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Making Room for the Disavowed: Reclaiming the Self in Psychotherapy.
By Paul L. Wachtel. Copyright © 2023.
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CHAPTER 1

Making Room for Thoughts and Feelings

Attachment, Self-Acceptance, and Emotional Immediacy

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Doing psychotherapy is a challenging occupation. Things rarely go as smoothly as manuals or, for that matter, books like this, can seem to imply. Patients sometimes come into sessions and have nothing to say, or they seem to be just telling a story that has nothing to do with the work. Sometimes it feels like they are just "complaining" about what other people are doing, and there is no obvious path into a dialogue that leads in therapeutic directions. Sometimes they seem unable to stay with the topic, especially when it seems we are getting closer to something important. At times, it may feel we are talking about the right things, and even able to stay with them, but the work just doesn't feel alive, or there is little sense of movement. The list of such conundrums is long, and almost every therapist could likely add many further examples. It is easy to call these behaviors "resistance," and sometimes (if resistance is understood in the less adversarial and pejorative way I discuss in Chapter 4) it may well be useful to think about them in this way. But I want in this book to explore ways in which these obstacles to movement and emotional aliveness derive as well from some of the most common assumptions and practices in our field.

My aim is to point to a therapy that is more accepting, more experiential, and more emotionally immediate. In that effort, I draw on developments across the psychodynamic, cognitive-behavioral, humanistic–experiential, and systemic traditions. I seek in doing so to illuminate both the often unappreciated overlaps in their ways of working and the processes they mobilize and, as well, the unique contributions that each

offers to the therapist who is open enough to accept their diverse contributions, even when they present themselves in an unfamiliar accent.

My own original training and background was in the psychodynamic tradition, and psychodynamic thought, especially in its newer relational forms, continues to inform and enrich my work to this day. But my psychodynamic sensibility owes as much to Robin Hood as to Freud. I steal riches from other orientations, and I do so openly and brazenly. And, like Robin Hood (at least the Robin Hood of myth), my aim is to give away the fruits of my thieving to those in need—in this case, my patients.

Rather early in my career, I saw important ways in which psychodynamic work and thought could be enhanced by attention to behavioral (Wachtel, 1977a) and systemic (Wachtel & Wachtel, 1986) perspectives and interventions. Subsequently, and increasingly, I have turned as well to the contributions of humanistic and experiential therapists—to the point where it may be most accurate to call my version of psychodynamic thought and practice a "psychodynamic–humanistic–experiential" point of view. This latter direction in the evolution of my thinking and practice was prompted by my concern that it was important that the patient come to *experience* and to *accept* his cast off thoughts and feelings, not just know them or be able to verbalize them.

My interest in the potential of approaches explicitly identified as experiential for this purpose will hardly be surprising to most readers. But many readers may be quite surprised that in seeking a more experiential, less intellectualized therapeutic approach, I also turned early to the methods of behavior therapy. The first thoughts that come to most readers' minds about behavior therapy are not likely to highlight behavior therapy as an approach that enhances the *experiential* quality of the therapy, much less as an approach that could not only be compatible with a psychodynamic way of working but could actually deepen and extend the clinical reach of psychodynamically guided practice. I discuss this experiential contribution of behavior therapy especially in Chapters 7 and 10.

More recently, two other sources have contributed especially prominently to the further evolution of my thinking and to the experience- and acceptance-centered emphasis of this book: attachment theory and what has been called third-wave cognitive-behavioral therapy (CBT). Attachment theory has in some ways been a significant part of my thinking for some time. But in recent years I have reexamined what I view as the most significant contributions of attachment theory to our understanding of personality dynamics (e.g., Wachtel, 2010b, 2017a), and those reconsiderations led to attachment theory playing an even more central role in my thinking and to its being a theoretical cornerstone of this book.

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The aspects of attachment research that are likely to be most familiar to readers center on attachment *categories* (secure/insecure, avoidant, anxious–ambivalent, etc.) and on the continuities in attachment status over time or between the attachment status of the parent and that of the child. This is important work, both strongly grounded in research and with significant clinical implications (e.g., Eagle, 2013; Holmes & Slade, 2018; Wallin, 2007). But the emphasis in this book is primarily on the *processes* of attachment rather than the categories. In particular, it is on the ways that adaptation to the emotional signals of the attachment relationship leads to selective access to only a portion of the potential repertoire of thoughts, feelings, and ways of interacting that we might bring to bear in living our lives, and on how the unconscious and automatic self-restrictions this entails affect our further development and interactions with the world.

It will be apparent as I proceed, especially in Chapters 8 and 9, that this process-centered understanding of attachment is not just about infancy and early childhood but is also about how the perceptions (and perceptual restrictions) that are initiated in our early attachment relationships become part of our way of life. In explicating this, I examine how the pattern is extended over time, as our habits and expectations elicit responses from others that tend to perpetuate those very habits and expectations. This is a conception of attachment that is suited not just for therapists whose work centers on tracing the origins and early roots of the patient's difficulties but also for therapists whose work focuses more on how the patient lives in the present.

Third-wave CBT has been an even more recent contribution to my thinking. Like the point of view that is central to this book, third-wave cognitive-behavioral approaches are less focused on *correcting* the patient's thoughts and perceptions than on promoting *acceptance* of them. This is especially true of acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 2016), but is an important element of all of the perspectives that are part of what has been called the third wave (Hayes et al., 2004). Just how new the third wave is, how much it genuinely differs from what could be called first or second wave approaches, has been a matter of controversy in the cognitive-behavioral community (e.g., Hofmann & Asmundson, 2008). With regard to the issues I discuss in this book, however, it will be apparent that the perspectives generally viewed as part of the third wave have quite different implications from versions of CBT more centered in theories and practices deriving from the work of Beck or Ellis. I especially elaborate on these differences in Chapter 7.

Also central to the point of view guiding the discussions in this book is a strong conviction that to understand human behavior and

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human experience properly, we must understand them *in context*. This, it may be noted, is also an important foundation of ACT, which is rooted in what Hayes (2013, 2016) calls contextual behavioral science. Contextual thinking is, as well, a quintessential property of the systemic point of view, which is another key foundation of the theoretical synthesis that underlies the approach to therapy discussed in this book. The contexts I consider in the clinical and theoretical discussions that follow range from the immediate interpersonal and relational contexts of the person's life (including, prominently, but not surprisingly, that of the therapeutic relationship), to the contexts of family, school, workplace, and community, to the larger contexts of race, class, ethnicity, and cultural values.

My earliest psychoanalytic grounding was strongly influenced by the culturally infused version of psychoanalytic thought advanced by Erik Erikson (e.g., Erikson, 1950, 1958, 1969/1993), along with the contributions of writers such as Fromm (1941, 1955) and Horney (1937, 1939), and I have been concerned with the intersections of psychoanalytic and psychological thought and larger social and cultural phenomena for many years (e.g., Wachtel, 1983, 1999). In this book, as I have previously (e.g., Wachtel, 2008, 2014a), I ground my analyses in a conception of the *contextual self,* a point of view I employ to represent the simultaneous realities of, on the one hand, our being powerfully shaped by our interactions with others and by social and cultural influences and, on the other, our actively giving meaning to and selecting among those influences, manifesting an individuality that is genuine and meaningful.

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Beyond Irrational, Infantile, Dysfunctional: From Uncovering, Correcting, and Pathologizing to Acceptance and Validation

For many years, much of psychotherapeutic practice centered on disabusing people of their illusions or misperceptions. These could be the infantile fantasies and defensive distortions that were long the focus of psychoanalytic work. They could be the irrational or dysfunctional beliefs that were central to the cognitive approaches of Beck and Ellis. They could be the self-deceptions that Fritz Perls relentlessly aimed to strip away in the early years of Gestalt therapy. Or they could be any of a range of other formulations, from still other frameworks, that are clearly intended to more accurately identify the sources of patients' or clients' suffering but that can ironically and unwittingly end up invalidating the patient's experience and contributing to his view of himself as damaged or deficient.

Along with these tendencies, there was a strongly pathocentric emphasis on disorders, deficits, and diagnostic entities. Psychoanalytic patients were viewed as fixated or arrested at early stages of development, looking like adults on the outside but deep down still viewing the world through lenses that were oral, anal, phallic; paranoid, depressive, schizoid; primitive, archaic, preoedipal; the list of terms is long and almost invariably uncomplimentary. From a different theoretical vantage point, behavioral and cognitive-behavioral therapists, after years of criticizing psychoanalysts as rooted in an outdated and inappropriate medical model, embraced with gusto the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), arguing that sorting people into psychiatric diagnoses was essential to any responsible investigation of therapeutic outcome (e.g., Chambless & Hollon, 1998; Chambless & Ollendick, 2001).[1] And across the range of orientations, the codes of the *International Classification of Diseases* (ICD) and the language of Axis I and Axis II, of borderline and narcissistic and comorbidity, became essential to learn not just for psychiatrists but for psychologists, social workers, and other mental health professionals as well.[2]

This book presents a very different vision of what psychotherapy is about and of how to understand the problems people bring to our offices. A central challenge it explores is how to attend seriously to the depth and reality of the problematic patterns of thought, behavior, and emotional meaning-making that bring people to therapy, and yet frame the understanding of those patterns in ways that promote validation and self-acceptance rather than grounding the therapeutic effort in conceptions of the patient as infantile, irrational, or distorting or misperceiving reality.

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Making Room for the Full Self

Central to the way the book addresses this challenge—and giving it its very title—is a vision of therapy as a means to *make room* for thoughts, feelings, perceptions, and desires that, over the course of development, the patient has come to experience as dangerous or shameful. Relatedly, the book examines the differences between a making-room-for emphasis and an emphasis on pathology, on identifying errors in the patient's

[1] For an alternative cognitive-behavioral view, see Barlow et al. (2017); Hayes and Hofmann (2018).

[2] Fashions in these terms keep changing, with some disappearing or falling out of favor and others emerging, but the medicalized and pathocentric structure has persisted.

thinking, and on uncovering what the patient has been *hiding* from himself.

To be sure, it is essential to keep in mind that the patient has come to see us because *something is wrong* in his life. As a consequence, it is essential we look in a clear-eyed way at the contribution to his difficulties or dissatisfactions deriving from how he thinks, interprets experiences, and interacts with others. This means we must also be attentive to how those ways of thinking, interpreting, and behaving must change if he is to live his life more comfortably and satisfyingly.[3] This implies not a single-minded focus on acceptance and validation alone, but a *dialectical* approach—as offered by Linehan (e.g., Heard & Linehan 2019), Bromberg (1993), and a range of other leading thinkers in each of the major orientations in our field—in which the tension between acceptance and change is not only acknowledged but embraced as a core guiding principle. Theoretical purity is the enemy of therapeutic success, and that holds as much for the make-room-for point of view at the heart of this book as it does for any other. When, in the witty words of Larry Beutler (2004), our discourse on therapeutic methods becomes a matter of "dogma eat dogma," it is the patient who is the loser.

Nonetheless, I believe—and it is one of this book's aims to elaborate on the logic and the observations supporting this view—that the most useful grounding for our work resides in thinking of psychotherapy as the effort to make room for thoughts and feelings that have come to be experienced as prohibited and have been excluded not only from the experienced sense of self but from the patient's repertoire of adaptive resources. Having been particularly alerted to this issue in the process of writing this book, I have noticed that when my work with a patient is not going well, reminding myself to refocus my attention on helping the patient *make room* for these excluded thoughts, feelings, and experiences is one of the most useful ways of getting back on track. Although I employ a wide range of other perspectives and ways of working, it is this element of the work that is particularly the focus of this book.

In this regard, it may be worth noting that it was only halfway through the writing of this book that I fully realized it was most fundamentally about "making room." I began with a set of interrelated themes, and the writing of the book was an effort to work out for myself the nature of their linkages and the implications for therapeutic practice. These included the particular take on attachment I mentioned previously

[3] As I discussed in the Preface, throughout this book, for purposes of clarity I refer to the therapist, when discussing therapists generically rather than referring to a specific person, with the pronouns *she, her,* and *hers* and to the patient generically with *he, his,* and *him*.

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(and discuss further later in this chapter and especially in Chapters 8 and 9); concern with making the work more able to promote self-acceptance and not just self-knowledge; related intuitions about how concepts such as interpretation and cognitive restructuring are more antithetical to that spirit of acceptance than is often appreciated; the importance of making the work more experiential and emotionally immediate; the ways that social realities and cultural values impact our patients' sense of possibility in life; and the critical import of grounding the work in the way the person lives in the world, not just what is in his head. As I explored the ways that each of these themes impacted the way I practiced and thought about psychotherapy, I only gradually began to see that the red thread through them all was making room for the thoughts, perceptions, feelings, wishes, and ways of acting that the patient had pushed aside or marginalized. Once I understood in this way what I was really up to, the writing became much easier.

But it is also worth noting that as much as this is a book that particularly highlights the concept of making room for the parts of the self that have been cast aside, I am not introducing one more entry into the endless stream of therapeutic brands that proliferate like viral mutations through the body of our field. This is not a book about MRFT ("make room for" therapy). There is no MRFT manual, and there are no MRFT training institutes, no certification in MRFT. The book is about a *way of thinking* about therapy, not about a *kind* of therapy. Much of what I describe may sound familiar to many readers. It builds on prior work in all of the major orientations in our field. But I believe that if the reader follows the argument and the clinical examples carefully, it is apparent that thinking in terms of making room for what the patient has pushed away or retreated from in himself can give the therapeutic process and the therapeutic interaction a substantially different feeling than much of what is common in contemporary practice.

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Early Attachment Experiences and the Shaping of the Self: Learning to Fear Our Thoughts and Feelings

The make-room-for perspective is rooted in a critical implication of the uniquely prolonged vulnerability and dependency that characterizes human infancy and childhood. Because of that dependency, we learn early, as best we can, to be who our key attachment figures *need us* to be—to be the kind of baby and then the kind of child that can elicit whatever nurturance and responsiveness they are capable of offering. To a substantial degree, we learn to bend our thoughts, feelings, desires, perceptions, and very sense of self in directions most likely to elicit

attuned responsiveness from our caretakers and to avoid eliciting disapproval, rejection, neglect, or other painful or deleterious responses.[4]

This doesn't always work out so well—that is, alas, why we are a thriving profession. But in small degree or large, almost all of us find a way to gain at least a measure of security via these (mostly unconscious) adaptations. Secure and insecure attachment do not constitute a binary; children or adults who are categorized as securely attached are by no means free of anxiety or self-doubts, and most people characterized as some version of insecurely attached usually can nonetheless establish relationships, hold a job, and generally carry on with their lives (albeit in ways that are likely less satisfying and effective as a consequence of their compromised attachment status). The differences picked up by measures of secure or insecure attachment certainly make a difference in the quality of people's lives in important ways, but the process of trimming the self to fit the needs of the attachment relationship is a human proclivity shared by secure and insecure alike. And even as this effort contributes importantly to whatever degree of attachment security we achieve, we also almost inevitably lose something precious as well. Even those of us who are all in all doing well in life inevitably turn away from certain parts of ourselves in the process of establishing as secure an attachment experience as we are able to in our particular emotional and familial circumstances. As I elaborate throughout this book, a good portion of the difficulties that patients bring to therapists are rooted in the ways that (mostly without awareness) we turn away from ourselves in the pursuit of responsive parental attention and affirmation. In particular, those difficulties are rooted in the ways we become afraid, guilty, or ashamed of thoughts and feelings that are an essential part of our genuine self and a critical resource for full and satisfying living. Attention to how the patient has learned to invalidate his own experiences and to what he has come to feel is most shameful or unacceptable is a central focus of the point of view presented in this book.

Attention to attachment phenomena has been an important focus

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[4] I am not here pointing to a simple conformity or obedience, automatically being exactly the way the parents want us to be. The interplay between needs for autonomy and self-expression and needs for parental approval and responsiveness is complex. But often, even in what looks like rebelling against what the parents seem to want or need, the power of those parental messages is evident. This is often especially the case in adolescence. Adolescents sometimes behave in ways that seem excruciatingly incongruent with how the parents want or need them to be, but at another level they may be seen as expressing a side of the parent that the parent has had difficulty expressing.

across a range of therapeutic orientations, from Susan Johnson's version of emotionally focused couple therapy (e.g., Johnson, 2019), which brings together humanistic–experiential and systemic thinking, to Diana Fosha's accelerated experiential dynamic psychotherapy (AEDP), which draws strongly upon both psychodynamic and experiential perspectives (e.g., Fosha, 2000), to attachment-based family therapy (e.g., Diamond, Diamond, & Levy, 2014), to a wide range of psychodynamic applications of attachment thinking (e.g., Fonagy, 2001; Holmes & Slade, 2018; Wallin, 2007). It has been less broadly influential in the realm of CBT, but important exceptions exist that I discuss further in Chapter 8 (e.g., McBride & Atkinson, 2008). Certainly there is little reason to think of attachment theory as in any way incompatible with a CBT perspective; attachment is a topic about which there is a vast body of systematic and carefully conducted research and thus seems a natural realm to explore by an approach like CBT, which prides itself on being solidly grounded in empirical research. It is also worth noting that Beck directly corresponded with Bowlby, stating explicitly that he saw Bowlby's views as relevant to and in many ways compatible with his own (Rosner, 2012). The attachment relationships of the early years invariably include a complex mix of attunement and misattunement, validation and invalidation. The final result is that some thoughts, feelings, and desires are able to be fully elaborated and represented in consciousness, whereas others are cast into shadow, not necessarily disappearing but rendered less able to be clearly experienced or articulated, less effectively integrated into one's adaptive efforts, and less able to contribute to a sense of vitality and clear direction in living.[5]

The luckiest among us end up born to parents who happen to like best (and be competent at dealing with) what is most characteristic of who we are. But even in this most fortunate state of affairs, this still does not mean they like or love every aspect of us equally. And long before we have learned to speak or to articulate in consciousness what this means or what it feels like, we have begun to learn how to adapt to these (usually unstated and often unacknowledged) parental preferences. We learn to put forward and develop certain of our qualities and to place others deep in the background, less called upon, developed, or experienced; and, over time, we essentially come to *define ourselves* in a way that reflects this self-editing. If not all of us go through life with one hand tied behind our back, all of us have at least a finger or two back there, not fully participating in the task of thriving in life.

[5] This conception of the influence of attachment experiences intersects in interesting ways with Stern's (1997) concept of unformulated experience.

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Therapy Need Not *Focus* on the Past to Address the *Impact* of the Past

What I have just described does not mean that infancy or childhood is destiny, nor does it imply a simplistic determinism in which we simply become what our parents want (or need) us to become. To begin with, often there are *two* parents involved, each of whom may be responsive to different aspects of the child. Even when there is just one, there are often grandparents, aunts, uncles, nannies, and then teachers, playmates, and a host of other figures who can open the field to a wider range of the developing child's inclinations and experiences. Secondly, the perceptions and responses of others are *influences* on our development, they are not irresistible forces before which we are utterly helpless. The growing child's temperament, desires, and ways of making sense of what he or she experiences are themselves shaping forces in the continually evolving interactions that develop between child and parent and child and world. We are not simply putty in the hands of our mothers and fathers.

But the dynamics of self-redaction I have been describing do take their toll, even in the best of upbringings. Much of this book examines the consequences of, in essence, building a life on the foundations of only a part of ourselves, and considers how the range of human interactions we have come to call psychotherapy can contribute to our bringing back into the picture the parts that got cast aside. To understand this impact and work effectively with it in therapy, we must consider not just the early years, when the process was initiated, but the feedback loops through which early patterns are perpetuated over time and the kinds of life experiences that can *disrupt* the pattern and lead to change. This complex amalgam of attention to subjective representations (as in the concept of the internal working model) and, equally and complementarily, attention to the impact of actual life events is the key to effective therapeutic leverage. It is a path as well to rendering the findings and conceptual tools that have accrued from attachment theory and research accessible to cognitive-behavioral, experiential, and systemically oriented therapists, many of whom center their clinical work on addressing the patterns and experiences of their clients as they are manifested in the present rather than focusing much attention on probing their early years.

As I especially elaborate in Chapter 9, current patterns and perceptions cannot be dissolved simply by demonstrating their link to the past, because they are linked not just to what happened years ago but to what happens *every day*. They are part of the patient's *way of life,* tied to the cycles that repeatedly generate actions in response to perceptions and

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perceptions in response to the consequences of those actions. Much of Part III is concerned with how to work with this challenge clinically. If we are to change those perceptions and expand the possibilities for new actions and new experiences, we must break into that self-perpetuating chain of events as the process is happening. We gain useful *perspective* from looking at the past, but we gain *therapeutic power* from working in the present.

Experience and Emotional Immediacy: Ensuring That the Therapy Is More Than Just Words

Both psychodynamic and cognitive therapy share a common vulnerability—they can sometimes be too intellectual, too "in the head," too purely verbal and insufficiently experiential. Almost all practitioners of either approach would regard such an overintellectualized state of affairs as a miscarriage of their approach; but it is a miscarriage that is not as rare as one might hope. When this happens, the patient can *say* things differently, sometimes even *see* things differently, without *being* different, *living* differently, *feeling* differently.

From a psychoanalytic vantage point, for example, Jacobs (2001), reflecting on many years of clinical experience, has commented:

> Increasingly, I have come to share my patients' view that, as important as it is—and unquestionably, it is of the greatest importance in paving the way for change—understanding the workings of one's mind is not a sufficient analytic goal. Too often in my work, I have witnessed the development of insight that remained just that: insight in a vacuum, insight divorced from action or change, understanding that had little impact on the patient's life or the difficulties that brought him or her to treatment. (p. 154)

Jacobs is clear that he does not mean that analysts must abandon interest in insight or self-understanding per se. While the version of psychoanalytic ideology that for many decades depicted a well-conducted analysis as aiming for change that is generated by "insight alone" or "interpretation alone" was deeply misguided (cf. Abend, 2007; Aron & Harris, 2010; Arlow & Brenner, 1990; Dewald, 1973; Gill, 1954, 1984; Stern et al., 1998), it remains the case that without a clear understanding of our feelings and aspirations, a deeply satisfying way of life is virtually impossible. Moreover, the real danger that the therapy can end up being "mere words" clearly does not mean that we can *abandon* words or verbal exchange in the work. Although I argue in this book for greater emphasis on the role of nonverbal, directly experiential and procedural

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learning, I have no intention to disparage (or even to play down) the verbal or linguistic dimensions of the therapeutic interaction. Nor, in highlighting the importance of emotional immediacy, do I intend thereby to somehow *replace* words with emotions or new experiences. Indeed, I have written an entire book on the artful use of words and language in therapy (Wachtel, 2011a), and I by no means aim to repudiate that book with the publication of this one.

But more often than one might hope, the words exchanged in the therapeutic dialogue do become *mere* words, and one important aim of this book is to help clarify when and how this occurs and to offer an alternative in which "the talking cure" is more than just talk. I consider throughout this book the ways that viewing the therapeutic task through the lens of making room for the thoughts and feelings that have been cast out of the experienced sense of self aids in generating a therapeutic process that does not remain solely on the verbal or cognitive level. When the main thing the therapist does is *point out* or *interpret* the patient's warded off thoughts and feelings or, as in cognitive therapy, critically examine the premises and assumptions that underlie the patient's thinking, there is not only a risk of sterile intellectualization but a risk as well that the patient will experience himself as getting "caught" doing (or thinking or feeling) something wrong. The make-room-for perspective provides a different set of images and metaphors, pointing to the therapist's *inviting* rather than interpreting the warded off thoughts and feelings. It encourages the patient not just to know or examine the feeling, but to *let it in*.

Inviting in the feeling or desire, embracing or accepting it, does not mean that there are no ways in which it needs to change. Years of being suppressed, unacknowledged, unable to participate in the countless interpersonal learning experiences that enable us to refine the way we express our feelings and desires can lead to their taking forms—a product of their very suppression—that really can create problems in many spheres of living (see especially Chapters 4 and 9). Thus, in order to make room for those cast off or disavowed thoughts, feelings, or self-experiences in an effective and enduring way, it is often necessary to help the patient shape them and express them in a way that does not generate consequences that will drive them back underground. Some therapeutic approaches are more explicit than others about helping the patient with the interpersonal and emotion-regulation skills needed to express effectively the newly emerging repertoire of feelings he is experiencing. But even approaches that in their manifest theoretical rationale eschew explicit advice, coaching, or guided structuring generally find ways to do this, often in implicit fashion. This can occur especially in the mutual interactions of the therapeutic relationship or in the ways that

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the therapist restates and reframes what she is hearing coming from the patient (Wachtel, 2011a).

Therapeutically useful acceptance is not *bland* acceptance, nor is it *blind* acceptance. The acceptance that contributes to therapeutic change is acceptance that takes account of how the very suppression of the person's conflicted inclinations can lead them to take forms that impede harmonious and satisfying relationships, but that at the same time conveys a fundamentally inviting and affirming attitude toward the patient's efforts to expand the expression of his subjectivity. Here again, in navigating the conflicting perceptions and guidelines the attentive therapist is likely to encounter, a valuable resource is provided by the dialectical formulations of Linehan (1993), Bromberg (1993), and other leading figures in each branch of our field.

But along with the necessity of what one might call sophisticated realism as a grounding element in therapeutically useful acceptance, it remains essential to be clear that the acceptance and the reappropriation of the disavowed thoughts and feelings must be pursued in a manner that is not overly tilted toward the verbal or cognitive realm. The patient must *experience* what he has previous disavowed or cast off, he must *feel* the previously forbidden feeling or wish if he is to genuinely reappropriate it. He must *go there* if he is to believe at more than an intellectual level that it is *safe* to go there; logic alone or verbalized insight alone won't do the job.

The point is well captured by Pascual-Leone and Greenberg's (2007) apt phrase, "the only way out is through." Their use of this phrase derives from their perspective as emotion-focused, experiential therapists, but it reflects a view that, stated differently, has proponents in each of the major orientations in our field. As I discuss at various points in the book, it overlaps conceptually with the foundations of cognitive-behavioral methods emphasizing exposure, as well as efforts to address experiential avoidance in ACT and related ideas and methods in other acceptance- and mindfulness-centered cognitive-behavioral approaches. At the same time, it is a key to understanding why I posit, in my discussion in Part II, an overlap between exposure methods in CBT and the qualities that make for genuinely effective psychodynamic interpretations. And it intersects as well with an important contribution of systemic approaches, which, in promoting new patterns of interaction in the emotional systems that are central to the patient's life, create direct experiences that take the person *through* experiences they have devoted their lives to avoiding. The overlaps and synergies among these various approaches to encouraging the patient to *move into* the experiences he has been avoiding rather than merely talking about them are a central concern of much of the rest of the book.

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Living-in-the-World: The Inseparable Yin and Yang of Culture and Self and Self and Context

Within the web of reciprocally reinforcing causal forces therapists need to take into account, social and cultural influences must be included as integral and inseparable. Often, in the training of therapists, they are implicitly presented as "additional" factors, addressed in special courses on multiculturalism, diversity, or cultural sensitivity. Such courses can be an enormously valuable contribution to future therapists' educations, but when they are thus isolated, their impact is limited and their very content is misrepresented. Culture is not an "additional" factor in people's psychology; it is not just a "surface" element to be distinguished from the "deep" layers of the psyche that most fundamentally drive our behavior and experience (Wachtel, 2003b, 2008). The values and assumptions of a culture are a prism through which almost every experience is filtered and given meaning.

At the same time, each individual in a culture absorbs that culture differently. This is especially the case in a society in which most people belong simultaneously to many different subcultures, with sometimes one element of the kaleidoscope of possibilities in the foreground of our perceptions and experience, sometimes another.[6]

All of us grow up in the particular (and particularly influential) subculture of the family, shaped by its specific *version* of the culture and its own *position within* the culture. That version and that position include the impact of race, class, ethnicity, region, occupation, and economic status, though here, too, none of these is automatically determinative; the meaning given to each of these elements of identity will be slightly different in each family. In turn, each individual in the family will take a somewhat different meaning from the family's messages, including the ways it reads and selects from the larger culture. These dynamic interplays, rather than either static cultural categories or fixed cultural values or characteristics, are what we need to trace as therapists. In doing so, it is important that we not overindividualize in the sense of underestimating just how powerful a role culture plays in how our patients see and experience the world. It is probably an occupational hazard of therapists to focus on our patients' individual experiences and proclivities in a way that underestimates the impact both of culture and of socioeconomic circumstances. But it is important as well that we not end up dismissing culture in a different way—by making

[6] See Sen (2006) for an important discussion of the underappreciated *multiplicity* of our identities and cultural affiliations.

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it a categorically powerful *external* force. Culture is *in* us. It is part of almost everything we do, every choice we make. As we interact with the world, the world interacts with us. *Who I am* cannot be divorced from *who I am in the world*.

The continuing interaction between the world of culture, society, and relational events and the world of subjective interpretation and experience requires the sensitive therapist to be attentive to a continually changing state of affairs. We observe and work with both stable—sometimes *too* stable—individual tendencies and, at the same time, a constantly changing interactive field. Both the stabilities and the variations are essential to track and work with, as are multiple dimensions of these stabilities and variations. How we *feel* matters; how we *see* or *interpret* or *make sense of* events and interactions matters; what we *do* matters; and the *context* matters. In recent years I have increasingly begun to think in terms of a phrase that I first borrowed (and modified) from the writings of existential and phenomenological writers to capture these complex, multifaceted, and reciprocal connections. The phrase is *living-in-the-world,* and it is designed to highlight the importance of action as well as experience and of awareness that both always occur in relation to some context; that is, the importance not just of what is happening in the person's head but of how he lives in the world. The hyphens connecting the words in the phrase, again borrowed from existential and phenomenological writers, are designed to emphasize the *inseparability* of the actions/experiences and the contexts in which they occur.

I first introduced this phrasing in a discussion of the limits of a purely *representational* psychology, and of the ways in which both psychoanalysis and cognitive therapy often exhibit this representational bias (Wachtel, 2019):

> Discerning people's representations, even in the most accurate and perceptive way, is like looking at a snapshot. It is a picture of what is "there" right now. But life . . . is a *process;* it always occurs *in time,* and it occurs as well *in interaction* with the environment, both the physical environment and the psychological environment. The still photo must be supplemented with a video.
>
> Put differently, the person's representations [must be seen] in the context of his or her *way of life.* And . . . that way of life [must be understood] not just as it is "represented" but as it is *lived*. That is the "video" that gives context and further meaning to the still photo. It is the "video" that shows us how the internal structures and inclinations both respond to *and* create the ongoing events in a continuous fashion; and in the case of psychopathology, how . . . the patient's problematic representations lead to behavior that elicits from others the very reactions that will maintain or exacerbate those representations. (pp. 339–340, italics in original)

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Throughout this book, I highlight the necessity for the therapist to keep her eye on both sides of this complex, reciprocally interactive reality. On the one hand, she needs to be keenly attentive to the patient's subjective experience and to the particular ways he gives meaning to events, rather than simply being passively shaped or determined by what is happening. On the other hand, his sense of self and his actions in the world *are* (inevitably and powerfully) impacted by the events he encounters (and participates in) and by the contexts in which his behavior and experience are manifested. Throughout this book, I particularly highlight the ways in which the work is enhanced by attention to the vicious and virtuous circles that characterize so much of our lives and to the concrete reciprocal interactions that create and recreate these circular patterns (see also in this regard Wachtel, 1994, 2008, 2009, 2011a, 2014b). I highlight as well how the therapeutic process must encompass both empathic resonance with the patient's subjective experience and attention to how the ways he interacts in the world contribute to the very experiences he has come to therapy to address.

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Psychotherapy as a Complex Amalgam: The Diverse Sources of Therapeutic Gain

This complex matrix of reciprocal causal influences means that the effective practice of psychotherapy requires continual midcourse corrections that test the mettle of any therapist and leave most of us, if we are honest with ourselves, feeling at sea much more often than we hope our patients can notice. In this challenging arena of human interaction, it is enormously helpful to have a broad range of models, principles, and guiding images to draw upon in those far from infrequent moments when (theory or manual notwithstanding) we actually don't know what to do next. Unless I am a particularly inept therapist (a real possibility, I must acknowledge, but one that the reader will surely understand is not my primary working hypothesis), therapeutic work *often* creates moments where the therapist's experience is "give me a tool, *any* tool; give me a way to get past this morass; a way to respond to what the patient has just said that gets us back on track; a way that helps me see *what track we even should be getting back on*."

To be sure, despite this view of therapy as often consisting of uncharted territory, this book aims to provide at least a partial road map through that territory. One primary route I chart, it should already be clear, moves away from an emphasis on uncovering self-deceptions, irrationalities, and dysfunctional beliefs toward greater *acceptance* of the thoughts and feelings that have been cast aside because they have

generated anxiety or threatened important attachment relationships, and points toward, that is, an emphasis on *making room for* those thoughts and feelings, on reappropriating them and making them more fully available to the task of living life well. A second key route moves from an emphasis on insight or other primarily cognitive or verbal efforts to a greater focus on the implicit, procedural, and experiential sources of therapeutic change, viewing emotional immediacy and lived experience as core elements of the process.

These, however, are not the only routes, nor are they one-way streets, leading from the "wrong" side of the tracks to the "right" side. The dimensions I am discussing in this book are not binaries that define wholly separate approaches to the therapeutic endeavor. To be sure, it will not be hard to detect that I view some therapeutic approaches as too centered on pathology or too verbal, cognitive, or intellectualized. But it would be a serious misreading to assume that my message is that one end of either continuum is always what should be emphasized. Some patients particularly benefit from a close examination of the implicit assumptions that shape their experience or guide their life choices or from greater insight into the feelings and desires they have obscured from themselves; without that clearer understanding of their underlying thoughts and feelings, even emotionally compelling experiences in the course of the work can lead to only fleeting gains. Likewise, some patients need a particularly clear and forthright focus on how their interpersonal behavior, emotional reactions, and ways of construing events and experiences *get them in trouble,* and a simply *accepting* stance does them a disservice and can replicate parental neglect rather than parental caring. Dialectical behavior therapy (DBT) in particular is noteworthy for providing that kind of "tough love" approach with regard to behaviors and emotional reactions that are highly problematic and require a frank response to that reality. DBT is also, at the same time, noteworthy for coupling that focus on what needs to change with a genuine emphasis on acceptance in a manner that is aptly named dialectical.

My emphasis in this book on acceptance, emotional immediacy, and *making room* for thoughts and feelings will most be of value if its limits are also appreciated. In this age of promoting therapeutic "brands" (see e.g., Rosen & Davison, 2003; Ablon et al., 2006) and allegiance to ever-proliferating acronyms (what I think of as "acronymphomania"), it is especially important both to disembed from that culture of advocacy and self-promotion and to explore the limits of one's favored point of view. Therapy is a complex amalgam; *many* forms of intervention, *many* ways of relating and interacting almost always are part of the process. There is usually much more that is relevant to therapeutic success than is typically highlighted in the literature of any of the current

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major theoretical orientations (which understandably emphasize those elements that appear unique to that orientation or are primarily emphasized in its conceptual framework).

Almost all treatments for any but the most simple of complaints mobilize a wide range of processes and experiences. These include the experience of being listened to in a respectful, empathic fashion by another person; the experience of being *understood* by the other person, of one's point of view being registered and taken seriously, even when alternatives are also offered; the offering of advice and direction (which happens, whether explicitly or more covertly, in *almost all* therapies, including those that claim to eschew advice or direction); the opportunity to practice new social behaviors and ways of expressing one's feelings to others; opportunities to learn new ways of regulating emotion, including new narratives that change the *meaning* of experiences or introduce new options; clarification of one's values, aims, desires, and phenomenological experience; enabling new ways of understanding the experience of the *other people* with whom one interacts or has a relationship (reflecting the importance of what Fonagy and his colleagues [e.g., Fonagy, Gergely, Jurist, & Target, 2002; Bateman & Fonagy, 2019] call mentalization). All these—and more—are elements frequently (if not always explicitly) part of the overall therapeutic process, contributing to the patient's experience and the prospects for change.

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Common Factors or Multiple Pathways to Change?

Some of what I have just depicted overlaps with the point of view generally described as the common factors perspective. But where the common factors approach seeks to reduce the apparent diversity of methods to just a few underlying dimensions, my aim here is to *dive into* that diversity, to point to the *many* things therapists actually do in interacting with their patients. My assumption is that the more methods, metaphors, strategies, and guiding images the therapist has available to guide her response to this constantly shifting landscape, the more likely she is to be able to find a response that meets the challenges the clinical moment presents.

This strategic choice does not constitute a critique of the common factors approach. Common factors theorists and researchers have made enormously valuable contributions to our field, especially in illuminating the ways that advocates often blur the distinction between evidence for the efficacy of their preferred approach and evidence of its superiority to other approaches. (For discussions of the methodological and rhetorical sleights of hand that can lead to confusions between the

former and the latter, see Shedler, 2010 and 2020, and Wachtel, 2010a and 2018.) The factors that have emerged from the analyses of common factors theorists—such as the therapeutic alliance, the generation of positive expectations in the client, and the provision of a convincing theoretical rationale for therapy (Wampold & Imel, 2015; Wampold & Ulvenes, 2019)—point to important core elements of therapeutic success, relevant across the boundaries of competing theoretical orientations. But the highly individual and often unpredictable ways in which patients can respond to the therapist's efforts mean that often we need many more images and guides to how to respond to what is happening than are provided by these few rather abstract factors. Different levels of analysis can be of value for different purposes.

Thus, to illustrate, while I am in strong accord with the view that it is critical to therapeutic success to establish a strong therapeutic alliance, it is also important to be clear that such a conceptualization offers rather limited real direction as to how to proceed. There is *an enormous number of ways* to establish an alliance effectively, and those ways will differ quite substantially from patient to patient. One patient will require that the therapist lay back, listen, not try to intervene or offer advice, and will be turned off by the therapist's playing too active a role or by her trying to help the patient "solve" the problem ("Just listen, hear me, understand me, don't try to tell me what to do"). Another may have quite different preferences and expectations. He may be put off and fail to develop trust or confidence in a therapist who "doesn't offer very much" or in a therapy that seems to him "just talk." He may *want* advice, *want* the therapist to take charge, may feel *abandoned* (or even in the hands of an incompetent) if the therapist mostly just listens and refrains from overtly intervening. And, of course, the potential variations go well beyond the simple distinction in the foregoing example. People—and therapeutic interactions—are not just of two types. Establishing (and maintaining) trust, commitment, and shared goals requires a wide range of concrete actions and responses with different patients, or even with the same patient at different points in the work.

Trying to build the therapeutic alliance without considering what *kind* of alliance the patient wants and without attending not only to the patient's general preferences and personal style, but also to the particular issues and life circumstances the patient is facing at any given moment, his present emotional state, and a host of other dynamic elements will leave the therapist with only the roughest outlines of a guide to how to respond to the challenges of the therapeutic moment. The alliance does, in a therapy that is going well, constitute a relatively stable foundation that can be fairly forgiving of errors and oversights. But it is nonetheless the product of—and potentially vulnerable to—a myriad of

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specific interactional moments that either deepen and consolidate it or impede and attenuate it. The idea of attending to, maintaining, or aiming to strengthen the alliance is a useful conceptual tool in guiding the therapist's efforts, but it is also a rather *abstract* tool, and does not offer much concrete advice to the therapist who is asking herself "What do I do *now*?"[7]

To be sure, the same can be said regarding making room for the patient's cast off or disavowed thoughts and feelings. Precisely *how* to make that room requires much spelling out and close examination, and it is one of the aims of this book to offer a clinically meaningful articulation of the range of ways this conceptualization can guide daily therapeutic work. Of particular importance in these discussions is consideration of how a deep grounding in the patient's subjective experience and subjective frame of reference can be combined with attention to the patient's *actions in the world*—to his ways of interacting with others, the reactions he evokes in them, the ways those reactions feed back to elicit further (often similar) behavior in him, and the ways these sequential and reciprocal elements organize themselves into patterns that frequently are self-perpetuating, eliciting the very responses that keep them going. These interactive and recursive processes bear quite directly on whether feelings and desires that were experienced as threatening can begin to be reintegrated or will continue to be excluded and treated as "non grata."

The complexity and multidimensionality of these patterns requires a similar multidimensionality in the conduct of the therapy. Making room for thoughts and feelings may sound at first like a singular therapeutic strategy, but, as the book proceeds, it will be apparent that as an organizing idea it is germane to a broad range of methods and perspectives while giving a particular cast to each.

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Generic Elements in the Work

Still further adding to the complex amalgam that is psychotherapy, and to the sense that more goes on in a typical therapy session than any book (or manual or protocol) can fully capture, is that much of what therapists do or say includes "generic" ways of communicating, ways of interacting

[7] In contrast, the literature on *ruptures* in the therapeutic alliance and repairs of those ruptures (e.g., Eubanks, Samstag, & Muran, 2023; Muran & Eubanks, 2020; Eubanks-Carter, Muran, & Safran, 2010; Safran & Muran, 2000), while also strongly grounded in systematic research, offers a much more *clinically applicable* look at these dynamics.

with others that are not only not specific to any particular therapeutic approach but not specific to psychotherapy in general.[8] Rather, they simply reflect how people learn to interact and converse with others in order to make things go relatively smoothly and comfortably. Many things go on in almost every session that were learned not in graduate school but in the ordinary give and take of living and interacting with other people.

These may range from an mm-hmm (that is, a *spontaneous* mm-hmm, not the self-conscious, beard-stroking mm-hmm of a late night movie about psychoanalysis), to a head nod, to a smile, to asking a question, to any of the many other things we say simply to maintain a comfortable flow of the conversation. The proportion of the interaction that constitutes these kinds of generic conversational activities will likely be different in the therapy context than in most conversations, and the differences are probably greater for some orientations than for others. They are also likely to vary from patient to patient and even for the same patient from one session or one interaction to another. But these traces of everyday conversational DNA are a discernable part of the interaction in almost all therapeutic work.

It is important to be clear that these kinds of everyday nonverbal and paraverbal responses are not simply filler; they are an intrinsic part of the process.[9] The well-documented finding (e.g., Wampold & Imel, 2015; Muran & Eubanks, 2020) that some therapists consistently achieve better outcomes than others, quite apart from whatever techniques or theoretical orientation they employ (and in comparison to others who use those same techniques or operate from the same orientation) is likely a product of skill in these everyday aspects of human relating. More generally, for all therapists, these kinds of communications contribute to establishing and maintaining the therapeutic alliance. They are part of the social lubricant that human relatedness depends on. If the therapist is focused exclusively on "the work," little work will be done. If she is too relentlessly "like a therapist," she will be a *poor* therapist. An enormous body of research documents the critical importance of the alliance in

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[8] Here again it should be evident that what I am referring to is not the same as what common factors theorists mean when they refer to nonspecific elements.

[9] They of course *can* be just filler. We all have moments in the session (many, really) where we are uncertain what to say and essentially *punt*, delay, or just "keep something going." Sometimes, this is just to cover up (perhaps even to ourselves) that we *do not* quite know what we are doing at that point, that we are a bit lost. But even here, such behavior on the therapist's part is not necessarily a bad thing or a sign of incompetence. The ability, *during* those moments, to maintain some kind of connectedness, flow, sense of "we are okay" can itself contribute to the therapeutic alliance, and hence to the progress of the work.

contributing to therapeutic success (Norcross & Lambert, 2019; Norcross & Wampold, 2019). But too often, discussions of the alliance treat it primarily in terms of *the proportion of variance* it accounts for. What clinicians really need is examination of *how* the alliance is maintained or strengthened, what they can actually *do* to facilitate this.

Attention to Omissions and Ambiguities

One further element in what I am calling the complex amalgam has to do with attention to ambiguities and omissions in the patient's narrative. One of the most important skills good psychotherapy training hones is the ability to *notice* ambiguities and omissions that might be passed over in most conversation. This is especially important because, as I discuss more in Part II, such ambiguities and unnoticed omissions in people's narratives (and self-narratives) account for a good deal more of the way people retreat from and marginalize thoughts, feelings, and intentions than do the standard "defense mechanisms" that are so prominent in the argot of our field. Here again, we see that a make-room-for perspective is likely to give a different tone to inquiry into these ambiguities and omissions, as it does to most of the therapeutic interaction.

Consider the following simple (but representative) example. A patient, several sessions into the work, says, "My wife and I have had a stressful few years—deaths of parents, losing jobs, four pregnancies, three to term." The death of a parent is obviously a real and important stress, as is losing a job (the latter was the precipitating event that brought this patient into therapy). But what caught my attention, and what I responded to in this instance, was the phrase "four pregnancies, three to term," and, specifically, the way in which "three to term" (I already knew he had three children) was added as an incidental aside. In one sense, he *was* signaling to me that the miscarriage was another of those meaningful stresses of these recent years. But at the same time, he was obscuring and minimizing the significance of this experience (probably to himself as well) by the incidental way he placed it in his narrative. He was, one might say, signaling that this was an area of *conflict,* something *not easy* to talk about.

It is not always clear whether it is a good idea to comment on a mode of narration such as this at any particular point in the process. On some occasions, a comment or question such as "oh, so there was a miscarriage?" or even a further elaboration such as "what was that like for you?" will feel like a lifeline to the patient, an indication that what he thought couldn't be talked about (or perhaps even *thought* about) actually could be. In the terminology of the important work of Weiss

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and Sampson and their colleagues (e.g., Weiss, Sampson, & Mount Zion Psychotherapy Research Group, 1986; Silberschatz, 2005), the therapist here may be "passing the patient's test," showing that his fearful expectation that people important to him will always collude in maintaining avoidance of painful or difficult topics need not be the case and that the feelings it raises can be not only shared but borne and worked through.

But with other patients, or at other points in the work, the same comment by the therapist might feel to the patient insensitively intrusive and, perhaps, require the therapist's skill in repairing ruptures in the alliance (Eubanks, Muran, & Safran, 2019; Eubanks, Samstag, & Muran, 2023; Muran & Eubanks, 2020; Safran & Muran, 2000). In these instances, we might say, passing the patient's test could mean understanding that the incidental way he dangles the topic indicates he needs us not to be intrusive, as perhaps his parent was, but rather to be sensitively patient and wait until he is ready before introducing the subject.

Thus, whether to *say something* about what one has noticed is a judgment call, and we cannot be sure in advance that we are making the right call. If one inclines toward the wait-and-see option as safer and less intrusive, for example, one must recognize that it could *also* trigger a rupture *not* to pick up on the hint. The therapist can potentially fail to pass the patient's test in these instances by confirming the patient's fear that "no one wants to touch those feelings; I better keep them to myself and try to bury them."

But *noticing* what is hinted at but not explicitly stated in the patient's narrative, *noticing* where something seems to be left out or minimized, is important either way. Whether it is talked about now or later—or even never talked about at all as an explicit topic, but rather serves to inform the therapist of a set of issues or sensitivities that form the background for her comments to the patient in a *different* context—it is the ability to *register* such ambiguities, omissions, and circumlocutions that distinguishes the listening and participation of the good therapist from the "mere conversation" it can often resemble.

The skills of the therapist have been described as "listening with the third ear" (Reik, 1949). What Reik was alluding to, and what many therapists aspire to, is an *interpretive* ear, an ear that hears the *hidden meaning* of the unsaid. To be sure, the capacity to hear and understand what is at most only implied is a real asset for a therapist. But accurately reading the meaning of the unsaid is a skill that therapists may believe they have to a much greater degree than they actually do. As in Lake Wobegon, every therapist thinks she is above average. The surer path to therapeutic success, less spectacular or impressive or "magical," but more reliable, more likely to be able to be *counted on* day in and day out, is a different kind of hearing what is unsaid—namely, noticing

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that something was unsaid, that there is an ambiguity or uncertainty or seeming omission in the narrative the patient is presenting to you—or to himself. If we can cultivate our *confusion* or *unclarity*, notice and acknowledge our *not* really understanding what the patient is saying (or, more often, not *fully* understanding), then we are in a much better position to be *reliably* successful.

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