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Pitfalls and Opportunities of the Therapist's Metacommunication: A Self-determination Perspective

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Abstract
Psychotherapy research identifies alliance ruptures and their resolutions as significant events in psychotherapy, influencing outcome. However, we know little about the process how such events influence outcomes, only assuming if clients stay in therapy that the rupture was resolved, and the outcome will be positive. The purpose of this paper is to problematize this assumption against the backdrop of self-determination theory, introducing motivation and relational positioning as relevant theoretical concepts for understanding rupture resolution and the effect on outcome. A therapeutic transcript demonstrating best practice for alliance rupture resolution in a brief integrative therapy is critically examined, calling the attention of both clinicians and researchers to the risk of prescribing and blindly following techniques during therapeutic impasses. Our analysis of metacommunication demonstrates how the therapist's use of a certain technique for resolving threats to the therapeutic alliance can lead to the client's external motivation and compliance, negatively influencing therapeutic outcome. Focusing on the therapist's relational positioning we present two alternative courses of therapeutic action, 'mindfulness in action' and 'embracing the patient's ambivalence', for supporting the client's autonomous motivation for the therapy process.

Keywords Relational psychoanalytic theory · Therapist's metacommunication · Alliance rupture resolution · Self-determination theory · Compliance

Introduction

Over the last twenty years, there has been a growing interest in psychotherapy research on the formation and maintenance of the therapeutic alliance (Cirasola & Midgley, 2023; Horvath, 2018), as well as factors associated with alliance ruptures and its relationship to outcome (Krupnik, 2022; Monticelli & Liotti, 2021; Tschuschke et al., 2022). The work of Safran and Muran (2000) on the negotiation of the therapeutic alliance is a foundation of this recent development. Their work on alliance rupture resolution synthesizes different therapeutic traditions but is most influenced by relational psychoanalytic theory. Their model has been extended by considerable empirical research, aiming to examining therapeutic communication during alliance rupture and repair processes, and has served as impetus for refining and developing the operationalization of relevant rupture markers (Eubanks et al., 2019; Gersh et al., 2018) as well as for developing an alliance focused training for therapists (Perlman et al., 2020).

Despite the recognition of the therapist as one side in the therapeutic communication, the empirical investigation of therapeutic ruptures has heavily concentrated on the communication of the patient, besides a few exceptions (Colli et al., 2019). Understanding ruptures only in terms of client behavior leaves half the story unexplored, and is contrary to a dyadic, relationally imbued understanding of therapeutic impasses (Eubanks et al., 2019). Examining impasses in terms of the therapist communicative behavior is notoriously difficult. One reason for this is the observation that successful resolution of a therapeutic rupture might be more a matter of following metacommunicational principles, reflecting therapists' relational positioning, than a matter of following

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behavioral techniques (Safran & Kraus, 2014; Muran et al., 2018).

Our paper's important contribution to current theorizing of alliance ruptures is the introduction of self-determination theory as a relevant theoretical framework for examining therapist's relational positioning and metacommunication. Self-determination theory is a theory of human motivation and regulation with solid empirical evidence across various domains (Ryan et al., 2021). It conceptualizes motivation in terms of quality, not quantity, ranging from external to intrinsic, with far-reaching consequences on behavior (Vansteenskiste et al., 2020). Most importantly, self-determination theory understands motivation, both external and intrinsic, as an essentially interpersonal phenomenon, being determined by the relationship between people involved. This aspect renders it relevant to examine therapeutic metacommunication, aiming for patient's psychic change.

Viewing through the lens of self-determination theory, the therapist communication and metacommunication can result in external motivation, leading to compliance and curtailing therapeutic change (Roth et al., 2019). Compliance without proper motivational internalization is also a pitfall of the therapist's metacommunication. The observation of Eubanks et al. (2019), that getting to an immediate resolution is *not* a guarantee for successful alliance repair can be explained by self-determination theory. Successful resolution of a threat to the therapeutic alliance is not just about avoiding rupture, but also about avoiding compliance (Ryan et al., 2021).

Taking the perspective of relational theory, this article is a critical examination of the therapists' metacommunication and relational positioning vis-à-vis a patient, presented in a published paper that represents recommended practice in a brief integrative therapy (Bennett et al., 2006; Parry et al., 2021). We analyze the transcript from the perspective of the metacommunication principles of Safran and Kraus (2014), the basic theoretical assumptions and clinical implications of relational theory (Aron, 2013; Benjamin, 2018; Stern, 2019) and through the lens of self-determination theory. Our critical examination of the therapist's metacommunication questions the attainment of rupture resolution of the presented transcript and raises the possibility that it depicts resolution by compliance, curbing the patient's long-standing change (Ryan et al., 2021).

The paper is structured the following way: First we present the theoretical and clinical tenets of relational psychoanalysis, with particular emphasis on the relational conceptualization of enactments and the corresponding therapeutic action. Second, we introduce the relationally imbued ideas of Safran and Kraus (2014) on the importance of the therapist's metacommunication during ruptures, and link these to the propositions of self-determination-theory (Ryan et al., 2021), a prominent motivational theory of solid empirical evidence, with implications for therapeutic communication. The core of the paper is the presentation and critical examination of a therapist's metacommunication during rupture in a brief integrative therapy, followed by a proposal of alternative therapeutic action that rely on relational techniques and support the client's self-determination. The discussion will summarize the findings and consider the theoretical and clinical implications for alliance rupture resolutions more generally.

Relational Psychoanalytic Theory of Enactments and Clinical Practice

Relational psychoanalysis is a contemporary and evolving school of psychoanalytic thought, considered by its founders to represent a paradigm shift in psychoanalysis (Hoffman, 2014). Relational theory was born from a synthesis of American interpersonal theory (Stern, 2019), the various insights of self-psychology (Magid et al., 2021), British object relations theory, and neo-Kleinian thought (Aron, 2013). A basic credo of relational theory, the one we also take in this study, is the understanding of the clinical situation in terms of a 'two-person psychology', as compared to mainstream psychoanalytic theory, criticized as being rooted in a 'one-person psychology' (Davies, 2018). Based on this new paradigm of the clinical situation, relational theorists have problematized and challenged two related clinical phenomena: 'enactment' and the underlying mechanism of 'projective identification' (Aron, 2013; Mitchell, 2022).

The theoretical critique directed toward the concepts of enactments and projective identification is twofold: First, mainstream psychoanalytic theorists understand *enactments* as 'put on stage' by the client, playing out his or her internalized object relations. They further assume that therapists can and should be able to differentiate the feelings that result from projective identification from what is part of their psychic content. Drawing on relational theory, we consider enactments as mutually constructed unformulated interpersonal events, emerging from the interaction of the participants' vulnerabilities (Stern, 2019). Enactment is conceptualized as mutual dissociation, an intersubjective process, when either the client or the therapist, or most often both fail to become conscious of the verbal or nonverbal meaning of the interaction in which they are together participating (Safran & Kraus, 2014). Therapists cannot naively assume that their seemingly neutral mentalization, their reflective observational stance is not the result of their own vulnerabilities and defenses. The therapist's insights are not only what he or she thinks they are: they are also participations in what most needs to be understood, communicated indirectly through metacommunication and relational positioning (Stern, 2019).

The other relational critique concerning 'enactment' contends that by isolating a certain 'event' of the therapeutic process as 'enactment' we inadvertently view the rest of the process as not being enactments, and these therefore remain unexplored in interactional terms (Aron, 2013). To speak of 'enactments' gives the impression that these happen every now and again (when the therapist cannot 'contain' the feelings aroused in him by the patient), but it denies that the client and the therapists are always 'enacting', mutually participating in a continuous flow of mutual relational configurations, from the beginning to the end of the therapeutic process. If the therapist focuses attention on an event he or she considers 'enactment', this will probably affect the extent to which he or she can hold awareness on the unfolding relational dynamic.

Relational clinicians emphasize the contrast between the twoness of complementarity that characterizes enactments, and the intersubjective space of thirdness that transcends this complementarity (Benjamin, 2018). Allying with this, our study also conceptualizes the therapeutic third radically differently from the concept of the therapist's neutral stance or observing function (e.g., Lacan, 1975; Ogden, 1994). The therapeutic third in relational theory bears similarities to Winnicott's concept of transitional space (Caldwell, 2022), but extend this concept by synthetizing it with the social constructivism of relational thinking, with direct implications on therapeutic practice.

Therapists operating within the third do not assume to have privileged access to their own motives that inevitably influence their interventions, nor do they claim to know what is best for their clients. For relational theorists, the objectivity of the therapist is not about demonstrating to the client how his or her transference ideas and expectations distort reality. Instead, it is for the therapist to notice and to realize other potentials in the therapeutic experience. The third, as an intersubjective space, requires an attitude of doubt and openness regarding the therapist's countertransference (Barreto & Matos, 2018; Tishby & Wiseman, 2022), a mindfulness in action (Eubanks-Carter et al., 2015; Safran & Muran, 2000).

Thus, the essence of the third position is to use it to step out of complementary power relations that characterize enactments (Benjamin, 2018, p. 21), by tolerating and nourishing the creative potential of the ambivalence of the client as a central component of therapeutic action. From this perspective, the 'bad object' that is lurking in every therapeutic situation is the one that pulls the participants into an absolute commitment to one side of the patient's conflict, with the result that the other side is repressed (Hoffman, 2014, p. 217). We propose that this view finds substantial empirical support from self-determination research, emphasizing the importance of the therapeutic support of autonomy and refraining from a controlling position vis-à-vis the patient's ambivalence (Roth et al., 2019).

From Relational Theory to Self-determination Through Metacommunication

That all therapeutic interventions are relational acts is an idea that most, if not all, therapists would agree with. When we communicate, we position ourselves to the recipient in a particular fashion. Communication theorists has long distinguished between the report and the command aspects of communication (e.g., Calvert et al., 2020; Watzlawick et al., 2011). The report aspect refers to the content of the communication, whereas the command aspect is an implicit interpersonal statement that is being conveyed. Correspondingly, therapists must monitor the relational implications of their interventions on an ongoing basis. This includes the mentalizing of their own motivations, not seldom defensive in nature, underlying their decision to use a therapeutic technique. Is the therapist making a definitive interpretation to affirm his or her own sense of potency, or, alternatively, to cover up anxiety?

Building on a solid base of relational psychoanalytic theory Safran and Kraus (2014) emphasize the importance of metacommunication during therapeutic impasses. Drawing on the idea that successful resolution might be less a matter of applying behavioral techniques and more a matter of following certain relational principles, they advocate both general and specific principles of therapeutic metacommunication. These principles promote relatedness between the therapeutic dyad, strengthen mentalization of the patient and ultimately lead to the patient's emotional healing.

We consider that the therapeutic principles of metacommunication and relatedness, as advocated by Safran and Kraus (2014) summarize and concretize both the conceptualization of enactments as mutual dissociation (Stern, 2019) and the conceptualization of the third as an intersubjective space transcending complementarity in the here-and-now of the therapeutic relationship (Aron, 2019; Benjamin, 2018). We further propose that these metacommunicational principles also stand in line with the tenets and sound empirical support of self-determination theory. Self-determination theory focuses on the importance of therapist's autonomy support for internal motivation. By taking an autonomy supporting position, the therapist promotes engagement and long-standing change, as opposed to external motivation and compliance (Roth et al., 2019; Ryan et al., 2021). Both relational theory and self-determination theory understand resistance as a product of the interpersonal matrix between the patient and therapist. Correspondingly, motivation is something emerging from the relational dynamics of the partners implied, forming a continuum: controlled and external on the one end to autonomous and intrinsic on the other

end (Ryan et al., 2021). Research on self-determination has consistently shown that conceiving motivation as simply an intrapsychic attribute of people, varying in quantity, misses something essential about its nature: the degree to which it is controlled versus autonomously endorsed.

The degree of autonomy support of the therapists affects the degree of autonomous regulation and motivation of the client. Correspondingly, while a controlling stance on the part of the therapist leads to external motivation and compliance, an autonomy supportive stance enables autonomous motivation, supporting solid and long-term psychological change, maintained across time and circumstances (Roth et al., 2019). A relational conceptualization of 'the therapeutic third' can also be read to describe the therapist's support of the client's autonomous motivation: it implies abstaining from any form of control of the other, the ability to take in the other's reality while accepting its separateness and difference (Aron, 2019; Benjamin, 2018).

Case Example of Rupture Resolution

As a brief integrative approach to psychotherapy, cognitive analytic therapy has been developed through synthetizing cognitive theory with analytic concepts, particularly the various contributions of object relation theorists (Ryle & Kerr, 2020). The collaborative reformulation of the client's problems early in therapy in terms of characteristic and problematic 'reciprocal role procedures', is a central feature of the approach. Reciprocal role procedures are defined as goal-directed sequences of roles which were acquired during development and are maintained and strengthened in subsequent relationships. Maladaptive deep-rooted reciprocal role procedures or the inflexible use of them are considered to constitute the underlying reason for problematic and often entrenched behaviors, which are understood as functionally protective, yet self-defying processes of avoiding the emotional experience associated with certain roles. The reformulation is meant to make the implicit relational patterns of the client explicit and functions as a tool for the development and strengthening of the patient's reflective self-observation (Simmonds-Buckley et al., 2022).

The therapeutic phenomena of transference, countertransference and the underlying process of projective identification are understood and conceptualized in cognitive analytic therapy as reciprocal role procedures between the therapist and the patient (Parry et al., 2021). During the therapeutic process the therapist expects the client to enact one pole of his or her characteristic role procedure, while putting simultaneously pressure on the therapist to assume the reciprocal role. Countertransference, on the other hand is conceptualized as the therapist own tendency to respond to this pressure (Ryle & Kerr, 2020), pointing to the importance of awareness and recognition of this dynamic.

Therapeutic alliance in the approach is explicitly thought to become facilitated and strengthened through a collaborative reformulation process, explicitly thought to support the therapist in avoiding collusion with the patient's problematic reciprocal roles (Simmonds-Buckley et al., 2022). This emphasis on problematic relational dynamics shares similarities with other brief integrative and dynamic therapies, focusing on an early conceptualization of the client's characteristic relational dynamics (Farber & Motley, 2023; Julien & O'Connor, 2017; Markin et al., 2018). Cognitive analytic therapy considers the collaboratively created reformulation the main tool and the most important therapeutic technique to guide the dyad out of impasses when the client's problematic relational dynamic threatens to lead to rupture in the therapeutic alliance (Parry et al., 2021).

Bennett et al. (2006) developed a cognitive analytic model for resolving threats to the therapeutic alliance, serving as guidelines for therapeutic practice. The aim of Bennett's article was to "test and refine the model of how cognitive analytic therapists successfully resolve threats to the therapeutic alliance, involving enactments of problematic relationship patterns". After presenting the collaboratively developed reformulation of the characteristic relational dynamics of the patient, Bennett et al. (2006) presents a transcript depicting what the authors consider a successful resolution to a threat to the therapeutic alliance, intended to demonstrate recommended practice in cognitive analytic therapy. Their model was recapitulated by Parry et al. (2021), who specify the therapist's skill to apply it during alliance ruptures as one of the key therapeutical competencies of the approach.

The Therapist Metacommunication: A Relational Critique

Our analysis examines the last part of the transcript presented by Bennett et al. (2006). As the established praxis in this type of process-research (Krause, 2023), we adopt a microanalytic level of analysis to compare a single idiosyncratic interaction sequence to a context-specific model, in this case a model for rupture resolution, that specifies what is expected to happen in the therapeutic process when rupture markers are identified (Safran & Kraus, 2014).

We analyze the transcript through two different theoretical lenses: through the perspective of the metacommunicational principles of successful rupture resolution (Safran & Kraus, 2014; Safran & Muran, 2000), and trough the examination of the interpersonal dynamics of the enactment: the relational positioning of the therapist vis-à-vis the patient during the interaction, affecting the level of the patient's autonomous motivation (Benjamin, 2018; Roth et al., 2019; Simmonds-Buckley et al., 2022). Although the examination of the transcript cannot escape the subjectivity of the authors of this article, we believe the criteria used makes

replicability of the analysis possible: the metacommunicational principles presented by Safran and Kraus (2014) are sufficiently concrete and precise to allow for a replication of the analysis.

Safran and Kraus (2014) present both general and specific principles of therapeutic metacommunication that promote relatedness between the therapeutic dyad, mentalization of the patient and leads to emotional healing. Examples of these principles are: 'explore with tentativeness', 'establish a sense of 'we-ness', 'do not assume parallel with other relationship', 'emphasize one's own subjectivity', 'emphasize awareness rather than change', 'accept responsibility for own contribution to the interaction', 'evaluate the client's responsiveness to all interventions', 'provide feedback regarding subjective experience'.

Our exploration and critique concentrate specifically on the metacommunication of the therapist: We operationalize pitfalls in metacommunication as the therapist's divergence from the communicative and metacommunicative principles specified by Safran and Kraus (2014), as well as the presence of complementary relational dynamics between therapist and patient (Benjamin, 2018), which -when left therapeutically unexplored- bear the risk of decreasing the patients' autonomous motivation (Roth et al., 2019). To analyze the therapeutic effect of the therapist's words on the patient, the patient's utterances are also examined. Does the therapist's communication help the patient to further explore his subjective experience? Or alternatively, does it contribute to closing the patient's exploration and withdrawal from the dialogue? The patient's utterances are also explored for examining the extent to which the therapist is responsive to them. Does the therapist react to the patient's expression or does the therapist ignore them? The examination of the extent to which the therapist takes into consideration the patient's perspective allows us to evaluate the therapist's support or lack of support of the patient's self-determination and autonomous motivation (Roth et al., 2019). Let us now turn to the first part of the transcript.

TRANSCRIPT 1/3

T160 I think what's happening here, what happened then, what's happening in you, is that part of you, that is desperately in need of some care, like you said last week, you wish to be able to be held and rocked and allowed to cry, which is understandable. That part of you, when you get any kind of sense of someone being there for you, you are so overwhelmed by the intensity of the feeling that you have to back off. There is such a well of neediness that you can't risk letting anyone near enough to help you. So you back off to the sand-dunes as if it is the only place to go.

P161 I disagree. Silence

P162 Are we talking about the past or on the ward?

T163 The ward, friends, me. In all those contexts, people are allowed so near and then you break contact.

P164 I still disagree. Silence

What first catches the attention of the reader familiar with the book of Safran and Muran (2000), which Bennett et al. (2006) use as a reference point for their model development, is the striking difference of metacommunication between what Safran and Muran (2000) explicitly advocate and the metacommunication of the therapist in the transcript. The therapist does not explore with tentativeness but tells the patient a strong interpretation, explicitly assuming a parallel with other relationships (T163). The patient repeatedly expresses disagreement with the therapist's interpretation, and gets silent in the end, possibly indicting relational withdrawal. These stay unexplored by the therapist. In their article, the authors of Bennett et al. (2006), emphasize the therapist's combined focus on the therapeutic interaction and on the patient's problematic relationship patterns, a key factor in achieving resolution. However, one of the consequences of assuming and expressing parallel with other relationships is that focus is shifted from the concrete and specific of the here-and-now of the therapeutic relationship and lead to generalized interpretation of the patient, silencing and closing intrapsychic exploration (Safran & Kraus, 2014). In fact, based on the patient's responses, the therapist's interpretation did not deepen the patient's exploration of his inner experience. The patient's utterances as compared to the therapist are few and limited to expression of disagreement with the therapist's interpretation in T160 and T163, except for one clarifying question. Maybe more importantly, as we can see from the next section, the therapist has not explored the patient's repeated disagreement, nor his possible gradual withdrawal that might lie behind his silence.

TRANSCRIPT 2/3

T165 Are you saying that that was one of the lessons not to get close to people because they are going to betray you?

P166 Yes, I still stood by her.

T167 With Anna, that was true, with Tina it wasn't true, you wouldn't go back, and you still feel angry with her. What about the therapy, you haven't felt betrayed yet, I hope you won't be but you may feel it.

T168 Can you risk it?

P169 No.

T170 Why is that more difficult?

P171 Because the things I want aren't going to happen (crying)

T172 One of the problems about the degree of want that you have and degree of need that you have is that it is very hard to know what you could take that is less than you need. In a sense, that is what you have to do always, get what you can from people, but nobody ever gets all they want, nobody ever gets everything made up for. In your case it is hard to take because there is so much deprivation there. But you have, for example, with Anna, not got all that you want but you got something, that's what you have to do and not be so angry and disappointed that you just cut off from it.

In T165 the therapist continues focusing attention on the patient's general tendency 'not to get close to people', rooted

in his characteristic problematic relational patterns. The therapist proceeds to point out in T167 that the patient's expectations of being betrayed are not substantiated by evidence.

In T167 the therapist changes to focus from the patient's problematic interpersonal pattern to the exploration of therapeutic relationship, presenting three questions from T167 to T170 with the aim of understanding his difficulties to take the relational risk specifically in therapy. It seems that this refocusing of attention on the therapeutic relationship has a positive effect on the patient, who in P171 is on the verge of connecting to deeper aspects of his experience. Here, our analysis agrees with Bennett et al. who also classify the therapist's utterances at P168 as emphatic exploration, followed by a deepening of affect.

One of the most touching utterances of the entire transcript is at P171, where after a long phase of a withdrawing position with short and limited utterances, the patient's feelings of hopelessness, desperation, disappointment, and fear regarding therapy come to the surface as he starts crying. Bennett et al. contend, that the therapist "facilitates the patient to be in touch with painful previously avoided affect" (p. 406), and state that this, combined with the "explicit self-disclosure, also reflects a therapeutic relationship in which there is authentic human contact" (p. 406).

Examining the metacommunication of the therapist points to another perspective. In P171 the patient presented an opportunity for the therapist to stay with him in the here-and-now: hearing, witnessing, and bearing with him his difficult feelings. The therapist does not stop to explore these inner meanings, but instead tells the patient about the problem of his 'unrealistic expectations' and what he should do, followed by two normative statements regarding objective reality. In T172, instead of exploration of feelings and open inquiry of meanings the therapist tells the patient how he should change. There is no explorative tentativeness, nor any hints of marking that what he or she says is a subjective opinion.

TRANSCRIPT 3/3

P173 I disagree, I've been so shat on…I deserve a good deal.

T174 Yes, you do, but a good deal can only be what people can manage and not something that is magical, that makes everything better or gives all that you need. you may deserve that but can only get what people can give. It's imperfect but human. Silence

T175 So you don't disagree too much about that?

P176 (different tone of voice) I wonder how my judgement formed?

T177 Your judgment is informed by many things but of the many things, I still see traces of your history, although you have rejected what people did to you, you have also incorporated some of it into yourself. I you hadn't lived your life in the way you were treated, you would get better, if you could give consideration to yourself like you do to others but part of you still treats yourself in the way you were treated, which I can understand, but I am not on that side. I am on the side of repair rather than continuing damage. Do you understand that?

P178 Yes.

In this last part of the transcript the patient expresses disagreement once more, a third time, indicating his emotional distancing, further away from the change that the therapist expects him to take. Here, from a self-determination perspective, the therapist self-positioning as an arbiter of objective reality, while ignoring the patient's repeated disagreement, clearly thwarts the latter's needs for competence and autonomy, undermining autonomous motivation for change (Vansteenkiste et al., 2020).

The therapist makes a last point, explaining the patient what he should do to get better: he should notice what went wrong in his developmental history and object relations and choose to do better. The therapist then points to the dynamics of the patient's ambivalence regarding change: there is the 'side of continuing damage', where he is treating himself the way he was treated in the past, and there is the other side, the 'side of repair', as represented by the therapist. The therapist then asks the patient whether he has understood what was said, -a rather patronizing expression- to which the patient responds with a short 'Yes'. Bennett et al. (2006) claim, that at this point the 'enactment' was over, and the therapist and the patient have together reached a resolution to a threat to the therapeutic alliance.

To sum up the critique: the transcript reveals pitfalls of the metacommunication of the therapist, when facing a potential rupture situation: the therapist (1) explicitly pointed out to the patient how his current behavior has been present in his life previously, moving the attention explicitly away from the therapeutic interaction of the here-and-now, (2) left unnoticed and unexplored the patient's repeated disagreement and the subsequent narrow participation in the interaction, possibly indicating relational withdrawal and compliance, (3) expressed normative judgements of the patients characteristic traits as perceived by the therapist, (4) presented subjective opinions as objective reality, and (5) took explicit side in the patient's ambivalence. Furthermore, the authors didn't examine or discuss what happened in the therapeutic relationships before and after the situation they describe as 'enactment'. Doing so would have provided a wider perspective on the relational dynamic of the therapeutic dyad, that remained unexplored in interactional terms (Aron, 2013).

Our exploration of the therapist metacommunication points out the stark differences between the approach of Safran and Kraus (2014) that is imbued with the sensitivities derived from relational psychoanalytic theory, and the actual approach of Bennett et al. (2006). The complementarity of 'doer and done to', transpiring from the transcript bears the characteristic of problematic enactments. When the therapist feels compelled to protect her internal, observing third from the patient's reality, this is a sign of possible breakdown into complementarity (Benjamin, 2018). The therapist also took

explicit side in the patient's ambivalence, underscored with normative judgments, that research had found to negatively influence outcome (Colli et al., 2019). From a self-determination theory perspective, a complementary positioning is a controlling positioning, where the patient's basic needs for autonomy, competence and relatedness are sidestepped, easily leading to compliance and external motivation (Roth et al., 2019).

Relational and Autonomy Supportive Metacommunication

Based on the communicational recommendations of Safran and Kraus (2014) and the work of relational theorists, here we present two examples of a more relational, autonomy supportive way of dealing with the threat to the therapeutic alliance in Bennett's et al.'s (2006) presented transcript. We concentrate on two basic therapeutic techniques: mindfulness in action, that strengthens the patient's mentalization while establishing we-ness (Safran & Muran, 2000; Stern, 2019), and the embracement of the patient's ambivalence that nourishes the patient's creativity and agency (Aron, 2013; Benjamin, 2018).

Mindfulness in Action

'Mindfulness in action' (Eubanks-Carter et al., 2015) is an example of the very same relational positioning that Stern (2019) takes in his theory of enactment as mutual dissociation, where both the therapists and the client are embedded in the relational configuration, mutually contributing to it. Had he or she been working with the sensibilities of relational theory, the therapist in the article of Bennett et al. (2006) could have mindfully mentalized the interaction between the therapeutic dyad in the here-and-now.

As an example of mindfulness in action, the therapist, in the silence following P164, could have mindfully commented on what is happening between them by saying e.g.: "*I notice that I have moved into a position, where I try hard to convince you of something, while you keep on disagreeing. Do you notice the same?*" Or, alternatively, the therapist could have said: "*When I hear myself talking to you, I notice in my voice a hint of blaming tone, is it something that you can also recognize?* ".

These kind of utterances of mindfulness in action exemplify many of the principles of metacommunication necessary to the resolution of therapeutic impasses, while simultaneously supporting the patient's needs for autonomy, relatedness and competence (Vansteenkiste et al., 2020): they exemplify exploration with tentativeness, establish a sense of 'we-ness' by commenting on what may be a shared experience, emphasize own subjectivity by accepting responsibility for one's own contribution, promote the practice of reflecting on one's mind trough modelling it, focus on the here-and-now of the relationship, as well invite the patient to explore the therapist's contribution. All these foster the capacity of mentalization (Barreto & Matos, 2018; Fonagy et al., 2019), the willingness to reflect on one's own experience and that of others, allowing us to detach from any interpretation of our own and remain open to whatever we encounter (Aron, 2019; Stern, 2019).

Embracing the Patient's Ambivalence, that Nourishes Creativity and Agency

As noted above, the therapist in the article of Bennett et al. (2006) may very well be embedded in a complementary relational configuration, where the therapist pulls the patient into a rigid commitment to one side of his ambivalent conflict, with the result that the other side is abandoned (Hoffman, 2014, p. 217). A central component of relational therapeutic action, the essence of the third position, is to use it to step out of this complementary power relation by tolerating and nourishing the creative potential of the ambivalence of the client. The third requires an attitude of curiosity and openness for alternatives to a linear complementarity (Benjamin, 2018). How to do this in practice?

One potential timepoint for the therapist in Bennett et al. (2006) to disengage from complementarity and building the third would have been after P171, the most touching and arguably the most crucial timepoint of the entire presented transcript. Here, the patient is in contact with his feelings on a new and deeper level than before. Instead of the therapist 'educating' the patient about 'reality', 'realistic expectations', and normative recommendations for behavior, he or she could have taken the opportunity to embrace ambivalence by entering the transitional space together with him, and playing with his fantasy (Aron, 2019; Winnicott, 2016). The therapist might have said something like the following, with a soft, empathic, and maybe somewhat playful voice:

> *I see. I hear what you say, you feel you must give up all those things you are so sorely longing for to happen and it tears your heart. Would you like to tell me what are these? I would very much like to hear them. Let's take some time together to play with that fantasy, the fantasy that you could get these things or some of them, how would that be?*

Playing with fantasy in the transitional realm is what Winnicott described is needed for the development of psychological growth, agency, and creativity (Caldwell, 2022; Ogden, 2021). Furthermore, playing with fantasy also has the powerful potential to take out the therapeutic dyad from linear complementarity (Aron, 2019). In the intersubjective

realm of the third that transcends complementarity, there is no need to establish whether the patient's expectations are realistic or not. They are not judged unrealistic, but neither are they validated as realistic, which would equal collusion. The therapist's worlds 'fantasy' and 'play' might be clear enough to function in the therapeutic interaction like the pivotal concept of 'marking' in parental communication based on mentalization theory (Fonagy et al., 2019), establishing both the therapeutic containment of the patient's unbearable affect and interpersonal relatedness, while supporting the patient's need for competence and autonomy (Vansteenkiste et al., 2020).

Playing with patients' fantasies opens the possibility to deepen exploration of their own subjectivity, to strengthen mindful awareness, to model them acceptance and cherishment of their inner world. Above all, it promotes patients' ownership of inner experience. Readiness to enter such a play from the part of the therapist is also an interpersonal statement of acceptance that establishes a sense of 'we-ness'. These are among the principles of metacommunication that Safran and Kraus (2014) advocated.

Discussion

To deepen our theoretical and clinical understanding of factors affecting the outcome of alliance ruptures, we have in this study bridged two contemporary theories of psychological change: relational theory and self-determination theory. In doing this, we have answered the call for research of Krause (2023), who in her thorough review of psychotherapy process research concluded, that in order to generate useful future knowledge in the field, change mechanisms need to be linked to ongoing process, requiring models of change that are transtheoretical by nature.

Taking a relational theory perspective, our study examined the therapist's metacommunication in the application of a cognitive analytic model for resolving threats to the therapeutic alliance. The analysis shows what pitfalls may arise in the therapist's metacommunication and relational positioning when under pressure of a therapeutic rupture. The presented transcript reveals the difficulties therapists face in dire impasses and the challenge of maintaining contact with the patient so that rupture does not occur. The therapist of the examined transcript managed to avoid a direct rupture. However, evading an immediate rupture does not necessarily inform about the long-term effect of the impasse on the therapeutic alliance (Eubanks et al., 2019). The therapist might have managed well with respect to avoiding immediate rupture, but perhaps less so regarding the avoidance of the patient's compliance, potentially curtailing internal motivation, and long-standing change (Vansteenkiste et al., 2020).

One of the best ways to evaluate the effectivity of a therapist's intervention is to examine whether it furthers the therapeutic inquiry or shuts it down (Mitchell, 2022). Based on the patient's verbal silencing, the therapist's utterances in the transcript cannot be considered effective: the therapist did not pay attention to this unfolding communicational and relational configuration, left unexplored the therapists normative and educative positioning, and did not notice or comment on the patient's gradual silencing.

The results stand in line with Muran et al.'s (2018) findings, that when confronted with problems in the therapeutic relationship, those therapists who tend to increase adherence to technique escalate the adverse dynamic that in turn correlates with negative outcome. More specifically, when initial reformulation of the patient's characteristic and problematic relational dynamics is used as a tool for the therapist to reach for when things get difficult in the therapeutic relationship, the reformulation becomes the third as an observing function that relational theorist so passionately argued against (Aron, 2006; Benjamin, 2018). By taking the side of the adult part in the patient's ambivalence, the patient's more traumatized, abandoned, or hated parts get easily silenced, possibly leading to pseudo maturity, compliance, or the strengthening of the 'false self', as it is called by Winnicott (Ogden, 2021). Relational theory encourages therapists to mentalize and be aware of their relational positioning, their implicit interpersonal statement when offering insight to the patient. When the therapist focuses attention on insight - the third, understood as an observing function - she will likely expect this insight to be accepted, meaning that the client's illness has caused the impasse. In therapeutic situations that are characterized by the 'doer and done to' complementarity (Benjamin, 2018, p. 59), there are only two possible outcomes: in the best-case scenario, the client feels partly content, because he or she has at least expressed protest, eliciting enough attention from the therapist that they can go on together- until the next time, when the same situation arises. In the worst case, the patient is left defiant or compliant, bearing the burden for 'being destructive', feeling the therapist has withdrawn or retaliated, in either case 'not survived' (Abram, 2021; Winnicott, 2016).

From a self-determination perspective, complementarity boils easily down to compliance of the client, a form of external motivation that empirical studies on self-determination have found to curb long-standing change (Roth et al., 2019; Vansteenkiste et al., 2020). Taking a controlling relational positioning in interactions strengthens external motivation and decreases autonomously endorsed psychological change and regulation. The key to psychological change and autonomous regulation is the therapist's support of the client's needs of relatedness, competence, and autonomy, best

achieved through refraining from a controlling interpersonal positioning, and sustaining the inner tension characterizing the patient's ambivalence (Ryan et al., 2021; Weinstein et al., 2022).

In the relational paradigm, the therapist's primary task is not to avoid collusion. Instead, the therapist's task is participation and mindful reflection and mentalization of his or her involvement (Safran & Kraus, 2014). The therapist is not considered to be in the position to objectively grasp this involvement and offer interpretation of it as it happens. Instead of assuming repetition of the patient's characteristic relational patterns, therapeutic action is grounded on the therapist's readiness to participate in an unfolding, emergent process and relentlessly reflect on their mutual participation.

Originally, in psychoanalysis the prevailing view was that psychoanalytic therapy was essentially informational: insight and awareness would bring about changes in the ways one would experience events and respond to them. Over time, there has been a shift from the informational to the transformational perspective, with an increasing emphasis on the experiential aspect of psychological change (Davies, 2023), where insight is retrospective. With the relational turn, the goal of psychoanalysis has further moved from insight to the freedom to experience and the expansion of relatedness (Davies, 2018; Schwartz Cooney, 2018).

Winnicott emphasized the 'transitional realm', between the realm of fantasy and reality, subjective and objective, as a facilitating environment creating the conditions for psychic growth and authentic agency (Ogden, 2021; Winnicott, 2016). Instead of a 'thing' to hold on in the therapist's mind, instead of an observing function, the third in relational theory is a process in a continuous flux, a shared intersubjective phenomenon, created by the therapist and the client together during their idiographic therapeutic process (Benjamin, 2018). To promote the third is to promote a quality of experience of intersubjective relatedness in a flow of change, a relationship that nonetheless also has a correlate of an internal mental space of the patient. It is the therapist's task to facilitate and consciously work towards building a shared intersubjective space between herself and her client.

The most important therapeutic task of the therapist is not about demonstrating to the client how his or her transference expectations twist reality. The task of the therapist is to become aware of complementarity and to realize more collaborative potentials in the therapeutic experience. For this to happen, however, there needs to be a model for therapeutic action, relying on theory, that guides therapists to allocate relentless attention to the present moment. As we have shown in this paper, 'mindfulness in action' of Safran and Muran (2000) and Benjamin's (2018) emphasis on 'embracing ambivalence' are prominent candidates for such therapeutic action.

While examining a specific interaction sequence allowed us to focus attention to potential pitfalls in rupture resolution processes, further research based on more systematic data collection is needed. Collecting video recordings of alliance rupture events, and analysis of the therapist's nonverbal communication in seeking resolution, could deepen our understanding of how therapist's relational positioning influences the patient. Our findings point to the promise that such study of relational positioning holds for informing both theoretical discussion and clinical work.

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Declarations

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