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# Dyadic Dynamism:
## The Dyadic Mechanism of Therapeutic Change

Sarah Ozol Shore, MS
*Clinical Trainer*
Media, Pennsylvania
sarahozolshore@gmail.com
sarahozolshore.com

**Author Note**

Dyadic Dynamism and the Clinical Discernment Framework are concepts under development by Sarah Ozol Shore, MS, as part of a broader clinical training model on therapeutic effectiveness and real-time clinical calibration. Correspondence regarding this paper may be directed to sarahozolshore@gmail.com.

**Abstract**

This theoretical clinical essay proposes Dyadic Dynamism as a cross-theoretical construct for naming the mechanism of change in clinically effective psychotherapy. Dyadic Dynamism refers to the iterative, clinically calibrated process inside the therapist-client dyad through which the client's psychological organization becomes active, contained, tolerable, and available for reorganization. Drawing from object relations theory, relational and intersubjective psychoanalysis, developmental regulation research, attachment theory, trauma and dissociation theory, mentalization, interpersonal neurobiology, alliance and outcome research, and experiential and integrative traditions, the essay argues that therapy cannot be reduced to supportive listening, weekly narration, technique delivery, insight production, or protocol adherence. Rather, the calibrated dyadic moment is proposed as the unit of therapeutic action. The essay further maps Dyadic Dynamism onto the Clinical Discernment Framework,

identifying six gates of client capacity — regulation and containment, relational contact, dependent agency and access to aggression, reflective and symbolic capacity, meaning-making structures, and integration and reorganization — that determine what kind of dyadic movement is possible in any given clinical moment. The paper is intended as the conceptual foundation for future clinical training on therapeutic effectiveness and real-time clinical calibration.

**Keywords:** *psychotherapy, clinical effectiveness, therapeutic action, dyadic process, relational psychoanalysis, object relations, mentalization, attachment theory, trauma therapy, co-regulation, therapeutic alliance, clinical training, clinical discernment, psychotherapy integration, process research*

## I. Introduction: What Makes Therapy Therapy?

A client may speak for fifty minutes without anything meaningfully therapeutic occurring. She may describe her week, identify her feelings, summarize her patterns, and repeat language she has learned from previous treatment. The hour may be supportive, thoughtful, and emotionally sincere. Therapy, in the stricter clinical sense, begins when something becomes active between therapist and client that can be met, tracked, regulated, and reorganized.

This distinction matters clinically and theoretically. Therapy is frequently confused with the activities that may occur during therapy: supportive listening, weekly reporting, delivery of technique, production of insight, agreement on goals, adherence to protocol. These activities are not without value, and some are necessary conditions for therapeutic work. But none of them defines therapy in the stronger sense, and their presence does not guarantee that anything clinically meaningful is occurring.

What defines therapy, this essay argues, is Dyadic Dynamism: the iterative, clinically calibrated process inside the therapist-client dyad through which the client's psychological organization becomes active, contained, tolerable, and available for reorganization. The construct is not an additional clinical model. It is a cross-theoretical name for the mechanism through which therapeutic change becomes possible — a name that synthesizes major clinical traditions while extending their shared logic toward a teachable, clinically applicable principle.

The dyad is therefore not merely the setting in which therapy occurs. It is the container of therapeutic process. More precisely, it functions as a clinical crucible: a bounded relational field in which the client's psychological organization can become activated without being merely repeated, intensified without being overwhelmed, and transformed without being prematurely interpreted away. Bion's container-contained model, Winnicott's holding and facilitating environment, and Ogden's analytic third each offer a language for this claim (Bion, 1962; Winnicott, 1965; Ogden, 1994a). The therapeutic dyad contains experience not by keeping it inert, but by allowing it to become sufficiently alive, sufficiently held, and sufficiently metabolizable for reorganization to occur. The dyad is not a safe space in the sentimental sense. It is a contained space in the clinical sense: a bounded field in which psychologically consequential material can become active without either overwhelming the client or being evacuated from the room. Containment, in this sense, is not the reduction of affect or the

therapist's control of the client's experience. It is the dyad's capacity to hold activation without foreclosing movement.

The argument proceeds in three movements. The first establishes the theoretical lineage: Dyadic Dynamism is not a free-standing coinage but a synthesis of what object relations theory, relational and intersubjective psychoanalysis, developmental regulation research, attachment theory, trauma theory, mentalization theory, interpersonal neurobiology, alliance and outcome research, and experiential and integrative traditions have collectively been describing. The second defines the construct with precision: what dyadic means, what dynamism means, and what the iterative quality of therapeutic movement requires. The third maps Dyadic Dynamism onto the Clinical Discernment Framework, a real-time assessment tool that makes the construct clinically legible by identifying the six gates of client capacity that determine what kind of dyadic movement is possible in any given moment.

Several points of clarification belong at the outset. Dyadic Dynamism does not require rupture. It does not require emotional intensity. It does not exclude technique, structure, or manualized treatment. It asks a different question of all of these: not whether they are present, but what they do in the dyadic field, and whether the client can use what they offer. The intervention is not the unit of therapy. The calibrated dyadic moment is.

A note on the opening figure is warranted. The client who narrates the week without arriving is not a failure of engagement or motivation. She is a clinical figure that recurs across practice settings, presenting problems, and theoretical orientations. Her presence in the argument is not as a cautionary example but as a diagnostic one: she makes visible the difference between an hour in which something therapeutic is happening and an hour in which it is not, without that difference being apparent from the surface features of the session.

## II. Theoretical Lineage: Why the Mechanism of Therapy Must Be Dyadic

Dyadic Dynamism does not emerge from a single theoretical tradition. It names what multiple traditions have converged on from different angles: that therapeutic change is a relational, iterative process held within an asymmetrical clinical frame — not a one-person event, not a technique-delivery procedure, and not adequately described by any model that locates the

mechanism of change solely inside the client or solely inside the technique. The sections that follow survey the traditions that provide Dyadic Dynamism's theoretical foundation.

## II-A. Object Relations: The Psyche Is Relationally Formed

If psychological life is formed in relationship, then therapeutic reorganization must involve relational experience, not merely private insight or technique delivery. This is the foundational claim of object relations theory, and it provides one of Dyadic Dynamism's strongest theoretical anchors.

Winnicott's concepts of the holding environment, the facilitating environment, transitional space, and the survival of destructiveness all point toward the same clinical premise: the client brings into therapy not only symptoms or stories but a relational organization that must become active in the presence of another mind if it is to be transformed (Winnicott, 1965, 1971). Bion's container-contained model describes the therapist as a mind that receives, metabolizes, and returns emotional experience in a form the client can use (Bion, 1962). Klein's account of internal objects, aggression, the depressive position, and reparation shows that the client's internal relational world becomes active in the dyad, including aggression, guilt, fear of damage, and longing for repair (Klein, 1935, 1946, 1975). Fairbairn's object-seeking self locates the client's psychological organization in internalized relational worlds that must be addressed through relational experience rather than through symptom reduction alone (Fairbairn, 1952). Guntrip's attention to schizoid withdrawal and the fear of contact describes clients who preserve the self by withdrawing from relational encounter, requiring the dyad to titrate contact itself (Guntrip, 1968). Ogden's analytic third extends this tradition by arguing that the dyad generates an emergent intersubjective field — a third process that belongs to neither participant alone and cannot be reduced to the sum of their individual psychologies (Ogden, 1994a).

Together, these thinkers establish the first foundation of Dyadic Dynamism: psychological life is relationally formed, and therapeutic reorganization must occur in a relational field in which the client's organization can become active and be met.

## II-B. Relational Psychoanalysis and Intersubjectivity: Therapy as a Two-Person Field

The shift from object relations to relational and intersubjective psychoanalysis deepens the relational premise by locating the therapist inside the clinical field rather than outside it. In a one-person model, the therapist applies treatment to the client. In a two-person model, the therapist participates in the very field through which the client's organization becomes known.

Mitchell's relational matrix offers the foundational critique: therapy does not occur outside the relational field; it occurs within it, and the therapist's participation shapes what can emerge (Mitchell, 1988). Benjamin's theory of mutual recognition and thirdness shows that agency, aggression, dependency, and recognition must be held in a dyad that does not collapse into complementarity — into doer and done-to (Benjamin, 1988, 2004). Aron's emphasis on the analyst's subjectivity establishes that the therapist's inner experience is not contamination but clinically relevant information about the field (Aron, 1996). Bromberg's work on self-states and dissociation shows that the dyad functions to bridge self-states that cannot yet be held inside one continuous experience (Bromberg, 1998). Stern's account of unformulated experience proposes that experience becomes formulated in the relational field rather than privately (Stern, D.B., 1997). Stolorow, Atwood, and Brandchaft's intersubjective systems theory argues that symptoms and affects are organized within relational contexts, including the therapeutic context (Stolorow, Brandchaft, & Atwood, 1987; Stolorow & Atwood, 1992). Hoffman's attention to ritual and spontaneity in the analytic process captures what Dyadic Dynamism requires of the therapist: structure without rigidity, and aliveness without loss of clinical discipline (Hoffman, 1998).

This tradition confirms that the therapist is not an operator administering treatment. The therapist is a participant in the field through which the client's organization becomes visible and transformable.

### II-C. Developmental Regulation and Implicit Relational Knowing

Developmental research provides one of the clearest empirical analogues for Dyadic Dynamism, because it shows that human psychological organization changes through lived dyadic process — through implicit procedural exchange — rather than through interpretation alone.

The Boston Change Process Study Group's foundational work on implicit relational knowing and the "something more than interpretation" describes therapeutic action occurring through altered relational moments — through moments of meeting, through shifts in the implicit procedural

texture of the relationship rather than through explicit interpretation of content (Stern et al., 1998; Boston Change Process Study Group, 2010). Daniel Stern's account of the present moment, vitality affects, and the moment of meeting in therapy shows that what changes in treatment is often something lived rather than understood (Stern, D.N., 2004). Tronick's mutual regulation model and dyadic expansion of consciousness establish that human development unfolds through moment-to-moment processes of mutual regulation, mismatch, repair, and implicit procedural learning (Tronick, 1989, 2007). Beebe and Lachmann's research on self- and interactive regulation shows how moment-to-moment dyadic exchange shapes internal organization (Beebe & Lachmann, 2002). Lyons-Ruth's work on implicit relational knowing and disorganized attachment shows that clinically significant relational patterns are often carried procedurally, outside narrative awareness (Lyons-Ruth, 1998). Sander's work on living systems and mutual regulation extends the developmental logic into the temporal structure of dyadic exchange (Sander, 2002).

Dyadic Dynamism extends this developmental logic into clinical practice: what changes the client is not only what is said but what becomes possible in the lived dyadic exchange. This is the meaning of "iterative" as the construct uses the term. Each move generates the conditions for the next possible move, and change accumulates through the implicit relational texture of the dyad rather than primarily through its explicit interpretive content.

This developmental literature matters because Dyadic Dynamism is not primarily a theory of what therapists say. It is a theory of what therapist and client become able to do together, moment by moment.

### II-D. Attachment, Mutual Regulation, and Developmental Repair

Attachment theory contributes the account of internal working models: procedural expectations about care, danger, dependence, protest, and repair that clients bring into the therapeutic relationship and activate within it.

Bowlby's internal working models describe the relational expectations that organize the client's experience of dependency, safety, and care (Bowlby, 1969/1982). Ainsworth's research on attachment patterns and maternal sensitivity shows that the quality of attunement shapes what becomes internalized (Ainsworth et al., 1978). Lyons-Ruth's research on disorganized attachment

and implicit relational strategies deepens this account by showing that the most dysregulated relational patterns are often carried without narrative access. Crittenden's attention to protective strategies under conditions of danger extends the framework to the clinical terrain of threat and adaptive response (Crittenden, 2006). Tronick's mutual regulation model links attachment to moment-to-moment dyadic exchange and to the developmental consequences of mismatch, repair, and accumulated relational experience.

These expectations are not merely discussed in therapy. They are activated in the dyad — in the client's experience of the therapist as safe, dangerous, intrusive, unavailable, dependable, controlling, fragile, or withdrawing. The dyad becomes a potential secure base, but it equally becomes a site where relational expectation is confirmed, avoided, or, under sufficiently calibrated conditions, reorganized.

### II-E. Trauma, Dissociation, and State-Dependent Functioning

Trauma theory deepens the requirement for a dyadic account of therapy because traumatic organization is often carried not as reflective knowledge but as state, body, defense, and relational expectation.

Van der Hart, Nijenhuis, and Steele's structural dissociation model, building on the foundational work of Pierre Janet on dissociation and the failure of psychological integration, offers a comprehensive account of how traumatic organization becomes partitioned and what clinical integration requires (van der Hart, Nijenhuis, & Steele, 2006). Herman's stage-based account of safety, mourning, and reconnection emphasizes that therapeutic work requires relational conditions to be established before proceeding (Herman, 1992). Van der Kolk's attention to the body and traumatic memory argues that traumatic organization is held somatically, in state, and in procedural form rather than primarily in narrative (van der Kolk, 2014). Pat Ogden's sensorimotor approach and Fisher's parts-oriented trauma work each describe the procedural and somatic dimensions of traumatic organization (Ogden, P., 2006; Fisher, 2017). Lanius's neurobiological research on dissociation deepens the account of what happens when the integrative function of the nervous system fails under traumatic conditions (Lanius et al., 2010). Bromberg's account of self-states and dissociation bridges the analytic and trauma traditions,

showing that the dyad functions to hold what cannot yet be held inside one continuous self (Bromberg, 1998).

Dyadic Dynamism asks whether the client can remain regulated, accompanied, and meaningfully present while traumatic organization becomes active in the room — and whether the dyad can hold what emerges without the therapist becoming overwhelmed, withdrawn, or falsely reassuring.

### II-F. Mentalization, Reflective Functioning, and Epistemic Trust

The capacity to think about experience while emotionally activated in relationship is not a fixed trait. It is state- and attachment-dependent, and it develops and can collapse within relational conditions.

Fonagy and Target's account of mentalization and reflective functioning establishes that the capacity to understand mental states develops through early relational experience and remains sensitive to relational conditions throughout life (Fonagy & Target, 1997). Bateman and Fonagy's clinical model shows how therapeutic technique can be organized around the restoration of reflective capacity when it has been impaired (Bateman & Fonagy, 2004). Luyten, Campbell, Allison, and Fonagy's work on the mentalizing approach and epistemic trust shows that psychotherapy depends on the client's capacity to trust communication from another mind — a capacity that is relationally opened and relationally closed, and that must be restored before the client can learn from the therapeutic relationship (Luyten, Campbell, Allison, & Fonagy, 2020).

Therapy cannot assume that insight is available simply because interpretation is offered. The dyad must first create conditions in which experience can be mentalized, communication can be trusted, and new meaning can be received as such rather than dismissed, appropriated, or managed at a distance.

### II-G. Autonomic Regulation, Polyvagal Theory, and Interpersonal Neurobiology

Before clients can reflect, symbolize, or reorganize, their nervous systems must register enough safety to remain in contact. Therapy is regulatory as well as symbolic, and its regulatory dimension is dyadic.

Porges's polyvagal theory offers one influential account of how the nervous system responds to safety and danger through neuroception — the detection of threat cues outside conscious awareness — and of how social engagement depends on physiological conditions that are partly regulated through interpersonal exchange (Porges, 2011). Dana's clinical translation of these ideas makes them applicable to therapeutic practice (Dana, 2018). Schore's affect regulation model emphasizes right-brain-to-right-brain communication as a central component of affective development and therapeutic action, and argues that implicit dyadic exchange is a primary mechanism through which early regulatory development can be repaired (Schore, 1994, 2003). Siegel's interpersonal neurobiology integrates developmental, relational, and neurobiological findings into a framework in which integration is both the goal and the mechanism of psychological health (Siegel, 1999). Tronick's mutual regulation model and Beebe and Lachmann's infant research extend this regulatory account into the moment-to-moment texture of dyadic exchange.

The therapist's face, voice, rhythm, silence, and timing are not stylistic features. They are regulatory cues. The client's capacity to think, feel, trust, protest, or receive care depends partly on whether the dyad sustains enough physiological safety for contact to remain possible.

### II-H. Alliance, Rupture-Repair, and Outcome Research

The alliance literature establishes empirically what relational and developmental traditions argue theoretically: the relationship matters to outcome, and the management of strain within the relationship is clinically significant. Dyadic Dynamism incorporates these findings while making a stronger claim.

Bordin's influential formulation of the working alliance identifies three components — agreement on goals, assignment of tasks, and development of an emotional bond — as central features of productive treatment (Bordin, 1979). Safran and Muran's rupture-repair research examines the therapeutic potential of negotiating strains in the alliance, showing that the collaborative resolution of ruptures is associated with positive outcome (Safran & Muran, 2000). Eubanks and colleagues have extended this research and examined the mechanisms through which rupture resolution operates (Eubanks et al., 2018). Norcross and colleagues have synthesized the evidence base for therapy relationships, establishing that relational and

contextual factors account for substantial variance in outcome across treatment approaches (Norcross, 2011). Wampold's contextual model challenges technique-specific accounts of therapeutic action and emphasizes the role of relational, expectancy, therapist, and contextual factors in explaining outcome (Wampold & Imel, 2015). Lambert's outcome research provides the broader empirical foundation for these claims (Lambert, 1992).

Dyadic Dynamism does not collapse into the alliance. The relationship is not simply a factor that supports therapy. The calibrated dyadic process is the medium through which therapy becomes clinically active. Rupture-repair is one important pathway through which aggression, disappointment, and separateness may become developmentally reparative. But the deeper requirement is access to aggression and agency inside the dyad — a claim the alliance literature approaches but does not fully elaborate developmentally.

### II-I. Experiential, Emotion-Focused, and Integrative Traditions

Change requires emotionally activated experience that can be processed, symbolized, and transformed in a relational context. This has been the claim of experiential and integrative traditions across several decades of clinical theory, and it converges with every strand of the lineage surveyed above.

Rogers's account of the necessary and sufficient relational conditions for therapeutic change — empathy, congruence, unconditional positive regard, and psychological contact — remains foundational for understanding what the therapist must provide for therapeutic movement to become possible (Rogers, 1957). Gendlin's felt sense and experiential symbolization describe the process through which experience shifts from inchoate body-sense to articulable meaning (Gendlin, 1978). Greenberg's emotion-focused approach provides an account of how emotion is transformed through processing rather than merely expressed or suppressed (Greenberg, 2002). Fosha's AEDP model, with its emphasis on dyadic affect regulation, undoing aloneness, and transformational affect, provides important clinical specificity for how the dyad holds and facilitates affective transformation (Fosha, 2000). Goldfried's transtheoretical change principles and Wachtel's cyclical psychodynamics each offer integrative frameworks that support the view that change involves more than explanation (Goldfried, 1980; Wachtel, 1997).

Dyadic Dynamism gives this convergent clinical premise a cross-theoretical name and a framework for clinical assessment.

## III. The Construct: What Dyadic Dynamism Names

Dyadic Dynamism refers to the iterative, clinically calibrated process inside the therapist-client dyad through which the client's psychological organization becomes active, contained, tolerable, and available for reorganization.

Three terms in this definition require careful elaboration.

Dyadic. Dyadic does not mean merely two people sharing a room. It means that the client's organization becomes active with this therapist, in this relational field, in this moment. The dyad is not interchangeable. It is the specific two-person field through which the client's psychological organization shows itself, and it generates something neither participant creates alone: an emergent clinical process with its own regulatory, relational, affective, and symbolic properties. The same client, with a different therapist, in a differently calibrated relational field, may encounter different possibilities, different exposures, and different tolerances. The dyad is the specific relational container in which the client's organization becomes active and through which reorganization becomes possible or remains foreclosed. The field does not merely reveal the client's organization; it participates in shaping what that organization can become.

Dynamism. Dynamism does not mean that the dyad is simply active or mutually responsive. It means that the dyad generates movement: iterative, calibrated movement in which contact and withdrawal, activation and modulation, regulation and exposure, enactment and symbolization, dependency and agency, challenge and repair are all possible and all clinically meaningful. Dynamism encompasses shame, dysregulation, refusal, care, aggression, meaning, and integration. It is the quality of clinically held aliveness in the exchange — what allows a therapeutic dyad to become more than a supportive encounter. Without dynamism, the dyad may be warm, consistent, and technically correct without anything in the client's organization becoming available for reorganization.

Iterative. The iterative quality of Dyadic Dynamism is what distinguishes it from mere mutual influence. In any relational exchange, therapist and client influence each other. What makes the

therapeutic dyad specifically powerful is that each move changes what the next move can be. The client moves toward contact; shame rises; the therapist recalibrates; the client returns. The client complies; the therapist invites refusal; the client discovers she can disagree and remain connected. The client discloses; the therapist remains genuinely present; the client experiences disclosure as survivable. The client attacks; the therapist survives the attack and continues thinking; the client encounters an object that neither collapses nor retaliates. Each iteration is a local event with systemic consequences, because what becomes possible between therapist and client gradually becomes available within the client.

The central teaching line follows from these three terms: the intervention is not the unit of therapy. The calibrated dyadic moment is.

What Dyadic Dynamism does not describe is worth naming precisely. A client who narrates her week with emotional sincerity and genuine engagement is not yet in Dyadic Dynamism if her organization is not active in the room. A therapist who delivers an empirically supported technique skillfully is not producing Dyadic Dynamism if the technique arrives in a dyad where the client cannot use it. A session that generates rupture and repair has produced one possible pathway of Dyadic Dynamism, but rupture is not the criterion. The criterion is whether something in the client's organization is active, whether the dyad can tolerate and calibrate what has become active, and whether the exchange moves something.

## IV. The Clinical Discernment Framework as a Map of Dyadic Dynamism

Dyadic Dynamism names the mechanism of therapeutic change. The Clinical Discernment Framework (Shore, 2024) maps the client capacities that determine what kind of dyadic movement is possible in any given clinical moment. The Framework does not replace the dyad with a checklist. Rather, it gives the clinician a way to read the dyad in real time: what is active, what is unavailable, what has exceeded capacity, and what kind of calibration would allow movement to continue.

The Framework identifies six gates. Each represents a domain of client capacity that the dyad must assess and work within simultaneously. Effective clinical work is work delivered within the

client's current level of capacity across all six gates. Dyadic Dynamism becomes clinically active differently at each gate, and the clinical question shifts accordingly.

*Gate 1: Regulation and Containment*

At the regulatory gate, the dyad functions as a container before it functions as an interpretive space. Dyadic Dynamism here appears as dynamic co-regulation: the client's nervous system responds to contact, recognition, challenge, and care, and the therapist tracks these responses, adjusting intensity, pace, proximity, and language of contact accordingly. Regulation is not only an internal client capacity. It is first a dyadic achievement. The clinical question is whether the client can remain within enough regulatory tolerance to use the contact — and what calibration of the dyad makes that possible.

*Gate 2: Relational Contact*

At the gate of relational contact, Dyadic Dynamism asks whether the client can be present with the therapist while experience becomes real. A client may speak coherently and at length without arriving — reporting affect without inhabiting it, describing relationship without entering one, discussing trauma while remaining profoundly alone. For many clients, the exposure is not the feeling alone but the experience of feeling in the presence of another mind. Contact itself is the exposure. The clinical question is whether the dyad can make that contact tolerable: not comfortable, but survivable.

*Gate 3: Dependent Agency and Access to Aggression*

At the dependent-agency gate, Dyadic Dynamism asks whether the client can bring both need and selfhood into the room — whether she can depend, receive, refuse, protest, disagree, and remain connected. Access to aggression is one of the central indicators that this gate is opening. Aggression, in this developmental sense, is not hostility. It is the force of separateness: refusal, boundary, protest, self-assertion, the hard no. Many clients can achieve dependency only by complying, or preserve agency only by refusing dependence. The client who can only comply, please, collapse, or withdraw without protest does not yet have full access to agency in relationship. The clinical question is whether the dyad can receive aggression without retaliation, collapse, appeasement, or control — whether the client's no can enter the relationship and be met.

*Gate 4: Reflective and Symbolic Capacity*

At this gate, Dyadic Dynamism asks whether the client can think about what is happening while it is happening, or whether the dyad must first restore the conditions for reflection. Reflective capacity shifts with regulatory state, relational safety, shame, and activation. A client who can reflect elegantly when calm may lose that capacity entirely when ashamed, dependent, or seen. Interpretation becomes therapeutic only when the client has enough reflective capacity to use it. Otherwise, the dyad must restore regulation and contact before meaning can emerge rather than be performed.

*Gate 5: Meaning-Making Structures*

At the gate of meaning-making, Dyadic Dynamism asks what the dyadic moment means inside the client's existing relational world. The therapist's care may mean pity. Silence may mean abandonment. A boundary may mean rejection. Interest may mean control. Disagreement may mean danger. The therapist's intention does not determine the client's experience. The clinical question is whether the dyad can make the client's meaning-making structure visible without collapsing into it — whether the meaning the client assigns to relational events can itself become the subject of the clinical work.

*Gate 6: Integration and Reorganization*

At the integration gate, Dyadic Dynamism asks whether what first became possible between therapist and client is beginning to become available within the client — whether dyadic movement is being internalized. Integration is not a discrete achievement. It is the gradual internalization of repeated dyadic movement: what was first regulated, held, symbolized, survived, and reorganized between therapist and client becomes part of the client's own psychological capacity. The clinical question is whether the client is carrying the dyadic experience forward, or whether each session requires the work to begin again from the same starting position.

The six gates are not stages to be completed in sequence. They are simultaneous dimensions of clinical assessment, each informing the others. A shift in regulatory capacity changes what is available at the contact gate. A change in the client's access to aggression changes what is available for integration. The framework is a real-time instrument, not a treatment protocol.

## V. Clinical Vignettes as Demonstrations of Dyadic Dynamism

The following vignettes are not case reports. They are clinical figures — compressed portraits of recurring relational configurations that Dyadic Dynamism is designed to make legible. Each figure names a gate, a primary clinical question, and the move the dyad must make if the configuration is to become therapeutically available rather than simply repeated.

The figures are arranged not by severity but by gate, moving through regulation, relational contact, dependent agency, reflective and symbolic capacity, and meaning-making. In clinical practice, these configurations appear in combination and in sequence. A client who narrates without arriving may also be protecting against shame. A client who attacks after dependency may also be unable to tolerate care. The figures are separated here for analytic clarity; the dyad holds them together.

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*The client who narrates the week but does not arrive | Gate: Relational Contact*

A client arrives each week and speaks well. She describes her week with accuracy and some feeling. She identifies patterns. She summarizes what previous clinicians have said. The hour is thoughtful, earnest, and emotionally sincere. The therapist listens. Something may be supported, but nothing in the client's organization appears to move.

What is absent is not content. The client has content in abundance. What is absent is relational presence — the quality of being with another mind while something real is happening. The client speaks alongside the therapist rather than toward her. She manages the session from a slight distance that is neither hostile nor defended in any obvious way. She simply does not arrive.

Therapy is not weekly reporting. The clinical question Dyadic Dynamism poses here is not what the client is saying, but whether the client can be present while she says it — whether the relational field has enough contact to become therapeutic rather than merely documented. The session may be pleasant, even occasionally moving, without anything in the client's organization becoming active enough to be reached.

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*The client who becomes ashamed when seen | Gate: Regulation and Containment*

The therapist reflects something accurate. She names a pattern, notices a longing, or simply looks at the client directly. The client stiffens. Her eyes drop. Something that had been available closes. The session continues, but the client has moved from contact into management.

Recognition can be exposure. The assumption that an accurate observation will be experienced as helpful belongs to clients whose regulation can hold the experience of being seen. For clients whose early relational environment made being perceived unsafe — because it preceded control, invasion, disappointment, or abandonment — the therapist's accurate attention is not soothing. It is activating. The regulatory system narrows not because the therapist has done something wrong, but because visibility itself is a form of vulnerability the nervous system has learned to treat as danger.

Dyadic Dynamism requires the therapist to track not only the accuracy of the observation but what the observation does in the dyad. Recalibrating — slowing, softening, moving to a less directly seeing posture — is not retreat. It is the clinical instrument of regulation. The therapeutic move is not to persist with accurate seeing but to restore enough regulatory tolerance that contact becomes possible again.

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*The client whose yes has no agency* | *Gate: Dependent Agency*

This client is cooperative, appreciative, and diligent. She completes the exercises the therapist suggests. She agrees with the reframes. She returns each week with evidence of having tried. She is, by every surface measure, an excellent client. The therapist feels useful. Neither of them notices for some time that the client has not disagreed once.

Compliance is not movement. What is absent in this dyad is not effort or goodwill. What is absent is the client's own agency — the capacity to bring a no, a refusal, a differing read of her own experience. The client has learned that relationship requires accommodation, that her own perceptions are less reliable than another person's, or that disagreement ends care. Her yes arrives quickly and thoroughly, covering a field that has never been tested.

Dyadic Dynamism does not become clinically active until the client's organization is actually in the room. A client who agrees with everything has not yet brought herself. The goal is not to

manufacture conflict but to notice that the absence of refusal is itself clinical information — and that the therapeutic work will not move the client's relational organization until that organization has room to appear.

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*The client who attacks after dependency | Gate: Dependent Agency*

The client has been moving toward the therapist. Over several months, she has allowed more need into the room — more longing, more reliance, more disclosure of what she wants from the relationship. Then something shifts. The therapist says something slightly off, or changes an appointment, or simply exists as separate. The client's tone turns cold. She questions whether the therapy has helped at all. She arrives the following week as though the preceding months have been revised.

Aggression may defend against need. What the attack announces is not that the relationship has failed but that dependency has become dangerous. The client has moved close enough to need the therapist, and the experience of needing — of being in the position of a person who can be disappointed — has activated the defense of aggression. The attack creates distance that the client cannot yet tolerate not having.

Dyadic Dynamism here requires the therapist to survive the attack without retaliation, collapse, or anxious repair, and to remain curious about what the aggression is protecting. Rupture-repair becomes one possible pathway, because the client's aggression has strained the dyad and the therapist's capacity to receive it, remain present, and continue thinking is itself a developmental event. The therapist who survives the attack without becoming the punitive or the injured object has demonstrated something the client has not yet experienced inside a close relationship.

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*The client who asks for skills to avoid contact | Gate: Reflective and Symbolic Capacity / Relational Contact*

The client arrives with a request. She has been anxious this week and wants tools. She asks for breathing techniques, grounding exercises, something concrete she can use. The request is reasonable. The therapist considers.

Tools can become avoidance. The clinical question is not whether the tools are real or whether the anxiety is real. Both may be. The question is what function the request is performing in the dyad at this moment. For some clients, the request for skills arrives precisely when something relational is becoming active — when the session is about to require more contact than the client knows how to tolerate. The tools become a way to manage the session rather than enter it.

Dyadic Dynamism does not preclude skills. It asks the therapist to notice when technique is being enlisted as a defense against the relational field itself. A therapist who complies with every request for tools without asking what the tools are organized around has, in some instances, agreed to help the client stay away. The move is not to refuse the request but to hold it as information — and to stay curious about what was alive in the room before the request arrived.

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*The client who tells the trauma story but remains alone* | *Gate: Relational Contact*

The client tells the story well. She has told it before, in other offices, to other clinicians, and the telling has become practiced without becoming integrated. She describes what happened, when, how, what she did, how she survived. The therapist listens. The client finishes. She looks at the therapist without expectation, as though the telling were a completed task rather than a bid for something.

Disclosure is not integration. What is absent is not narrative. The client may have considerable narrative access. What is absent is accompaniment — the experience of telling while being with another person who receives, metabolizes, and remains present. Integration does not occur because the story is told. It becomes possible when the story can be told inside a dyad that can hold it without being overwhelmed, without turning clinical, and without leaving the client alone with what she has just made real in the room.

The trauma has been documented many times. It has not yet been survived in the presence of another mind. Dyadic Dynamism asks whether the client can remain in contact while the story is told — whether she can inhabit the telling rather than perform it, and whether the therapist can remain genuinely present rather than carefully managing the therapist's own response to what is being heard.

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*The client who performs being a good client* | *Gate: Meaning-Making Structures*

She brings the right material. She brings material that appears clinically rich: dreams, somatic sensations, childhood memories, relational patterns. She has read about therapy and performs the genre correctly. She reflects, connects, and uses the language of the field with precision. The therapist finds her compelling. The session moves well. Months pass.

Therapy can become performance. The question Dyadic Dynamism poses here is not whether the client is engaged but what the engagement is organized around. For this client, the meaning of therapy has become a relational achievement — being good at it, being the client the therapist finds interesting and useful, sustaining the therapist's investment. The performance is not cynical. It is a relational strategy as old as the client's earliest experience of how to remain in relationship: she is being what the other person needs.

What has not yet entered the room is the part of her that does not perform. The clinical task is not to expose the performance but to remain curious about it — to notice that the most alive therapeutic material may be precisely what the client has not yet brought, because bringing it would require risking the relationship rather than maintaining it.

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*The client who cannot tolerate care* | *Gate: Meaning-Making Structures*

The therapist says something warm. She notices the client's effort, reflects her courage, or simply names what she sees with care. The client deflects. She minimizes, jokes, changes the subject, or turns the comment into something slightly different from what the therapist intended. The therapist tries again, gently. The client accepts the second attempt with a thin smile and moves on.

Care may be experienced as humiliation. The therapist's intention does not determine the client's experience. For a client whose early relational environment taught her that being cared for meant being pitied, controlled, indebted, or exposed as inadequate, warmth from another person is not neutral. It activates a meaning structure in which care and diminishment are adjacent. To receive the therapist's care would require tolerating the position of a person who needs caring for, and that position may carry more shame than the client can currently hold.

Dyadic Dynamism asks what the client is doing with the care — not whether the care was offered well, but what it means inside the client's existing relational world. The therapist who persists with warmth without tracking the client's experience of it is not providing care. The therapist is managing the therapist's own discomfort with the client's deflection. Calibration here means slowing, staying close to the client's actual experience of the exchange, and allowing the meaning structure itself to become the subject.

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*The client who has insight but no dyadic movement* | *Gate: Reflective and Symbolic Capacity*

This client understands herself. She can describe her patterns with clarity, trace their origins, name the defenses, and explain why she does what she does. The insight is genuine. It is also inert. She explains herself to the therapist with the same fluency she uses to explain herself when alone, and neither the explaining nor the understanding moves anything.

Insight is not reorganization. The capacity for reflection, when it operates at sufficient remove from relational activation, becomes a tool for managing experience rather than transforming it. This client has learned to think about herself as a way of not being in herself — not in the activated, relational, exposed sense that would require another person to be genuinely present with her while something occurred. The reflection is real. The dyad is not yet inside it.

Dyadic Dynamism becomes active not when the client produces insight but when the insight emerges while something is happening between therapist and client — when the understanding arises from contact rather than from the management of it. The clinical question is not whether the client can think about herself but whether she can think while being in relationship, while something is active, while the therapist is actually present rather than serving as an audience for a private process.

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Across all nine figures, a single clinical principle holds: what is clinically significant is not the content the client brings but the organization she enacts. The organization becomes visible in the dyad — in what can be tolerated, what collapses, what is defended against, what cannot be received. Dyadic Dynamism gives that organization a name and asks what calibration would allow it to become active, survivable, and available for reorganization.

## VI. Technique, Support, and Manualized Therapy Reconsidered

Dyadic Dynamism does not argue against technique, structure, support, or manualized treatment. It relocates them.

A technique becomes therapeutic only when it enters the dyadic field in a way the client can use. The same technique, delivered at different points in a relationship, to different clients in different regulatory states, within dyads calibrated to different levels of contact, will produce different results — not because the technique varies but because what the client can use varies. The technique does not produce change by itself. It becomes an instrument of Dyadic Dynamism when the clinician can track what the technique does in the relational field and calibrate accordingly.

Support may be a necessary condition for therapeutic work, but it is not sufficient to produce reorganization. The supportive encounter that soothes, validates, and accompanies is clinically meaningful. It becomes therapy in the stronger sense only when it participates in the reorganization of the client's regulatory, relational, reflective, or agentic capacities — when the dyad does more than hold the client steady and begins to move something.

Manualized therapy raises the same question at the level of treatment structure. A manual can organize treatment, specify the sequence of interventions, and increase treatment fidelity. It cannot replace the clinician's moment-to-moment assessment of what is happening between therapist and client. The clinician who follows the manual without tracking the dyad may produce technically correct treatment without producing Dyadic Dynamism. The clinician who tracks the dyad while using the manual as structural guidance may produce both fidelity and clinical movement.

Insight presents the same limitation. A client who understands her patterns with clarity and fluency has achieved something real. She has not necessarily changed her organization. Insight becomes reorganizing when it arises within an activated relational state — when it emerges from contact rather than as a substitute for contact, when understanding is inhabited rather than performed.

Wampold and Imel's contextual model, Norcross's synthesis of the therapy relationship literature, and Goldfried's transtheoretical principles each establish that therapeutic change cannot be adequately explained by technique in isolation; relational, contextual, expectancy, and therapist factors substantially shape outcome (Wampold & Imel, 2015; Norcross, 2011; Goldfried, 1980). Dyadic Dynamism specifies what those relational and contextual factors are doing: they are calibrating the dyadic field so that what the clinician offers can become available to the client.

## VII. Aggression as Agency: The Client's No Inside the Dyad

One of Dyadic Dynamism's most important clinical claims requires careful formulation: the dyad does not require rupture, but it does require access to aggression.

Aggression, in the developmental sense intended here, is not hostility or attack. It is the force of separateness: refusal, protest, boundary, disagreement, disappointment, and self-assertion. It is the capacity of a client not to comply, not to accommodate, not to manage the therapist's comfort at the expense of her own reality. A client who can only comply, please, collapse, withdraw, or depend without protest does not yet have full access to agency in relationship. The therapeutic dyad becomes developmentally reparative when the client's no, anger, disappointment, or refusal can enter the relationship without destroying it.

The distinction between aggression and rupture matters clinically. Rupture is an event: a breakdown in the collaborative texture of the alliance, a moment in which the relationship becomes strained, contested, or disrupted. Rupture-repair is a documented pathway of change, particularly when the resolution of rupture allows the client to experience that disagreement, disappointment, and repair are possible inside the same relationship (Safran & Muran, 2000). But rupture is not required. Aggression is a capacity, not an event. Many clients can bring their aggression into the dyad without ever rupturing the alliance — through disagreement that is named and metabolized, through refusal that is received without retaliation, through self-assertion that is welcomed rather than managed. What is required is not that the relationship break and be repaired, but that the client's aggression can enter the relationship and be met.

Winnicott's account of the object's survival of destructiveness offers one of the most important theoretical formulations of this principle: the client's capacity to experience separateness without

destroying the relationship depends on the therapist's capacity to remain intact rather than collapsing, retaliating, or appeasing (Winnicott, 1971). Benjamin's theory of mutual recognition extends this into the territory of agency: genuine recognition requires that both parties remain subjects, which means the client's aggression, refusal, and self-assertion must be survivable for the dyad (Benjamin, 1988, 2004). Klein's account of the depressive position describes the developmental achievement of holding love and aggression toward the same object without destroying the relationship in fantasy (Klein, 1975). Bion's container-contained model addresses what the therapist must be able to hold when the client's aggression enters the dyad (Bion, 1962).

The clinical task is to make the dyad a field in which the client's aggression can enter relationship — not as sanitized affect, not as prematurely managed material, but as real, directed, relational force that the therapist can receive, metabolize, and remain present within. When these expressions strain the dyad, rupture-repair may become one pathway of change. But rupture is not the requirement. The requirement is that aggression can be brought into relationship, met without retaliation or collapse, and gradually integrated as part of the client's selfhood.

## VIII. Therapist Subjectivity as Clinical Instrument

The therapist's subjectivity is not noise in the treatment. It is one of the primary instruments through which Dyadic Dynamism is perceived and calibrated.

This claim does not mean that therapist self-expression is inherently therapeutic, or that countertransference disclosure is always indicated, or that the therapist's own psychology should organize the clinical encounter. It means that the therapist's inner experience of the dyad — the pulls to rescue, explain, defend, soothe, withdraw, confront, comply, or disappear — may be information about the field the therapist is in. The therapist who notices an urge to rescue may be in the field of a client whose distress has historically required rescue. The therapist who notices an urge to explain may be in the field of a client who has historically organized others around the provision of answers. The therapist who notices a wish to disappear may be in the field of a client whose relational presence has been organized around making others invisible.

The task is neither to act on these pulls nor to suppress them. The task is to metabolize them clinically — to allow them to become information about the dyadic field rather than either

enacted or managed out of existence. This requires of the therapist a form of affected discipline: the capacity to be genuinely moved by what is happening in the room while remaining able to think rather than simply react.

Heimann's early formulation of countertransference as a clinical instrument rather than a therapeutic failure established the foundational shift in how therapist subjectivity is understood (Heimann, 1950). Racker's distinction between concordant and complementary countertransference provides analytic precision about what the therapist's inner experience reveals about the relational field (Racker, 1968). Sandler's account of role responsiveness extends this into the language of enactment and procedural pull (Sandler, 1976). Aron, Ogden, Mitchell, and Bromberg each extend this tradition in the relational direction, showing that therapist subjectivity is a structural feature of the dyadic field rather than an individual failing to be managed (Aron, 1996; Ogden, 1994b; Mitchell, 1988; Bromberg, 1998). Hoffman's account of disciplined spontaneity captures the clinical stance that Dyadic Dynamism requires: alive enough to know the field, structured enough to think within it (Hoffman, 1998).

The therapist must be affected enough to know the field and disciplined enough not to make the therapeutic work about the therapist's own needs. This is the core requirement of therapist subjectivity as clinical instrument: not neutrality, not transparency, but the capacity to be fully in the room while remaining oriented toward the client's organization rather than toward the therapist's own comfort, competence, or relational needs.

## IX. Clinical Effectiveness as Dyadic Calibration

Clinical effectiveness is not the selection of the correct intervention for a given diagnosis. It is the accurate calibration of the therapeutic process to the client's actual capacity in each clinical moment.

This distinction has practical consequences. A clinician who selects an evidence-based intervention for a presenting problem and delivers it with technical skill may not be clinically effective if the intervention arrives in a dyad in which the client cannot use it — if the client's regulatory capacity has narrowed, if relational contact is unavailable, if reflective capacity has collapsed under shame, if the care implicit in the intervention is experienced as humiliation.

Effectiveness depends not on the quality of the intervention in the abstract but on what the client can receive, hold, and use in this moment, in this dyad, with this degree of calibration.

Dyadic Dynamism provides the medium through which clinical effectiveness operates. The clinician must assess not only what the client says but what the client can use. The Clinical Discernment Framework makes this assessment teachable by naming the six domains of capacity that determine what is available. The clinical questions this assessment generates are not peripheral to treatment. They are the questions that determine whether the therapeutic work becomes clinically effective or remains technically correct and therapeutically inert: Is the client regulated enough for contact? Is relational contact itself the exposure? Has agency disappeared into compliance? Can the client reflect, or is interpretation premature? What does the therapist's care mean inside the client's relational world? What is this dyadic moment meaning to the client? Is what is happening between therapist and client beginning to be internalized?

The common factors literature has established that relationship and therapist factors are central to outcome across treatment modalities (Norcross, 2011; Wampold & Imel, 2015; Lambert, 1992; Bordin, 1979). Fonagy and colleagues' work on epistemic trust shows that the client's capacity to learn from the therapeutic relationship depends on relational conditions that the clinician must actively create and maintain (Luyten et al., 2020). Schore's affect regulation model argues that right-brain-to-right-brain exchange is a regulatory mechanism, and that the clinician's moment-to-moment responsiveness shapes the physiological conditions under which therapeutic movement becomes possible (Schore, 2003). Dyadic Dynamism extends these findings by specifying the proposed mechanism: not the relationship in general, but the calibrated dyadic process through which clinical movement becomes possible.

Clinical effectiveness requires calibration. Calibration requires real-time assessment of client capacity. Real-time assessment requires a clinician who can track what is happening between therapist and client at the level of regulation, contact, agency, reflection, meaning, and integration simultaneously. Dyadic Dynamism names the process. The Clinical Discernment Framework makes it assessable. The question the framework puts to every clinical moment is the same: what is actually available here, and what calibration does this dyad require?

## X. Conclusion: Therapy as Dyadic Reorganization

Therapy is not the room, the hour, the weekly report, the therapist's kindness, or the intervention. Therapy is the clinically calibrated dynamism in the dyad that moves something.

Across these traditions, the language differs: holding, containment, recognition, implicit relational knowing, internal working models, mentalization, co-regulation, alliance, emotion transformation. Yet each tradition points toward the same clinical reality: therapy changes people through a lived relational process that makes old organization active under new conditions. Dyadic Dynamism synthesizes what these traditions have been describing separately and gives it a name that is both theoretically grounded and clinically teachable.

What these traditions share — and what Dyadic Dynamism synthesizes — is the claim that the clinically significant event in therapy is not what the therapist does to the client but what becomes possible between them: what the client's organization can become active as, what the dyad can tolerate, regulate, symbolize, survive, and reorganize. The calibrated dyadic moment is the unit of therapeutic action because it is in that moment that the client's psychological organization is most alive and most available for something different to occur.

Several implications follow for clinical training and for the ongoing development of the Clinical Discernment Framework as a teachable instrument. If the calibrated dyadic moment is the unit of therapeutic action, then clinical training must address not only which interventions to use but what the clinician is tracking in the dyad when deciding to use them. It must address what regulatory capacity looks like when it narrows. It must address how contact becomes the exposure. It must address what compliance without agency looks like and what the dyad must do when it appears. It must address how meaning-making structures shape the client's experience of care, challenge, and recognition. It must address how the therapist's subjectivity can be an instrument rather than a contaminant. These are trainable skills, and they can be assessed in real time. The Clinical Discernment Framework is designed to make that assessment legible.

Therapy is the dynamism in the dyad that moves something. When clinically held, what it moves is the client's capacity for regulation, contact, agency, vulnerability, reflection, meaning, integration, and freedom. Dyadic Dynamism names this movement. It is the living process through which therapist and client enter a bounded, asymmetrically held, clinically calibrated field — a container and crucible — where old organization becomes active, tolerable, and

available for reorganization. This is what makes therapy more than support, more than technique, more than insight, and more than the story of the week. It is what makes therapy therapy.

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Note. This is a working paper. References are provided for scholarly orientation and will be further refined in subsequent versions.

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