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Abstract
This article considers how new ways in which a client and therapist relate emerge out of old ways the client related to others, with the subsequent transformation of maladaptive schemas and ego state relational units (Little, 2006) into more adaptive schemas. The author explores the nature of the client's pathology and maladaptive relational schemas and the therapeutic action that might be transformative for the client. He also examines a modern perspective on the transference-countertransference matrix and explores further the concept of optimal neutrality.

Keywords
relational, ego state relational units, transference-countertransference matrix, needed relationships, repeated relationships, optimal neutrality, assimilation, accommodation, therapeutic engagement, interpretation

Psychotherapy unfolds in a relational context. Both the therapist and the client bring to the relationship their own subjectivities, motivations, relational needs, and pathologies. In addition, both parties have their conscious and unconscious expectations and phantasies (Lemma, 2003). Many contemporary theorists believe that the outcome of therapy is related to the successful elaboration and reevaluation of patterns of relating that become accessible through the analysis of the transference-countertransference matrix (Lemma, 2003; Sandler & Sandler, 1997).

This article is my attempt to account for the process of change when working within an integrated relational transactional analysis orientation. I consider how the transformation that takes place within the transference-countertransference matrix occurs largely at the level of implicit unconscious processing. This entails working mindfully with unconscious processes through the transference-countertransference matrix, with the aim of having "one foot in and one foot out" (Eusden, 2011, p. 275), which includes both reenactments and enactments. I will develop and incorporate Žvelc's (2010) excellent work into my thinking on ego state relational units (Little, 2006),

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transference-countertransference, and therapeutic action. I also describe my understanding of the integration of healthy relational experiences into the integrating Adult ego state.

Although this article repeats some of what I have written previously, it integrates various strains of my thoughts and concepts into a more coherent whole. My intention is for this article to be able to stand alone, without reference to previous publications.

Psychological Development

Adaptive and Maladaptive Relational Schemas. Žvelc (2009, 2010) has described how infants grow, develop, and learn to relate to their environment and to those who occupy it as well as the way in which they internalize these experiences as relational schemas. Various authors support the notion that it is relationships that are internalized as self-other configurations (Beebe & Lackmann, 1988; Loewald, 1970), and these representations influence the child's behavior (Horner as cited in Schore, 1997). Schore (1997) connected with neurobiology when he said, "Representations are distributed in the orbital cortex and its cortical and subcortical connections, and . . . they act as templates guiding interpersonal behavior" (p. 828). The infant internalizes the experience of the whole relationship with the other at a particular moment in time. These early internalizations are laid down in implicit memory, which consists of procedural knowledge of relationships and the rules of how to be with someone as established through a process of trial and error.

Schemas (Piaget, 1952; Wadsworth, 1989) are described as the mental structures by which individuals intellectually adapt to and organize the environment; schemas adapt and change with mental development. *Relational schemas* are, therefore, a particular grouping of structures that consist of self in relation to another. Eagle (2011) described how "on the basis of repeated interactions early in life with parental figures [the infant/child forms] implicit representations that constitute abstractions or generalizations of prototypic interactions" (p. 126). Once formed, they influence the individual's expectations and representations of self and others. This notion is similar to D. N. Stern's (1985) ideas of RIGs (representations of interactions that have been generalized), which could be described as relational schemas. These representations belong to the category of "procedural knowledge" (Boston Change Process Study Group, 2010, p. 31), which Lyons-Ruth (1999) described as "implicit relational knowing" (p. 605). This perspective on development constitutes a relational model of the mind.

The infant internalizes a memory of self in relation to another, thus creating a schema. This usually occurs during "peak affect states" (Kernberg, 2004, p. 9). Kernberg and his colleagues (Yeomans, Clarkin, & Kernberg, 2002) described these experiences as coalescing into those with pure positive affect and those with pure negative affect. At this stage, self and others are perceived in extreme, absolute terms.

Gradually, through normal development, the extreme positive and negative segments of the mind become integrated into more complex and nuanced representations of self, others, and affects. Ambivalence, acceptance, flexibility, and the notion of *good enough* will guide the individual's perceptions of self and others.

Psychopathology

Ego State Relational Units and Maladaptive Schemas. When we examine the nature of the relationship, we can distinguish between tolerable and intolerable experiences that have been internalized as relational schemas. Those internalizations that consist of the tolerable, good-enough experiences in nonconscious implicit memory are nonstructuring internalizations and an aspect of the integrating Adult ego state. These represent autonomous, here-and-now functioning from an open system (Little, 2006, 2011b), with the capacity for assimilation and accommodation (Piaget, 1952; Žvelc, 2010). In Summers's (2011) dynamic model of ego states, the term *unconscious* is reserved for those experiences that have become repressed or dissociated from and reside in ego state relational units

(Little, 2006). These experiences were described by Freud as the dynamic unconscious. Nonconscious is used by Summers (2011) to describe those experiences that are not conscious, not defensive, and do not reside in ego state relational units but nevertheless influence our behavior. If there is insufficient holding and containment or the child experiences trauma, or if there is a predominance of all-bad, aggressive internalizations, then the child may not be able to integrate its experiences, and these will remain as a dissociated structure. These constitute defensive schemas (Žvelc, 2010), which others call *maladaptive* (Eagle, 2011).

From a transactional analysis perspective, these defensive schemas are described as ego state relational units, which "develop defensively in response to unbearable or unmanageable experience" (Summers, 2010). Although we internalize both the tolerable and intolerable experiences, it is the intolerable and unsatisfactory experiences that have been introjected and fixated in Child-Parent ego state relational units (Little, 2006). Such structuring internalizations are unintegrated and result in a closed script system, located in unconscious, implicit memory and forming the foundation for characterological structure and defenses.

Characterological Structure as Ego State Relational Units. Psychopathology can be seen, therefore, as manifesting in the persistence of early modes of relating and consisting of defensive relational schemas. This entails clinging to early self-other schemas that may result in a conflict between a desire to merge, on the one hand, and strivings for autonomy and separateness, on the other. Psychopathology includes the absence of affect regulation, which arises out of a lack of good object experiences and a secure base (Eagle, 2011). As Schore (1997) wrote, "Grotstein (1986) has asserted that all psychopathology constitutes primary or secondary disorders of bonding or attachment and manifests itself as disorders of self and/or interactional regulation" (p. 830). In more severe cases, the ego state units will constitute a part of the characterological structure—as in borderline, narcissistic, and schizoid personalities—where the individual is dominated by primitive ego state relational units.

Transference. When we examine how these ego state relational units manifest in therapy, we need to consider the nature of the transference-countertransference matrix (Little, 1999). Freud first used the term *transference,* believing that it came about as a result of a "false connection" (Freud & Breuer, 1905/1974, p. 390) by the patient.

A modern view of transference proposes that it is more than a repetition of the client's patterns of relating to significant figures from the past. What is enacted in the here and now are the internalized self-object relations. Unlike Freud, many contemporary therapists understand transference as a process in which current emotions and parts of the self are externalized into the therapeutic relationship.

A Transactional Analysis Perspective on Transference. Moiso (1985), in his significant article on "Ego States and Transference," developed Joines's (1977) transference diagram and identified transference as consisting of the projection of either second-order (P_2) or first-order (P_1) Parent ego states onto the therapist. I have suggested elsewhere (Little, 2006) that P_2 consists of whole objects and is oedipal or postoedipal, whereas P_1 is made up of part objects, is preoedipal in origin, and is more primitive.

What Moiso did not describe was the possibility that second-order (C_2) or first-order (C_1) Child ego states may be projected onto the therapist. This occurs when the client is attempting to find identification with the therapist. Clarkson (1992) used the term *concordant transference* to describe this process, a term borrowed from Racker (1972). As Žvelc pointed out, we need to bear in mind when making use of Moiso's representation of transference that "the therapist has nothing to do with the transference projection" (G. Žvelc, personal communication, 15 April 2012) and the therapist is just a blank screen to be projected onto.

For his part, Erskine (1991) viewed transference variously as:

(1) the means whereby the patient can demonstrate his or her past, the developmental needs that have been thwarted, and the defenses that were erected to compensate;
(2) the resistance to full remembering and, paradoxically, an unaware enactment of childhood experiences;
(3) the expression of an intrapsychic conflict and the desire to achieve intimacy in relationships; or
(4) the expression of the universal striving to organize experience and create meaning. (pp. 73-74)

A Relational Perspective on Transference. I take the view that transference consists of previously formed psychological structures, or templates, that are an expression of a universal psychological striving to organize experience and construct meaning (Stolorow, Brandchaft, & Atwood, 1995). Transference consists of both conscious and unconscious affective and cognitive responses of the client to the therapist; countertransference is defined as the conscious and unconscious response of the therapist to the client (Maroda, 2004, p. 66). Both parties bring their own personalities and particular styles of relating to the relationship, which is thus cocreated.

Transference is considered to be an expression of the client's past as well as a current reaction to the therapist's personality. Both the therapist and client are seen as mutually influencing each other in the context of an asymmetrical relationship. The transference-countertransference matrix is the mold in which these influences are shaped.

Schore (2003) wrote,

> It is now thought that "cues" generated by the therapist, which are absorbed and metabolized by the patient, generate the transference (Gill, 1982) [which] . . . crystallizes around perceived expressions of the therapist's personality, therapeutic style, and behavior . . . . The patient is especially sensitive to . . . perceiving aspects of the treatment situation which resemble "the parent's original toxic behavior." (p. 72)

Hoffman (1983) elegantly described a radical view of the patient's transference reaction as having a basis in here-and-now interaction and viewed it as having four distinguishing features: (1) the patient's selective attention to certain behaviors in others, (2) a predisposition to choose one set of interpretations regarding behavior over possible others, (3) the client's adaptations are unconsciously determined by and governing of the beliefs he or she has adopted, and (4) a tendency to behave in a manner that elicits responses consistent with one's expectations (p. 394). From this perspective, transference is viewed as a means of construing and constructing relationships.

Countertransference. In Freud's time, psychotherapists regarded their emotional reactions to their patients as manifestations of their own blind spots or pathology. Their feelings were, therefore, going *counter* to the transference. Heimann (1989) was one of the first to redress this attitude. She favored viewing countertransference as a technical tool, not as a hindrance. In contemporary therapeutic circles, countertransference is seen as a privileged source of knowledge about the mind of the patient and the nature of the therapeutic dyad.

Many clinicians today view countertransference as all of the therapist's reactions to the client, regardless of the source. This allows for greater tolerance of the therapist's subjectivity. From this perspective, the therapist's task is both to understand who he or she has come to represent for the client and to be aware of his or her own ego state relational units that have been activated.

When countertransference is generally taken to mean the therapist's total response to the client (Kernberg, 1965), it may include the therapist's identification with those of the client's ego state relational units (Little, 2006) that have been projected onto the therapist, the reality of the client's life and the therapist's reactions, the therapist's own transference dispositions as determined by his or her ego state relational units, and aspects of the reality of the therapist's life that may influence how he or she behaves with the client.

Hoffman's (1983) description of transference can also be applied to countertransference. Perhaps because of the therapist's theoretical orientation, understanding of the psychotherapy process, and experience of supervision and therapy, he or she may attend to certain of the client's behaviors, have

a particular bias in terms of how he or she responds to the client's behavior, and also tend to elicit client reactions that are consistent with what is expected. All of this contributes to construing and constructing the therapeutic dyad. Some aspects will be conscious and represent an attitude consistent with the therapeutic stance whereas some will be unconscious and possibly motivated by Child-Parent ego state relational units.

From a relational perspective, countertransference has been described as *cotransference* (Orange, 1995) to differentiate it from the notion of a pathological response on the part of the therapist. From Stark's (1999) relational perspective, countertransference is a story, not only about the therapist's past but also about the client's impact on the therapist.

Transference-Countertransference: Two Interlocking Components. In drawing together and considering these various views, we can suggest that a contemporary view of transference and countertransference involves two interlocking components of one process. For Stolorow et al. (1995), the transference and countertransference "together form an intersubjective system of reciprocal mutual influence" (p. 42). Countertransference is the therapist's identification with the internal intrapsychic representations of the client, either the Child or Parent ego states. It is also a manifestation of the therapist's psychological structures and organizing activity (Stolorow et al., 1995). These reactions help the therapist determine the role that the client is unconsciously inviting the therapist to occupy and thus provide a means for understanding the client's internal world. Therefore, as therapists, we can draw tentative conclusions about the client's psychological experiences by understanding those experiences, feelings, thoughts, and relational longings of which he or she may not be fully conscious or able to speak.

Enactments. When the therapist's and client's ego state relational units unconsciously engage with each other and a game (Berne, 1964/1966) ensues, we can refer to this as an *enactment.* The literature suggests that in such cases, the client's problem engages with difficulties the therapist is experiencing either temporarily or chronically in his or her own life. As a result, the client and therapist both unconsciously find expression in the other for his or her own issues. Enactments are thus joint creations of the therapist and client (Mann, 2009, p. 8). Neither is conscious of what is really going on at the time. Both are caught in archaic, primitive unconscious processes that cannot be known beforehand but only afterward (p. 10).

An enactment may be considered part of a larger sequence of events, including what went before as well as the possibility of working through in the aftermath. The therapeutic significance of the enactment lies in how it is dealt with, not in the enactment itself. Through joint engagement in an enactment, the therapist and client may begin to speak what has previously been unspoken (Little, 2012).

Therapeutic Action

I use the term *therapeutic action* here to refer to what is healing in the therapeutic work (Ehrenberg, 1992).

The Repeated and Needed Relationships. The therapist's presence, attunement (Erskine, Moursund, & Trautmann, 1999), and empathic understanding of the client will be likely to stir relational, self-object, and ego development needs previously sequestered or dissociated. Alongside this reawakening will be fears of frustration and retraumatization (Novellino, 1985). This manifests as two types of transference-countertransference relationship (Little, 2011b).

The *repeated relationship* is potentially traumatizing, nongratifying, attacking, and/or rejecting and may evoke defensive behavior. S. Stern (1994) described it as "being organized in terms of familiar pathogenic relationship patterns" (p. 318). This relationship usually involves the bad object,

whom the individual "hates and fears, who is experienced as malevolent" (Rycroft, 1968, p. 100). It is the source of conflict, with its expectation of selfobject failure (Stolorow et al., 1995). This is the repetitive dimension of the transference and often gives rise to the antirelational Child-Parent unit that is focused on preventing the individual from forming an attachment with the therapist. Jealousy of the emerging therapeutic relationship may be the motivating force for this. The emerging therapeutic relationship may also include the exciting but disappointing object (Fairbairn, 1952; Little, 2001). Mitchell (1988) described it as the *relational-conflict transference.*

The *needed relationship* consists of the other as a "self-facilitating object" (S. Stern, 1994, p. 317), including a desire for an object who can attend to the vulnerable self with its unfulfilled need for growth and development. This addresses a selfobject function that was "missing or insufficient during formative years" (Stolorow et al., 1995, p. 102) and represents the sought-after good object described as the one "who is experienced as benevolent" (Rycroft, 1968, p. 100). This relationship may contain the unmet needs for attachment and an empathic, attuned secure base (Bowlby, 1979, p. 103) and gives rise to the relationship-seeking unit. Mitchell (1988) referred to this as the *developmental arrest transference.*

The Old and the New. Clients will unconsciously invite the therapist to engage with them in old familiar experiences, but they will also long to be exposed to new experiences. For therapy to work, the client needs to experience the therapist both as someone new and someone from the past (Cooper & Levit, 1998). Therapists who tend to focus exclusively on repetition, in the form of games (Berne, 1964/1966), may overlook how new capacities for relating are emerging out of the old. Within the relational model, we may be too quick to offer a new reparative relationship, thereby defensively welcoming aspects of the new but in doing so seeking relief from the old repetitive problematic relationship. We need to balance staying with the old while understanding the "therapeutically required relationship" (Little, 2011b, p. 34) so that the new may emerge out of the old (Little, 2006). Therapy is the search for a transformational experience (Bollas, 1984/1987) that will allow the client to understand the repeated relationship as well as to experience the therapeutically required relationship (Little, 2011b).

In the initial stages of therapy, the client may experience the therapist as someone new, which will enable the therapy to begin. At a later date, the therapist may need to shift the balance toward the old repeated object to enable the therapy to proceed. Conversely, if a new client experiences the therapist as the old object, with no apparent experience of the new, then the therapist may need to shift the process to include the experience of the new in order for the work to continue.

Transformation of experience occurs when the client assimilates and accommodates to the experience with the therapist and then begins to allow the emergence of previously dissociated emotions and needs. The therapist responds by acknowledging that the client is giving expression to previously repressed feelings. This process occurs within the transference, which allows the client and therapist to create a new relational schema.

The Therapeutic Stance

The Therapeutically Required Relationship. I want to examine the therapeutic stance and distinguish here between the needed and repeated transference-countertransference relationships and the therapeutically required relationship. The latter can tolerate and respond to both the repeated and needed relationships, with the therapist being experienced as the good and the bad object as well as the good and the bad self. The therapist will probably always have parts of himself or herself that resonate with both the longed-for good self-object unit and the feared bad self-object unit. Without this, projective identification would not work. The therapeutically required relationship also involves the old and the new experiences. Tolerating and integrating both the needed and repeated relationships and

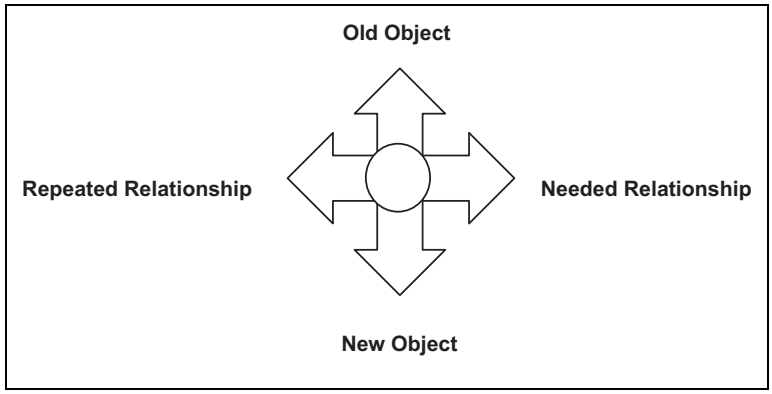

Figure 1. The Position of Optimal Neutrality (previously described as technical neutrality, Little, 2011b, p. 34).

the old and the new experiences requires the therapist to assume a therapeutic stance that maintains optimal neutrality.

Optimal Neutrality. In the past, I used the term *technical neutrality* (Little, 2011b) to refer to this quality, but because it connoted a more intellectual and cognitive response, I have changed the term here to *optimal neutrality*. Optimal neutrality (Figure 1) requires that the therapist not be invested in one relationship over the other, that is, in either the needed or the repeated relationship. Instead, the therapist must be willing to remain equidistant from both. It is an attitude of mind, a nonjudgmental stance, not a set of behaviors. At various times in therapy, one or the other of the two transference-countertransference relationships will be dominant or need attention. When the therapist offers the therapeutically required relationship, he or she will be working with both transference domains and will be at times feared and at other times longed for. There are times in treatment when one or other of the two transference relationships will be in the foreground and the focus of attention. For the sake of clarity, I am describing these two relationships as separate entities, but in clinical practice they are usually interwoven. The object of the needed relationship is seen as standing in the shadow of the feared object of the repeated relationship. During enactments the focus will be on the repeated transferences of both client and therapist.

Optimal neutrality also attempts to find a balance between engagement and observation, the experiencing and observing egos, and an attitude and stance between being perceived as the new object and the old object (Greenberg, 1986). A balance also needs to be struck between participation and nonintrusiveness (Aron, 1996, p. 106). As described earlier, the therapist will sometimes seem like someone from the client's past and sometimes as someone new. Optimal neutrality involves accepting all parts of the client and therapist. This enables the client to work through the old object relationship, find the new object, and reclaim the self. Neutrality is measured by the client's experience of the therapist as both the old and the new object.

Optimal refers to what is most favorable to a given client and therapist relationship. Neutrality refers to nonalignment with one aspect—either the old or the new object, the needed or repeated relationship—over the other. Neutrality also refers to maintaining a balance, over time, and holding a position equidistant between self and other representations and between split-off and dissociated aspects of the personality. Optimal neutrality is not a rigid position adopted by the therapist but one that takes into account the push and pull of the therapeutic dyad.

Optimal neutrality is an aspect of the therapeutically required relationship (Little, 2011b) and represents that which is appropriate for the therapist to provide as opposed to that which was needed from the primary caretakers but was missing, insufficient, or part of a traumatic experience and that will need to be understood and mourned.

Assimilation and Accommodation. I will now examine the process by which, on the one hand, individuals both develop and adapt to their environment and, on the other, seem to maintain their script systems. I will use Piaget's (1952) theory of schema, assimilation, and accommodation, drawing extensively on the writings of Wadsworth (1989) and the comments of Davies (1996), Wachtel (2008), and Žvelc (2009).

The individual is seen as continuously assimilating experiences, absorbing them into various relational schemas, and then accommodating and adapting to the experiences and harmonizing with them. As the child develops, the schemas become more differentiated (Wadsworth, 1989, p. 11). The processes responsible for the change are *assimilation* and *accommodation.*

Assimilation is the cognitive process by which new experiences are integrated into existing schemas. Assimilation does not result in a change of schemas, but it does affect their growth and is thus part of development. Assimilation is the part of the process by which the individual cognitively adapts to and organizes the environment.

Piaget accounted for the change of schemas through the notion of accommodation, which occurs when, for example, a child is confronted with a new stimulus and he or she tries to assimilate it into existing schemas. However, this is not always possible. According to Wadsworth, the child can do one of two things: create a new schema into which to place the stimulus or modify an existing schema so that the stimulus can be assimilated.

During assimilation, a person imposes his or her available structures on the stimuli being processed. On the other hand, in accommodation the person changes his or her schema to fit the new stimuli (Wadsworth, 1989, p. 15). There needs to be a balance, or equilibrium (Piaget, 1952), between assimilation and accommodation to detect similarities and difference in life.

An infant's schemas are global, imprecise, and frequently inaccurate. They are constructions, and as such, are not accurate copies of reality. Over time they may come to more closely approach reality in appearance.

Schemas are inferred to exist and are hypothetical constructs. They are structures that organize events as they are perceived by the organism and are classified into groups according to common characteristics. They are repeatable psychological events in the sense that a child will repeatedly classify stimuli in a consistent manner. Žvelc (2009) described relational schemas as constantly in flux and available to change. He suggested that each time a schema is activated, there is an opportunity for it to change.

Assimilation and Accommodation Without Change: Maintaining Script. If we view individuals as continually changing, developing, and adapting to their environment, then we need a theoretical way to understand why some individuals seem not to change, instead perpetuating their script. As therapists, we need to understand the capacity that individuals have to maintain old structures and schemas, even in the face of experiences that disconfirm their expectations.

Hoffman's (1983) description of transference as having four distinguishing features, including a tendency to behave in a manner that elicits responses consistent with one's expectations, describes the tendency individuals have to provoke the feared situation or behavior in others, thus repeating earlier traumas or unsatisfying experiences. This will occur through reenactments and enactments and also involves the processes of assimilation and accommodation. When an individual is repeating painful, unfulfilling experiences, on the surface it appears that he or she is only assimilating the experience but not changing or accommodating to it. Rather than integrating the experience, it becomes part of an introjected, fixated structure.

We use our various schemas to process and identify incoming stimuli. In this way, the individual is able to differentiate between stimulus events and to generalize. This does not appear to be happening when painful repetitions occur. If we use the process of introjective identification to make sense of this, we can see that the individual will have a *phantasy* (referring to unconscious activity)

regarding the other; he or she will then put pressure on the other to fulfill those expectations. When the other person, under pressure, acts in a way that is consistent with the phantasy, the person applying the pressure can now assimilate and accommodate the experience to some limited extent and therefore reinforce his or her script beliefs and expectations. From this perspective, the individual may be viewed as manipulating the environment in such a way that he or she will only have to accommodate in the slightest of ways. Žvelc (2010) suggested that defensive schemas resist accommodation of new experiences. He also wrote that "a defensive relational schema . . . [fulfills] the function of dissociating certain elements of experience" (Žvelc, 2009, p. 34).

If the therapist can experience the pressure to act out or totally fulfill the expectations of the phantasy but not do either and instead find a way of thinking about his or her own countertransference reaction (thus making the countertransference an object of analysis), then he or she becomes, in that moment, a new bad object. The therapist is a bad object because he or she is under pressure to act like the bad object and, to some degree, may be fulfilling expectations, but he or she is also thinking differently and holding a different position, thus becoming a new object. What is now assimilated and accommodated and recorded as a new memory is a different experience.

Working in the here and now has the potential to include an overlapping of the old and new experiences. We can see that the new emerges out of the old. When enactments occur in therapy, accommodation can begin to take place when the therapist and client process together what has occurred between them.

Examining this process from a different perspective, Pally (2007) integrated neuroscience with psychoanalysis and wrote that the brain makes predictions about what is likely to happen before events occur. This then sets in motion the emotions, behaviors, and ways of relating "that best fit with what is predicted" (p. 861). She also suggested that nonconscious predictions alter the outcome of events because they "alter brain activity in the direction of what is expected" (p. 862). She went on to indicate that "we learn from the past what to predict for the future and then live the future we expect" (p. 862). Pally described how unlike nonconsciousness, consciousness has the capacity to monitor errors in prediction and to take control of our behavior, thus freeing us from repetition through self-reflection.

The implication of what Pally (2007) described is that the client, unconsciously, will anticipate that the therapist will react to him or her in the same manner that his or her parents and others from the past did. The client, therefore, will activate his or her defenses even before the therapist has said anything and will subjectively experience what he or she expects when the therapist does speak (p. 875).

The implications of all of this for working within the transference-countertransference are that if clients experience the difference between what happens and what they expected to happen, this will help the deconstruction of old ways of relating and enable the emergence of the new. The client thus has an experience that is more profound than would be the case with insight alone.

The New Emerging Out of the Old: Being the New Bad Object. Therapy includes the integration of dissociated self and other relational schemas and the internalization of new self-other experiences. For Davies and Frawley (1994), this includes "the capacity to strike an optimal balance between reworking the old and co-creating the new" (p. 201).

Further, transference consists of clients interpreting the therapist's behavior and the situation in which they find themselves, attempting to make sense of the various cues that they perceive (Gill, 1982). They interpret these cues in a particular manner, selectively attending to some and not others (Hoffman, 1983). They then respond in a manner consistent with that perception, eliciting in the therapist the expected response. This is an interactional process between therapist and client.

Although behaving consistently with the client's expectations, if the therapist manages to think about his or her countertransference reactions and, for example, offers the client an interpretation, in that moment the therapist, as Hoffman (1983) described, "casts doubt on the transference-based

expectations" (p. 415). By demonstrating to the client that what he or she has "attributed to the analyst occupies only a part of his response to the patient, the analyst also makes it apparent that he is finding something more in the client to respond to than the transference-driven provocateur" (p. 415).

What Is the Nature of Therapeutic Engagement? From a relational perspective, who we are, and our relational schemas, on the one hand, and the new experiences we encounter, on the other, constantly shape each other (Wachtel, 2008, p. 130). Davies (1996) described the process as follows: "Schemas affect the way in which each individual views reality, and reality affects the ongoing structural nuances of schemas" (p. 557). In addition, Wachtel (2008) pointed out, "We are always experiencing the world in terms of the structures that evolved in the past and always modifying those structures to accommodate to the present" (p. 133). From this perspective, we construct the event, making sense of it on the basis of the psychological structures that have evolved for us up to that point (p. 134).

People often come to therapy to address their persistent, self-defeating behaviors. For change to occur, the therapist must be experienced as both a new object and an old object. The therapist needs to be attentive to the pull of both the old and the new and be able to integrate the two. For the therapist, there is an ongoing tension between the two pulls: a tension between the client's structures and schemas and the actual qualities and behavior of the therapist. The client will be attempting to make sense of the various cues from the therapist.

On encountering each other, the client and therapist will interpret and react to each other, and their perceptions of one another will change what happens next between them. I want to highlight this with a description adapted from the examples of Wachtel (2008). If person A perceives person B's behavior as unfriendly and hostile, A will not be likely to behave in a warm and friendly manner. This will likely result in B's somewhat unfriendly behavior in return, further perpetuating the hostile encounter. Now, whether or not B was intentionally unfriendly in the first instance, A and B are certainly behaving currently in an unfriendly way with each other. The process has become a self-fulfilling prophecy.

It would seem to A that his or her initial perception of B as hostile was correct. It is, in a sense, accurate, because A has elicited the feared behavior from B. Thus, assimilation has occurred, an old perception of the world is maintained, and the script has been reinforced.

Therapist and client will, on occasion, find themselves in a reenactment with each other. This process is bidirectional, and if B had maintained a more friendly or nonhostile response, the reinforcing accommodation would have been challenged. As Wachtel (2008) suggested, accommodation "will eventually lead to registration of this difference from the initial expectations, rooted in past experiences, and what one is presently encountering" (p. 135). This process will take time and repeated experiences because schemas evolve and accommodate gradually and slowly. Working within the transference-countertransference matrix offers an opportunity for a new accommodation and consists of what D. N. Stern and his colleagues (D. N. Stern et al., 1998) described as "interactional, intersubjective processes that alter the relational field within the context of what we call the 'shared implicit relationship' " (p. 905).

Working Within the Transference-Countertransference Matrix. To stand opposite the client, supporting his or her problems being concentrated within the therapeutic relationship, entails addressing the client's difficulties live, in the here and now. This provides a space within which the intersubjective and unconscious dynamics can take form, and it entails drawing the client's feelings toward the therapist.

Each relational transactional analyst will have his or her particular emphases within the relational approach. For example, I (Little, 2001, 2006) first stress that working relationally entails working primarily in the here and now within the therapeutic dyad. Second, I focus on how it involves working with the defensive schemas and being available to be impacted and affected by the client

(Erskine et al., 1999). The focus and object of the client's communication is the therapist. Recognizing that requires examining the client's experience of the therapist's subjectivity (Aron, 1996; Hoffman, 1983). The therapist becomes an observing participant in the work.

Working within the transference, the therapist becomes the trigger for the client's feelings. These may combine responses to the therapist directly as well as those previously felt toward someone else and suppressed. They are now felt with the therapist, who needs to respond nondefensively (Gill, 1982). In this way, the work is with the past in the present.

The client has the opportunity to experience with the therapist feelings, fantasies, and needs in the presence of the person to whom they are now directed. The individual experiences the therapist responding in a nondefensive manner, even after an enactment, and the therapist helps to establish meaning and understanding. This has the possibility of transforming the closed script system and liberating the client's creativity and spontaneity.

As the client and therapist work through feelings and needs in the here and now, emotional memories may be stirred up and connections with earlier traumatic experiences made. The therapist may then become the "secondarily longed-for receptive and understanding" other (Stolorow, 1994, p. 51) and a witness to the expression of previously repressed and dissociated feelings. Thus, the therapist offers a relationship that hears and witnesses the expression, maybe for the first time in the client's life, of these feelings. The therapist is a new object who responds at an appropriate level to the needed relationship.

The benefits of working within the transference-countertransference matrix, include the following: (1) here-and-now dynamics are alive and immediate and hence verifiable in the present, (2) there is an opportunity to make use of the emotional immediacy of the situation, (3) here-and-now working facilitates an increase in interpersonal intimacy and demonstrates attunement to the client's current experience, and (4) interpretations allow the therapist to address the client's defenses against intimacy as they emerge, thereby contributing to a strengthening of the therapeutic alliance.

The aims of a here-and-now focus are to help the client recognize and own dissociated aspects of the self, become aware of the discrepancy between how she or he perceives the therapist and how the therapist actually is, and modify the force of the bad internal object. The overall aim is to establish a link between internal and external figures (Lemma, 2003).

Making Use of Countertransference. Speaking at a conference, Schore (2007) wrote, "It is countertransference that provides the healing in psychotherapy: as therapist and patient together create trust—a safe place—the patient begins to dare to reexperience small doses of trauma or the hurtful feelings that had not been experienced, remembered, or expressed."

Working within the transference-countertransference matrix will more readily evoke a countertransference. In addition, as therapists we need to create a space within us in which we can receive and resonate with the client's projections. Novellino (1984) suggested that we need to give ourselves permission to have a countertransference response and then to examine it before intervening. Bollas (1984/1987) suggested that the therapist is compelled to relive elements of the client's early history through the countertransference. Through this process, the client communicates what he or she cannot put into words. Bollas also offered that we need to look for the "patient" within the therapist.

When I examine my countertransference reactions, I engage in self-analysis, and when I find an aspect of the client within me, I often offer the client an interpretation rather than self-disclose my reaction. As stated by Wachtel (2008), for some therapists, self-disclosure has become equated with the relational approach. As therapists I believe we need "to consider what we might be disclosing, when and when not to disclose, and if we do, how we do and the motivation for it" (Little, 2011a, pp. 49-50). Disclosing our countertransference is just one of several options.

Interpretation, Memories, Emotions, and Transformation. When working within the transference-countertransference, the therapist's responses, interpretations, and understandings will occur within this matrix in terms of he or she being a new/old transference object. In addition, if we accept that

games (Berne, 1964/1966), reenactments, and enactments are inevitable aspects of working within this matrix, we can then see that if they are addressed from within, transformation can occur in the working through.

During this process, the therapist may be experienced by the client as the person she or he is and also, through projection, as a historical figure. Thus, the processes of assimilation and accommodation will take into account the interpretation in addition to what has transpired behaviorally and emotionally. This process is equivalent to a new experience, albeit a combination of new and old.

The ego state relational units that are involved in the transference-countertransference relationship are, in effect, memories of previous relational failures that remain unintegrated but have assimilated numerous other experiences, thus becoming reinforcing script beliefs. When an ego state unit is active, a memory is being relived, unintegrated but modifiable. Let us imagine the therapeutic dyad as being affectively charged, with the therapist emotionally impacted by the client and the client emotionally stirred and perceiving the therapist as some variation of an old object. At this point, if the therapist can offer an interpretation or an emotional response that does not fit with the client's expectations, this creates a new memory with the client in the present moment. This may also happen without an interpretation from the therapist but through the process of implicit relational knowing (Boston Change Process Study Group, 2010; Lyons-Ruth, 1999). When I refer to interpretations, I am not limiting the therapeutic action to a cognitive process alone. Interpretations are emotionally charged, here-and-now activities. Bleichmar (2004) highlighted that the memory evoked in the moment is in a labile state and will be restructured, adding elements that were not part of the original circumstances. This, in effect, creates a new memory from the current experience, the latter of which may evolve out of an enactment when the therapist or client realizes and begins to address what has transpired. Something new between therapist and client emerges in the present moment (D. N. Stern, 2004). This involves an expansion of the relational matrix in which something previously unspoken or repressed is expressed and addressed. It represents another aspect of a new old object.

When working within the transference-countertransference matrix and emotions are stirred, responded to, and interpreted, a new experience occurs that is tied to a past experience, and the corresponding memories, the current experience, and the old rest together in such a manner that a reconsolidation of old memories occurs (Bleichmar, 2004). It is not enough for the client to talk about current or old experiences; he or she needs to experience the emotions. Alternatively, the client may experience emotions that relate, on the surface, to current experiences with the therapist while unconsciously the experiences also overlap with historical events and past experiences, as in an enactment.

The key to the process is the lived emotional experience, whether that is a current experience with the therapist or a historical experience or a combination of the two. The re-creation of an emotionally charged memory with the therapist offers the opportunity to restructure the memory within the present experience.

Interpretations. Berne (1964/1966) described "psychodynamic interpretation" (p. 241) as the method by which he deconfused the Child ego state, thus addressing its pathology. He defined interpretation as "a therapeutic operation" (p. 365) and wrote that the "Child presents its past experiences in coded form to the therapist, and the therapist's task is to decode and detoxify them, rectifying distortions, and help the patient regroup the experiences" (pp. 242-243). The decontaminated Adult is seen as an ally in this task, with the Parent resisting the process. The Adult is seen as testing the therapist's interpretations against reality. I would suggest that deconfusion addresses both the Child and Parent ego states, which are linked as a unit.

I would like to consider here my use of the term *interpretation.* I am aware that some relational authors have moved away from and object to the use of this term because to them it connotes an authoritative therapist giving an objective interpretation to the passive client (Aron, 1996, p. 93). I

believe what they have moved away from is the therapist's more cognitive, one-person understanding of the client's unconscious processes. I agree with Aron, who stressed the positive use of interpretation by emphasizing "the individual's unique, personal expressiveness" (p. 94). The interpretation is "a creative expression of his or her conception of some aspect of the patient" (p. 94). I view an interpretation as a bidirectional communication. It is an attempt to make meaning and to symbolize the current experience of the transference-countertransference matrix. This includes the possibility of an interpretation by the client (Hoffman, 1983).

Interpretations are offered as the therapist's experience and understanding of the way the therapist and client are relating. It addresses how they are interacting with each other, the roles in which they are cast, and the feelings, fantasies, and associations they have about each other. In this process, the therapist supports the client in discovering the subject-subject relationship while also understanding the subject-object relationship (Benjamin, 1990). The task in offering an interpretation is to verbalize a description and clarification of what the client and therapist are experiencing in the present moment. Because it is undertaken in the here and now, it is likely to be emotionally charged and therefore facilitate an intersubjective process. The overall goal of an interpretation is to facilitate integration and differentiation.

Aron (1996) described an "interpretation as a mutual, intersubjective, affective, and interactive process" (p. 118). He also wrote that an interpretation connects the therapist and client, "linking them in a meeting of minds" (p. 121). D. N. Stern (2004), on the other hand, took another perspective. He suggested that when an interpretation is used, "implicit processes are still called into play. In fact, they facilitate the effect of the interpretation. The implicit and explicit are deeply interwoven" (p. 188). He suggested that a moment of meeting can occur as a result of the therapist's letting the client know that "he or she has understood the affective impact of the interpretation" (p. 189). As with the impact of enactment, the therapist needs to monitor the impact of an interpretation, and to be mindful of the dangers of explaining when interpreting, which may result in closing down an intersubjective experience rather than opening it up.

Although at times some of what I have described here sounds more like a one- or one-and-a-half-person psychology and at other times like a two-person psychology (Stark, 1999), I see the latter position as a holding frame in which the work occurs. In Stark's conceptualization, Model 3 (the two-person psychology) emphasizes engagement and relationship. In it, interpretations "direct the patient's attention to her relational dynamics—that is, those aspects of her internal dynamics that she actually plays out (enacts) in her relationships" (p. 24), in particular within the therapeutic dyad.

From this perspective, interpretations are emotionally charged experiences in which the cognitive element is only part of the process. The emotional element and tone, in addition to the meaning making and understanding, are significant. Further, the mechanisms that support transformation are not limited to interpretation and include other experiences that are transformative, though not explicit, as described by the Boston Change Process Study Group (2010) as *noninterpretive mechanisms*.

Conclusion

From an integrated relational transactional analysis perspective, I have described how the mind develops from various relational experiences and is constructed of numerous relational schemas. Psychopathology is seen as consisting of various Child-Parent ego state relational units, which in more severe cases constitute characterological structures. The goal of treatment from this perspective consists of identifying the ego state relational units, particularly as they manifest with the therapist, and the desired outcome is the modification and integration of these maladaptive schemas into Adult ego state functioning.

What I have attempted to do in this article is to examine early psychological development, highlighting the pathology that results in ego state relational units that emerge out of trauma and

developmental deficit. In addition, I have commented on what I consider to be the process of therapeutic action when working with the unconscious processes of the transference-countertransference matrix. I have also discussed how the client's new experience emerges out of old, familiar ways of relating.

This article represents a further integration of a relational approach with transactional analysis. Challenges remain to developing these ideas, which I hope future authors will take up.

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