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THERAPEUTIC RELATEDNESS IN TRANSACTIONAL ANALYSIS: The Truth of Love or the Love of Truth

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ABSTRACT: Berne was quite critical and skeptical of those forms of therapy that encouraged feeling over thinking, referring to "Greenhouse" games in which clients escalate feelings, often idealizing feelings over thinking. For the past decade, however, TA seems to be developing in a different sort of "Greenhouse," one of enforced warmth, idealized relationships, and attachment/empathy-based clinical strategies. When we were originally trained in the 1970's, TA therapists were supposed to confront people into health. Now it seems we are to attach, attune and empathize clients into health. Yet Berne's treatment group was not an empathic holding environment; it was an interpersonal study matrix. This essay offers a critical review of clinical applications within transactional analysis of theories of attachment, attunement and empathy. It will discuss the clinical models of therapeutic relatedness offered by Berne, Winnicott, Bowlby, Kohut, and Stark and present a clinical model of phenomenological inquiry and therapeutic space.

Introduction

The past decade has seen a shift in clinical theorizing among ego oriented psychodynamic theories, Transactional Analysis among them. Interpretation and insight are no longer viewed as the primary means of therapeutic change. Therapists of many theoretical orientations now focus on the relational, transferential and countertransferential components of the therapeutic process. The clinical literature is full to overflowing with relational models and language: mutuality, empathy, attunement, attachment, object relations, implicit relational

knowing, intersubjectivity, reciprocity, emotional synchronicity, connectedness, the moment of meeting and resonance. The relational zietgiest has been further fueled by the popularity of such feminist centered models as the relational model being developed at the Stone Center of Wellsley College and trauma-centered perspectives, both of which emphasize the active, maternal/corrective/relational role of the therapist. The maternal/relational perspectives have done much to correct the unidirectional, paternalistic, authoritarian styles that dominated classical psychoanalytic and cognitive/behavioral orientations, but we see an unquestioning applications of various relational models in contemporary TA that we think merits a serious critique.

In "Analysis Terminable and Interminable," a deeply reflective clinical essay written shortly before his death," Freud (1937) was still struggling with the nature of the therapeutic process. For Freud it was the love of the truth, the willingness to acknowledge psychic realities, to face oneself as honestly as possible that was at the heart of the therapeutic process. We see the commitment to therapy as a commitment to ruthless honesty on the part of both client and therapist. It seems that in many contemporary therapies, the relational field between therapist and client has been reversed from the love of truth to the truth of love, where the experience of being cared for and mirrored supersedes the experience of facing and understanding emotional and characterological realities.

There has always been a tendency within TA psychotherapy to focus on personal change and management of emotions, rather than to struggle for a deeper understanding of the ambivalences of love and hate that motivate all human relationships. The central premise of this paper is that if TA does not face and treat the darker, more conflictual aspects of people's functioning, we will be limited in what we offer clients and equally limited as to which clients we can effectively treat.

This essay will examine the applications within transactional analysis of theories which emphasize empathy, attunement and attachment as the primary orientation of the therapeutic repertoire. We suggest that such an orientation can enact a subtle form of reparenting, which represents a considerable deviation from Berne's emphasis on personal responsibility, intrapsychic conflict, interpersonal manipulation, and the construction of one's life script. We find that the overuse of relational concepts can result in an oversimplification of the therapeutic process and a turning away from intrapsychic and interpersonal conflicts as crucial elements of psychotherapy.

The Parent Ego State and the Role of the Therapist

Since its origin, transactional analysis has placed great emphasis on the therapist's use, in one form or another, of the therapist's Parent ego states.

Berne's delineation of the Parent ego state, both in structure and function, was an important correction of the classical psychoanalytic position of the neutral observer and of the mechanistic operations of the behavioral models that Berne challenged during his lifetime. There has been a long-standing and problematic tendency in TA theory and technique to project the "bad stuff" out onto parental failure, environmental failure and the larger social structure. This projective stance has been imbedded in TA language and theory from the beginning, as exemplified by Berne's notions of the "ogre father" and "with mother," (1972), Steiner's use of the "Pig Parent" (1974) and the entire reparenting model of treatment (Schiff, et.al., 1975; Schiff, 1977). All too often the TA therapist is cast as a provider of the "good stuff," rather than as a clarifier of how the client maintains ineffective, other-destructive and self-destructive patterns of defense. This bias in TA theory creates a consequent pressure upon the therapist to move into a good parent/ good object position vis-a-vis the client. When we help a client to "experience enough," to draw upon a frequently advertised TA parenting slogan as an example, frequently all that we have accomplished is a temporary, mutually gratifying, narcissistic merger. When we envelope a client in empathic and attuned mirroring, we suggest that little is actaully repaired, that nothing is different in the client's psychological structure. By calming distress – the therapist's as well as the client's – we merely eliminate or postpone the basis for the struggles that are necessary for characterological change and psychological mastery. More problematically, we are in danger of promoting a nostalgically idealized infantile/maternal fantasy split off from the ongoing difficulties of actual life, not to mention the meaner side of human nature.

Berne's departure from the psychoanalysis of his day represented an effort at a radical critique of the traditional analysis of the individual psyche through free association, dream interpretation and other classical techniques. Berne clearly created a *transactional* analysis, *not* a *relational* psychotherapy. He watched, listened, thought about, described, interpreted, analyzed and disrupted how people transacted with one another. Ultimately, he maintained a one-person psychotherapy in that these interactions were analyzed in the light of the social and psychological advantages the individual believed could be gained from the interactions. Berne offered an opportunity to see, think about and alter how one thinks and behaves. Empathy, holding, and attachment were not among Berne's eight therapeutic operations (1966, pp.233-247). Berne's TA was intended to unsettle a client's familiar, defensive frame of reference through description, confrontation, interpretation and humor. It seems quite clear that Berne's intent, consistent with a classical psychoanalytic position, was to alter the intrapsychic structure and function of the client through clarifying interventions, not through offering a corrective relationship. Berne writes, "Introspection, on the other hand, takes the cover off the black box, and lets the Adult of the person peer into his own mind to see how it works: how he puts sentences together, which directions his images come from, and what voices direct his behavior" (1972, p273).

Berne's treatment group was not an empathic holding environment, it was an interpersonal study matrix. In *Principles of Group Treatment*, Berne (1966) outlined eight therapeutic operations that "form the technique of transactional analysis" (p.233): interrogation, specification, confrontation, explanation, illustration (humor and simile), confirmation, interpretation and crystallization (pp.233-247). These therapeutic operations are carefully described, illustrated and clarified with warnings about how and when to use and not to use them. They are therapeutic interventions designed to elicit self-observation and curiosity, to decontaminate and stabilize Adult ego state functioning. Berne goes on to describe "other types of interventions" (p.248-249) in which "the therapist may have to function deliberately as a Parent rather than as an Adult for a shorter or longer period, sometimes extending into years" (p.248). These Parental interventions are support, reassurance, persuasion and exhortation, which Berne suggests are most appropriate and necessary in the treatment of active schizophrenics.

Unfortunately, we see here a vagueness and confusion in Berne's use of terms, a confusion repeated over and over again in Berne's writing and TA practice. His capitalizing Parent and Adult in this section suggests that he is describing a shift from the therapist with Adult ego state in executive to Parent ego state in executive. We doubt that Berne intended that the therapist become a parental figure, but that in fact has become common TA practice.

For Berne, the therapist sometimes made explicit use of his Parent ego state, as is clear in his description of the Parental functions of the transactional analyst in the use of permission, protection and potency:

> Now we can speak with some assurance of the "three P's" of therapy, which determine the therapist's effectiveness. These are potency, permission, and protection. The therapist must give the Child permission to disobey Parental injunctions and provocations. In order to do that effectively, he must be and feel potent: not omnipotent, but potent enough to deal with the patient's Parent. Afterward he must feel potent enough, and the patient's Child must believe he is potent enough, to offer protection from Parental wrath.
>
> Here the transactions are: (1) Hook the Adult, or wait until it is active. (2) Form an alliance with the Adult. (3) State your plan and see if the Adult agrees with it. (4) If everything is clear, give the Child permission to disobey the Parent. This must be done clearly and in simple imperatives, with no ifs, ands, or buts. (5) Offer the Child protection from the

> consequences. (6) Reinforce this by telling the Adult that this is all right. (1972, pp.374-375)

Berne is clearly focused on the identification and management of intrapsychic conflict. It is as if he is saying to the client, "I am strong enough to stand up to and outside of the psychic forces operating inside of you. You can see that it is possible to tolerate the internal conflict which attends change. You can make choices of your own." Berne models containment, offering not so much a holding environment as a facilitating environment, to draw upon the language of Bion and Winnicott. Berne offers a model of challenge, alignment with the Adult, and thoughtfully timed interventions to free a client to think and feel autonomously. Berne does not close the "as if" space of the therapeutic process by <u>becoming</u> a parental figure. He draws upon the force of the parental attitudes of permission, protection and potency to create a psychological space within in which the client has the opportunity to develop autonomous functioning.

Mother/Infant Research: Clinical Implications

Even as we appreciate Berne and his therapeutic stance, we do not wish to ignore his limitations. It is clear that cognitive insight, interpretation, the analysis of transactions, blackboard diagrams, and wittily phrased observations are not always sufficient to reach the deepest levels of the psyche that sometimes fear and oppose psychological awareness and change. TA and other psychodynamic therapies have begun to look at the research on early human development in order to develop deeper understandings of pre-Oedipal disorders. One of the strengths of the approaches emphasizing empathy and attachment is the attention to preverbal formative experiences, since difficulties in the earliest months of life may underlie aspects of later script decisions.

Berne had little sense of the preverbal mother/infant relationship. In *What Do You Say After You Say Hello*, his discussion of prenatal and infant influences on script development consists of little more than clever lists of "breast-fed titles" and "bathroom scenes." He seems to have given little or no attention to Winnicott's infant (1958, 1965) mother observations which were published during the same period of time in which Berne was writing.

The mother/infant research that has taken place since Berne's death, including that of Mahler (1975), Stern (1985), Tronick (1999), Lachmann & Beebe (1996), Emde (1988), Ainsworth (1991), and Main (1995), among others, has added rich dimensions to our understanding of the somatic and relational elements of script. This research has demonstrated the complexity of the infant's unfolding psyche with its gradual and relentless integration of limbic, sensorimotor and cognitive functioning (Bucci, 1997; Lichtenberg, 1989; Downing, 1995). Recent years have also seen the gradual application of infant research to adult psychotherapy. These clinical speculations are important, but it is equally important to see that the adult therapeutic relationship is <u>not</u> a mirror or recreation of the mother/infant

relationship. Certainly, aspects of the mother/infant experience will emerge in the therapeutic process with many clients, but so too will many other aspects and periods of psychic development.

A recent volume of the *Infant Mental Health Journal* (Tronick, 1999) was devoted in its entirety to a series of papers generated by the Change Process Study Group of Boston on the application of infant research to adult psychotherapy. These initial efforts are exciting, fascinating and seriously flawed. In a critical discussion of the papers in that journal, Modell cautions:

> The analogy between adult and infant dyads breaks down at several points. One is that the adult therapeutic dyad, unlike the mother-infant dyad, is not a biologically determined process; second, in the adult therapeutic dyad both participants are encumbered with the weight of their affective memories of the past, whereas in the infant-mother dyad, the infant's past is just beginning. Therapeutic change in the adult entails a retranscription of affective memory; there is, especially in the cases of trauma, an implicit agenda -- a transcendence and transformation of the past. This is not the infant's agenda. (1999, pp.242-243)

Over-emphasis on the mother/infant relationship as the model for psychotherapy forces a regression in the therapeutic relationship and discounts the lived experience of the adult. Concerns over attunement, mirroring, or mutual regulation which have emerged from attention to the mother/infant relationship are one aspect of psychic development, but so too are the infant's and child's capacities for motoric and cognitive competence, self-understanding and individuation. Lichtenberg (1983, 1989, 1992) presents a comprehensive application of infant research to developmental forces that span the human life and to adult psychotherapy. In a theory of motivation that is remarkably similar to Berne's conceptualization of human hungers, (perhaps because they both come from a background of psychoanalytically-oriented ego psychology) Lichtenberg describes five motivational systems. They are: 1) the psychic regulation of physiological requirements, 2) the attachment-affiliation system, 3) the exploratory-assertive system, 4) the aversive system, and 5) the sensual-sexual system. Relational hungers are but one element in this motivational system which emphasizes differentiation and competence as much as relational attachment and contact. We strongly suggest that any comprehensive model of psychotherapy must involve each of these motivational systems, being careful not to valorize one over another.

Bowlby & Winnicott: Achieving a Therapeutic Stance

The awareness of infant psychic processes came as a new awareness to ego psychologists and is enabling them to work more systematically and effectively with early developmental disorders. However, the psychic life of infants has been explored by the Kleinians and the British Independent/Middle school for decades. Analysands of Ferenzci, namely Melanie Klein who began lecturing in England in 1925 and Michael Balint who migrated from Hungary in 1939, addressed the manner in which infants apprehended, perceived and experienced relationships with objects both, internal and external. Fairbairn (1952), Guntrip (1961), Winnicott (1958, 1965), Balint (1969), Bion (1977) and Bollas (1987, 1989) have built upon this work. Decades before the direct infant observation research in the U.S., these theorists saw the foundations of psychic structure and unconscious processes as rooted in the earliest months of an infant's life. They emphasized the crucible of the mother-infant relationship and posited curiosity as a basic drive and phantasy as a basic mechanism of all mental activity. Parallel with the work of these object relations theorists, John Bowlby conducted research with infants and children which lead to his theories on separation, attachment, loss and the secure base.

In the current practice of TA, versions of Bowlby's emphasis on attachment patterns,
Winnicott's holding environment, and Kohut's empathic attunement are replacing the original conceptualization of the nurturing parent. There is much to be appreciated in this addition to TA practice. However, in our reading of recent TA literature and through our participation in examination preparations and processes, we have grown concerned about the misunderstanding and fusion of disparate theories and techniques. Mixing the ideas of Bowlby(an ethnological model based on instinctual drives), with Kohut (a relational model developed to address American ego psychologist's disinclination to work with pre-Oedipal conditions) and Winnicott (an observer of mother-child interactions) has occurred without also noting critical differences. Not only does this theoretical hash suggest a convergence of views that is inaccurate, it undermines the conceptual soundness of various efforts to deepen transactional analytic theory. To contribute to that deepening and the need for clarification, we will concentrate here on the concepts and techniques that, in current discussions, are most frequently referenced, those of Bowlby, Winnicott and Kohut.

As we examine the applications of Bowlby's work and attachment theory to adult psychotherapy (Bowlby, 1979; Holmes, 1996; Gaines, 1997; Karen, 1998), we find descriptions of a therapeutic relationship and process that are remarkably like Berne's. Attachment therapists utilize a concept of "internal working models" that is virtually indistinguishable from the essence of Berne's script theory. In Bowlby's description of the tasks of the therapist (1979, pp. 145-149), he sounds quite like Berne. The "secure base" (1979, pp.145-146), a fundamental concept in this model, is not an empathic immersion, but is a solid ground from which the

patient can explore himself and the world. Bowlby invited the patient to observe relational patterns and their underlying beliefs in order "to help him consider how the situations into which he typically gets himself and his typical reactions to them, including what may be happening between himself and the therapist, may be understood in terms of real-life experiences he had with attachment figures during his childhood and adolescence (and perhaps may still be having) and of what his responses to them then were (and may still be)" (1979, p.146). Attachment based therapists now stress the patient's development of the "reflexive self function" (Fonagy, 1991; Fonagy, et.al., 1991; Holmes, 1996), again remarkably consistent with Berne's emphasis on capacities of the Adult ego state to observe the total person.

In Winnicott's object relations model, there is a progressive & ever-differentiating development that moves from absolute dependence to relative dependence to relative independence and then to interdependence. This is paralleled by the development of the interaction with the primary caretaker which moves from merger with the object to relating to the object, to destroying the object, to the ability to use the object. In Winnicott's understanding of the role of the primary caretaker, there is first a phase of "Primary maternal preoccupation," beginning during pregnancy and lasting the first few weeks of the baby's life. Winnicott describes the mother as being in a special state of consciousness, with her self and bodily experience centered almost exclusively on the baby's somatic life. In his description of the holding function in the parenting of an infant, Winnicott presents a protective and provisional phase of parenting that is deeply anchored in the body. He describes the function of the holding environment as being one of bringing the world of reality to the infant in manageable doses. Winnicott sees the holding function as one that re-emerges throughout life at transitional phases of childhood and adolescence and during times of severe loss, stress and disorganization in adult life.

The holding function is, however, more complicated than the simple provision of safety and empathic responsiveness to the infant. Winnicott stresses that during infancy there are times when the parent not only holds *on to* the infant but also holds *against* the baby, surviving aggressive urges and ruthless demands. Central to Winnicott's thinking is the importance of the parent surviving the infant's aggression and hatred without undo punishment and retaliation. While parental failure was inevitable and a healthy force in development, retaliation was not. The security that developed through the parent's survival of the infant's aggression gradually enabled the infant to be alone with well-being in the presence of another. Winnicott postulated that only in this secure aloneness could the true self emerge.

Winnicott saw parallels in the treatment of difficult, regressive patients:

> ...the analyst, the analytic technique, and the analytic setting all come in as surviving or not surviving the patient's destructive attacks. ...In psychoanalytic practice the positive changes that come about in this area can be profound. They do not depend on interpretive work. They depend on the analyst's survival of the attacks, which involves and includes the idea of the absence of a quality change to retaliation. (Playing & Reality, 1971, p91)

Slochower (1992) offers an excellent case discussion of this aspect of Winnicott's conceptualization of holding, which has far less to do with an attuned understanding of the client as with the containment of her own affect and her survival of her patient's behavior.

The Winnicottian infant, rather like the Winnicottian patient, is a complex creature -- not simply the passive recipient of parental (or therapeutic) largesse. Aggression is defined by Winnicott as movement in the world, beginning with the infant's first kick. The Winnicottian infant, one remarkably similar to those we see in direct infant observation and research, is an active, ambivalent and aggressive creature, moving away from as well as toward the parent. Winnicott's mother/infant observations and clinical writings were full of exquisite paradoxes. In an article on "Primitive Emotional Development," for example, he observes:

> I will just mention another reason why an infant is not satisfied with satisfaction. He feels fobbed off. He intended, one might say, to make a cannablistic attack and he has been put off by an opiate, the feed. At best he can postpone the attack. (date, p.154)

How often does a therapist offer, wittingly or unwittingly, empathy and comfort -- the opiate, the feed -- to ward off the ambivalence or aggressiveness of a client?

The Winnicottian infant becomes impatient with holding, with feeding. There is a powerful developmental pressure for conflict and differentiation. The primary parental activities shift – often at the infant's initiative -- from that of providing comfort and responses to physiological and affect states to that of facilitating and enjoying the motoric activity, independence and competence of the baby. According to the Winnicott, the infant's psyche then begins to dwell within the infant's body and the baby begins to differentiate self from other. The infant, in its developing motoric and ego capacity, presses on:

> The ego *initiates object-relating*. With good-enough mothering at the beginning the baby is not subjected to instinctual gratification except in so far as there is ego-

> participation. In this respect it is not so much a question of giving the baby satisfaction as of letting the baby find and come to terms with the object (breast, bottle, milk, etc.) (date, pp.59-60, emphasis in original)

The Winnicottian infant (and patient) are restless, impatient, demanding individuals, much more interested in competence and differentiation than in perpetual contact and feeding. As he clearly delineates in the classic article, "Hate in the Countertransference," the Winnicottian mother and therapist are not perpetually attuned and contactful creatures either. Winnicott stresses that unless the mother can tolerate her hate of the baby, she cannot tolerate the baby's hatred of her, and no true affect and no true self can emerge. Instead the false self will exhibit sentimentality and the true self will remain hidden.

Therapeutic Empathy: A Critique

The centrality of an empathic stance in psychotherapy has emerged largely from the work of Kohut and other self psychologists. In Moses's (1988) detailed examination of the role of empathy in psychotherapy, he points out that Kohut was cautious, if not downright skeptical, of the use of empathy early in his work, warning against a "sentimentalizing regression to subjectivity" (1971, p.301) and empathy "when it is surrounded by an attitude of wanting to cure directly through the giving of loving understanding..." (1971, p.307). By the end of his life, however, Kohut had come to see empathy and mirroring as curative agents, warning against the consequences of empathic failure and arguing for a prolonged period of validating the patient's reality during which it is the therapist's responsibility to demonstrate his understanding of how the patient feels. This attitude casts the therapist/analyst into the role of the good self-object, as seen in *The Theory and Practice of Self Psychology*:

> ...the therapist ultimately has the task of trying to become the good self-object... [The therapist] will have to empathically try to understand where the adult patient failed to receive the emotional oxygen he or she needed to develop a healthy self and ...begin to fulfill this void. (1986, P. 36)

This model is of a psychopathology rooted in developmental deficits and deficiencies, which the therapist/analyst is then positioned to redress by filling voids and providing emotional nutrients.

Through their numerous papers over the past twenty years, Erskine and Trautmann are probably the most influential representatives of this perspective within the contemporary TA literature:

> With my understanding that *life script and ego states are compensating attempts to manage relationship hunger and a*

> *loss of internal contact, the therapeutic focus can be placed on the relationship itself* …. From this perspective the purpose of analyzing ego states or a life script is not to erect a new, more useful structure, but rather to gather information about which relational needs were not met, how the individual coped, and even more importantly, how the satisfaction of today's relational needs can be achieved (Erskine & Trautmann, 1996). These therapeutic tasks are accomplished through contact-oriented, relationship focused methods:
>
> -- *inquiry* into the client's phenomenological experience, transferential process, system of coping, and vulnerability;
>
> -- *attunement* to the client's affect, rhythm, developmental level of functioning, and relational needs; and
>
> -- *involvement* that acknowledges and values the client's uniqueness. (1997, p.15; italics in original)

This description of the central therapeutic task is now common in the practice of TA, whether it carries a reparenting, parenting, corrective parenting, empathic or attachment label. If psychopathology is environmental in origin, the argument goes, then psychotherapy must be environmentally compensatory in its essential tasks. Storr (1988) reminds us that when Freud was asked what constituted health, he replied that it was the ability to love and work. Storr points out that human relationships are "*a* hub around which a person's life revolves, not necessarily *the* hub" (1988, p.15).

Stern discusses empathy in the context of the parent-infant research:

> Seen in this light [Intersubjectivist and Self Psychology], the parent-infant "system" and the therapist-patient "system" appear to have parallels. ...I wish to inject some caution in drawing these analogies too closely, however. What is meant by the therapeutic use of empathy is enormously complex from our point of view. It involves an integration of features that include what we are calling core-intersubjective, and verbal relatedness as well as what Schafer (1968) has called "generative empathy" and what Basch (1983) has called "mature Empathy." ...attunement between mother and infant and empathy between therapist and patient are operating at different levels of complexity, in different realms, and ultimately for different purposes. (1985, pp.219-220)

Moses (1988) argues, “Current theory and applications of empathic techniques, however, have become filled with illusions, fallacies and misapplications to the point that the concept is so overextended that it lacks any special meaning and its use has become quite unconstrained,” (1988, p.578). He worries that empathy “has unconsciously and universally slipped into our clinical vocabulary with little scrutiny” (p.579). Among the therapeutic liabilities that Moses discusses in connection with empathy is the risk that the treatment process and the therapist will be held hostage to the client’s or the therapist’s narcissistic wounds and vulnerabilities. The therapist may become preoccupied with the fear of being perceived as an uncaring or persecuting object. Perhaps there is also the fear of being perceived, by client or self, as a stupid object, an uncomprehending object, one that does not or will not understand. With the illusion of sufficient empathy, “The therapist does not have to confront the fear of not understanding the patient, or worse yet, let the patient know [that] he doesn’t understand, [that] certain experiences are beyond comprehension” (1988, p.590). The mutual wish and subsequent pressure for therapeutic empathy and attunement may create a process in which the therapeutic understanding takes place more in the effort and mind of the therapist than of the client, something which we imagine would trouble Berne and which certainly troubles us.

Not knowing or understanding the other can create a rich, if somewhat anxious, space. Bollas challenges the American demand for knowing and understanding:

> “In the United States of America, where many people sue at the drop of a hat, psychoanalysts might live in dread of a patient bringing a court action on the basis that his psychoanalyst doesn’t know what he is doing. After all, other mental health professionals, armed with their diagnostic manual - the DSM III - can practice with certainty. To me this not knowing is an accomplishment. (1989, p.62)”

For Bollas, as well as Winnicott, empathic failure, rather than inevitably creating or recreating a narcissistic wound, can offer creative space and opportunity. Bollas is far more invested in the creation of differentiated and imaginative space than of confluent contact and attuned relatedness.

Stark’s recent work (1999) enters the contemporary debate about relational processes in psychotherapy by delineating three central and enduring modes of therapeutic action and interaction. She does not privilege one mode over another, valorize one at the expense of others. She defines the therapeutic purposes of different aspects of therapeutic relatedness, suggesting that a comprehensive psychotherapy requires differing modes of relatedness over the course of treatment. Stark defines the first mode as that of providing knowledge

through insight and interpretation, a model based on intrapsychic, structural conflict as in the classical psychoanalysis in which Berne had his beginnings. The second therapeutic mode is rooted in the models of developmental/structural deprivation and deficit. In this mode the primary therapeutic action is the therapist's provision of a corrective relational experience, which is what we see emphasized in the current TA approaches centered on attunement and attachment. As summarized by Stark, the second mode stresses: "(1) the therapist's actual participation as a new good object, (2) the therapist's actual gratification of need, and, more generally, (3) the therapist's provision of a corrective (emotional) experience for the patient" (1999, p.28). The third mode of therapeutic action, as outlined by Stark, is that of authenticity and intersubjectivity, therapeutic encounters between two real people in the here and now that manifest and alter archaic beliefs and behaviors.

In Stark's delineation of these modes, the deficit model (mode #2) emphasizes the absence of good in the client's life, while the object relations/ intersubjectivist perspective of mode 3 examines the presence of bad in the client's motivations and functioning. In the third mode, the "therapist participates authentically in a real relationship with the patient—the intention being both to enhance the patient's understanding of her relational dynamics and to deepen the level of their engagement. Accordingly, in the third mode, the intersubjectivist therapist might choose to focus the patient's attention on (1) the patient's impact on the therapist, (2) the therapist's impact on the patient, or (3) the here-and-now engagement (or lack thereof) between them" (1999, p.126). Within this perspective, the therapist pays close attention to how the client through actual interactions, projections and fantasized distortions creates and maintains bad objects and ineffective or destructive relationships.

Berne's own style, and that typified by classical TA practitioners, was certainly rooted in the model Stark characterizes as Mode 1. We are suggesting that the TA models based in reparenting, attachment and attunement models are examples of Mode 2. We are not arguing for a distant, neutral therapeutic stance or for a constantly interpretive and confrontive one. We are arguing here that while empathy, attunement or attachment are perhaps necessary conditions for therapeutic change, these are not sufficient for enduring psychological change. Our concern here is that when empathy and/or attachment are conceptualized as curative agents, a serious disequilibrium is introduced into the therapeutic process. TA clinical theory has grown significantly past Berne's original style through the incorporation of models of corrective psychotherapy typical of Stark's mode 2 but has offered little to examine and actualize Mode 3. We are strongly suggesting here that there was much in Berne's original model that continues to be of value. We are further suggesting that for TA to be an effective and comprehensive psychotherapy, it must include a process of mutually achieved <u>relatedness</u> in addition to the therapist's provisory relationship. We are arguing

for the articulation within the TA literature of a more complex and conflictual therapeutic space.

Inquiry, Disturbance and Creativity

Bollas (1989) sees the therapist and a balanced therapeutic process serving the dual functions of soothing and disturbing the client. Bollas delineates two fundamental and ongoing tasks in working within the transference relationship, that of elaborating and that of deconstructing. Elaboration has to do with states of mutual reverie in which the therapist enters the client's field of transferential desire, so as to open the unconscious communication between therapist and client to new possibilities of self-expression and relational wishes. The quiet receptivity, inactivity and frequent silence of the therapist are crucial here. The therapist's silence allows the client an intrapsychic, associative freedom for self-discovery, and a constructive solitude in the presence of the other. In the deconstructive function, the therapist serves as a disturbing force within the client's interpersonal field, presenting interpretations, queries & disruptions, in much the way Berne worked. Renik offers a similar perspective when he suggests:

> What the patient wants—and, best case, gets—from the analyst is a perspective different from the patient's own. It is to be hoped that the analyst's perspective is a particularly wise one, but that cannot, and need not, be assumed. Ultimately, an analyst's expertise and appropriate authority do not rest on the premise that the analyst's view of the patient's conflicts is necessarily *more valid* than the patient's own, but rather on the fact that the analyst can provide an *alternative* perspective, a new way of constructing reality, that the patient can put to use—or not—according to the merit the patient finds in it. (1996, p508, emphasis in original)

Donnel Stern (1988) contrasts empathy with the therapeutic function of "inquiry" as described by Harry Stack Sullivan:

> ...tolerance of uncertainty and ambiguity are built into the clinical practice of detailed inquiry (Sullivan, 1954). The aim of psychoanalysis carried out according to these precepts is not necessarily to know what the patient does not know, but rather to specify *that* the patient does not know, and where and when this not knowing takes place. The psychoanalyst who depends on inquiry is not responsible for knowing the

> patient before the patient does. (1988, pp.602-603, emphasis in original)

Stern's thinking is similar to ours and the model we want to offer here as an alternative to or expansion of concepts of attunement and attachment. Stern acknowledges that the therapist's questions may well emerge at times from the therapist's empathic imaginings of the client's experience, but he argues that the therapist's task is to *identify* the client's gaps in experience, not to *fill* them. Filling the gaps in experience is the responsibility and freedom of the client. Stern's perspective is one in which the therapist "wishes to stimulate the patient's curiosity about experiences the patient never formulated" (1988, p.601). The formulation becomes that of the client, not of the therapist, much as Berne would say that the decisions are those of the client, not of the therapist.

In *The Empathic Imagination*, Margulies (1989) casts the therapeutic uses of wonder and empathy not in terms of relationship and attunement but of self discovery. He writes, "I am interested here in the challenges of perceiving freshly and in particular of opportunities for the self to conceive of the self anew; in other words, the therapeutic activity of creativity to the image of self, the opening of new possibilities of self-perception" (p.10). In Margulies' utilization of empathy, he seeks to engage in a creative, rather than compensatory, process with clients. Empathy, in Margulies model, is a means of wonder, challenge, questioning, enlivening – at times a clash of world views, rather different from a goal of matching and entering the client's lived perspective. The therapist's curiosity about the meaning the client has made of his/her lived experience can awaken the client's curiosity and lead to an examination of and reflection upon underlying basic assumptions.

Conclusion

We have drawn here on the challenges of Margulies, Donnel Stern, Stark and Bollas, among others, to offer TA therapists an expanded framework to consider the central tasks and activity of the therapist and of the therapeutic relationship. We find these perspectives are consistent with the stance originally proposed by Berne, though with a depth of affective understanding and involvement that Berne did not accomplish in his lifetime.

It seems crucial to us that transactional analysts draw upon original sources to gain a thorough understanding of human development. The work of Winnicott and Bowlby supplemented by the newer research of Stern, Emde and others who are observing real children interacting with parents teaches us the norms of development. This knowledge can help the therapist identify deviations from those norms when they are exhibited by clients. This is crucial to the understanding of childhood decisions and script formations and provides a

reference point for the therapist's curiosity about what leads to these deprivations and deviations in a particular individual and how they are defensively maintained in adult life. We further suggest that it is the therapist's and client's mutual curiosity and exploration of an individual's experience that is ultimately curative, rather than the alleviation of the psychic pain, which has developed because of these experiences.

Pain, ambiguity, paradox and conflict are inevitable in life. They are necessary in a deeply searching psychotherapy, and, most importantly, can become vitalizing resources in living one's life. After a half century of writing about psychoanalysis and the nature of human beings, Freud was still wondering about the heart of the therapeutic process. For Freud it was the love of truth, the willingness and capacity to acknowledge reality about the self, that was essential in the therapeutic endeavor. The attunement and attachment models suggest that it is the truth of love that is at the heart of psychotherapy. These theorists suggest it is the client's internalization of the therapist's love, understanding and corrective provision that allows the client to leave the office and create a different life. While we would not disparage the experience of therapeutic empathy and attachment, we are warning against a romanticizing and idealizing of its curative power. We are suggesting that it is the gradual development of the client's capacities for curiosity, self-scrutiny, differentiation and relational conflict within the therapeutic relationship that is carried outside the office, forming the bases for lasting structural and interpersonal change.

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