Relational Competence Theory
This volume is dedicated to Bess L. L’Abate for all her direct and indirect support that made this work possible throughout the years since its inception in 1988 during the first visit to Padua by the first author and to Sharon Panulla, Executive Editor at Springer Science+Business Media, for her continuous, decade-long support of the first author of this volume and her belief in the validity of relational competence theory. This volume would not have been published without her support.
Preface

The purpose of this book is to elaborate and update with recent and relevant research a contextual and developmental relational competence theory (RCT) in intimate/nonintimate relationships (L’Abate, 1976, 1994a, 1994b, 1997a, 1997b, 2002, 2005, 2006, 2008a, 2008b, 2008c, 2009a, in press, 2009c; L’Abate & Cusinato, 2007; L’Abate & De Giacomo, 2003). RCT focuses on how effectively we deal with each other, with intimates and nonintimates in close/distant, committed/uncommitted, dependent/interdependent/independent, and short/prolonged relationships. Relational means bidirectional rather unidirectional interactions with intimates and nonintimates in a continuous interdependent and reciprocal exchange of resources available to us. Effectiveness is evaluated by how we feel, how we think, how we act, how we are aware, and how we evaluate proximal and distant subjective contexts as perceived by us. Theory means a hierarchical framework akin to the table of organization of any human enterprise with various levels expanding downward from generality to specificity and from abstract to concrete, going from overall general assumptions (Part II), theory-specific assumptions (Part III), normative models proper (Part IV), models clinically relevant to dysfunctional conditions (Part V), to the improvement of competence (Part VI).

However, not all models of RCT have been evaluated empirically; hence, this volume represents research in progress, because only a limited number of models have been evaluated, whereas others have been ignored for at least two reasons. First, the literature on “ignored” or “bypassed” models is so extensive that it is questionable whether anything additional can be added empirically. However, that is not an excuse. Second, certain models were selectively evaluated more frequently than others because they were easier to evaluate than others, or they seem to be more relevant than others. Consequently, there are considerable gaps in the theory that have not been plugged but which are in the process of being plugged (Cusinato & L’Abate, 2009).

The field of intimate relationships is a vast and exciting one (Brehm et al., 2002; DeGenova & Rise, 2005) that perhaps no single theory or theoretical framework can encompass. The theory updated here is an attempt to develop such an encompassing framework, even though it may fall short of its admittedly grandiose and ambitious goal. The field of relational competence and intimate relationships is so complex that to reduce it to a few models may be an exercise in futility. Nonetheless,
the complexity of intimate relationships is a challenge that cannot be ignored. Will it be possible to reduce such complexity to a given number of theoretical models that are verifiable in the laboratory as well as applicable in the clinic? Not only should such models be verifiable in the laboratory, but they should also be verifiable in their applications to primary, secondary, and tertiary prevention approaches. Hence, this theory attempts to fulfill a tall order to make sense of a complex field that, thus far, and to the first author’s knowledge, lacks an adequately integrative, verifiably unifying theory or encompassing theoretical framework.

Plan of the Book

Part I covers two chapters necessary for the conceptual and empirical bases of the whole theoretical framework. Chapter 1 includes definitions of conceptual terms necessary for the elaboration of the theory, including (1) relational, (2) competence, and (3) theory, which involve four major requirements necessary for this theory: (1) verifiability in the laboratory, (2) applicability to functionality and dysfunctionality in relational competence and in mental health interventions, (3) redundancy in how different models offer different perspectives to view conceptually similar constructs, and (4) fruitfulness, how a theory generates testable hypotheses and methods to evaluate its models. This is where the hierarchical framework is introduced. Chapter 2 includes research data about established external resources, already validated test instruments, and rating scales used to evaluate new internal measures specifically created to verify the validity of selected models of the theory.

Part II includes three metatheoretical assumptions about whatever knowledge has been accumulated that helps us understand relational competence according to Model1 (Chap. 3) about the width of relationships, and which is based on a horizontal circular model involving five components: emotionality, rationality, activity, awareness, and context (ERAAwC), evaluated with the Relational Answers Questionnaire. Chapter 4 (Model2) deals with the depth of relationships based on two major levels composed of (1) description, consisting of two sublevels, the public-presentational façade exhibited outwardly and the private phenotype exhibited in the privacy and secrecy of one’s home, and (2) explanation, consisting by two sublevels, the internal genotype and the historical, intergenerational–generational family of origin, those characteristics that include physical, emotional, and intellectual development. Relational competence occurs within the range of various, objective settings as summarized in Chap. 5 (Model3), such as the home, school/work, and in transit (buses, cars, roads, etc.), and transitory ones (church, grocery store, barber, beauty salon, etc.).

Part III includes three theoretical assumptions about basic abilities that determine relational competence, including Model4 (Chap. 6) about the ability to love and Model5 (Chap. 7) about the ability to control or regulate self. The ability to love relies on a dimension of distance defined by extremes in approach–avoidance, with functionality balanced in the middle. The ability to regulate self relies on a temporal
dimension of control, defined by extremes in discharge/disinhibition and delay, inhibition/constraint, with functionality balanced in the middle. When both abilities are combined into an orthogonal model (Model 6, Chap. 8), this combination yields four quadrants with three levels of functionality. Functionality in relationships is an appropriate balance of approach–avoidance and discharge–delay functions that varies according to task demands at various stages of the life cycle. A third corollary to both abilities included in Chap. 9 (Model 7) involves the contents of relationships, what is exchanged among individuals through the Triangle of Living composed of being, doing, and having.

Part IV includes five major developmentally normative models derived from both metatheoretical and theoretical assumptions: In Chap. 10, Model 8 deals with developmental self-identity differentiation, according to a curvilinear dimension composed of six degrees. From these six degrees, three relational styles are described in Chap. 11 (Model 9) and expanded into intimate interactions in Chap. 12 (Model 10). In Chap. 13 (Model 11) a selfhood model related to functionality and dysfunctionality is expanded to relate to the DSM-IV psychiatric classification. In Chap. 14 (Model 12) priorities include synonymous constructs such as goals, motives, intentions, needs, and attitudes.

In Part V, four additional, clinically relevant models are related to mental health interventions, all derived from the previous assumptions and major models, and applied to dysfunctional and clinical relationships. Chapter 15 (Model 13) includes three roles of pursuer (approach), distancer (avoidance), and regulator (contradiction in approach–avoidance). Chapter 16 (Model 14) includes a pathogenic drama triangle, which includes simultaneous roles of victim, persecutor, and rescuer. In Chap. 17, Model 15 is defined as the sharing of joys as well as hurts, including forgiveness of errors and transgressions. In Chap. 18 (Model 16), the structure and process of problem solving involves, among others, a multiplicative function of three factors: (1) level of functionality in negotiating parties (ill), which in some way determines (2) the abilities necessary to negotiate (skill), and (3) motivation to negotiate (will).

Part VI is dedicated to the improvement of competence through interactive practice exercises or workbooks. In Chap. 19, the promotion of competence, what in the past was called primary prevention, includes positive approaches related to models of the theory through enrichment programs for couples and families, and self-help and low-cost approaches to promote physical and mental health, including interactive practice exercises for functional populations, such as children, children and their families, adults, couples, and families. Chapter 20 focuses on prevention of incompetence in targeted, undiagnosed but at-risk populations, such as adult children of alcoholics, through a variety of interactive practice exercises specifically designed for these populations. Chapter 21 includes face-to-face, replicable prescriptions that derive from models of the theory that can be administered verbally as well as in writing in interactive practice exercises from single- and multiple-score tests and dimensions of severe incompetence.

In Part VII, the concluding chapter (Chap. 22) discusses the major issue facing research for RCT. Most of the research summarized in this volume was performed
by Italian-speaking experimenters and participants. Nonetheless, the major evaluation instruments derived or related to models of RCT have been published and are available in English. Furthermore, all the interactive practice exercises have been published in English. Consequently, the future of RCT lies in the hands and minds of English-speaking students, researchers, and professional mental health helpers. Nonetheless, from all models of the theory it is possible to conclude that fully functioning relational competence involves loving self and intimates, controlling self, being present and performing in various settings, adopting a creative–conductive style, volunteering, playing, and bestowing importance to self and intimates by keeping one's priorities straight.

Readership

This book is oriented toward graduate courses in personality theories and graduate programs in psychotherapy and couple and family counseling and therapy, and especially toward academic researchers in psychology, relationship science, and sociology and toward practicing professionals in the major mental health disciplines, such as clinical psychology, counseling, psychiatry, social work, and pastoral counseling.

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Part I
Introduction to Relational Competence Theory
Chapter 1
Background for a Hierarchical Theoretical Framework

...a critical issue for the relationship field is whether a grand, overarching theory of relationships can be developed. Such a theory would directly address the principal relationship types, delineating the similarities and differences among them with respect to the causal conditions associated with various relationship phenomena

(Bersheid, 1995, p. 529)

What is needed is a focused attention on the evidence for theories, not on the psychological quirks of theorists

(Sober & Wilson, 1998, p. 9)

I look forward to the day when we have created a single theory or conceptual framework that provides a lingua franca for researchers from different disciplines interested in the study of personal relationships

(Mikulincer, 2007, p. iv)

The purpose of this chapter is to introduce relational competence theory (RCT) by defining these three terms with regard to their conceptual, research, and practical applications and implications, and to present the structure and rationale for its hierarchical, pyramidal structure. This introduction updates and expands on previous publications that will not be referred to again in this volume unless necessary (L’Abate, 1976, 1986, 1994a, 1994b, 1997a, 1997b, 2002, 2003, 2005, 2006, 2008c, 2009a, 2009c; L’Abate & Cusinato, 2007; L’Abate & De Giacomo, 2003).

Relational

“Relational” within this context means that there are prolonged bidirectional and interdependent exchanges between two or more individuals. An example of interdependence among partners and family members is found in couples where the
woman has breast cancer. Significant partner effects from stress and negative effects in women with breast cancer were related to their partners’ depression. Quality-of-life rates and direction of change over time revealed that quality-of-life trajectories were also along similar paths. As the emotional well-being of women improved or deteriorated, their partners’ well-being also changed (Segrin and Flora, 2005). Whatever happens between two human beings without a bidirectional exchange seems a human impossibility, in spite of past attempts to conceptualize behavior as growing and living in an environment void of human relationships.

No matter what one does or says to another human being, even if seemingly completely neutral, such as “Pass the butter,” affects the interaction: “Pass the butter please,” is different from saying “Give me the butter, you moron.” How the request is made, the tone of voice, let alone the words have an impact on the recipient. This bidirectionality implies also that one is dependent on the other, bringing to the fore a third quality of relational competence (RC), reciprocity. What if the recipient of the simple request for passing the butter were to answer with “Get the d..n butter yourself. What do you think I am, your servant?” Even if the request is not honored, the way it is honored, rather than silence, indicates that there was reciprocity even if it was not in kind.

By the same token, there is a continuous progression of interactions from internal resources (physiological, physical, intellectual) to external nurturances, even though one could argue that any human and animal development is produced by external sources and that there is no development without a continuous interaction between internal and external resources, two sides of the same coin. For the present purposes, by “development” is understood a process of internal physical growth. By “socialization for RC,” on the other hand, is meant a process of reception, inclusion, and ingestion of tangible elements (food, warmth, shelter, clothes) necessary for survival and of intangible elements, such as emotional, cognitive, actional, and awareness of self and others necessary for enjoyment that are received from nurturing sources, caretakers, parents, siblings, relatives, and friends, i.e., intimates.

Unfortunately, not all human beings receive nurturing experiences. There is still a great deal of abuse and neglect that occur every day and that determine the flip side of competence, that is, incompetence (Spitzberg, 1993).

**Socialization for Relational Competence in Intimate Relationships Is Relational**

Nurturing, as alluded to already, occurs through a lifelong process of socialization. Culturally, Bengston (1975) identified two major value dimensions in socialization, defined by the polarities of humanism–materialism and collectivism–individualism. The dimension of collectivism–individualism seems more affected by generational transmission than the other dimension. Within each culture, family structure and intimate relationships defined here as close, committed, interdependent, and prolonged are affected by socioeconomic factors (Bradley & Caldwell, 1979, forth-
Relational coming). Societies based on agriculture or herding, for instance, tend to rank high on responsibility and obedience training in contrast to a complementary pattern of societies ranking high on achievement and independence. By the same token, for instance, Japan is an industrial society that ranks high on responsibility and dependance. Societies that provide for a relatively intense interaction between infant and nurturer show a relatively undifferentiated local jurisdictional hierarchy. Societies which separate infant and nurturer may have a more sophisticated and elaborate set of categories (Welch, 1978a, 1978b).

Family structure determines in some ways patterns of attachment and separation in its members. For instance, Lopez, Campbell, and Watkins (1988) found two significant and stable roots representing two dimensions, conflictual overinvolvement, on one hand, and differentiation, on the other. Both dimensions, however, might be associated with different separation patterns across genders. Thus, we need to distinguish appropriate from inappropriate family structures. Appropriate family structure will determine a gradual and positive separation and individuation for both men and women (Wesley & Epstein, 1969). Inappropriate family structures will affect differentially men and women (Mikulincer & Shaver, 2007).

Henggeler and Tavormina (1980) found few social class and race effects in well-functioning families. Sons’ level of competence might be best predicted by parental involvement and socioeconomic resource classes, whereas measures of conduct might be best predicted by estimates of paternal competence and family cohesion (Kotler, 1975). Parental ideology and family relations are important determinants of a student’s ideology (Kraut & Lewis, 1975). Leftist parental ideology and high family conflict may each lead to leftist student ideology. An interesting possibility lies in the finding that nonpolitical interpersonal relations in the family of origin could be translated into political ideologies in the offspring.

RC takes place before the child is born. As results of the Character Research Project showed (Barber, 1979), for instance, sex role stereotyping takes place, wittingly or unwittingly, in families with more than one child of the same sex. Sex role stereotyping is not present in families with one child or with children of both sexes. Thus, if these results are valid, one would extrapolate that the crucial time to avoid such stereotyping may be when the second child of the same sex as the first child is born. Same-sex parents tend to have a greater awareness of their children’s problems than opposite-sex parents (Collins, Cassel, & Harper, 1975). Interestingly enough, assertiveness might be related more to affection than to control factors, suggesting that assertiveness may be a quality of parents who assert their importance and the importance of their children in a clear and firm fashion that communicates love and caring rather than fear and anxiety.

Psychological androgyny is associated with high levels of warmth and involvement, particularly with the same-sex parent, and in females, with maternal cognitive/achievement encouragement. Sex typing took place when both parents modeled traditional sex-role attributes, and for females with extreme closeness to the father in the absence of maternal cognitive/intellectual encouragement. An undifferentiated sex-role orientation might be associated with low emotional and cognitive involvement with the father in males and with an undifferentiated but emotionally
involved mother in females. Cross-sex typing in both sexes might be associated with parental rejection, low femininity in both parents, and an absence of warmth or cognitive encouragement from either parent (Orlofsky, 1979).

Middle-class socioeconomic status, a nuclear family system, and entrepreneurial occupations are associated with high-achievement motivation, whereas upper and lower socioeconomic status, a joint family system, and bureaucratic occupations are associated with low-achievement motivation. The interaction of socioeconomic status with nuclear or joint family systems might be significant, whereas other interactions among variables might not (Ojha & Jha, 1979).

Males, 12th graders from rural, economically deprived areas, with high identification with their fathers may have higher levels of aspiration, more self-confidence, and greater satisfaction with school experiences than males drawn from the same population with low identification with their fathers (Jackson, Meara, & Arora, 1974).

Cohen (2004) showed how (1) increases in perceived availability of social support are associated with a further reduction in the association between psychological stress and depressive symptoms in college students; (2) perceived availability of emotional support buffers the association of the number of stressful life events and mortality in initially healthy Swedish men aged 50 years; (3) greater social integration is associated with lower levels of mortality; and (4) a greater number of social roles is associated with decreased susceptibility to the common cold. By the same token, negative interactions and relationships can be a source of stress in intimate relationships (Cicchetti, 2004), whereas Cohen suggests that lack of social support may be a source in the development of psychopathological behavior.

Social support buffers stress by eliminating or reducing the effects of stressful experiences by promoting less threatening interpretations of adverse events and effective coping strategies. Social integration, independent of stress, promotes positive psychological states (e.g., identity, purpose, self-worth, and positive affect) that induce health-promoting physiological responses. [It] provides information and is a source of motivation and social pressure to care for oneself. Negative interactions [and] relationships as a source of stress elicit psychological stress and in turn behavior and physiological concomitants that increase risk for disease (Cohen, 2004, p. 677).

There may be gender differences in commitment and autonomy. Men possibly may favor autonomy over commitment, whereas women may favor commitment over autonomy (Buunk, 2005). These possible differences need to be evaluated further in more mature populations than just college students.

This brief review suggests that socialization and relationships in one’s family of origin may sculpt and leave indelible effects on our RC. On the other hand, we cannot forget that nowadays the concept of the ideal, intact family constituted by two parents and two children includes only about 25% of all domiciles in the USA. The other 75% are composed of single adults, remarried couples and their families, same-sex couples with or without children, and grandparents and their grandchildren. When we add ethnic and racial factors to this definition, we can only resort to using the term “intimate relationships” as defined above to encompass factors within the construct of “family” that comprise and encompass them (Hofferth & Casper, 2007).
Competence

Competence has been defined in so many ways that would be difficult to limit it, except by how effectively we are in dealing with ourselves and others, intimates and nonintimates, during stressful and nonstressful events at various stages in our lives. The concept of competence can be traced historically to White’s (1959) pioneer paper as eventually elaborated by Phillips (1968). In those years, the construct of competence became a rallying point to counter the negative terminology of psychiatry and psychotherapy. It appeared in many psychoeducational, social training programs of the time and in many preventive approaches that developed during the third part of the last century. White’s original suggestion of competence as a motivational concept was followed by Phillips and Zigler’s research with schizophrenics that culminated in Phillips (1968) influential work. This work was followed by Phillips (1978), Wine and Smyte (1981), Marlowe and Weinberg (1985), Sternberg and Kolligian (1990), Settersten and Owens (2002), and Demick and Andreotti (2003).

Another source (Spitzberg & Cupach, 1989) consisted of an annotated bibliography about “interpersonal competence research.” Three major areas were considered as defining competence, skills, knowledge, and motivation, with three additional themes present in the competence literature, control (to be considered in Chap. 7), collaboration, and adaptability, topics that will be considered in various chapters of this volume, using perhaps completely different but related constructs. Spitzberg and Cupach stressed also the need for theory development because of the “fragmented” nature of research in competence. Among the theories suggested by Spitzberg and Cupach were self-efficacy, social learning, coordinated management of meaning, and impression formation.

Because of the paucity of theory aimed at explaining competence, bodies of research lack organization and coherence. The impetus for much of the research is a-theoretical. The choice of variables and research questions is driven more by pragmatics or intuition than by theory.... Most of the research ignores the big picture by creating thematic or contextual models of competence, to the exclusion of investigating the fundamental processes and mechanisms involved in competent social interaction. It would be extremely difficult to find a unified and parsimonious set of theoretical principles (p. 217).... Part of the difficulty lies in attempting to explain such a broad range of phenomena. Interpersonal competence encompasses myriad of affect, cognition, and conation. It would be extremely difficult to find a unified and parsimonious set of or theoretical principles to cover such a divergent range of human behavior. A grand theory of competence would run the risk of being too general to permit predictive precision. At the same time, situation-specific theories run the risk of lacking explanatory power and generality (p. 218).

Spitzberg and Cupach’s (1989, p. 21) comprehensive, but by now outdated, bibliography of interpersonal competence is only matched and updated by the number of references cited earlier. Furthermore, in their consideration of “priorities for interpersonal competence research,” Spitzberg and Cupach asked for inclusion of “context” in interpersonal research (pp. 227–230), without any mention of the family and intimate relationships as the most relevant, proximal context for RC, not to speak of school, work, and leisure time settings considered in Chap. 5 of this volume, among others.
Spitzberg and Cupach did consider the “situation,” including settings as part of context. However, they failed to mention that the most lasting and more influential setting for RC is family and intimate relationships. We do not develop competence in short-lived superficial situations. We develop RC within the context of enduring, involved, committed, and lasting intimate relationships. Chapter 5 illustrates how settings (home, school, work, and leisure time) are specified as being influential in producing positive or negative RC.

In addition to stressing theory to drive research, Spitzberg and Cupach stressed the need to consider the importance of context (pp. 227–231) in studying competence. This concern is even more relevant since RCT is imbedded into concrete and specific intimate relationships rather than vague and general terms such as “situation” and “culture.” Even the impersonal attribute of “interpersonal” is another example that denies the importance of family and intimate relationships. Competence does not arise from “interpersonal situations,” which may be short-lived, superficial, and distant. It arises from prolonged, protracted, close, interdependent, and committed relationships, as found in families and in some friendships, that is, intimate relationships.

Various chapters about competence have appeared in the past literature as, for instance, in the developmental aspects of competence reviewed by Phillips and Zimmerman (1990). However, that chapter reports on a research project, and does not consider all the various aspects of competence, which, however, were considered fully in other chapters of the same publication. Nonetheless, a great deal of information has been acquired since that book was published, practically a generation ago. Another chapter, by Moretti and Higgins (1990), stressed the other side of competence from the viewpoint of psychopathology.

RC as the vehicle for personality development and growth has been reviewed by Settersten and Owens (2002), including specific periods in the life cycle, focusing, however, on adulthood rather than on earlier or later stages of the life cycle. It includes relevant settings, such as families, neighborhoods, communities, friendships, and work settings. Intimate relationships are clearly the most consistent background for RCT. Demick and Andreotti (2003) stressed both the intraindividual and the relational aspects of “development” but not of “RC,” again not including or overlooking an overarching theoretical framework. Most chapters in that treatise were not connected with each other because of the lack of a comprehensive, overarching theory, as is the case with many personality theories (John, Robins, & Pervin, 2008).

Recently, a plethora of works (Aspinwall & Staudinger, 2003; Keyes & Haldt, 2003; Peterson & Seligman, 2004) in line with the recent movement about “positive psychology” have stressed the importance of positive terms, such as competence, to counter negative terms used in psychiatry, psychopathology, and psychotherapy. However, such a movement ignores completely the other realistic side of the coin that, for lack of a more positive word, is indeed “incompetence,” consisting of inadequately critical, consistently chronic or repetitive clinical conditions requiring external professional help, as covered in Part VI.

As we shall see throughout this volume, competence arises from intimate relationships, as defined above. Hence, the term “competence” is still in vogue. It has withstood the test of time, and is relevant to present concerns about stressing the
positive side rather than the negative side of RC. Nonetheless, one cannot consider competence without considering different degrees of incompetence. Whether the rest of this book satisfies the need for specificity, which includes precision and specification, remains for the reader to decide. From this brief historical background grew the notion that competence was the most important observable and measurable behavior that encompasses more evanescent and difficult-to-quantify concepts such as “personality,” “self-concept,” and “self-esteem,” and even more hypothetical intrapsychic concepts, such as ego, id, and superego. None of these concepts can be videotaped and recorded. Competence, on the other hand, can be viewed, videotaped, recorded, reproduced, and analyzed.

The Nature of Hierarchy in Theory Construction

This section outlines the pyramidal nature of RCT for intimate and nonintimate relationships. The pyramidal hierarchical framework composing this theory includes metatheoretical and theoretical assumptions, normative models proper, and clinical applications. Specific, concrete, and testable models have been generated from seemingly abstract and general assumptions and constructs. Measures to evaluate selected models were created and their psychometric qualities validated with scientific, that is, replicable, evidence summarized in this volume.

As already noted, a theory is a speculative framework about a topic that lends itself to empirical verification and validation in the laboratory and to applications in health promotion, prevention, and clinical settings. There are informal, linearly sequential theories in which each component of the theory follows after another, as in most personality and attachment theories (John et al., 2008; Mikulincer & Shaver, 2007). However, the relationships among components are either unclear or missing. Formal theories, on the other hand, are framed according to a hierarchical structure (Harkness, 2007). By “hierarchical” is meant a layered framework, akin to the organization table of any human, industrial, military, political, or religious enterprise, from the top of an organization to the bottom, ranging from generality to specificity and from abstraction to concreteness.

This pyramidal structure is found in models of RCT supported by conceptually similar but independent secondary sources (L’Abate, 2009a) and by direct measures included in various chapters of this volume specifically created to validate them. The seemingly abstract nature of RCT has been reduced to a structured interview as well as practice exercises that can be administered verbally or in writing, respectively (L’Abate, 2009a, 2010; Part VI). Harkness (2007) cited as examples of hierarchical conceptualizations Guilford’s (1975) structure of personality and used the meta-analysis of 44 scales by Markon, Krueger, and Watson (2005) as an extensive example of a personality framework. The theory of evolution, of course, is a primary example of a hierarchical structure.

The importance of hierarchical frameworks is relatively novel in psychological and relational theory building, considering that most theories in personality
psychology and attachment (Mikulincer & Shaver, 2007) are typically presented in an informal, linear fashion. Each aspect of the theory follows after another, with possible sequential connections among component parts but with apparently no differentiation of functions among them. A formal hierarchical framework, on the other hand, in which levels and models are interconnected, may allow a more nuanced differentiation of functions than is provided in traditionally linear theories. This hierarchical approach is followed in communication theories (Sabourin, 2006) and in the analysis of couples and families in sociology (Sayer & Klute, 2005).

Hierarchically, models of RCT (Fig. 1.1) differ along two dimensions of abstraction and generality at the top level to lower metatheoretical, theoretical, and applied models at lower levels. However, an important feature of RCT lies in its reduction of all seemingly abstract components into concrete and specifically verifiable models, regardless of their position and function in the hierarchical structure. By reducing each theoretical model into a verifiable, specific, and concrete format, and creating specific measures to evaluate their psychometric properties, the seemingly abstract and general nature of these models becomes amenable to empirical validation and verification one by one (L’Abate, 2008c, 2009a). The overall validity of the theory, therefore, is measured by the total sum of the provisional validity of each model, positive, questionable, or negative.

RC, resulting from prolonged interactions with significant and non-significant others, as noted, is viewed as the totality of an individual’s characteristic effectiveness in intimate and nonintimate relationships, as outlined here (Fig. 1.1), expanded here with research, and expanded elsewhere in previous writings cited earlier. RC is achieved through a continuous process of socialization molded by lifelong intimate and nonintimate relationships, with their associated pleasurable and painful events. Intimate, communal, and expressive relationships are close, committed, and prolonged. Nonintimate, instrumental, and exchange relationships are agentic, distant, opportunistic, superficial, autonomous, and short-lived (Bakan, 1968; Brehm, Miller, Perelman, & Campbell, 2002; Clark & Mills, 1979; DeGenova & Rise, 2005). It is impossible to disentangle RC from intimate and nonintimate relationships because RC is circularly and contextually a product and a producer at the heart of those relationships.

In hierarchical RCT, intimate and nonintimate relationships vary along dimensions ranging from functional to dysfunctional styles and prototypes in traditional psychiatric classification (American Psychiatric Association, 1994; Davis & Millon, 1995; Krueger & Tackett, 2006). Connections to dysfunctional prototypes anchor and link theoretical models to real-life conditions rather than to abstract, hypothetical, inferred, or ideal constructs or relationships (Fig. 1.1). These connections attribute dimensional, relational, and contextual meanings to otherwise static, monadic, and nonrelational psychiatric categories. These categories are contained within the functionality–dysfunctionality dimension of each model, thus integrating two traditionally different views of psychopathology: the dimensional and the categorical, as suggested by Maser et al. (2009).

RCT, therefore, has the advantage of providing a pyramidal framework to understand psychiatric classification according to relational dimensions that include and
### Requirements

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<tr>
<th>Verifiability</th>
<th>Applicability</th>
<th>Redundancy</th>
<th>Fruitfulness</th>
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### Meta-theoretical Assumptions about Relationships

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<td>Emotionality</td>
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<td>A</td>
<td>Rationality</td>
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<td>C</td>
<td>Awareness</td>
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<td>Context</td>
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<tr>
<td>2</td>
<td>Settings</td>
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### Theoretical Assumptions about Relationships

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<th>Ability to Negotiate</th>
<th>Both Abilities</th>
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<th>Distance</th>
<th>Control</th>
<th>Functionality</th>
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</tr>
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<tbody>
<tr>
<td>Approach/</td>
<td>Discharge/Delay</td>
<td>High/Middle/</td>
<td>Being/Doing/</td>
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<tr>
<td>Avoidance</td>
<td>Low</td>
<td>Having</td>
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<tr>
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<th>Axis II, Cluster C</th>
<th>Axis II, Cluster B</th>
<th>GAF* (100 to 0)*</th>
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### Normative Models of the Theory

<table>
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<tr>
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<th>Likeness Continuum</th>
<th>Functionality</th>
<th>Importance</th>
<th>Survival/Enjoyment</th>
</tr>
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<tbody>
<tr>
<td>a.</td>
<td>Symbiosis/Alienation</td>
<td>Abusive/Apathetic</td>
<td>Divisive</td>
<td>No-self</td>
</tr>
<tr>
<td>b.</td>
<td>Sameness/Oppositeness</td>
<td>Reactive/Repetitive</td>
<td>Subtractive/Static – or +</td>
<td>Selfless/Selfish</td>
</tr>
<tr>
<td>c.</td>
<td>Similarity/Differentness</td>
<td>Conductive/Creative</td>
<td>Additive/Multiplicative</td>
<td>Selffull</td>
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<thead>
<tr>
<th>DSM-IV</th>
<th>a. Axis I</th>
<th>a. 100 to 70 on GAF</th>
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<tbody>
<tr>
<td>b. Axis II, Cluster B</td>
<td>b. Conflict high</td>
<td>b/c. 69 to 40 on GAF</td>
</tr>
<tr>
<td>c. No diagnosis</td>
<td>c. Conflict low</td>
<td>d. Below 39 on GAF</td>
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### Applications of the Theory

<table>
<thead>
<tr>
<th>Models</th>
<th>Distance Regulation</th>
<th>Drama Triangle</th>
<th>Intimacy</th>
<th>Negotiation</th>
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<tbody>
<tr>
<td>Pursuer/Distancer/Regulator</td>
<td>Victim/Persecutor/Rescuer</td>
<td>Sharing Joys, Hurts, &amp; Fears of Being hurt</td>
<td>Structure/Process (Ill, Skill, Will)</td>
<td></td>
</tr>
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*GAF = Global Assessment of Functioning (DSM-IV). Adapted from L’Abate, 2008-b.

**Fig. 1.1** Summary of a theory of relational competence in intimate relationships
integrate within each dimension categorical lists of symptoms and syndromes (Beutler & Malik, 2002; Dischion, 1999), as shown in Fig. 1.1 and in previous publications.

RCT, therefore, is differentiated from either personality or relationship science theories on the basis of its hierarchical framework and its more specific applications to dyadic and multirelational functioning. The original theory (L’Abate, 1976) was created to understand and help the individual within a verifiable family context rather than to study individuals in a vacuum of relationships or in families without interacting individuals. This monadic vacuum is still present in many conceptualizations of emotions and of personalities (Mesquita & Albert, 2007; Rime, 2009).

The theory outlined here includes 16 models (Fig. 1.1) that encompass RC socialization in different contexts, different settings, and in different relationships. Ideally, if at all valid, this theory should apply not only to individuals in communal relationships but also to dyadic and multirelational systems, such as couples, families, parents and children, siblings, and in-laws as well as to nonintimate agentic/exchange relationships. This is clearly an ambitious if not grandiose undertaking. On the other hand, human relationships are too complex to be encompassed within a single model. A multiplicity of testable models with related measures, viewing human relationships from a variety of redundant vantage points, is necessary to make sense of their complexity.

**The Role of Models in Relational Competence Theory and Practice**

Models are now becoming fashionable (Becvar, 2003; Robbins, Mayorga, & Szapocznik, 2003; Sabourin, 2006). However, there is a great deal of confusion about what models are (L’Abate, 2009c). For instance, Sexton, Weeks, and Robbins (2003) equate models with different theoretical and therapeutic approaches for example: object relations and psychodynamic, family of origin, interactional and solution-focused, among others. Supposedly, a practice model derives from a theoretical framework that determines how therapy is to be conducted. Therapeutic practice, therefore, should ideally be equated with its underlying model or, in other words, the practice is (or should be?) isomorphic with the theory. A therapeutic model assumes, as Sexton et al. do, the validity of the theory behind it and, oftentimes, co-opts the name of the theory itself.

However, more often than not, the validity of the underlying model is evaluated verbally, by what therapists say or do within their sessions, which are kept private and are difficult to replicate, except, perhaps, for possibly self-serving psychotherapy notes. The whole burden of proving the validity of a theoretical model in therapy rests on words. Unless a researcher obtains grant money to evaluate the empirical validity of a theoretical model and as long as just words are used in the process of therapy, it will be difficult and expensive to prove its validity (L’Abate, 1999a, 1999b). No wonder that most therapists claim to be “eclectic” in their practices (Norcross, 1996). If there is no one-to-one isomorphism
between theory and practice, how can anyone discover how any particular theory or model is related to practice?

Therefore, an important issue in regard to the role of models in RCT relates to how much a theory or a model influences and affects directly therapeutic practice. Supposedly, practice derives from a theory or a model assuming that either the theory or the model have already demonstrated some replicable validity. The issue lies in how valid the claimed link between theory and practice really is and how it can be validated in face-to-face talk-based therapy. L’Abate (1999a, 1999b, 2008a, 2008c), L’Abate & Cusinato, 2007, and L’Abate & De Giacomo, 2003, for instance, have argued that as long as therapy of any kind occurs verbally, it might be difficult for most therapists to show a definite link between theory and practice. This link may be found in laborious work by few endowed researchers who transcribe tapes, categorize them, and reach results through research grants in ways that are difficult if not impossible to replicate and, therefore, make them available to therapists on Main Street. This issue will be expanded in Chaps. 19–21.

A relationship between theory and practice can be reached first when a theory is first dismantled into its component models, if there are any models, or a theory is just a model L’Abate, 2009c. Second, the validity and relevance of the model could be established in the laboratory, as is the case of research reported in this volume. Third, only when a model’s validity has been established, even provisionally, can it or should it be applied in actual practice. Ultimately, the validity and usefulness of a model, of course, is established in the real world of self-help (Harwood & L’Abate, in press), promotion and prevention (L’Abate, 2007), therapy, and even play (L’Abate, 2010) not just in the laboratory.

It is practically or realistically impossible to apply all the models of any theory at any one time in therapy. Among the bewildering plethora of theoretical models available in family communication (Sabourin, 2006), for instance, one model at a time must be chosen to evaluate its relevance to family functioning and to family therapy. Therapists themselves, therefore, might need to prioritize what model if any is relevant, important, and necessary to improve family functioning, including, of course, priorities, as presented in Model1 (Chap. 14).

**Requirements for a Hierarchical Theory of Relational Competence**

Any psychological theory, as a framework amenable to critically evaluate conceptual and empirical evidence, can be evaluated according to four overlapping requirements, such as those necessary for any formal, hierarchical framework, such as RCT. They include the following: (1) verifiability, which has been achieved in the laboratory through paper-and-pencil, self-report tests or tasks specifically created to evaluate each model of the theory (L’Abate & Wagner 1985, 1988); (2) applicability to include health promotional, preventive, psychotherapeutic, and rehabilitative interventions along a continuum of functionality/dysfunctionality.