Introduction: The Growth of Relational Therapy

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This issue is devoted to the topic of relational therapy, an exciting and rapidly expanding body of knowledge. The “greening of relational science” (Berscheid, 1999) refers to the recent establishment of relational science (Lebow, this issue), which increasingly informs the field of relational therapy, as a discipline in its own right. The term relational therapy does not connote a particular technique or method, as the reader will see in the diversity of orientations in this issue. The various forms of relational therapy have as their common referent an emphasis on how relationships are expressed in dyadic, triangular, or larger systems. Concomitantly, there is an assumption that the therapeutic process relies most heavily not on the techniques but on the quality and mutual experience of these relationships.

In one sense, all therapeutic endeavors are broadly “relational.” Behavior therapists, cognitive therapists, experiential therapists, psychodynamic therapists, and even pharmacotherapists all conduct the therapeutic transaction within the relational matrix. Thus, although relational therapy is by no means new, the theoretical landscape is in continual flux as new forms develop and integrative models are offered. Many therapists and theorists are rediscovering, experimenting with, blending, and modifying elements of traditional and nontraditional approaches and are emphasizing the importance of the relationship. Although there are many forms of relational therapy, common roots and elements exist that indeed tie them together. The field of relational therapy has not evolved in linear fashion, as other “schools” of psychotherapy have developed, but rather has emerged from the convergence of a number of separate but parallel ideas and movements. In this issue, these various branches of relational therapy will be explicited to clarify their contribution to the tree of psychotherapy.

The Branches of Relational Therapy

The major theoretical and empirical developments that have advanced the field of relational therapy are (a) the intersubjectivity of the dyadic relationship, (b) the development of triadic theory, (c) the centrality of relationships in women’s development, (d) the therapeutic alliance and, (e) a new model of relational diagnosis and treatment.

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The Dyadic Relationship

The trunk of the tree of psychotherapy split early on as Freud's emphasis on the self differentiated from those emphasizing the self in the relationship. The divergence of relational therapy can be seen very early in the evolution of psychotherapy, when Ferenczi (Ferenczi & Rank, 1925) began to experiment with various ways of intensively engaging patients, emphasizing the relational field as opposed to the technical aspects of traditional psychoanalysis (i.e., neutrality, interpretation, development of transference neurosis).

Ferenczi offered a "real relationship," later referred to as intersubjectivity, as opposed to a transference relationship. In other words, the therapeutic narrative and experience is not objectively observed but a perspective is mutually developed. In Ferenczi's model, the therapist did not sit passively behind the couch but faced the patient in a more intimate way, exposing his/her body language and reactions and actively engaging the patient. Ferenczi suffered considerably for his experimentation and his divergence from the status quo. Many of his seminal articles were repressed until recently (Rachman, 1997). His work, however, is perfectly relevant today, especially his belief that the main ingredient of change is the quality of the therapeutic relationship or alliance as it is currently conceived. He believed the therapeutic relationship was elastic and should be a joint partnership with the patient. This notion, that the quality of the therapeutic relationship is an essential element of the change process, has been empirically validated in modern psychotherapy research, which found common factors (i.e., expectancy, trust, collaborative nature of relationship, empathic attunement, and so forth) to be essential elements in all orientations of psychotherapy.

After a century of modern psychotherapeutic progress, it also has become clear that the "self" of the therapist and the establishment of core conditions for conducting the therapy, as well as the mutuality in the relationship, form the foundation of all effective treatment. The question of stance (i.e., neutral/abstinent, self-disclosing/revealing) arouses much polemics but most believe that the therapist's stance should vary depending on the needs of the patient(s) and no one stance is appropriate for everyone (Magnavita, 1997, 1999). In the past, schools of psychotherapy have emphasized one stance over another and argued for superiority of a particular position. Today, therapists seek clinical utility and are generally more integrative and eclectic in approach.

The Triangular Relationship

The next major event in the evolution of relational therapy that transformed the field was sparked by the development of General Systems Theory in the 1930s (von Bertalanffy, 1952). General Systems Theory is a model for understanding the often concurrent and overlapping feedback loops that occur in complex systems. This theory has been applied to the behavioral sciences including cognitive science, communication theory, and neuroscience. Originally, the systems model was used to try to understand the communication patterns in families with a schizophrenic member, whereby an interdisciplinary team observed the way two family members from different generations created problematic coalitions at the expense of a third family member. A classic article, The Family of the Schizophrenic: A Model System (Haley, 1959), showed that there was evidence of complex and contradictory communications in these systems. This was the beginning of triadic theory, which is now the cornerstone of family therapy (Imber Coopersmith, 1985).

Bowen (1978), another early innovator of family therapy, expanded the general systems theory and triadic models by further developing the construct of triangular config-
urations in human systems and the rules by which they operate. He also demonstrated how triangles serve to reduce anxiety in a dyad or individual by drawing in another person to diffuse and absorb the anxiety. Thus, therapists commonly see unresolved marital tension being absorbed or deflected by a symptomatic child (i.e., behavior disorder, psychosomatic illness, depression) or in the enactment of an affair. This construct, along with the operating principles, represented a major breakthrough in the field of psychotherapy. The old model of psychopathology existing solely within the individual was transformed. As the systems model took hold, the traditional child guidance model of the 1960s gave way to the relational model of family therapy, changing the way psychotherapy was delivered. In the child guidance model, the child and parent were seen separately. The therapist could now bring the child and parent(s) into the same room, to observe and involve him/herself in the process and dynamic flow; this represented a phenomenal shift in the therapeutic action.

A new way of understanding the dynamic relationship among symptoms, interpersonal relationships, and family systems was now possible. Instead of viewing psychopathology and symptom constellations as existing within the closed system of the patient (intrapersonal), it now became possible to view the relational matrix in all its complexity using basic concepts such as homeostasis, fusion, and differentiation. Guerin, Fogarty, Fay, and Kautoo (1996) best describe the clinical utility of the triangle:

Knowing about triangles, being familiar with how they work, and having a repertoire of interventions for exploring and resolving them are invaluable weapons in the therapist’s armamentarium, no matter what the therapist’s theoretical orientation. Whenever you look carefully at cases that don’t respond to treatment or seem stuck, look for a triangle you haven’t seen yet. Whether the treatment is systems therapy, psychodynamic therapy, medical treatment, or some combination, you’ll find that defining and modifying the relationship triangles surrounding the symptom bearer or the relationship conflict is essential to therapeutic progress.

(pp. 28–29)

Marital and family therapy became popular following these pioneering developments. Many psychiatrists, psychologists, social workers, and mental health counselors sought training in systemic approaches and a new discipline, marital and family therapy, was born. Berscheid and Reis (1998) write of this aspect of the field of relational therapy: “As the divorce rate escalated in the 1960s and 1970s, the public increasingly demanded expert help with their relationships. As a consequence, mental health professionals began to practice relationship therapy, and today, many embrace a ‘systems’ approach to the treatment of distressed individuals in which the individual is viewed as embedded in a dysfunctional system of relationships which itself warrants treatment” (p. 194).

The field of family therapy is a burgeoning one and the developments it has offered inalterably changed the theoretical and clinical landscape of the field of psychotherapy by expanding the intrapersonal orientation of psychoanalysis, and the later interpersonal orientations to a broader frame. The main models of relational therapy on this branch of the tree are integrative ones blending psychodynamic, systemic, and behavioral principles (Magnavita, 1999; Pinsof, 1995; Wachtel, 1997).

The Centrality of Relationships—The Psychology of Women

One branch of the tree of relational therapy was developed in reaction to women experiencing a disconnection or therapeutic misalliance in many forms of traditional, abstinence therapy. “The seeds of the relational theory were presented by Miller (1976), a classically trained psychiatrist, in her book, Toward a New Psychology of Women”
A group of like-minded, feminist psychologists created a pragmatic shift by developing a theory of women’s psychological development that emphasized the centrality of connections in women’s lives. Miller’s theory was expanded by a number of theorists including Jordan (1986), who discusses one aspect of her approach in this issue of *In Session*. What this approach shares in common with other relational models is the belief that the self is located in the relational field and not within the individual (Sullivan, 1953). In particular, it emphasizes the importance of relationships as a organizing feature, central to the development and psychological well being of women. Many of the theoretical developments have been accepted into mainstream psychotherapy.

**Alliance Building and Maintenance**

The other branch of the tree of relational therapy grew out of more formalized attempts to conceptualize and research the therapeutic alliance (Safran & Muran, 1995). Therapists recognized the fact that when the therapeutic relationship is not strong, treatment outcome is jeopardized and premature termination often results. A major effort to understand the active ingredients of the therapeutic alliance was initiated by proponents of various theoretical orientations. The importance of factors such as active collaboration (Horvath, 1995) and interpersonal relatedness (Raitt, 1995) as well as how to handle inevitable ruptures of the alliance (Watson & Greenberg, 1995) became important topics in clinical and empirical research. Approaches to therapy emphasizing the importance of creating and maintaining a therapeutic alliance conducive to the therapeutic progress were developed and continue to evolve (Safran & Muran, 1999).

**Relational Diagnosis**

Yet another, separate branch in the tree of relational therapy grew from the limitations and dissatisfaction with the dominant individualistic approach to diagnosing mental disorders, as reflected by the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994). A movement began to develop an alternative, known as “relational diagnosis” (Kaslow, 1996). Relational diagnosis has been in the gestational stages for some time and is slowly evolving into a formalized system, although empirical support is still needed. Relational diagnosis is based on the assumption that psychopathology has its roots within relationships and that diagnosis should consider the relational field. Kaslow explains why this system is important:

> On a clinical level, a widely accepted relational diagnostic schema would permit us to clearly and accurately convey to other mental health professionals our assessment of our clients’ problems and the rationale behind the treatment plan and interventions used. In addition, such a taxonomy would simplify the task of researchers seeking to mount or replicate a study involving relational dynamics and patterns. (p. xii)

It is my hope that this issue of *In Session* will spark further interest in this area, but more importantly, will provide clinicians with some new ideas and new approaches to treat the complex human conditions that we encounter in our therapeutic relationships.

**Organization of this Issue**

This issue devoted to the topic of relational therapy will offer the reader a small but incisive sampling of the some of current cutting edge work being done by innovative
clinicians, theorists, and researchers in this area. These articles are intended to excite and engage the reader while providing helpful concepts, strategies, and techniques that have distinctly clinical utility. The issue begins with a thought-provoking and challenging article by Jordan. In this article, the author presents her understanding of the central role that mutual empathy plays in the therapeutic relationship. Jordan challenges us to reconsider the distance that many therapeutic approaches eschew for their practitioners. My reading of the article made me think deeply about the level of vulnerability I can manage and the intensity of engagement I offer my patients.

The second article by Rigazio-DiGilio presents an innovative non-pathology-based model for relational diagnosis and treatment. This model provides a framework for assessing the contribution of multiple factors in the relational matrix, which affords clinicians the opportunity to intervene systemically at critical fulcrum points while drawing from a variety of therapeutic approaches.

The third article by Diamond, Diamond, and Liddle provides another perspective on developing a therapeutic alliance. The authors present a three-phase model to facilitate building an alliance with the parent in the family therapy of adolescents. They offer expert guidelines on how to manage the alliance so that the often precarious attachments in the family of a depressed adolescent can be mended. These attachments often have been disrupted by abuse and a multigenerational lack of effective parenting.

In the fourth article, I present my model of integrative relational psychotherapy and demonstrate how it can be used in the treatment of the complex syndromes that are often seen in clinical practice. Along with this model, I briefly present a new classification system for what I term the dysfunctional personologic system and ten subtypes that are fairly common in clinical practice. The difficulty and importance of ending the multigenerational transmission process in these systems is highlighted.

The fifth article by Watson and McDaniel emphasizes the collaborative stance needed to work effectively with families with somatoform disorders, a particularly challenging group. They emphasize the importance of collaboration with the healthcare team and review the foundation principles for working with these families.

The final article in this issue by Lebow does an excellent job of summing up the research in relationship-centered therapies. He underscores the fact that relationship functioning and individual functioning co-evolve and argues for a biopsychosocial framework.

There is, I believe, and as I hope the reader experiences, a true synergy in this volume. The authors are innovative thinkers, therapists, and leaders in the field, and this issue represents an attempt to provide a useful balance among theoretical developments, clinical utility, and empirical findings. Many aspects of relational therapy are considered from varying vantage points such as mutuality, therapeutic alliance, and collaboration. The authors provide complementary perspectives for understanding the similar but complex phenomenon we know as relationships and how they are used in the art and science of healing.

Select References/Recommended Readings


