knowledge*, nonetheless, has been the key operating metaphor.

Certainly, as I discuss further later in this chapter, the promotion of increased self-knowledge and self-understanding remains of great concern and value (and is in fact pursued by therapists of almost all orientations, whatever terminology they use to depict the process). But something else is happening in successful psychodynamic treatments as well that is usually less well understood, or even noticed. In the process of promoting insight, of interpreting (and hence interrupting) defenses that keep the patient out of touch with his experience,[2] a successful psychodynamic therapy brings the patient *into closer contact with* the experiences that have been warded off. The patient thinks the thoughts and feels the feelings that he has previously avoided—or, put differently, he is *exposed* to them.

Depicting the process as significantly one of exposure provides an alternative perspective on what is happening in psychodynamic therapies, and it happens to be a perspective that highlights the more *experiential* nature of the therapeutic process. It is not a matter of mere words or knowledge, even "emotional" knowledge. Nor is it exclusively or even predominantly a matter of "interpretation." Interpretation and self-knowledge do contribute to the process, but something else that is very important is also involved. The process of change proceeds to a significant degree through *direct experience*. (For an interesting discussion of the experiential—rather than exclusively or primarily interpretive—element in the psychoanalytic process, see D. N. Stern, 2004; D. N. Stern et al., 1998; Lyons-Ruth, 1998, 1999. These authors, rather than thinking in terms of exposure, introduce a different perspective on directly experiential sources of change, rooted in an emphasis on procedural learning and on what they call "implicit relational knowing." Their perspective, however, is thoroughly compatible with that presented here; see P. L. Wachtel, 2008.)

One particularly important implication of the exposure perspective on what happens in psychodynamic therapy is that what we know about exposure as a general process suggests that usually it is necessary for the patient to experience *repeated* exposure for the anxiety to begin to significantly diminish. This

[2]Cognitive–behavioral therapists think of very closely related processes in terms of response–prevention, or what Barlow and his colleagues (e.g., Ehrenreich, Buzzella, & Barlow, 2007) referred to as disruption or prevention of *emotionally driven behaviors*.

is something that is implicitly understood by dynamic therapists as well and is embodied in the concept of working through, which similarly emphasizes the limits of a single encounter with what has previously been fearfully avoided (i.e., the limits of a single acknowledgment or experience of the previously repressed or warded-off thought or feeling). But because the concept of working through evolved out of a therapeutic conception that was so strongly rooted in the ideas of insight, interpretation, and *knowing about* what one has hidden from oneself, it is not as clearly and experientially spelled out, either conceptually or procedurally, as it might be if the element of exposure were more clearly and explicitly understood and appreciated. A variety of somewhat modified procedural guidelines follow from an understanding of the process of working through as largely one of repeated exposure (see P. L. Wachtel, 1997).

In the sessions that are presented later in this book, the reader will see examples of how this intersection of psychodynamic and cognitive–behavioral perspectives is played out in the therapeutic interaction (as she will see ways in which systemic and experiential perspectives figure in how I proceed as well). On the one hand, my understanding of the therapeutic process as very significantly a matter of exposure to what has been fearfully avoided leads me to engage in the process between myself and the patient in a somewhat different way from many other dynamically oriented therapists. In this sense, what is evident is a psychoanalytically guided process that is modified by an immersion in the alternative universe of cognitive–behavioral therapy. But from a reverse lens, what is at least as important is that I am largely applying the cognitive–behavioral conception of exposure to a set of experiences that are usually only incidentally or glancingly focused on by cognitive–behavioral therapists. My central concern in the work depicted in these transcripts—achieved to varying degrees in the different sessions, or even from moment to moment within each—is to enable the patient to *reappropriate* the thoughts, feelings, and perceptions that have come to feel forbidden in the course of growing up and of living one's life.

Although I share with behavior therapists and social learning theorists a concern with understanding people in relation to the actual events they encounter (i.e., in relation to what is often called the *stimulus* or *situation*—see Magnusson & Endler, 1977), I bring to the therapeutic process a particular concern with addressing the complexities of the patient's subjective experience and the aspects of his or her experience that have been warded off, fearfully avoided, truncated, construed in limited (and in certain respects distorting) ways, and in other respects too can be described as having been *defended against*. Put differently, I bring a psychoanalytic or psychodynamic sensibility that highlights a broader and deeper range of experiences than is typical in nonpsychodynamic therapies, but I elaborate that sensibility theoretically in a way that enables it to interface with important features of the cognitive–behavioral tradition and

is compatible with many of the key observations and methods that derive from that tradition.

FROM SELF-UNDERSTANDING TO SELF-ACCEPTANCE

In addition to highlighting the therapeutic value of thinking explicitly in terms of exposure, a second important consequence for therapeutic technique follows as well from a clearer understanding of the central role of anxiety (along with guilt and shame) in the dynamics that bring people to therapy. As I shall now elaborate, it can point us toward an approach to the work that is less adversarial and more affirmative and supportive of the patient's self-esteem without compromising the commitment to understanding the patient (and helping him to understand himself) in depth. In older psychodynamic models, in which the primary focus was on "uncovering" and "interpreting," there was often an unwittingly adversarial and accusatory tone to the therapeutic dialogue. Much of my book on therapeutic communication (P. L. Wachtel, 1993, in press) was devoted to explicating this adversarial and accusatory dimension (which can be quite subtle, if nonetheless potent) and to spelling out alternative ways of approaching the work (see also Havens, 1986; Renik, 1993; Shawver, 1983; P. L. Wachtel, 2008; Weiss & Sampson, 1986; Wile, 1984). The discussion in this book of my sessions with Louise and Melissa aims to further this exploration of pitfalls and alternatives.

Leston Havens (1986) has put the matter especially pithily: "In the current interpretive climate of much psychotherapeutic work, patients sit waiting for the next insight with their fists clenched. Small wonder, for it is rarely good news." (p. 78) Where does this unfortunate state of affairs come from? It derives in good part, I suggest, from a failure of many psychodynamic therapists to sufficiently appreciate the implications of the revised theory of anxiety discussed above. Prior to the introduction of this revised understanding—and, for much of mainstream psychoanalytic practice, even many years after its introduction—the main issue that was seen as essential to address was that the patient was *hiding* something, denying something, evading reality. The therapist's job was to challenge and confront this deceit, in essence to force the truth on an unwilling opponent of it. Hence such concepts as resistance. The patient inevitably resisted the analyst's efforts to get at the truth, and much work needed to be done to overcome this resistance.

Of course, this was not necessarily done inhumanely or without appreciation that the patient was avoiding out of terror, that what was being hidden felt to the patient dangerous and unacceptable. In some sense the understanding that behind repression was anxiety, articulated explicitly by Freud in 1926 as a revision of his prior views, was always there in psychoanalytic thought in

some form. At the very dawn of psychoanalysis, it was at the heart of Freud's differences with Breuer and with Janet—Freud saw defenses as *motivated* whereas they saw the inaccessibility of certain experiences as largely the consequence of an altered state of consciousness. Part of why we chuckle at Havens's characterization is that it (knowingly) highlights only a part of the therapeutic process. The patient is not just the target of an aggressive attacker; the history of psychoanalysis is replete with comments about the importance of kindness, caring, and the offering of the analyst's more benign vision of what is possible for the patient as a substitute for the patient's harsh superego (e.g., Ferenczi, 1926; Loewald, 1960; McWilliams, 2004; Schafer, 1983; Stone, 1961, Strachey, 1934).

But also part of what makes Havens's comment funny is that he does capture what is often a significant part of the psychoanalytic relationship, a part that has not been acknowledged in most discourse on psychoanalytic practice but that is so embarrassingly obvious nonetheless that Havens's pointing to it resonates easily with any open-minded practitioner (or patient) who reads it. In an authoritative philosophical inquiry into psychoanalysis, Ricoeur (1970) has described psychoanalysis as part of a larger "school of suspicion" in which the individual's "false consciousness" is stripped away to reveal the hidden truth behind the mask. Other later authors have similarly depicted "suspicion" of the patient's account of his life and his motives as a central feature of the psychoanalytic approach (e.g., Messer, 2000; Schafer, 1997; Wolff, 2001)

To be sure, none of these authors intended the word *suspicion* to imply anything malign about the analyst's intent; they were all *advocates* of psychoanalysis, describing what they viewed as an essential feature of any therapy that was to achieve real depth. As I elaborated on the topic elsewhere (P. L. Wachtel, 2008), attempting to capture both the positive intent and the potential problems that are unwittingly revealed in this terminology,

> the "suspicion" which the psychoanalytic way of looking or listening implies could be seen as simply another way of referring to the unconscious, to the idea that what we *say* we are feeling or *think* we are doing is far from the whole story and must be carefully probed if both patient and therapist are not to collude in an illusion that is ultimately the source of the patient's suffering. The problem arises in the implicitly adversarial cast that this "suspicion" may give to the therapeutic work, in the potential for invalidating of the patient's conscious experience as a "false" or "distorted" consciousness, in the readiness to see "resistance" when the patient views things differently from the therapist, and in the temptation to view the patient as benighted and needing the therapist to disabuse him of the distortions that constitute his conscious experience. (p. 178)

With full consideration of the implications of the "shifting of the cornerstone" of psychoanalysis, in contrast, one may approach the patient in a way

that aims to go just as "deep" but that does so in a way that is more fully on the patient's side and less hampered by an unwittingly adversarial attitude. The patient, from this vantage point, is not "resisting," he is not holding out on the therapist in order to secretly gain infantile gratifications; he is *terrified*. He has learned in the course of his development that some of his deepest and most fundamental needs are unacceptable, that they threaten his attachment figures to the degree that his attachment to them and his very survival feel threatened (Wallin, 2007). And hence he has rejected vital and important parts of himself in the service of safety. The aim of the therapy, from this vantage point, is not to confront the patient with his deceptions but to create a sense of safety sufficient to enable him once again to reappropriate the parts of his own experience that have, out of terror, been cast out of his awareness and his sense of self. The differences between the therapeutic interventions that derive from these two contrasting visions of the therapeutic enterprise were a central focus of my book on therapeutic communication (P. L. Wachtel, 1993, in press). In discussing the sessions that are the focus of the present book, I will have further occasion to elaborate on these differences.

SELF-UNDERSTANDING: RATIONALIST AND CONSTRUCTIVIST APPROACHES

The shift in emphasis from undoing repression to diminishing anxiety, guilt, and shame does not mean that attaining greater self-understanding is no longer relevant or important. The goal of greater self-understanding is valued across virtually the entire spectrum of therapeutic approaches, if in different ways in different orientations. Cognitive therapists, for example, focus primarily on the assumptions that lead the patient to draw conclusions that generate problematic feelings and experiences of the self. Those assumptions are generally not in the patient's awareness in any focal way at the beginning of the therapy, and much of the process of cognitive therapy entails enabling the patient to become clearer about what they are.

It is important to note, however, that cognitive therapists differ substantially among themselves in how they address these premises once brought to light, and in certain respects those differences parallel the differences between psychoanalytic work undertaken from the vantage point of the school of suspicion and the less critical version of psychoanalytic work with which I have contrasted it. In particular, those cognitive and cognitive–behavioral therapists who emphasize disputation of the patient's premises and demonstration of their "irrationality" (generally followers of the ideas of Aaron Beck and Albert Ellis) differ quite significantly in their clinical approach from more *constructivist* cognitive therapists (e.g., Mahoney, 1995, 2003; Neimeyer & Mahoney, 1995).

In contrast to rationalist cognitive therapists, constructivist advocates of the cognitive paradigm attempt to articulate the patient's assumptions in a fashion that, to a surprising degree, resembles the work of relational psychoanalysts, who also operate from a constructivist framework (e.g., Aron, 1996; Hoffman, 1998; D. B. Stern, 1997; P. L. Wachtel, 2008). Both, moreover, resemble Rogerian and other humanistic therapists in their emphasis not on *critiquing* the patient's assumptions or pointing out their "erroneous" or "irrational" nature but simply on articulating them, bringing them closer to the forefront of the patient's awareness so that the patient himself can examine them and draw his own conclusions. In contrast, the *rationalist* cognitive therapy approach, with its emphasis on demonstrating the *faulty* or *unrealistic* nature of the patient's core assumptions about life and the world, actually bears considerable resemblance to the problematic emphasis in some psychoanalytic work on finding the "primitive," "archaic," or "infantile" foundations of the patient's psychological organization. (For an interesting critical examination of the latter and its implications, see Aron, 1991.)

Needless to say, despite this important and insufficiently appreciated convergence between the rationalist cognitive approach and the traditional psychoanalytic approach, there are also many significant differences between the two, both in theory and in specific procedural features. Clearly, both Beck and Ellis introduced their approaches as *alternatives* to the psychoanalytic approaches of the time, in which both men were originally trained. But a consequential similarity between rationalist cognitive therapy and classical Freudian therapy in *critiquing* or *unmasking* the way the patient sees the world has been insufficiently appreciated by therapists of both orientations. Similarly unappreciated on both sides of the divide are the parallels in the development of an alternative to this pathologizing vision in both the cognitive–behavioral and the psychoanalytic traditions. Here again, there are clearly important differences in the ways that cognitive–behavioral and psychoanalytic thinkers have developed their constructivist, nonpathologizing visions, but there exists as well a good deal of overlap. Both aim to *enter into* the patient's experience rather than critiquing it, and both root the therapeutic effort in the dialectic between *accepting* the patient's experience of the world and helping him to *change* those features of his assumptive world that are contributing to his pain (e.g., Bromberg, 1998b; Hayes, Follette, & Linehan, 2004; Hayes, Strosahl, & Wilson, 1999; Hoffman, 1998; Linehan, 1993; Linehan & Dexter-Mazza, 2008; P. L. Wachtel, 1993, 2008).

EMBRACING AFFECT

Further understanding of the "cross-orientation" convergence I am highlighting here leads us to consideration of the role of *affect*. In the ratio-

nalist version of cognitive and cognitive–behavioral therapy, the patient's affective experience is largely treated as both an epiphenomenon (you are only feeling the way you do because you are thinking the way you do) and as something that should be gotten rid of (if you only can learn to think rationally, there will be no need to feel angry, or hurt, or depressed).

When I first began my efforts to integrate psychodynamic and behavioral therapeutic approaches (P. L. Wachtel, 1977b) I had already completed my psychoanalytic training but needed to complement that with an immersion in the practice of behavior therapy. I found some formal training opportunities, but I also benefitted from the enormous generosity of some of the leading figures in behavior therapy at the time, who granted me first-hand access to their work in a variety of ways. I was struck by the clinical adeptness of these behavior therapists, who provided me with just what I was looking for—a set of skills and perspectives that both complemented what I already knew and *added to* my clinical repertoire in important ways. Their clinical sensitivity and humane attentiveness to the patient was a far cry from the caricatured vision of behavior therapists I had picked up by being immersed in a psychoanalytic community.[3]

Troublingly, a number of years later, as the *cognitive* influence in behavior therapy began to increase, and most behavior therapists began to think of themselves as cognitive–behavioral therapists, the clinical sensitivity and nuance I had been struck by a few years before appeared to be far less evident. Influenced by the rationalistic trend that was dominant in the early years of cognitive–behavioral therapy, some of these same therapists I had once admired began to resort to the unfortunate trend I alluded to at the beginning of this section—attempting to talk the patient out of his feelings, to "demonstrate" to him why it was "irrational" for him to feel angry or sad or disappointed. I could see these changes in their clinical practice both in observations through one-way mirrors and through watching tapes of their work. These retreats from affect and turns toward critique rather than exploration of experience seemed to me a great loss (both for patients and for the field). I was therefore heartened, after a time, to see emerging a newer thrust in cognitive and cognitive–behavioral therapy, the constructivist, dialectical, and acceptance-oriented approaches I mentioned earlier.

This alternative cognitive and cognitive–behavioral paradigm exhibits much the same attitude toward the patient's affect that is evident among many contemporary psychoanalytic thinkers. It is an attitude of acceptance of the patient's experience, including even his "irrational" affective experiences. The

[3]I hope it is not necessary to point out here that the caricaturing went in both directions. Behavior therapists' vision of psychoanalytic thought and practice was often equally biased and inaccurate.

aim is not to "talk the patient out of" his anger or hurt or sadness. Rather, it is to *understand* it, to accept it, and—through that very process of acceptance—to enable the patient to go *through* it and come out the other end with, potentially, a different experience of where he is in his life and what his options are. This new trend in the cognitive and cognitive–behavioral tradition, which encompasses the range of constructivist cognitive therapies (e.g., Neimeyer, 2009; Neimeyer & Mahoney, 1995), the dialectical behavior therapy originated by Linehan (e.g., Linehan, 1993; Linehan & Dexter-Mazza, 2008; Swales & Heard, 2009), and the "acceptance and commitment" therapy of Hayes and his colleagues (e.g., Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes, Strosahl, & Wilson, 1999), has been called a "third wave" in the cognitive–behavioral therapies, following the first wave of stimulus–response behavior therapy and the second of rationalist cognitive therapy.[4]

This new wave in the cognitive–behavioral realm converges in important ways with a related new wave in psychoanalytic thought that similarly bears labels such as *constructivist* and *dialectical* (e.g., Hoffman, 1998) but is most often referred to as *relational* or *intersubjective*. It is this version of psychoanalytic thought that is at the core of my own clinical work, interacting synergistically with related evolving ideas from the cognitive–behavioral, family systems, and experiential traditions. The reader will be able to see this approach to the patient's affective life in the sessions with Louise and Melissa that are presented in their entirety in Part II of this book. There are many things that I am trying to help Louise and Melissa to change, but my approach is not to try to persuade them that they are being irrational or that their behavior or experience is the thinly disguised product of infantile roots or of primitive and archaic mental representations.

My aim, rather, is to *enter into* their experience with them, to join them, validate them, help them to understand *what makes sense* in their experience, what it is in response to. I do hope that in helping them to see more clearly what they are feeling, in making room for feelings that they themselves may have attempted to short-circuit or run from, a process of "feeling through" the feeling and reaching a different point can be achieved. This is the paradoxical or dialectical element that is shared by a range of cognitive–behavioral (e.g., Linehan, 1993, Swales & Heard, 2009) and psychoanalytic (e.g., Hoffman, 1998) thinkers. In good part, change is reached by *not trying* to change the patient, or, more accurately I think, by *both* trying *and* not trying at the same

[4]In addition to this "third wave" approach, some "mainstream" cognitive–behavioral approaches similarly point to the limitations in what can be accomplished when strong affect is avoided rather than addressed (e.g., Allen, McHugh, & Barlow, 2008; Barlow, 2002; Ehrenreich, Buzzella, & Barlow, 2007; Moses & Barlow, 2006).

time (cf. Bromberg, 1998b; P. L. Wachtel, 2008). It is when the patient feels understood and accompanied in the difficult feeling (cf. Stolorow, Brandschaft, & Atwood, 2000) that he begins to be more able to reexamine and reexperience the feeling and to come out the other end feeling and seeing things differently.

A SUPPORTIVE EXPLORATORY THERAPY

To offer a different, but closely related, perspective on what I have been discussing up till now, the emphasis on the centrality of anxiety in the casual nexus at the heart of the patient's difficulties and the emphasis on constructivism and on acceptance of the very experiences that the therapy is also aiming to change converge in creating a therapeutic approach that is less critical and more supportive. The central focus is not on the patient's distortions, irrationalities, or self-deceptions—though they are attended to, and the clarification is helpful and usually needed—but on the anxiety, guilt, and shame that keep the patient from experiencing it as safe to feel what he is feeling. The aim certainly includes promoting greater *understanding* of the aspects of the patient's experience and underlying psychological structure that have been hidden from view; but it is even more to create the circumstances whereby he can *feel* the forbidden feeling without the anticipated catastrophic consequences.

For many years, the central tenet of psychotherapy that aimed at deep and comprehensive personal change was, as Wallerstein (1989) put it, "Be as expressive as you can be and as supportive as you *have to* [italics added] be." This way of thinking was closely associated with an emphasis on such ideas as anonymity, neutrality, avoidance of "gratifying" the patient's wishes, and avoidance of self-disclosure on the therapist's part whenever possible. In contrast, the approach that is illustrated in this book views these attitudes as anachronistic and therapeutically limiting. I titled one chapter of an earlier book (P. L. Wachtel, 1987), for example, "You Can't Go Far in Neutral," and have written pointed critiques of the traditional psychoanalytic attitudes toward self-disclosure and support (P. L. Wachtel, 1993, 2008). In contrast to the rubric described by Wallerstein, I have suggested that a more useful principle to ground the therapeutic work might be, "Be as *supportive* as you can be, *so that you can be* as expressive or as exploratory as you will need to be" (P. L. Wachtel, 1993, p. 155). The assumption in my work, in other words, is that not only are support and deep exploration not as antithetical as has often been assumed but indeed, a warmly supportive stance toward the patient is the best facilitator of his capacity to explore previously warded-off thoughts, feelings, and wishes.

ATTENTION TO THE PATIENT'S ACTUAL BEHAVIOR AND THE GENERATION OF VICIOUS CIRCLES

Another central characteristic of the integrative approach that guides the work presented in this book is its strong focus on the patient's actual behavior in his daily life and on the ways that behavior tends to become organized into feedback loops that perpetuate both the behavior pattern itself and the intrapsychic and relational configurations that are at once a cause of the behavior pattern and its consequence. It is this repetitive playing out of vicious circles, virtuous circles, and self-fulfilling prophecies that is at the heart of the theoretical perspective I call "cyclical psychodynamics" (e.g., P. L. Wachtel, 1987, 1993, 1997, 2008), a point of view in which neither "internal" nor "external" influences are primary but rather their repetitive recreation of each other.

For many years, psychoanalytic thinkers regarded overt behavior as but a surface expression of deeper currents that were the true source of the patient's difficulties and the necessary target of therapeutic focus and therapeutic work. Daily interactions were certainly not ignored by analysts (and, even in that earlier era, *good* analysts, one suspects, spent a good deal more time immersing themselves in the details of the patient's daily life than their writings might suggest). But there was (and often continues to be) a theoretical bias that gave relatively short shrift to these "surface" details. As a consequence, the degree of attention I give in my work to the patient's actual behavior and its consequences is rather atypical of psychodynamic approaches. (In contrast, it scarcely needs to be said, behavior therapists have always been interested in the patient's behavior—although their interest was most often on the particular individual behaviors that were direct targets for change, not on how complex *patterns* of behavior and the feedback they generate contribute to cyclical processes in which intrapsychic and behavioral–interactive elements perpetuate and reproduce each other.)

In my own efforts to draw on the strengths of both the psychoanalytic *and* the behavioral traditions,[5] a key element in reconciling the two paradigms was attention to the vicious circles that provide the link between manifest behavior and more "internal" psychological phenomena such as thoughts, feelings, and motives. These feedback loops characterize both the basic structure of personality (P. L. Wachtel, 1977a, 1994) and the processes at the heart of the difficulties that bring the patient to therapy (P. L. Wachtel, 1987, 1993, 1997, 2008). If one observes closely and pays attention to a broad sample of the

[5]As will be apparent shortly, as my work evolved I aimed to include as well methods and perspectives from family systems and experiential therapies. This broader emphasis will be apparent in the sessions presented later in this book.

patient's behavior and experience, with remarkable frequency one comes upon a tendency for internal and external processes to reproduce each other in recursive fashion. The characteristics of each person's inner state and psychological organization lead her to behave in the world in ways that evoke a particular subset of responses from others, and those responses in turn feed back to affect the first individual, more often than not recreating the same or a very similar mental state or organization. As a result, the conditions are in place for the same sequence to be repeated yet again. The process—on the part of all who interact to create the repetitive pattern—includes not just the "behavior" per se but the affective tone, which is often the crucial element in keeping the pattern going.

Consider, for example, someone who learns early in life that expressions of anger or disagreement are met with a chilling withdrawal or laceratingly demeaning reaction from key attachment figures. As he attempts to gain a measure of safety or security in such circumstances, he is likely to begin to suppress awareness or expression of such feelings, even where appropriate. He may begin to exhibit a notably unassertive way of interacting with other people or to manifest what psychoanalytic writers describe as a reaction-formation against anger or expressions of disappointment in others, creating a gap in his capacity to deal effectively with some of life's common challenges and demands. He may become *excessively* nice, cooperative, helpful to others[6] and as a consequence may give short shrift to his own needs. He may so dedicate himself to avoiding ruffling anyone's feathers that the harmony he achieves is at the expense of being consistently overlooked or given the short end of the stick.

The irony is that living in such a way almost inevitably stirs feelings of envy and resentment, whether consciously acknowledged or not. In turn, the stirring of such feelings once again evokes anxiety, and so once again, even more urgently, the individual entrapped in such a pattern *suppresses* these resentful feelings, acting in such a way as to hide them, both from others and from himself. But the result is that the circumstances are thereby created for still more experiences of being overlooked and short-changed, hence still more evoking of unacceptable resentment, still more automatic exaggerations of more "acceptable" emotions and behavior, and so on and so forth. The pattern may have *started* early in life, as psychoanalysts often highlight, but it continues not just because of its early origins but because *every day* it is being

[6] I emphasize the excess here because obviously being kind or cooperative or helpful to others is not a bad thing in itself, nor is it even a trait that leads the kind or cooperative person to lose out on his fair share. Cooperativeness and consideration for others—when not driven to excess by fear of *ever* expressing disagreement or asking for more—can often result in obtaining the rich share of life's rewards that comes to people who are liked and respected.

refueled anew by the consequences it evokes. The other people in his life, who may not intend to treat him dismissively, are almost inevitably drawn into such behavior by the way the patient's real wishes are disguised, and hence they become "accomplices" (P. L. Wachtel, 1991) in the pattern whether intending to or aware of it or not.

In similar fashion, someone who has learned early in life that expressions of need or dependency are likely to be ignored or treated dismissively may develop a tough skin and a seeming independent streak that leads to asking little of others and, often as a corollary, taking on too burdensome a share of responsibilities on one's own. Living this way often creates a sense of isolation and of deprivation of the support and sympathetic understanding that most people need to sustain a sense of comfort in the world. Consequently, such a life pattern is likely to stir forbidden wishes for the nurturance or reassurance that has not been forthcoming. But given the patient's anxieties and conflicts in this realm, and the need to protect himself against painful and humiliating disappointment, whatever expressions of these wishes the patient allows himself are likely to be so hedged and ambiguous that they are easily ignored or not noticed by the other person. This then "confirms" the feeling that one cannot rely on others or dare not ask others for help because others continue to appear to be unhelpful and unresponsive. As a consequence, the sense of vulnerability associated with the awareness and expression of such feelings is sustained, as is the tendency to submerge them or to express them in the most hedged and indirect way. Thus, here too the pattern is repeated and perpetuated by its own consequences, and others are recruited into the pattern as accomplices, perpetuating the problematic state of affairs as their response to the highly ambivalent and overly subtle signals for help—or to the implicit and anticipatory resentment that comes with expecting not to get that help—ends up confirming the first person's deepest fears.

In thinking about such patterns and their implications for psychotherapy, it is important to understand that one implication of the circularity of the patterns I have been describing is that the starting point for the description is arbitrary. Who is the "first" person and who is the "responder" is a matter of where one begins the narrative, as family therapists have frequently discussed under the rubric of "punctuation" of systemic patterns. Similarly, one could as readily begin the account not with the inner state but with the behavior, or with the situational context. The point is that (especially once the pattern is well established) each element brings forth the next in predictable fashion, thereby creating the circumstances for the other elements in the pattern to call forth the first yet again. Much of the debate between different theoretical models largely comes down to different theories focusing on different parts of the sequence or on different starting points in

describing it (E. F. Wachtel & P. L. Wachtel, 1986; P. L. Wachtel, 1973b, 1977a, 1994).

VARIATIONS IN THE PATTERN AND THEIR THERAPEUTIC IMPLICATIONS

It is also important to be clear that none of these patterns are inexorable. If they were, there would be little point to attempting psychotherapy. To begin with, the patterns are both probabilistic and never exactly the same each time. Heraclitus's point that we never step into the same river twice holds even more fully for the flow of behavior and experience. The interactive sequences I am discussing here are, to use Sullivan's (1953) apt phrase, "envelopes of insignificant differences" (p. 104). That is, there is enough similarity in form and outcome that a meaningful pattern can be discerned by a good observer and that, often without awareness, the perceptual processes that lead each party to react to the other's behavior are likely to register what is happening as "more of the same." But the pattern *is* different each time, and thus there is always a possibility for a slightly different outcome that can become the beginning of a new direction instead of the perpetuation of the old.

Further contributing to the possibility of change in these patterns is that they are contextually responsive and dynamically interactive. The power of the patterns that bring people to therapy lies in the pervasiveness of their perpetuation—that is, in the way that the patient seems to evoke a similar (and problematic) response from *a wide range* of people, leading once again to a similar response on his part that evokes still again a similar response from others, ad infinitum. But even the most general and pervasive patterns in people's lives are rarely if ever manifested with everyone. The same behavior or affective cue may evoke one response from one interactive partner and a different response from another. (For example, a style of interaction that many people find hostile and difficult may feel like amusing and enlivening banter to at least a few.) The range of people, roles, and relationships that we encounter in the course of a day or week or month is such that, almost inevitably, some people will respond quite differently to the very behavior that has evoked pattern-confirming responses from most people.

When such atypical responses occur—as they almost always do at least occasionally—several things can happen. Perhaps the most common is that the pattern becomes more differentiated. It is manifested in certain contexts and not others. One implication of this, often given minimal attention in discussions of psychopathology, is that even the "sickest" patient is likely to look "normal" or "healthy" some of the time. Few, if any, people are miserable (or angry,

or demoralized, or deluded) *all* of the time.[7] People come to us, rather, because they feel bad more than most people, or more than they wish they did, not because they feel bad *all* the time (and this is so even if the patient himself does not frame it this way). Moreover, it is important to be clear that the times and circumstances in which the patient feels better are not theoretical chaff or error variance. Rather, they are a crucial part of the overall clinical picture that provides an essential foundation for therapeutic change. Without these alternative kernels of healthier or more adaptive behavior, successful psychotherapy is extremely difficult (see P. L. Wachtel, 1993, especially Chapter 7).

A second important implication of the variability in the way that different people respond to the same behavior by the patient is that when the anticipated response does not occur, it can, over time, contribute to weakening the pattern as a whole. This is the logic behind such therapeutic concepts and strategies as the corrective emotional experience (Alexander & French, 1946), new relational experience (Frank, 1999), new object experience (Loewald, 1960), moments of meeting, (D. N. Stern et al., 1998), passing the patient's tests (Weiss & Sampson, 1986), repairing ruptures in the therapeutic relationship (Safran & Muran, 2000), and "an actual relationship with a reliable and beneficent parental figure" (Fairbairn, 1958, p. 377). When the patient has repeated experiences with the therapist that disconfirm his problematic beliefs or expectations, the strength of those expectations and the likelihood of the behaviors and affective experiences associated with them gradually diminish.

These considerations do not, of course, imply that all of the variance lies in how other people respond to us. To be sure, I have been highlighting here the responsiveness of our behavior and experience to the actual occurrences in our lives. But it is important to be clear that I have done so in the context of a theoretical outlook in which the traditional concerns of dynamic therapists regarding the patient's subjective experience and psychological organization also have a central role. The point has been that "internal dynamics" and "external events" are not really separate domains but aspects of a larger recursive pattern in which each facet is both crucial and dependent on the other. In attending to and attempting to intervene in that pattern, it is essential not to give short shrift to the dynamic organizing processes that *give meaning* to the events encountered (P. L. Wachtel, 1980, 2008). We do not respond to events in some "objective" fashion that is unmediated by our proclivities, anticipations, perceptual biases, and so on. Much of the process of psychotherapy, after all, entails enabling the patient to see alternative ways of understanding, experiencing, and responding to what goes on in his life.

[7]When this variability is not evident, or is evident only very minimally, it is likely that we are dealing with a disorder that has a strong biological component, and the use of adjunctive medication is something that the therapist should be especially open to considering.

THE IMPORTANCE OF THE PATIENT'S LIFE OUTSIDE THE CONSULTING ROOM

From a different vantage point, it is also essential to be clear that new experiences with the therapist are likely to have limited impact if not accompanied by efforts to address the patient's experience with people *outside* the consulting room (see P. L. Wachtel, 2008, especially Chapters 4 and 12). As I noted above, the patterns in the patient's life, rather than being completely general and pervasive, are likely to become differentiated, evident in certain contexts and relationships and not in others or manifested to different degrees in different contexts. Therapists who pay too much attention to the therapeutic relationship, apart from its relation to the *other* important relationships and experiences in the patient's life, may be misled into thinking the patient is getting better because his relationship with *them* is getting better. But the patient may, in essence, learn that *in this room* it is safe to express his true self and true feelings but may still find that difficult in the rest of his life (perhaps even without noticing that this differentiation is taking place).

It is not that the therapist is necessarily a more empathic person per se; in their own personal lives, therapists probably vary in this quality as much as the general population does. But the therapist does have two important qualities that enable her to respond to the patient differently in certain ways from most other people in his life. First, she has a set of skills that derive from her training—skills both in observation and in knowing how to respond facilitatively to the patient's struggles. Second, she has the luxury of being both in *and* not in the patient's life; that is, we care about the patient and have an emotional stake in his welfare, but we do not expect the same reciprocal gratifying of other needs that we do in the rest of our lives or that others in the patient's life reasonably expect.

We do, of course, get caught at times in what has come to be called *enactments*, and, indeed, the working through of those mutual enactments is a central feature of the therapeutic process (see, e.g., Bass, 2003; Frank, 2002; Safran & Muran, 2000; D. B. Stern, 2003; P. L. Wachtel, 2008). But the degree of our dogged persistence in the role of accomplice is, one hopes, considerably less than it is with those who are not in a *therapeutic* relationship with the patient. In other relationships, even with close friends and loved ones who have the patient's interests very much at heart, the degree of reflective distance from the pattern in which they are entrapped is likely to be considerably less, and hence the unwitting perpetuation of the pattern is likely to be considerably more.[8] As a

[8]This holds, of course, even if these personal relationship partners are psychotherapists in their professional life.

consequence, it is crucially important that even therapists who center much of their therapeutic efforts on the immediate relationship in the room *also* attend—and attend closely and continuously—to the patient's life outside the therapy room. Helping the patient extend whatever changes are achieved in the consulting room into his daily interactions with other people, working on the ways that his behavior with others may evoke different responses from them than from his therapist, helping him to break those cycles and to see how the way he feels about himself has been affected by them—these are essential features of an effective and comprehensive therapeutic approach.

It is important to be clear as well that the cyclical patterns that characterize the patient's life are not limited to patterns with negative consequences. Facilitating change as effectively as possible requires as well that we understand and work with the *positive* cycles in the patient's life. The patterns in people's lives that yield satisfaction, intimacy, and harmonious relationships are *also* characterized by feedback loops in which the internal state of each individual brings about consequences that help to maintain that state and thus to bring about a similar consequence still again. As I have emphasized strongly elsewhere (see especially P. L. Wachtel, 1993, 2008), and as will be evident in the sessions presented in this book, attention to and building on the patient's strengths, rather than attending to pathology alone, is a central key to good therapeutic practice. Good relationships don't just maintain themselves automatically. They remain good when—and because—they continue to elicit the responses from others that are needed to maintain them. This is not a tautology but a statement about their dynamics.

SYSTEMS, NARRATIVES, AND UNDERSTANDING PEOPLE IN CONTEXT

Not long after I completed my first major integrative effort, focused specifically on psychoanalysis and behavior therapy (P. L. Wachtel, 1977b), I became aware that much of the way I was conceptualizing the development and dynamics of personality dovetailed with the theoretical perspectives of family therapists and other systems thinkers (E. F. Wachtel & P. L. Wachtel, 1986). Much of the convergence relates to the shared emphasis on vicious circles and recursive feedback loops that is characteristic both of the cyclical psychodynamic model and of most systems models (see E. F. Wachtel & P. L. Wachtel, 1986; P. L. Wachtel, 1997). It will be evident particularly in the sessions with Louise presented in Chapters 3 and 4 that the work is very much rooted in attention to how the interactions between Louise on the one hand and her husband and his family on the other create such feedback loops in ways that perpetuate the problem she wishes to address. In considering those sessions, it will be apparent

that they reflect simultaneously attention to her individual dynamics (including the persisting legacy of some central experiences and themes from her childhood) and to the systemic dynamics in her marriage and between her and her in-laws. In certain ways, the session works on the couples and family issues through the medium of the individual session and works on the individual issues through examination of the couple dynamics and their larger systemic context.

An additional point of convergence between the cyclical psychodynamic perspective that underlies much of the therapeutic work presented in this book and the methods and viewpoints of therapists guided by a family systems perspective lies in the ways that forward-pointing alternative narratives[9] are used both by a range of family therapists and other systems thinkers (e.g., Angus & McLeod, 2003; Molnar & de Shazer, 1987; E. F. Wachtel, 2001; Watzlawick, Weakland, & Fisch, 1974; White & Epston, 1990) and by the cyclical psychodynamic approach. In a related vein, at workshops over the years in which I have presented the approach described in this book, quite a few attendees have pointed out similarities to the set of approaches deriving from the work of Milton Erickson (e.g., Erickson, 1982; Erickson & Lankton, 1987), which also is strongly rooted in narrative redescription or what has been called a *solution-focused* approach (e.g., McNeilly, 2000; Miller, Hubble, & Duncan, 1996; O'Hanlon & Weiner-Davis, 1989; Zeig, 1985).

This interest in narrative redescription points to another way in which the effort to help the person understand himself differently has evolved from the early conceptions of "insight" that dominated the field for many years. Even within psychoanalysis, there has been increasing recognition that the insights achieved in analytic work are not simple "discoveries," resembling the process of digging up buried archaeological shards. Rather, they are more a matter of new constructions or new narratives, of the patient's coming to organize his understanding of himself and his life in ways that have more benign implications for how he feels and lives in the future (see, e.g., Hoffman, 1998, Schafer, 1992; Spence, 1982, 1983; P. L. Wachtel, 2008). When successful, psychotherapy helps the patient to retell his life story, to provide a different frame and give a different moral to the story. Hence, it enables him to give different *meaning* to events and experiences that had previously been a source of hopelessness and blockage and had contributed to a demeaning or depressing view of himself and of his life. In this respect, the approach described in this book converges with those aspects of cognitive and cognitive–behavioral therapy that also aim to help the patient see himself and the prospects in his life differently. But it does so in a less didactic and objectivist manner than in the rationalist tradition of

[9]Elsewhere (P. L. Wachtel, 2008) I have discussed such alternative narratives for the patient's life as narratives of possibility, in contrast to the narratives of *explanation* that are more typical of "interpretations."

cognitive therapy and more in the spirit of the constructivist and acceptance-oriented approaches discussed above.

THE EXPERIENTIAL DIMENSION

From another vantage point, the approach depicted here overlaps considerably with a variety of approaches that have come to be described as *experiential* (e.g., Fosha, 2000; Fosha & Yeung, 2006; Greenberg, 2002; Johnson, 2004; McCullough, 2003; Pos, Greenberg, & Elliott, 2008). From the very beginning, of course, insight-oriented approaches have aimed to promote "emotional insight," not just "intellectual insight." But that idea has often been honored more in the breach than in practice. The emphasis on "discovery" of the hidden sources of the patient's difficulties (see P. L. Wachtel, 2008, especially Chapters 2 and 6, for a discussion of the origins and consequences of this tendency) led to an overvaluation of words and an inclination to "explain" to the patient why he is experiencing what he does (see Aron, 1996) and to insufficient appreciation of the need to *experience* the forbidden, to *go through* it in order to move beyond it. (See in this connection the earlier discussions regarding the role of exposure in overcoming anxiety, as well as the importance of *acceptance* of the patient's experience as part of the very process of promoting change in that experience.) The importance of "embracing affect," discussed earlier, implies that the patient must fully *experience* the forbidden. Here again, the idea that the forbidden must be experienced with full affect represents in one sense a return to a fundamental early tenet of psychoanalysis; but it also again represents an ideal that has often been honored more in the breach. The contemporary approaches that cluster under the label of experiential psychotherapies do take this idea seriously, and it is no coincidence that they have often also described themselves as affect-centered or emotion-focused.

THE IMPORTANCE OF CULTURE

In addition to approaching the therapeutic task in ways that are informed by psychoanalytic, cognitive–behavioral, experiential, and systemic perspectives, the approach described in this book places a strong emphasis on attending to the impact of the historical, cultural, and economic dimensions of people's lives (see, in this connection, P. L. Wachtel, 1983, 1999, 2003). These latter influences on our experience of ourselves and our lives are recognized as crucial by almost every therapist in the course of her everyday life. We all "know" this, and our daily conversations with friends, colleagues, acquain-

tances, and loved ones attest to and reflect this. But in clinical practice, these crucial dimensions of living are often bracketed, kept separate from the focus of the therapeutic work, as if they were "something else." But they are *not* "something else"; they are an integral part of the way the patient experiences and constructs his life and of the stresses or opportunities to which he responds. Even the very role of the therapist, or the very idea of psychotherapy as a profession, are historically contingent reflections of a particular cultural context. As Frank (1973) has ably demonstrated, for most of human history the functions we serve were the reserve of priests and shamans, and the particular practices in which psychotherapists engage today are infused with the sanctions and meanings that our particular society attributes to them.

In my own thinking about personality and the therapeutic process, sociocultural and sociohistorical dynamics are not something external to or separate from psychological dynamics and experience but are part and parcel of them. I have used the same vicious circle analysis that guides my thinking about my patients as individuals in addressing the broad cultural and historical dynamics that have underlain modern societies' emphasis on economic growth, an emphasis that is associated with multiple ironies and contradictions from the vantage point of individual human experience (P. L. Wachtel, 1983, 2003), and I have similarly used the analysis of vicious circles to address equally significant ironies in the realm of race relations (P. L. Wachtel, 1999).

The impact of cultural values and assumptions in shaping the context of patients' choices and in framing their experiences will be evident throughout the sessions that form the core of this book. For Melissa, they are strongly evident in her initial framing of her dilemma as a conflict about choice of jobs. In a society in which health care and resources for retirement were organized differently than in the United States, Melissa's conflicts about her work and career would necessarily take a different form. Indeed, whatever deeper uncertainties might be feeding this conflict would very possibly be expressed in a realm other than work altogether. In the case of Louise, the issues she is addressing are strongly reflective of her struggle to reconcile the experience of growing up in Sweden and now living in the United States. She wrestles both with the stereotypic conceptions that place boxes around the idea of Swedishness or Americanness for her and with the very real differences that characterize life in the two societies. In turn, these cultural differences are both expressed in and contradicted by the similarities and differences between the family she grew up in and the family into which she married. In these sessions, as in the lives of all of us, the closer we look, the more arbitrary appears the difference between "internal" and "external" or "individual" and "social." Like a path along a Moebius strip, we cannot proceed in exploring the "inside" without finding ourselves encountering the "outside," nor can we then move very far along the "outside" without finding ourselves back "inside" again. "Inside"

and "outside" are distinctions we are virtually forced to make by the nature of language, but it is their intertwinedness and mutual cocreation that must be at the heart of our understanding.

THE CULTURE OF PSYCHOTHERAPY

No discussion of culture in the practice of psychotherapy would be complete without attention to the culture of psychotherapy itself. Our field is presently marked by deep divides that separate the proponents of the different orientations to theory and clinical practice. We are accustomed to thinking of these differences in terms of deep seriousness: They are *philosophical, theoretical, empirical*. On closer examination, however, they often appear to be akin more to the divisions between ethnic groups. In many respects they are less matters of rationally evaluated judgments than they are matters of identity and identification, of which group I *belong* to. Stereotyping, "us–them" thinking, and a strong emotional preference for one's own group's linguistic forms—these are the characteristics of ethnic identity and ethnic rivalry or mistrust. They are also, to a striking degree, the lens through which therapists of one theoretical orientation view therapists of another. As an integrative therapist, it is in part my aim to break down these stereotypes through pointing to convergences in conceptions or in practice that are missed by those immersed in the particular style and the particular theoretical language of their own orientation. But my experience as an integrationist, which has brought me into close contact and exchanges with therapists of each of the key orientations in our field, has also brought home to me how hard these stereotypes are to overcome.

In this chapter, I have attempted to show in various ways some of the overlaps that exist between orientations if one goes beyond the different language used to express closely related ideas. In the next chapter, I discuss in more detail the aspects of my thinking and my clinical work that derive from what has come to be called the *relational* point of view in order to help the reader understand as fully as possible what I was up to in the sessions that follow. In good measure, my aim is to alert the reader to some significant changes in psychoanalytic thought in recent years, changes of which many from outside the psychoanalytic world are unaware. As Westen (1998) has noted, to many nonanalysts (and, to be sure, to a subset of analysts as well), psychoanalysis is about egos and ids, Oedipus complexes and phallic symbols, life instincts and death instincts. These concepts, which are close to or more than a hundred years old, fit comfortably into the stereotypes held by therapists of other orientations and serve for some to bolster their image of psychoanalysis as the product of fevered minds with little interest in or connection to either science or common sense. Today, however, as Westen pointed out, "most psychodynamic

theorists and therapists spend much of their time helping people with problematic interpersonal patterns, such as difficulty getting emotionally intimate or repeatedly getting intimate with the wrong kind of person" (p. 333). Moreover, as Westen also demonstrated, many of the key concepts in contemporary psychoanalytic thought have received significant empirical support from a range of studies conducted from the vantage point of cognitive psychology, social psychology, experimental personality research, and cognitive and affective neuroscience.

For readers whose "ethnicity" is other than psychoanalytic, I wish to alert you to the unfamiliar territory you are about to enter in the next chapter. My aim is both to clarify how psychoanalytic thought and practice contribute to the overall integrative approach represented in the sessions and to explicate some of the newer modes of thought in psychoanalysis with which many readers may not be familiar. I ask the nonpsychoanalytic reader to attempt to enter this unfamiliar territory with the same open-minded curiosity with which I would hope she approaches her encounters with the experiential world of her patients. Elsewhere (e.g., P. L. Wachtel, 2010a), I have addressed in some detail the nature of the evidence for the ideas that guide the range of contemporary therapeutic approaches and the complexities and confusions that have characterized discussions of "evidence-based" or "empirically supported" treatments. But my aim at this point is to invite the reader to entertain a more subjective mode of inquiry, rooted in the experience of both parties in the therapy room and the effort to achieve some sense of order and understanding in the complex back and forth that constitutes the therapeutic interaction.