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Thirteen Points for Recognizing Past/Historical Issues in the Therapeutic Relationship

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Abstract

This paper aims to inform therapists by training them on the "past/historical" processes in their therapeutic relationships. Horvath and Bedi (2002) considered these processes the second component (with the alliance) of the "therapeutically active ingredients" of the therapeutic relationship. Relational science provides a fresh look at these processes, including the effects of attachment on the right hemisphere (Shore) and the sociometer theory of self-esteem (Leary), a relational self-model of transference (Andersen et al.), contingent self-worth domains, and achievements of "emotional highs" (Crocker & Parker). This work proposes a *relational self s* perspective that offers a more comprehensive conceptualization of the therapeutic relationship, including 13 "points of recognition" for therapists in training.

Keywords

Attachment, Nonverbal, Right Hemisphere, Selves, Transference

1. Introduction

Often when "stuck", in therapeutic issues, beginning therapists will frequently ask their supervisors, "What should I do?". The typical answer is in verbal terms. The findings from research on relationships reviewed in this paper, however, indicate that there are multiple aspects of relationships that are not confined to observable verbal exchanges, but these aspects have received limited attention in the therapeutic relationship literature (with the notable exceptions of Muran, 2006, and Wallin, 2007) and consequently in their training.

These relational science findings selected for their relevance to client-therapist relationships are: 1) the therapist's own interpersonal history and sense of self with the client will affect the relationship, 2) the processes of the right cerebral hemisphere will be affected by attachment experiences and by experiences in therapy,

3) nonverbal communications between therapist and client may affect the strength and quality of their relationship, 4) clients have different implicit senses of self in their different relationships, 6) the affective associations of previous experiences in domains linked to low self-worth need to be explored to promote client experiences of "emotional highs", and unconscious processes of both therapist and client will operate simultaneously in the relationship. While none of these considerations are new discoveries, when linked together, they may offer a more complete formulation for understanding the complexities of the therapeutic relationship.

Table 1. Past/historical issues in your therapeutic relationships.

1	Your own interpersonal history and the interpersonal history of your client will interact to affect the "chemistry" between you.
2	Your own sense of self and your client's sense of self will vary somewhat with each of your interactions with others.
3	The degree to which your client will be able to explore difficult problem areas will be influenced by his early attachment experiences of having a secure base.
4	Improvements in your client's affect regulation will be strongly influenced by the nonverbal communications between you that are processed in the right hemisphere.
5	Recognition and use of nonverbal communication between you and your client can lead to, in a sense, an upgrading of the "wiring" in the right hemisphere.
6	You and your client may be more attuned to negative evaluations of your respective values for one another relative to more positive evaluations.
7	Who you are to the client depends on who you represent in the client's history; who the client is to you depends on who she/he represents in your history.
8	You need to be alert to signs (increases in negative affect, decreases in positive mood) that the client may be experiencing some aspect of her/his "dreaded self" in your relationship, and then explore that.
9	Through exploration you need to help the client examine their experiences in previous anxiety-linked "contingent" domains, particularly their affective associations.
10	For a growth experience in therapy, clients need to experience the "emotional hfgh" of an enhancement of their relational value.
11	You need to be alert to the possibility that you have unconscious goals related to the therapeutic relationship that conflict with the unconscious goals that your client may have regarding the relationship.
12	You need to be aware of the possibility that the client is transmitting a nonverbal message of the "unthought known" and that your own nonverbal reactions will provide cues to "decode" the message.
13	Do not be so captured by the content of your therapy conversations that you fail to recognize the "affectively toned, preverbal, preconscious processing" that is happening in your session.

Our intent here is to first examine the relationship literature, each from a different angle, for the purpose of providing a perspective for beginning therapists in their recognition of the "past/historical" issues. In each of these literatures, we will suggest their relevance for the therapeutic relationship. A later section will further elaborate on the application of a relational self's perspective for the therapeutic relationship. Recognizing these past/historical issues provides an important complement to learning skills in case formulation and techniques, but is often neglected

in training programs. Toward this end, we will highlight specific "recognition" points as we proceed, as guides for beginning therapists, also listing these points in Table 1.

The empirical research literature on the therapeutic relationship has focused almost exclusively on one component, the therapeutic alliance. The alliance is generally considered to be a "common factor" operating across different therapy orientations (e.g., Bachelor & Horvath, 1999; Castonguay & Beutler, 2006; Wampold, 2001). In their review of studies yielding 91 effect sizes over a period of 24 years, Horvath and Bedi (2002) found the mean correlation between the alliance and outcome across studies was .21; the median effect size was .25, accounting for about 5% of the variance in outcome. These results represent a consistent but not a robust relationship. Calculating generalizability coefficients, however, Crits-Christoph et al. (2011) found that using alliance measures from fewer than four sessions underestimated this variance in outcome due to the alliance. They also noted that using alliance measures from later sessions in therapy could misrepresent reciprocal causation, as improvements in depression may inflate alliance scores.

Horvath and Bedi (2002) define the alliance as specific to the psychotherapy situation, purposeful, and mostly conscious for both parties. However, they suggest that the therapeutic relationship is a construct broader than the alliance since it also includes elements representing experiences in past interpersonal relationships of both client and therapist. "It seems to us that a combination of these two components, the alliance, and the past/historical elements, in combination, may provide a useful overarching model of the therapeutically active ingredients of relationship" (p. 41, italics added). We would maintain that the past/historical component is also a common factor that has effects on the therapeutic relationship across the use of diverse therapy techniques.

2. Thirteen Recognition Points

2.1. Therapist Recognition Point 1: Your Own Interpersonal History and the Interpersonal History of Your Client Will Interact to Affect the "Chemistry" between You

Research on the therapeutic alliance has been immensely important in bringing recognition of the contributions of the relationship to outcome in the psychotherapy research field. It is, however, limited in its contribution to understanding the dynamics of the therapeutic relationship. Measurement of the alliance has been, for the most part, the completion of items on scales separately by clients and therapists. This process is individual, cognitive, conscious, and predominantly verbal. From an examination of relationship literature, this method does not adequately capture the interactive, emotional, unconscious, and nonverbal qualities of the therapeutic relationship.

The Relational Selves Perspective

A fundamental conceptualization of the relational self's perspective assumes we

experience ourselves differently in interactions with different people, and this is influenced by our past interpersonal experiences. Carl Rogers' view of multiple selves posits that the self is a "fluid and changing process, but at any given moment, it is a specific entity" (cited in Meador & Rogers, 1979: p. 147). Harry Stack Sullivan offered that each of us may have as many personalities as we have interpersonal relationships (cited in Sullivan, 1964). Muran (2006) described a postmodern view of the self as: "There is no basic structure that is the self, no true or real self, but rather a number of selves that are equally real. Each self is constructed out of social encounters that comprise one's relationships, and each requires a social context if it is to exist and become present in experience" (p. 5).

Although each of us has a set of fixed core characteristics of the self that remain across different relationships, including temperament, cognitive capacities, culture, and physical attributes, our implicit sense of self varies with each interaction partner. Our more implicit sense of self with romantic partners differs from that with employees, superiors, friends, etc., although these different senses usually do not intrude clearly into our awareness. Influenced by our associations with our interpersonal histories, each interaction partner elicits unique internal reactions, emotions, behaviors, thoughts, and corresponding perceptions of our value to the partner.

2.2. Therapist Recognition Point 2: Your Own Sense of Self and Your Client's Sense of Self Will Vary Somewhat with Each of Your Interactions with Others

2.2.1. Early Relationships and Experiences of the Self

This relational self's perspective does not assume that early interpersonal experiences determine adult interpersonal relationships; this perspective acknowledges that experiences throughout life can influence a person's view of self at any age. The perspective does assume that relationships early in life will continue to have powerful influences on the sense of self throughout life (Fogel, 1993).

2.2.2. Attachment Theory

Attachment theory, developed by Bowlby (1969, 1973, 1988a) and his collaborator Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978), proposes that there is a need for the child to attach to a person who will provide protection and security. There are two basic needs according to this theory: survival and exploration, and both require secure attachment experiences. To be secure, the caregiver serves as a haven from threats to survival and functions as a secure base from which the child can explore the world and return to safety.

Feeney (2004) notes the difference in functions provided by these different secure attachment experiences. For the safe-haven function, the caregiver offers responsive support and care to the child experiencing threat, injury, or other forms of stress, reflected in the related concept of proximity-seeking. For the secure base function, the attachment figure provides support that encourages the child's exploration and discovery. Feeney (2004) found that the manner in which support was

offered by partners in intimate relationships was related to exploratory behaviors. Support behaviors that were responsive, sensitive, and non-intrusive promoted exploration, while support behaviors that were controlling or intrusive had negative effects on exploration. These findings suggest that clients' tolerance for exploring difficult areas will be constrained by the nature of support for exploration in their earlier relationships.

2.3. Therapist Recognition Point 3: The Degree to Which Your Client Will Be Able to Explore Difficult Problem Areas Will Be Influenced by His Early Attachment Experiences of Having a Secure Base

Bowlby (1988b) believed that from experiences with caregivers, the child develops internal working models. These models include a set of rules and expectations that the child, and later the adult, used to interpret the emotions of others and to anticipate the reactions of others. The internal model of the self includes the degree to which the person has an internalized sense of self-worth based on the behaviors and attitudes of the caregiver toward the child. The internal model of others includes the degree to which others can be expected to be available, protective, and supportive based on the degree of responsiveness of the caregiver to the child's needs.

Recent conceptualizations of working models have moved toward different models for different relationships, rather than being limited to the self and other models functioning in a trait-like fashion in all relationships. Collins, Guichard, Ford, and Feeney (2004) propose a default hierarchy with models for people in general at the top level, domain-specific relationship models at the intermediate level (e.g., parent-child, friends, colleagues), and relationship-specific models for particular persons.

Attachment and the Right Hemisphere

Early adult attachment theory focused on the activation of the attachment system when an infant faces threat or stress, and the various insecure strategies employed to manage that activation. Over the last decade or so, however, several researchers and theorists have broadened their interests to consider the enduring effects of early attachment experiences on the right cerebral hemisphere (e.g., Cozolino, 2006; Fonagy & Target, 2005; Sarkar & Adshead, 2006; Schore & Schore, 2008).

The right hemisphere sustains the paths for visuospatial functions and emotional regulation functions that are important for the infant's survival. These functions mature earlier and more quickly, typically in the first 30 months of life (Schore, 2003), than the language-dominant left cerebral hemisphere (Chiron et al., 1997).

Thus, attachment experiences occurring during critical periods of right brain development likely precede the modifying effects of cognitive executive functions that are predominantly in the left hemisphere (Stern, 1985, 1997, 2010).

Secure attachment experiences, which produce adaptive affect-regulation, lead to optimal right hemisphere maturation during this critical period (Schore, 2000). Insecure attachment experiences such as abuse, neglect, or inconsistent responsiveness during this period can impair the development of neural pathways, potentially leading to lifelong emotional regulation difficulties—a central feature of many personality disorders (Sarkar & Adshead, 2006). Schore and Shore (2008) reviewed psychobiological research findings and concluded that positive affective communications between child and caregiver facilitated the maturation of the child's brain systems regulating emotion and self-views.

One's awareness of and sense of self that are related to attachment experiences are predominantly emotionally charged and likely stored in the right hemisphere. Devinsky (2000) concluded, "Several lines of evidence [including reports on patients with right hemisphere damage and neuroimaging studies] suggest that the right cerebral hemisphere is dominant for a sense of physical and emotional self; specifically, for an individual's awareness of his or her own corporeal being and in relation to the environment and affective state" (p. 60). Feinberg and Keenan (2005), in their review, stop short of claiming that the self "resides" in the right hemisphere. However, they conclude: "... these findings suggest that the right hemisphere is dominant for these aspects [creation and maintenance] of self" (p. 675). To extrapolate from these findings, we might speculate that the right hemisphere is important for the beginnings of a person's internal working models of the self and of others. Although such findings may well oversimplify the left/right dichotomization of the brain into perhaps overly precise task-specific categories, these findings suggest that changes in the sense of self during therapy likely involve significant alterations in the right hemisphere, as proposed by Schore and Schore (2008).

Devinsky (2000) analyzed findings from several neurological studies (Shallice et al., 1994; Fink et al., 1996) and concluded: "that the right frontal and temporal lobes may be important in autobiographical memory, especially for those with emotional content" (p. 66). This would suggest that attachment experiences applicable to transference phenomena have been stored in the right hemisphere.

Since the verbal functions of the left hemisphere are not well developed before the first two and a half years of the infant's life, communications with primary caregivers during this stage must be largely nonverbal. Infants cannot clearly express their needs with words, and they cannot fully comprehend the content of the words of their caregivers. Infants communicate by crying, grimacing, fussing, wiggling, and thrashing. Infants can comprehend their caretakers' touch, the tone and inflection of their voices, how they hold the child, their facial expressions, and their posture. Thus, communications between infants and their caretakers at this early attachment stage are primarily through right hemisphere functions. These nonverbal communications lay the groundwork for future developments of affect regulation, sense of self in their relationship with the environment, and emotion-related memories of their interactions with their caregivers.

2.4. Therapist Recognition Point 4: Improvements in Your Client's Affect Regulation Will Be Strongly Influenced by the Nonverbal Communication between You That Are Processed in the Right Hemisphere

In a series of classical conditioning experiments, Baccus, Baldwin, and Parker (2004) explored methods for modifying individuals' implicit self-esteem. In their studies, pictures of faces with accepting, frowning, or neutral expressions were paired with personal information about the participants (e.g., birthday, hometown). If the self-information was paired with accepting faces, self-esteem increased, while aggressive thoughts and feelings decreased. This enhancement did not occur in the control condition, where self-information was randomly paired with frowning or neutral faces. This finding suggests the importance of nonverbal communication of acceptance (or not) from the therapist to the client for their relationship.

Right Hemisphere in Therapy

Schore and Schore (2008) propose that just as the right hemisphere communications are critical for the child's development, they are also important in the therapeutic relationship. They suggest that such implicit right hemispheric communications (facial expressions, posture, prosody) are expressed by therapist and client in the therapeutic relationship. They conclude that, particularly with personality-disordered clients, effective therapy ultimately promotes increased complexity in the right hemisphere system. Schore (2000) further notes that the orbitofrontal system is involved in "emotion-related learning" and retains plasticity in later life that allows therapy to modify early emotion-related attachment patterns.

This plasticity supports the Sullivan notion (Sullivan, 1953) that therapy involves "emotional re-learning" and can now be framed as: "therapy upgrades the wiring of the right hemisphere".

2.5. Therapist Recognition Point 5: Recognition and Use of Nonverbal Communication between You and Your Client Can Lead to, in a Sense, an Upgrading of the "Writing" in the Right Hemisphere

Siegel (2006) summarizes the different modes of processing of the two hemispheres. The left hemisphere processes inputs linearly, logically, linguistically ("words are the left's love", p. 96), and literal, right/wrong thinking. The right hemisphere processes inputs more holistically; it works well with visuospatial patterns and nonverbal inputs, tolerates nonlinearity and ambiguity easily, and is related to several functions, including stress reactions, spontaneous emotion, and nonverbal aspects of empathy.

In therapy, the left hemisphere processes are particularly important for the task and goal aspects of the therapeutic alliance, or the more collaborative and purposeful "work" of therapy and the "work supporting bond" as emphasized by Hatcher and Barends (2006: p. 296). Right hemisphere processes seem particularly im-

portant for the more emotional and nonverbal aspects of the "potentiating bond" (Hatcher & Barends, 2006: p. 296) and for the emphasis by Bordin (1979) and Safran and Muran (2000), on the affect-laden negotiations between therapist and client concerning tasks and goals.

Sociometer Theory and Relational Value

Leary and colleagues proposed the sociometer theory of self-esteem (SE) (Leary, Tambor, Terdall, & Downs, 1995; Leary & Baumeister, 2000; Leary, 2005). The sociometer is a hypothetical unconscious mechanism that, similar to a thermostat, monitors one's relational value, i.e., the probability of being included or excluded in relationships. In this view, SE serves as an internal readout of the sociometer, reflecting one's current chances of inclusion. Thus, SE is not merely a private self-evaluation. This theory maintains that "in reality, people are trying to increase their relational value in other people's eyes rather than their [own] self-esteem per se" (Leary, 2005: p. 91). The sociometer continuously scans the person's past relationships as well as present ones for indications of negative evaluations of the person by others, and it activates the person's efforts to improve or at least maintain inclusion. Further, the sociometer anticipates likely evaluations of the person in future relationships.

Inclusion vs. exclusion in an evolutionary sense is a matter of survival. Given this extraordinary significance, the sociometer is calibrated to be highly sensitive to negative evaluations by others, but less sensitive to positive indications of relational value. Due to this calibration, one's sociometer is not precisely accurate in gauging relational value and is prone to misinterpretation of more subtle and symbolic communications from others. The therapeutic relationship would be no exception. In the therapeutic relationship, as in other relationships. Both therapists and clients may misinterpret each other's communications as negative evaluations of themselves and tend to be less attuned to more positive messages.

2.6. Therapist Recognition Point 6: You and Your Client May Be More Attuned to Negative Valuations of Your Respective Values for One Another Relative to More Positive Evaluations

Interpersonal histories significantly influence current expectations of relational value. Studies of the parental behaviors toward their children find positive and accepting relationships are related to high self-esteem, while more negative and rejecting relationships are not (e.g., Felson, 1989; Garber, Robinson, & Valintentiner, 1997). Related to attachment experiences, Shaver and Hazan (1987) noted that low SE would follow naturally from a negative internal working model of the self. Leary and Baumeister (2000) suggest that a history of relational devaluation experiences has the effect of calibrating the sociometer to be overly sensitive to possible negative evaluations. Thus, adults with low relational value are likely to have had repeated experiences with others who show disinterest, rejection, and even ostracism in their interactions with the person.

Findings by Murray, Griffin, Rose, and Bellavia (2003) suggest that people can activate multiple sociometers that differ in specificity, including a more global sociometer that operates with strangers. More specific sociometers operate with different established relationships. In therapy, it might be expected that the more global sociometers of each party would operate initially; more specific sociometers would develop as their relationship evolves. It is assumed here that early relationship experiences will interact with later experiences to influence adult interpersonal transactions.

Relational Self-Model of Transference

The model of transference studied by Andersen and colleagues (Andersen & Chen, 2002; Andersen & Sariby, 2006; Glassman & Andersen, 1999; Miranda & Andersen, 2007) suggests that transference is a normal phenomenon stemming from interactions with significant others, past and present. It is not limited to client-therapist relationships. Nor does transference derive from the more drive-structure assumptions of early childhood as first conceived of by Freud. Their relational self-model "holds that people have a repertoire of relational selves in memory, each linked with a specific significant other" (Andersen & Saribay, 2006: p. 1). The belief is that the need for connection and security is fundamental. Koi both attachment theory and Andersen's relational self-model. Bowlby's attachment figure would be a representation of a significant other in transference in Andersen's model.

A significant other, according to Andersen and Saribay, is a person who is deeply influential in the person's life. Influential persons may have been early caretakers, but not exclusively so. Various expectations, perceptions, emotions, and perceived relational values are associated with the significant other based on the history of the person's interactions with the influential person (Memories Stored in the Right Hemisphere, Devinsky, 2000). Current characteristics of situations or individuals may activate associations with the significant other, which may then be projected onto the new situation or individual.

Andersen and colleagues have studied transference as a social-cognitive phenomenon of common everyday experiences in everyday relationships. They found significant other representations to be readily accessible and to persist over time (Andersen, Glassman, Chen, & Cole, 1995). Andersen and Saribay (2006) established that transference effects can occur without awareness of the connection with the significant other, in this model. The term "countertransference" would lose its meaning since therapists could be transferring their experiences with their own significant others to the client in the same manner as the client transferring those experiences to the therapist. (Protter (2006) prefers the term "co-transference matrices" (p. 324) as representing a more participative-interactive therapeutic relationship than the classical view of transference as being unidirectional.)

Andersen and colleagues have studied dyadic interactions between strangers to assess the process of transference, after planting the suggestion that a dyadic part-

ner is either similar to or different from a participant's "significant other". The Andersen group emphasizes (Andersen & Saribay, 2006), based on their findings, that we have had different experiences with different significant others and that our sense of self varies with those different experiences. Hinkley and Andersen (1996) found that participants changed their working self-concept when interacting with representations of their significant other. When the significant other was evaluated positively, the change in self-concept was positive. This finding supports the premise that in transference, one's sense of self is influenced by the cues triggered by the new situation or person. These cues activate a particular significant other representation and the experiences of self-association with that particular significant other. When in any given new interpersonal situation, who we are depends on "who" the new person represents.

In the therapy situation, this relational self's perspective raises the question, "Who is the therapist to the client?" and "Who is the client to the therapist?" as well. Andersen's work would suggest that to the degree that person in the therapy situation has characteristics similar to those of significant others in that person's history, this will influence the person's experience of self in the therapeutic relationship. This influence could lead to feelings of comfort and safety or to discomfort and defensiveness in either person, depending on their histories, without their awareness of the link to their significant others. These influences may contribute to the initial interpersonal "chemistry" between therapists and clients found by Sexton, Hembre, and Kvarme (1996).

2.7. Therapist Recognition Point 7: Who You Are to the Client Depends on Who You Represent in the Client's History, Who the Client Is to You Depends on Who She/He Represents in Your History

In their discussion of the implications of their work on transference for the psychotherapeutic relationship, Miranda and Andersen (2007) warn that even those reputedly positive therapist characteristics such as being understanding and empathic may be aversive for the client if those characteristics are associated with negative experiences with a significant other. They acknowledge the greater complexity and the higher "labor-intensive" costs of researching relational self-transference operating in therapy relationships, compared to research using alliance self-reports.

From this conception of transference, therapists would need to anticipate that at the beginning of work with a new client, certain aspects of the client's expectations of the therapist may be communicated nonverbally (e.g., posture, eye contact) or in the pattern of interacting (e.g., difference, challenging, maintaining distance) may reflect their associations with significant others. The therapist would need to assess whether the client's reactions are to the therapist's role or associations with significant others. Parallel to that assessment, therapists should closely examine their reactions (especially emotional reactions) to the client for similarities with other possible significant others in the therapist's life. This awareness on

the part of the therapist could aid the therapist in anticipating and recognizing problematic issues that may arise in the therapeutic relationship.

Therapists cannot have objective or first-hand knowledge of the behavior or attitudes of their clients' significant others, nor do they need to have such knowledge. It is important to recognize that the attitudes or behaviors that the significant other directed toward the person, be they either negative or positive, are not the determinants of the person's sense of self-worth. Rather, the determinant is the experience of the self when the person is interacting with that significant other (Andersen & Miranda, 2006). Based on client reports, it can be tempting to judge the client's significant others, but this detracts from a focus on the client's experience.

In their studies on the emotions evoked in transference situations, the Andersen group (Andersen & Saribay, 2006) found that, for some certain representations, the reported overall evaluation of the significant other was positive, but the emotional response to representations of that person was negative. Andersen and Saribay term this a disruption of a generic positive mood associated with the particular significant other. One factor that may contribute to such a disruption is described as "an enactment of a dreaded version of the self" (Andersen & Saribay, 2006: p. 22). In the original patterns of interactions with the significant other, individuals often exhibited aspects of themselves that felt inconsistent with their true selves, yet they felt compelled to display these traits in order to gain approval from the significant other. As the authors note, if the significant other were a family member, the person probably would not have been able to either change the pattern or completely leave the relationship. Findings of "dreaded sell" responses in transference conditions were that the participants experienced increases in negative affect and decreases in positive mood. In the therapeutic relationship, should clients have the dreaded self-experience, they could well terminate the therapy. This might happen if the therapist is, consciously or unconsciously, encouraging the client to change in directions similar to past dreaded self-enactments.

2.8. Therapist Recognition Point 8: You Need to Be Alert to Signs (Increases in Negative Affect, Decreases in Positive Mood) That the Client May Be Experiencing Some Aspect of Her/His "Dreaded Self" in Your Relationship, and Then Explore That

A common theme in the above conceptualizations is the emphasis on the multiplicity of relational processes as opposed to single, independent, or constant influences. The newer view of internal models in attachment theory includes three levels related to different relationships. In sociometer theory, self-esteem varies in value from more general to more specific relationships. Andersen and colleagues found that people have multiple significant others and correspondingly multiple relational selves. From this perspective, therapists should avoid viewing their clients' interactions in categorical, trait-like, or static terms, including diagnostic labels (e.g., "she relates in typical borderline fashion").

Domains of Contingent Self-Worth

According to Crocker and Park and Associates (Crocker & Wolfe, 2001; Crocker, Luhtanen, Cooper, & Bouvrette, 2003; Park, Crocker, & Vohs, 2006), self-worth is not a general trait, it is domain-specific, including areas like academic success, appearance, or relationships Self-worth is closely related to the concept of relational value in sociometer theory. Specific experiences in domains in childhood (e.g., rejection, neglect, denigration) that are linked to anxiety, overgeneralize to adulthood and serve to give that particular domain critical significance for the person's sense of worth. In therapy, this conceptualization would emphasize the importance of helping the client identify such "contingent" domains, explore them, and help weaken the anxiety link with them.

2.9. Therapist Recognition Point 9: Through Exploration, You Need to Help the Client Examine Their Experiences in Previous Anxiety-Linked "Contingent" Domains, Particularly Their Affective Associations

Through therapeutic exploration, clinicians help clients examine experiences within prior anxiety-linked *contingent domains*, with particular emphasis on the *affective associations* that have become conditioned to those domains. Anxiety disorders are widely understood as involving learned associations between specific contexts and emotional responses, often acquired through classical and operant conditioning processes (Mineka & Zinbarg, 2006; Bouton, 2004). These contingencies are not merely cognitive appraisals but encompass affective memory, physiological arousal, and implicit meaning structures that shape threat perception (LeDoux, 2000; Phelps & Hofmann, 2019).

From a cognitive perspective, anxiety is maintained by maladaptive belief systems and catastrophic interpretations that become contextually bound (Beck & Clark, 1997; Clark & Beck, 2010). Repeated exposure to anxiety-provoking situations paired with negative outcomes strengthens associative learning, leading individuals to automatically link specific domains (e.g., social evaluation, performance contexts) with fear, shame, or helplessness (Craske et al., 2017). These associations are frequently reinforced by avoidance behaviors, which prevent disconfirmation of threat expectancies (Mowrer, 1960; Hofmann, 2008).

Psychodynamic and affect-focused models further emphasize that anxiety-linked contingencies are often rooted in earlier relational experiences in which affective states such as fear, guilt, or shame were paired with interpersonal threat or loss (Greenberg & Watson, 2006; Shedler, 2010). These affective associations may operate outside of conscious awareness, yet continue to organize emotional responses in present-day situations. Exploration within therapy facilitates the articulation of these implicit emotional memories, allowing previously unexamined effect to be experienced, symbolized, and integrated (Lane et al., 2015).

Affective neuroscience research supports this emphasis on exploration, demonstrating that emotional learning is encoded in neural systems that are not fully

accessible through purely cognitive interventions (LeDoux, 2000). Therapeutic exploration that brings affective associations into conscious awareness promotes emotional processing and memory reconsolidation, thereby weakening maladaptive fear networks (Ecker, Ticic, & Hulley, 2012; Phelps & Hofmann, 2019).

Across therapeutic orientations, exploration functions as a mechanism of change by increasing client awareness of the links between past experiences, emotional reactions, and present anxiety responses (Hayes, Strosahl, & Wilson, 2012; Kazdin, 2007). By systematically examining anxiety-linked contingent domains and their associated affective meanings, clients gain greater psychological flexibility and a more differentiated understanding of their emotional experience. This process supports symptom reduction not by suppressing anxiety, but by transforming the emotional significance of previously threatening contexts (Craske et al., 2017; Greenberg, 2011).

The Role of Self-Worth

People develop self-validation goals for negatively experienced domains as ways to bolster their self-worth. Park et al. suggest that people with relational vulnerabilities often make efforts to improve their self-worth in ways that are motivated to validate their self-worth but at the expense of connecting with others, which often results in unsuccessful relationships. While the domains, self-worth, and self-validation goals vary with each person's unique history, the common underlying motivation is to "regulate anxiety, feel secure in relationships, and achieve the emotional high that accompanies success in domains of contingency" (Park et al., 2006: p. 86, italics added). For successful therapy (beyond symptom reduction), the work of Crocker and Park suggests that the client must also experience the "emotional high" that comes from enhancing their self-worth.

2.10. Therapist Recognition Point 10: For a Growth Experience in Therapy, Clients Need to Experience the "Emotional High" of an Enhancement of Their Relational Value

Bargh and Morsella (2008) have argued that psychology research has focused too heavily on conscious processes. Bargh has long argued that automatic or nonconscious cognitive processes have adaptive and extensive psychological effects. The title of one of Bargh's first articles was "The unbearable automaticity of being" (Bargh & Chartrand, 1999). Social and evolutionary psychology conceptualize relational value as the degree to which an individual perceives themselves as valued, wanted, and significant to others (Leary & Baumeister, 2000). Humans possess a fundamental need to belong, and perceived increases in relational value are associated with positive affect, motivation, and psychological well-being. Conversely, threats to relational value reliably elicit anxiety, shame, and depressive affect.

In therapeutic contexts, clients frequently enter treatment with chronic deficits in perceived relational value, often shaped by early attachment disruptions, interpersonal trauma, or repeated experiences of rejection or invalidation (Mikulincer

& Shaver, 2016). Growth, therefore, requires not only symptom relief but an experiential shift in how clients perceive their worth in relationship to others.

The term "*emotional high*" aligns with what psychotherapy research describes as transformational affective experiences—moments characterized by intense positive emotion, vitality, relief, or joy that signal a reorganization of emotional meaning structures (Greenberg, 2011). These moments are not superficial pleasure states; rather, they emerge when a client experiences themselves as more worthy, more acceptable, or more impactful than previously believed.

Process research demonstrates that such affective peaks often occur when:

- Clients experience deep validation or recognition from the therapist;
- Previously shame-laden material is met with acceptance rather than rejection;
- Clients assert needs or emotions and experience relational safety rather than loss.

These emotionally salient moments are predictive of therapeutic outcome across modalities (Pascual-Leone & Greenberg, 2007).

Relational Value as the Source of Emotional Highs

Attachment theory provides a central framework for understanding why enhancement of relational value is so powerful. Secure attachment is characterized by an internal working model in which the self is experienced as worthy of care and others as responsive (Bowlby, 1988a). Many clients seeking therapy operate from insecure attachment schemas that encode the self as unlovable, inadequate, or burdensome.

Therapy can function as a corrective emotional experience (Alexander & French, 1946) when the therapist consistently responds with attunement, reliability, and emotional availability. Meta-analytic evidence indicates that improvements in attachment security during therapy are associated with symptom reduction and improved relational functioning (Taylor et al., 2015).

Critically, moments in which clients feel seen, chosen, or emotionally important to the therapist can generate powerful positive affect—what the client may subjectively experience as an "emotional high". These experiences directly contradict earlier relational learning and promote revision of maladaptive self-schemas (Mikulincer & Shaver, 2016).

Affective neuroscience further supports the idea that enhanced relational value produces emotionally salient "highs". Positive social evaluation and experiences of acceptance activate reward-related neural systems, including dopaminergic pathways implicated in motivation and learning (Eisenberger & Cole, 2012). Social bonding and perceived care are also associated with oxytocin release, which facilitates trust, emotional openness, and stress regulation (Porges, 2011).

These neurobiological mechanisms suggest that relationally mediated positive affect is not epiphenomenal but integral to learning and change. When clients experience heightened positive effects in relational contexts, new emotional memories are encoded that compete with or override earlier anxiety-based associations

(Lane et al., 2015).

The therapeutic alliance—particularly its emotional bond component—has one of the most robust empirical relationships with outcome across psychotherapies (Horvath et al., 2011). Importantly, alliance ruptures and repairs are especially potent moments for enhancing relational value. When a rupture is addressed successfully, clients often report intense relief, gratitude, and empowerment—affective states consistent with the proposed "emotional high".

Emotion-focused therapy research specifically demonstrates that experiencing oneself as valued and accepted while expressing core emotions predicts enduring change (Greenberg & Watson, 2006). These experiences help clients internalize a new relational template in which emotional expression leads to connection rather than abandonment.

From a clinical standpoint, this research implies that growth-promoting therapy must facilitate experiences in which clients:

- Feel emotionally impactful and significant to another person;
- Experience validation of previously devalued aspects of self;
- Encounter acceptance at moments of vulnerability;
- Revise expectations that authenticity leads to rejection.

The resulting emotional "high" is not incidental; it serves as an affective signal that relational value has increased, reinforcing adaptive self-representations and motivating further engagement in growth-oriented behaviors.

In sum, the idea that therapeutic growth requires an "emotional high" rooted in enhanced relational value is strongly supported by research across multiple psychological disciplines. Such experiences reflect moments in which clients emotionally register that they matter more than they believed—an insight that is not merely cognitive, but affectively and relationally encoded. These moments catalyze change by restructuring attachment expectations, activating reward systems, and embedding new emotional meanings that support long-term psychological resilience.

Each of the conceptualizations discussed above carries the assumption that important processes in relationships operate outside the awareness of the participants. Internal models in attachment theory are primarily considered to be unconscious. Likewise, sociometers are automatic and operate outside of awareness. In transference conditions, participants usually do not make connections between their experience of a new interaction partner and their experiences with significant others, nor could they articulate the resulting difference in their implicit sense of self.

Interpersonal goals are defined in this work as those that "attain, maintain, or avoid a specific end state for the partner or the relationship" (p. 150). These are goals fundamentally directed at the relationship itself. Lakin and Chartrand (2003) found that mimicry of bodily movements in a dead was related to the unconscious goal of achieving rapport with another person. Fitzsimmons and Bargh suggest that problems in relationships may be due to conflicts between the nonconscious

goals that each participant has for the relationship. Such conflicts could arise in therapy as well as in other relationships.

2.11. Therapist Recognition Point 11: You Need to Be Alert to the Possibility That You Have Unconscious Goals Related to the Therapeutic Relationship That Conflicts with the Unconscious Goals That Your Client May Have regarding the Relationship

Murray and Holmes (2011) have developed the "interdependent mind" theory to explain how and why mutually responsive or non-responsive patterns develop in close relationships. Essential to their theory is the assumption that only by recognizing the operation of the unconscious in conjunction with the conscious can the responsiveness of partner interactions be understood. As part of what they term the "smart relationship unconscious", they introduce the concept of the "impulsive barometer of trust", which represents an unconscious evaluation of the partner's commitment to the relationship. This indicator supplements and may override the "reflective barometer of trust", which is a rational consideration of evidence for and against the partner's commitment. The relevance for the therapeutic relationship may be that the therapist and client process experiences at both the nonverbal unconscious level and the conscious verbal rational level. Since the "impulsive barometer" can trump the "reflective barometer", the therapist may occasionally feel perplexed by the sense that the relationship is functioning well at one level while also lacking some degree of mutual responsiveness, leaving the client uncertain about trusting the therapist.

Relational Selves in the Therapeutic Relationship

From this relational self-perspective, important past/historical processes operate in the therapeutic relationship and are often not clearly recognized by either the therapist or the client. Previous experiences with significant others will influence the perceptions and expectations of both the client and therapist toward one another; their respective past interpersonal patterns will determine the significance of this particular relationship for each. Their experiences with one another, including both verbal and nonverbal communications, will affect how each experience themselves in the relationship and determine their corresponding experienced relational value to the other in the relationship.

In this paper, we emphasized the importance of nonverbal communication between the client and the therapist. Wallin (2007) has applied attachment theory and research to psychotherapy and describes different forms in which nonverbal communications may be expressed. He cites "Bollas (1987) for coining the term '*unthought known*' referring to implicit relational experiences that are registered outside of our awareness and remain 'unverbalized' or unverbalizable" (p. 115).

One nonverbal form is the enactment in which the "unthought known" is expressed in interactive events between client and therapist. Such enactments are here-and-now behavioral manifestations with roots in what the client and thera-

pist experienced with their attachment figures (Farber, Lippert, & Nevas, 1995). In a second form, the client's experience evokes in the therapist a similar emotional response, through facial expressions and through "voice tone, rhythm and contour" (cites Ekman, 2003). Ekman believes that one's voice both communicates and activates emotion in the other, just as facial expressions do. Wallin emphasizes that the therapists' own reactions will be important for understanding the client's nonverbal communication.

Another nonverbal, nonconscious relational process is the "synchrony" or the similarity in bodily movements between interactants, with the other interactant. Ramseyer and Tschacher (2011), in a sample of patients in cognitive behavior therapy, found that patients in dyads with higher synchrony had higher relationship quality and experienced greater self-efficacy. Relationship quality was high when the patient imitated the therapist's movements; self-efficacy was high when the therapist imitated the patient's movements.

2.12. Therapist Recognition Point 12: You Need to Be Aware of the Possibility That the Client Is Transmitting a Nonverbal Message of the "Unthought Known" and That Your Own Nonverbal Reactions Will Provide Cues to "Decode" the Message

Therapists must remain attuned to the possibility that clients communicate psychologically salient material through nonverbal, embodied channels that precede or bypass conscious symbolic thought. This phenomenon has been conceptualized in psychoanalytic theory as the "*unthought known*"—implicit knowledge derived from early relational experience that has been affectively encoded but not yet cognitively represented (Bollas, 1987). Although the original formulation is theoretical, subsequent empirical and clinical research has demonstrated that such implicit relational knowledge is reliably expressed through posture, tone, rhythm, gaze, affective shifts, and somatic tension, rather than through explicit verbal content.

Contemporary relational and intersubjective theories describe how clients enact internal working models of relationships through moment-to-moment nonverbal behavior. The Boston Change Process Study Group (BCPSG) introduced the construct of implicit relational knowing, emphasizing that much of what is communicated in therapy occurs at a procedural, nonverbal level and is only accessible through interaction rather than introspection (Lyons-Ruth et al., 1999). These implicit communications are not consciously intended messages but enacted expectations about how others will respond.

Empirical psychotherapy process research supports this view, demonstrating that nonverbal coordination, affective synchrony, and micro-regulatory patterns between therapist and client are associated with therapeutic alliance quality and outcome (Tronick, 1989; Beebe & Lachmann, 2002; Beebe et al., 2010). These findings indicate that clients "tell" their emotional histories through how they relate, not merely through what they say.

The therapist's own reciprocal nonverbal and affective responses—traditionally conceptualized as countertransference—are increasingly understood as vital sources of information rather than contamination. Modern views frame countertransference as a co-constructed, embodied response that can provide access to the client's implicit emotional world when reflected upon with discipline and curiosity (Hayes et al., 2011).

Research indicates that therapists' somatic sensations, emotional shifts, and action tendencies often mirror the client's unformulated affective states, especially when those states originated in early attachment relationships (Gabbard, 2001). These reciprocal reactions function as "decoding devices", allowing the therapist to register the client's unthought known before it is symbolized in language.

Affective neuroscience provides a biological substrate for understanding how nonverbal messages are transmitted and decoded. Research on embodied simulation and mirror neuron systems demonstrates that observing another person's emotional expressions or bodily states activates corresponding neural representations in the observer, enabling direct, pre-reflective emotional understanding (Gallese, 2007). This mechanism helps explain why therapists may "feel" something before they "know" it cognitively.

Such processes are particularly relevant in psychotherapy, where subtle shifts in facial expression, voice prosody, or posture can activate affective resonance in the therapist, offering insight into the transactional process between client and therapist

The clinical task, therefore, is not to immediately interpret nonverbal communications but to hold them in awareness, observe their impact on the therapist's own embodied experience, and allow meaning to emerge through reflective dialogue. When therapists prematurely translate nonverbal signals into explicit interpretations, they risk foreclosing the developmental process by which the unthought known becomes thinkable.

Process research suggests that therapeutic change often occurs when implicit relational patterns are first *enacted*, then *recognized*, and only later *symbolized* (BCPSG, 2010). Nonverbal decoding is thus a prerequisite for deeper mentalization and affects integration.

Revisiting the initial question posed by therapists in training, "What should I do?", the answer often lies beyond a language-centric solution. Essays and case histories in psychotherapy literature typically feature what clients say and how therapists respond. Much of psychotherapy research has centered on these verbal exchanges or written responses to administered measures. Breuer's "talking cure" description of Freud's early work as the "talking cure" continues to accurately reflect what is documented in psychotherapy today. Language, however, is not the only, and perhaps not even the most important, characteristic of the therapeutic process. Both supervisors and trainees may become distracted by concentrating on the content of therapist-client dialogues and neglect the "affectively toned, preverbal, preconscious processing" of experiential self-experience (Whelton & Greenberg, 2006: p. 88).

Managing Multiple Selves

In discussing the central features of their process-experiential perspective on changing the self in therapy, Whelton and Greenberg (2006) refer to a "parliament of selves" as: "There are, in each of us, multiple self-organizations emotionally anchored in the body and orienting us toward or away from activity that would produce and sustain for our growth and well-being" (p. 94). In therapy, they suggest that change in selves must be emotionally experienced: "In therapy, high-level, abstract, conceptual discourse between therapist and a unitary self, although indispensable at certain moments, is usually insufficient to produce a big and lasting change ... it is even more important to achieve change and reorganization within self-schemes" (p. 97, italics added). A basic principle of existential therapies, they suggest "is that it is not enough to talk about these self-organizations" but rather what is required is "... an indispensable immediacy to a client being subjectively engaged at the moment in a self-state". Such immediacy "allows for an experiential reprocessing of the beliefs, feelings, and meanings of a given self-organization" (p. 99, italics added).

2.13. Therapist Recognition Point 13: Do Not Be So Captured by the Content of Your Therapy Conversations That You Fail to Recognize the "Affectively Toned, Preverbal, Preconscious Processing" That Is Happening in Your Session

Clinically meaningful change is often mediated by affectively toned, preverbal, and preconscious processes that unfold beneath explicit narrative exchange. While verbal content provides important symbolic material, it represents only a fraction of the psychological activity occurring in-session. A narrow focus on conscious cognition risks obscuring the implicit emotional communications that organize the therapeutic encounter and drive change.

Research in affective neuroscience and developmental psychology demonstrates that emotional meaning is frequently encoded and communicated prior to and independent of language. Early relational experiences are stored in implicit memory systems that operate outside conscious awareness and verbal recall, yet continue to shape affect regulation and interpersonal expectations throughout adulthood (Schore, 2012). These implicit processes manifest in tone of voice, rhythm, facial expression, posture, and autonomic arousal—channels that are active in every therapy session, regardless of spoken content.

Neuroscientific evidence indicates that subcortical and right-hemisphere systems involved in affective processing respond more rapidly than cortical systems responsible for linguistic representation (LeDoux, 2000). As a result, therapists may observe shifts in affective tone or bodily tension before clients are able to articulate emotional meaning. Attunement to these preverbal signals is therefore essential for understanding what is psychologically salient in the moment.

The Boston Change Process Study Group introduced the construct of implicit relational knowing to describe how individuals "know" how to be with others in ways that are enacted rather than verbalized (Lyons-Ruth et al., 1999). In psycho-

therapy, this knowing is continuously expressed through micro-interactions, affective coordination, and nonverbal timing between therapist and client.

Assessing Therapeutic Change

Process research shows that therapeutic change often occurs through moment-to-moment affective exchanges rather than through insight alone. When therapists attend only to narrative content, they may miss shifts in implicit relational patterns—such as withdrawal, expectancy of rejection, or bids for connection—that are central to the client's difficulties and growth.

Affect-focused psychotherapy research consistently demonstrates that emotional arousal and affective experience are stronger predictors of outcome than cognitive elaboration alone (Greenberg & Watson, 2006). Emotional shifts—such as sudden sadness, relief, anger, or vitality—often indicate that implicit material is becoming activated and available for integration. These affective markers may be subtle and easily overlooked if the therapist is preoccupied with thematic coherence or interpretive accuracy.

Experimental and clinical studies show that successful therapy involves helping clients experience, regulate, and symbolize affect, rather than merely describe it (Pascual-Leone & Greenberg, 2007). Attending to preverbal effect allows therapists to intervene at the level where emotional meaning is actually organized.

The therapist's own emotional and somatic responses—often conceptualized as countertransference—are increasingly understood as informational signals of the client's implicit emotional state rather than as distortions to be eliminated. These reactions frequently emerge in response to preverbal and preconscious communications and can alert the therapist to affective dynamics that are not yet symbolized by the client (Gabbard, 2001). Empirical work indicates that therapists who are able to reflect on and regulate their internal responses are better positioned to recognize and respond to implicit affective communication, thereby strengthening the therapeutic alliance and facilitating change (Hayes et al., 2011).

Taken together, this research underscores that effective psychotherapy requires a dual attention: engagement with verbal content alongside sustained sensitivity to affective tone, bodily expression, and relational rhythm. When therapists privilege narrative meaning at the expense of preverbal processing, they risk colluding with defensive intellectualization and missing opportunities for emotional integration. Conversely, attending to affectively toned, preconscious processes enable therapists to work at the level where emotional learning, attachment revision, and durable change occur.

3. Summary

In discussing the therapeutic relationship as the context within which client self-states can be explored, Muran (2006) suggests two conditions, "... first, we are always embedded in an interpersonal field that exerts a great influence on the emergence of self-state that we experience in a given moment and second, that greater

self-definition can be achieved only by defining the edges of oneself regarding another self—in this case, the patient concerning the therapist (cites Ehrenberg, 1992)" (p. 353). Presumably, the "interpersonal field" would include the interpersonal histories of client and therapist and any transferential reactions to the therapist and by the therapist will affect the immediate sense of self. We expect clients' "greater self-definitions" would depend on their perceived relational value to the therapist.

For the client to experience desired changes in therapy, it is fundamental that the client and the therapist feel comfortable with their experienced selves in their interactions with each other, and each must sense an acceptable level of relational value from the other. In other words, they would have good "chemistry" with each other, as their right hemispheres can communicate effectively. They would have high readings on both barometers of trust. The client would feel "known" to and understood by the therapist (Engel, 1988). With comfortable selves in their relationship and experiencing relational value from the other, clients will feel secure enough to explore the effect, behavior, or cognitions. To lead to helpful change by the client, this exploration needs to contribute to an "emotional high", or the thrill of feeling successful in a domain critical for self-growth.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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