We are all relational, but are some more relational than others?
- completing the paradigm shift towards relationality

by Michael Soth

A Discussant Paper in response to: Ray Little: ‘The New Emerges out of the Old’

Building on Ray Little's integration of humanistic TA with both traditional and relational psychoanalysis, this paper explores both shared ideas and assumptions as well as reflecting critically from the vantage point of a wider broad-spectrum integrative perspective, with an emphasis on TA's sister tradition of Body Psychotherapy.

The problems, inconsistencies and contradictions within the integrative project are discussed, with particular reference to our humanistic origins during the 1960's and their – partially reactive - differentiation against psychoanalysis, which leaves us with unresolved legacies in the form of fixed assumptions regarding both theory and practice, and key concepts like 'ego' and 'working alliance'. Taking the key notion of the therapist's "equidistant position" between the "needed" and the "repeated" relationship as its starting point, this paper works towards 'enactment' as the central notion of relationality. In the process, a multiplicity of diverse therapeutic kinds of relatedness is affirmed as valid, and different notions of the 'relational' and inconsistencies and ambivalences in our integrative formulations are addressed. The aim is a more solid and robust integration which is grounded in a bodymind understanding of enactment as the paradoxical essence of therapeutic action.

Introduction

Ray Little has been doing an urgent, significant and sterling job, bringing together TA and psychoanalysis (especially its relational branch). His grasp of the two traditions, their historical roots, their respective meta-psychologies and their – in some respects: contradictory - paradigms allows him to fashion an attempt at integration that combines the best of both worlds and that is larger than the sum of its parts. This work constitutes a quantum leap and is taking TA a long way from its origins in the 1960s towards the 21st century.

Integrated or integrative?

I think calling it an 'integrated' - rather than 'integrative' - relational model is claiming too much. This is still a work in progress, reaching towards integration, rather than having arrived, as Little himself indicates:

“This article represents a stepping stone towards a further integration of a relational approach with TA and there remains a challenge for further development.”

Apart from some distinct areas of dis-integration (or lack of integration) which I will try to discuss as issues for further exploration and discourse, to me 'integrated' would require more than bridging the humanistic-psychodynamic divide (which is indeed a crucial step in the integrative project).

It would also need to imply a significantly wider range of approaches from across the therapeutic spectrum coming to the ‘integrated’ party.

Considering that psychotherapy integration has now more than 20 years of history in this country as a distinct branch of the field, we can draw on its findings in terms of different avenues towards integration. Any model that calls itself ‘integrated’ would need to build on a comprehensive foundation that includes not only all the approaches, but also all relational modalities (building on Clarkson 1994).

As a discussant, I would like to take the opportunity to brainstorm and outline some of these challenges - which Little alludes to - for the further development of relational TA towards a formulation that might eventually be called ‘integrated’. My understanding of Little’s integrative endeavours is supported by an awareness that very similar developments have occurred in TA’s humanistic ‘sister traditions’, e.g. Body Psychotherapy and Gestalt. But my perspective is also informed by other approaches (e.g. existentialist or post- Jungian) which are more outside our shared humanistic heritage and would be more critical of some of our taken-for-granted assumptions.
The legacies we inherit from the 1960’s

Having been involved in similar struggles within the tradition of Body Psychotherapy – and yes: struggles they are - I recognise the growing pains and maturational challenges that need to be confronted by many of the humanistic approaches in ‘coming of age’ (see my 2005 paper in Therapy Today, or my chapter in Hartley 2008).

We tend to underestimate the historical legacies we inherit as communities of practitioners - in terms of practice, theory and subcultural norms and principles (not to say: ‘credos’) - from the originators of our approach and their times (Berne in the case of TA, Reich in Body Psychotherapy or Perls in Gestalt, etc). They each struggled and defined themselves as distinct from their psychoanalytic teachers, therapists, mentors and elders, and in the process established precious new insights and ways of working, which we are benefiting from. Because these were not just theoretical or philosophical divergences, but very deeply-felt and personal struggles, loaded with intergenerational transferece and countertransference entanglements, our humanistic traditions also inherit an atmosphere of reactive protest, of anti-authoritarian rebellion which characterises our origins. Berne, Reich, Perls and others reacted against out-dated principles and wanted to liberate humanistic creativity and human potential, but in the process often jumped from one extreme into the other. Their frequently dogmatic anti-positions are as absolutising and categorical as the psychoanalytic orthodoxy they were trying to overcome and get beyond.

To this day, the humanistic field suffers from this reactive bias, and whilst in many ways some serious ‘growing up’ has taken place over the last 30 years, we will not become fully mature unless we become aware of and work through these wounds of our origins.

We can draw instructive parallels here between our model of individual development, and the life story of our therapeutic traditions. As in the psychology of the individual, our early development has left both unhealed injuries and scars which are denied, dissociated and compensated for. These wounds at the root of our traditions have generated defensive reaction formations and compensations, manifesting as theoretical dogmatisms and fixed assumptions, lending each community of practitioners its particular ‘character’ (and I mean character in the Reichian sense, as a script-based protective mechanism, rationalised and with fixed perceptions, beliefs and behaviours).

In a nutshell, as therapists we inherit the wounds of our family ancestors, the wounds of our cultural and sub-cultural forefathers and –mothers and also the wounds of our therapeutic ancestors.

We could think of Eric and Wilhelm as our fathers, whose unresolved struggles against grandfather Sigmund leave us caught in a stance of protesting and polarising against Freud, who is nevertheless active as an introjected internal object in the psyche of the TA, Gestalt and Body Psychotherapy communities, and the humanistic movement in general.

Their unresolved conflicts manifest as gaps, contradictions and lacunae in our theory, language, meta-psychology as well as in our practice. Moving towards an integrated position significantly involves addressing those reactions, wounds and conflicts, getting beyond defensive, dogmatic and polarising stances, and establishing a third position that both transcends and includes both polarities.

This is work which I have attempted to do within the Body Psychotherapy tradition, by reflecting on the developmental steps we went through over the last 30 years (Soth 2005, 2008), and which I see being carried within TA by Cornell, Erskine (2007, 2009) and clearly being spear-headed also by Little in this paper.

A growing consensus: the developmental origins of relational patterns

The sections of Little’s paper on psychological development, psychopathology and characterological structures represent, as far as I can see, a growing consensus across various developmental approaches, supported by neuroscience and infant research. Although the traditions use different terms and language, there is a large overlap in theoretical understanding as to how “intolerable experiences” in early development are internalised and become the internal blueprint through which later relationships are perceived, interpreted and shaped.

“how the mind develops from various relational experiences and is constructed of numerous relational schemata.”

Implicitly integrating one of the core concepts of the Body Psychotherapy tradition, i.e. "characterological structures and defences” (as initially described by Reich and developed into an integrative theory by Stephen Johnson), Little brings together a range of humanistic and psychoanalytic ideas concerning the developmental and etiological origins of what we are dealing with in therapy. His formulations are rooted in TA concepts, but draw in and circumscribe a depth-psychological consensus across a number of otherwise divergent traditions as to how a person’s ‘primary scenario’ (the emotionally significant forces in the child’s early environment) continues to shape their identity and being-in-the-world.
Object relations theory forms an important bridge here between diverse traditions, that helps us integrate TA, Reichian character structures, aspects of integrative Gestalt and various branches of psychoanalysis (British independent tradition, Kernberg as well as relational psychoanalysis), as it informs our perception and conceptualisation of the processes of introjection and internalisation which are essential ingredients in any relational model of developmental injury. All these approaches recognise that what gets introjected by the child are not just certain ‘traits’ or particular feelings, but a whole relational dynamic with all its significant relational poles, figures and attendant web of implicit and explicit messages. This focus on systemic-relational dynamics (rather than supposedly individual minds – see Atwood/Stolorow’s (1994) critique of the classical psychoanalytic position) is a key feature, and a perceptive capacity, which unites the disparate factions of the relational movement. I have suggested elsewhere (Soth in Totton 2005) that we might conceptualise this key understanding in terms of parallel process, which can then tie together (see Fig. 1):

1. the originally wounding relationship between parents and child which …
2. gets internalised as an object relationship in the clients inner world of character, with the …
3. re-externalisation of that internal(ised) dynamic in adult relationships, including the transference. This in turn engenders parallel processes in the therapist’s countertransference (in the way that Little describes transference and countertransference as “two interlocking components”), which then become replicated in supervision as the kind of parallel process which is a well-established concept (Hawkins/Shohet 2012).

Fig. 1: The Three Parallel Relationships: Past - Internal - Present

This graphic summarises some shared underlying assumptions of psychoanalytic traditions (especially object relations, eg Otto Kernberg), developmental and attachment theory, neo-Reichian Body Psychotherapy, Transactional Analysis and Character Styles (Stephen Johnson):
- how the originally wounding relationship becomes internalised and re-externalised in the here & now of the transference
- describing the client’s internal conflict as a relationship pattern
- describing transference and countertransference as parallel process
This formulation covers the same ground and describes the same phenomena as Little, and shows just how much overlap there is in our understanding: the same relational dynamic is recognised as running throughout the whole sequence of relational dominoes (past wounding relationship -> internalisation -> internal relationships -> transference -> countertransference -> supervision) and shapes and constructs the themes and vicissitudes of these interconnected systems of relationships.

A couple of specific points may serve to illustrate how far this consensus goes: "Although we internalise 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 internalisations are un-integrated and result in a closed script system, located in unconscious, implicit memory, forming the foundation for characterological structure and defences." Like Little, I usually insist to reserve the term ‘internalisation’ only for those wounding experiences which were intolerable (and which therefore lead to what in Body Psychotherapy we call ‘character formation’). I agree with Little that supposed internalisations of good objects become part of the child’s ‘functioning from an open system’ and are not experienced as alien and dissociated in the same way that ‘bad objects’ are.

“What Moiso does not describe is the possibility that C1 or C2 may be projected onto the therapist. This occurs when the client is attempting to find identification with the therapist.”

Like Little, along with most modern psychoanalysis, I consider the projection of C1 and C2 onto the therapist, and the therapist’s projective identification with these projections, a crucial feature of the countertransference (and one that many humanistic therapists overlook in working with the transference, with disturbing and destructive effects on the working alliance, something I come across frequently in supervision). Although I find Little’s clarification “This occurs when the client is attempting to find identification with the therapist.” dubious and misleading (as it fails to differentiate which part of the client is making that attempt, and significantly omits the equally strong impulse to evacuate unwanted and unbearable experience), this misgiving regarding the supposed aim and origin of the projective process is minor. What matters in practice is that as therapists we can enquire into our countertransference experience with this possibility in mind.

So we can say in summary that at least the developmental origins of our clients’ suffering (and, of course, our own) - which is directly relevant to how we perceive, understand and engage the client’s presenting problem - is an area that many of us from different traditions can agree on.

**Shared relational assumptions across humanistic and psychoanalytic traditions**

It is satisfying to recognise that our shared understanding – although largely developed in parallel rather than through mutual influence and direct cross-fertilisation - goes beyond this. Especially between those factions of the various approaches which call themselves ‘relational’ there is a growing cross-modality consensus about the philosophical underpinnings and the intersubjective complications of the therapeutic endeavour.

The shift into a two-person meta-psychology, although ambiguous and pervaded by confusions and misunderstandings, has brought humanistic and psychoanalytic traditions into closer contact and dialogue, leading to all kinds of creative integrative initiatives and hybrid approaches. Still, what we actually mean by ‘relational’ and how the various traditions seem to appropriate the term, often without questioning their own inherited assumptions and how these are challenged by quite different versions of the ‘relational’ in other modalities, means that the potential paradigm shift is far from complete. In this maelstrom of integrative confusion regarding the ‘relational’ (‘tower of Babylon’ comes to mind), Little is managing to put down some important markers. Whilst I have some misgivings regarding the language and terminology (which I will say more about later), the substance of these ideas is precious to me. I am thinking here of the distinctions which Little makes between the repeated, the needed and the therapeutically required relationship, and especially the notion that therapeutic action relies on the therapist’s capacity for what he calls – following Davies and Frawley (1994) – “optimal neutrality”.

“... Davies and Frawley (1994) includes “the capacity to strike an optimal balance between reworking the old and co-creating the new.” I prefer the other formulation of what I consider this paper’s key idea for therapeutic action which describes the therapist’s position as “equidistant”: “Involves not being invested in one relationship over the other. Instead, the therapist must be willing to remain equidistant from both.”

It is my perception that it is on this point that - over the last 30 years - humanistic attempts at integrating psychoanalysis and work with the transference have largely fallen down. Under the guise of being the client’s ally or being ‘alongside’ the client (see Gomez 2004) (which usually rests on
a semi-conscious identification with the client’s wound), humanistic practitioners on the whole have had no trouble perceiving and identifying the transference process in the room, but have implicitly championed the reparative modality, being unable to sustain the heat of the transference arising from sticking with what Gomez calls the ‘opposite’ position. In thus dodging the uncomfortable experience of being perceived, related to and sometimes accused as the ‘bad’ or ‘wounding’ object, the full experience of enactment has been sidestepped, and the transformative potential of the constellated transference/countertransference process aborted. I agree with Little that in this case - by losing the equidistant position (or never taking it in the first place, often because they themselves never had it modelled as a reference point) - therapists inadvertently deprive the therapeutic space of the key ingredient that – according to Little – makes therapy ‘work’. The client misses out on the depths of therapeutic action, which - in the good case - leads to superficial, unsatisfying and unsustainable therapeutic shortcuts, or - in the bad case - to a disappointing breakdown or bland petering out of the therapy.

As this sounds very categorical, we may want to soften this statement by specifying what we mean by therapy ‘works’: the notion of therapy implicit in this statement is work in the realm of the characterological foundations of human suffering - there are other realms in which other kinds of therapy may be seen to work, through different modes of therapeutic action.

But with this specification in mind, I can wholeheartedly agree that in formulating the notion of the equidistant position, Little names a key feature of relational work: the transformative capacity of the therapeutic container or frame as an ‘alchemical vessel’ depends on the therapist’s capacity to ‘allow themselves to be constructed as an object by the client’s unconscious’, and that needs to include all kinds of ‘objects’, including ‘bad, ‘idealised’ and ‘transformative’ ones. The therapist’s capacity to do this is limited and hampered by what I am used to calling their ‘habitual position’ (Soth 2007a) which determines and circumscribes the kind of relational and therapeutic space which the therapist is capable of offering. As the therapist’s implicit relational stance it is informed by an amalgamation, as I indicated earlier, of their inherited wounds through family and cultural ancestors, but importantly also their therapeutic ancestors, manifesting across all levels of their being, from the somatic and physiological through the emotional and mental to the social as well as the theoretical and meta-psychological implications of their chosen therapeutic tradition.

**The ‘characterological’ wounds of TA**

This is where the differences between our traditions allow us a helpful outside perspective on the ‘character’ and habitual stance of other traditions, including their shadow aspects, taken-for-granted assumptions and wounds, and where we might imagine a kind of mutual, dialogical therapy between the approaches. In simple terms, we might imagine Berne and Reich being in therapy with each other (and with Freud, etc), and what kind of profound encounters, unmanageable impulses, creative confrontations, enlightening and paradigm-shifting transformations they might be able to facilitate in and with each other.

So what kind of countertransferential perceptions might Reich, or a modern Body Psychotherapist, have of TA and its ‘character’ as a community of practitioners?

**The language and style of mid-20th century America**

In the first instance, and on the most superficial level, I find myself reacting against some of the language: I stumble across certain terms and their connotations. In most cases, these are probably linguistic relics which, on closer inspection, are probably not understood the way they sound to me, as a cognitive and discursive style reminiscent of the 1950's and 1960's, i.e. when our humanistic forefathers, including Berne, were beginning to formulate their critique of psychoanalysis.

For example, although I understand and agree with what the term is pointing to, I find it hard to use words like 'adaptive' without flinching. Whether used in an evolutionary or social sense, it is used to supposedly indicate psychological health. But what are we meant to be adapting to? Hasn’t there been a comprehensive postmodern (feminist, existential, sociological) critique of the normative and conformity-enforcing dangers of psychotherapy, i.e. as - in simple terms - oriented towards adjusting healthy protest and supposedly dysfunctional abnormalities to the moral majority of a sick society, by labelling them as ‘mal-adaptive’?

Even a term like ‘optimal neutrality’, in itself a supposed improvement on ‘technical neutrality’, is loaded with connotations of implicit medical model thinking. This kind of language flies in the face of the sensibilities of a diverse range of other psychological modalities and perspectives (e.g. existentialists, Gestalt, and elders like Laing and Hillman). And the irony is, of course, that it even grates on some essential relational sensibilities, with its opposition to classical psychoanalytic neutrality, modernist 19th-century ‘medical model’ assumptions and an emphasis on non-neutral subjectivity and intersubjectivity.
As I will address in more detail later, we could argue that the essence of enactment is precisely that every semblance of therapeutic neutrality, intentionality, ‘optimal anything’ gets lost, subsumed and overwhelmed by apparently counter-therapeutic unconscious processes, and that that loss is not only inevitable, but positively necessary to therapeutic action. Little refers to this quite clearly, in quoting Mann (2009):

“Neither is conscious of what is really going on at the time. They are both caught in archaic primitive unconscious processes that cannot be known beforehand, they can only be known after the event has occurred.”

So if any traditional semblance of therapeutic position has to get lost in enactment, why re-institute a language that is steeped in traditions and meta-psychologies which were incapable of embracing, and - as we can see with hindsight: actively defensive against - enactment?

Don’t get me wrong: although the language does superficially put me off, it does not by any means stop me from seeing through to the experiential substance, the intended meaning and the validity of the ideas it is pointing to. But then, these linguistic niggles draw my attention to deeper misgivings which arise in relation to some of the fundamental concepts and models, and especially the meta-psychological paradigms which underpin them.

The ‘American Dream’ at the root of the humanistic movement

In a nutshell (these are, of course, huge over-generalisations of a much more complex and varied picture, which I hope you will forgive me for the sake of clearly establishing some tendencies): although the humanistic movement had a strong emphasis on anti-establishment social and collective values, especially in the US it did not entirely escape the American dream of the ‘self-made man’, with its inherent bias towards individualist agency and fulfilment. Resting upon the foundations of underlying imperialism and conformism, and wider pre-feminist patriarchal assumptions still dominant in the mid-20th century (rationalism, mind-over-body dualism, technocratic pragmatism, progress through ‘growthism’) it took only two decades or so to lead to the excesses of consumerist narcissism (‘Boomeritis’, see Wilber 2003), partly fuelled by the self-centred shadow aspects of humanistic ‘self-actualization’.

I have summarised the shadow aspects of the early humanistic movement elsewhere (Soth 2007b):

“One of the inherent contradictions of the humanistic revolution is its emphasis on groups and the collective, whilst also championing individual freedom over and against social constraints. As necessary and liberating as both of those elements were, arguably the underlying tensions were not fully resolved, and therefore humanistic […] practice remains influenced by that unresolved dichotomy, as well as pervaded by a reactive bias against authority and any kind of hierarchy (see Bly, 1996). This – I suggest – is reflected in unworked-through attitudes towards three key issues […]: (1) the conflict between individual versus collective perspectives; (2) the tension between power differential versus equality; and (3) the dialectic between structure versus unstructured space.

Any [integrative] formulation […] would therefore need to resolve, or at least address, these inherent dichotomies to the point where both the productive and the defensive aspects of each of the polarities can be appreciated.”

The therapist as ‘doctor’ – disavowed and hidden ‘medical model’ assumptions

The birth of the humanistic movement was focussed in the US and is, therefore, pervaded by its zeitgeist and cultural environment at the time. Alongside an over-emphasis on individualist agency, autonomy, control and power-over and corresponding notions of the mind and psyche (cognitive, rational, focussed, abstract), the cultural bias also included a traditional tendency of both psychoanalysis and psychotherapy in the US to be less precious than its counterpart in the Old Continent about the ‘medical model’.

Therapists in the US have been quite pragmatic about therapy as ‘treatment’ (see the US version of the Israeli TV series renamed “In Treatment”) and used to have less qualms than we Europeans did about referring patients elsewhere without much concern about the attachment. This is precisely one of the issues which the relational movement is having an impact on, but as a lingering historical influence it can still be traced.

There is no space here to discuss how I perceive humanistic practice as pervaded by hidden and disavowed ‘medical model’ assumptions which are profoundly at odds with our explicit humanistic philosophy, values and principles. I have addressed this issue repeatedly (Soth 2008a, 2008b), and have come to a paradoxical position which neither excludes nor entirely subscribes to the ‘medical model’ in therapy, but does validate it as one of the relational modalities (in addition to Clarkson’s (1994) five modalities of the therapeutic relationship).
The therapist as ‘educator’?
If we question the notion of the therapist as doctor, a similar discussion is necessary regarding therapy as education, something which traditionally TA is quite keen on and which the zeitgeist of the early humanistic movement would have unquestioningly supported. But both psychoanalytic and relational sensibilities alert us to the profound dilemmas and double messages which the therapist as educator not only invites, but may actively and unwittingly set up.

In the same way that Berne saw scripts as palimpsests - later layers upon earlier writing – in what follows I will try to trace some of these earlier issues shining through Ray Little’s paper.

**TA’s humanistic belief in autonomy**

In the 1960’s, the taken-for-granted aim of healthy psychological development was autonomy (rather than interdependence, as some of us relationalists might venture today), and approaches as diverse as ego psychology and TA over-emphasised that key characteristic of the American dream. Maybe I am mis-reading this, but some flavour that independence is considered the healthy norm, and everything else is inferior, if not pathological, comes across, for example, here:

“Psychopathology can be seen therefore as manifesting in the persistence of early modes of relating, consisting of defensive relational schemas. This entails clinging to early self-other schemata which may result in a conflict between a desire to merge on the one hand and strivings for autonomy and separateness on the other.”

This is conflating two separate issues: the a) the static inertia and imperviousness to change of relational schemas with b) developmental conflicts between merging and differentiation.

Some developmentalists would prefer to see that conflict between merger versus separateness as relevant across the lifespan at all developmental stages and all levels of maturity. That conception then obviates the pejorative connotation of ‘clinging’.

But more importantly we could ask: who - in this formulation - is doing the clinging (i.e. which ego state, internal object or relational unit)? The educated guess is that the formulation implies a ‘childish’ fixation, but in that case ‘clinging’ is the self-schema, and does not inhere in any agency separate from the self-schema that might be able to operate upon it. But the consequent application of the theory of relational units would not allow us to locate the ‘clinging’ in the Child only, but as interactively co-created within the child-mother dyad. We might, therefore, include the ‘clinging’ as also belonging to the other pole of the relational unit, which may, for example, appear to manifest in the Child only via the mother evacuating it into the Child.

Over-emphasising the ego’s capacities and degree of agency?

The bias towards independence and autonomy can be seen as only a special instance of a deeper problem: our conception of the ego, its role and power within the psyche, its capacities and functions and its relation to non-ego processes (unconscious, somatic, involuntary, spontaneous).

As there is an ingrained habit in our culture (and throughout the therapeutic field) of oversimplifying the mind-body relationship, by equating consciousness and voluntary agency with the mind on the one hand and spontaneity and involuntary feelings and behaviours with the body on the other, it is important to note that spontaneous processes occur all over the bodymind spectrum, and not just in the somatic sphere. There are any number of involuntary mental spontaneous processes, like images, dreams and obsessive thoughts.

Internal objects – and the relational units they constitute – are whole bodymind processes, i.e. flesh-and-blood realities, not merely mental representations or cognitive scripts. Internal objects manifest across the whole bodymind spectrum, as neuro-bio-psycho-social ‘holons’ (Wilber 2000) with gestures, feelings and corresponding thoughts and identities.

What we have traditionally subsumed under the notion of ‘ego’ is not a separate entity in a supposed meta-position to the supposed inner world or ‘Id’, but a cognitive fantasy which combines disparate conflicted fragments across the characterological bodymind matrix. TA’s notion of the integrated ‘Adult’ ego-state suffers from Freud’s underlying reification of the ‘Ego’ in his structural theory, which obscures the view of ego as process (and significantly as a conflicted process of split, dissociated and opposing ‘sub-egos’). The equivalent is true for the Child ego-state, which confusingly gets conflated with the body and spontaneity, as Cornell (2008) has pointed out.

Neuroscience has increasingly de-constructed the supposedly dominant position that the 20th century still has attributed to cognitive processes, the mind, the ego. When we consequently follow through neuroscience ideas regarding implicit relational knowing, right-brain-to-right-brain attunement, non-verbal communication and implicit memory, then some cherished assumptions of traditional psychotherapy need to be questioned, and may not be saved into the 21st century. I am thinking here about traditional notions and understandings, for example, of the ‘working alliance’, ‘containment’, ‘working-through’, which all were formulated originally and still retain their traditional bias towards the ‘ego’.
Traditionally, the working alliance was considered to be occurring between the two healthy parts of the two egos (or Adult ego-states) via an explicit contract, and suffused with implicit ‘medical model’ attitudes regarding the therapist’s ego and its stance and influence in therapeutic strategy, interventions and interpretations. These notions inform our assumptions about the role of both the client’s and the therapist’s reflective mind in recovering from enactments (by naming, negotiating and making meaning out of the unconscious entanglement). Whilst this recovery from enactments is understood as much more than a cognitive process, in practice there remains a conceptual vacuum as to what therapeutic responses might actually go beyond client and therapist exchanging their respective narratives of the enactment by ‘talking about it’.

I’m also thinking about explanations and other educational methods which are quite widely used and favoured throughout TA as a fairly habitual stance, apparently without much recognition as to why psychoanalysis usually takes a very dim view of such interventions.

But I have saved to the last the most controversial question which arises out of these challenges to the notion of ego and its postmodern de-throning and de-construction:

Time to question the concept of ‘ego-states’?

“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.”

Why continue to use the term ‘ego’ for an experience which both subjectively and objectively is far from a sense of ‘I’ or self? Why stretch the term beyond all recognition, beyond its original meaning, almost into its opposite meaning? Why not use new, more fitting terms, and leave the old terms to accurately refer to their respective realm of experience, which we have now grown beyond and therefore understand as partial? Most ‘ego-states’ are not conscious, the person is not (consciously) identified with the state or aware of it, nor has any sense of agency in relation to the state (it’s more like a being possessed). Significant aspects of ‘ego-states’ operate from and within implicit memory, and are communicated and perceived subliminally, i.e. in any conventional understanding or definition, ego does not come into it. Thus it could be argued that the idea of ‘ego-state’ poses a conceptual glass ceiling on grasping the non-ego embodied nature of the state we are trying to describe – the more we follow the actual phenomenology of the ‘state’, within and beyond the internalised parent we find the grandparents and family ancestors, i.e. aspects of experience far beyond the ego.

When we amalgamate ‘ego-states’ with Kernberg’s object relational units (as Little does), it becomes more apparent that we have a term that includes both ego, pre-ego and non-ego aspects; more importantly, in the light of the neuroscience that Little does draw on, we might even stretch beyond Kernberg’s notions to grasp relational units as bodymind processes, that cut across and manifest across neurological, physiological, somatic, emotional and mental functions, all of which have conscious and unconscious aspects to them, and all of which have ego, pre-ego and non-ego aspects.

It is one of the strengths of character theory as developed by Reich, that from the beginning it was what we would call today a holistic-systemic (or maybe ‘integral’) approach to the bodymind, in which the ego and ego capacities were understood as (merely) functions or consequences of the underlying character, which allows or limits and pre-structures all ego-activity. Inevitably, the more we make ego our central explanatory focus, the more we tend to get caught in a bias towards the mind and verbal-cognitive-reflective functioning. I perceive an equivalent development in the psychoanalytic field: the more Fairbairn shifted his focus towards the split ego (libidinal versus anti-libidinal), the more he actually lost connection with libido, instinct and the body.

Integrating the recent insights of neuroscience, we find that the role and the significance of anything we might call ‘ego’ shrinks, as the importance of the body and non-ego processes is increasingly recognised, in the individual, in relationship and in therapy.

It needs to be said that many writers throughout TA (Cornell, Erskine and others) have tried to extend the meaning of key TA concepts, trying to make them more holistic, less cognitive-biased, more inclusive of early development and of pre- and non-verbal experience. I am not trying to minimise their efforts, but I am posing the question: is it useful to continue stretching a framework – both conceptual and linguistic – that in many ways belongs to a different historical period? Its fundamental assumptions and its terminology may now so be at odds with current relational theory and practice that it is increasingly becoming counterproductive.

I have picked out three examples – autonomy, ego and ego-states, but more would be possible to make the general point that a new conceptualisation and language may become necessary.
The dangers of attempts at integration

In the section above I have summarised what I perceive to be some of the wounds, shadow aspects and relics from the origins of TA in the 1960s, which are liable to hamper the kind of integrative project Little is formulating. To some extent, these issues come across to me as inherent inconsistencies between TA as it has been handed down to us on the one hand and the principles of traditional psychoanalysis plus the new perspectives emerging from neuroscience and relationality on the other.

I perceive inherent paradigm clashes and contradictions, which - if not explicitly acknowledged, addressed and resolved - typically lead therapists into oscillating between contradictory principles, thus unwittingly giving double messages to their clients. As a consequence, the client’s overall experience of integrative therapy may become less rather than more containing, as the therapist may be perceived as fickle and vacillating rather than flexible, evoking parallels with insecure parenting. This is precisely the problem which Gomez (2004) warned about: that an attempt at integration might create relational disturbances and disadvantages which limit the unquestionable benefits of the larger, more integrative frame.

What is ‘relational’?

So the question is: is there a way in which a relational perspective can bring these contradictory principles together, and do justice to the precious gifts of each approach without minimising the contradictions between them?

As I try to show later in my concluding remarks, I believe there is, but it depends upon whether we can transcend the current confusion between the multiple competing meanings which different approaches claim for the term ‘relational’. In my view Little is crystallizing the key features of the ‘relational’ as a qualitatively new set of ideas, awareness, skills and attitudes, whereas many people seem to be appropriating the buzzword ‘relational’ for what they have always been doing within their established way of working, thus reducing Clarkson’s (1994) multiple relational modalities to their own taken-for-granted singular version.

Thus, it is not uncommon for therapists who, for example, appear to be working almost exclusively within a reparative mode to be claiming they are ‘relational’ on the basis that their form of relating, i.e. providing the ‘needed’ relationship in Little’s terms, is highly sensitive, attuned and therapeutic. This kind of claim, seen in the light of Clarkson’s seminal insights from the early 1990’s, is of course entirely valid. The only problem is that it is very partial and one-dimensional, and so inherently too dogmatic.

As a first step beyond such partial definitions of the ‘relational’, we therefore need to re-affirm Clarkson’s insight: diverse - and therefore partly contradictory – modalities of therapeutic relating co-exist within the field, and each and all have their necessary place and situational validity. Rather than attempting to integrate different therapeutic theories and techniques, the focus shifts radically towards an integration of different kinds of therapeutic relatedness which need to be understood and used - on their own terms - as both antagonistic and complementary to others. But beyond this appreciation of the different relational modalities - in their overlaps with each other and the tensions between them – the significance of Little’s contribution is that he establishes a second step which helps us define the essence of the ‘relational’ in a way that I recognise and resonate with: by stipulating the optimal therapeutic position as equidistant between the ‘needed’ and the ‘repeated relationship’, he affirms that the enactment of the ‘wounding relationship’ in therapy is not only unavoidable, but necessary to therapeutic action. I take this to be a crucial insight which constitutes a paradigm shift in terms of our understanding of relationality.

The three relational revolutions

I find it helpful to think about the last 100 years of psychoanalysis/psychotherapy in terms of three relational revolutions (see Fig. 2):

1905: Freud reframes transference from an obstacle to the treatment into the ‘royal road’ into the unconscious

1950’s: the countertransference revolution (Heimann, Racker, Searles) reframes countertransference from the therapist’s pathology into another ‘royal road’

1995 onwards: enactment revolution
Enactment as the central notion of relationality

I have suggested elsewhere (Soth 2008) that the notion of enactment offers an avenue into a paradigm shift towards a paradoxical therapeutic position which can indeed embrace contradictory theories and models, precisely because it is no longer theory-led, but relationally aware of the defensive and counter-therapeutic dangers of theory. From this position we understand that all therapeutic theories and techniques - however appropriately and sensitively the therapist may use them and however well-intentioned the therapist may be in using them - can become vehicles of enactment.

Rather than imagining therapeutic action to inhere in the supposed ‘correct’ use of theory or technique, relationality attends to how the therapeutic space and the client-therapist interaction within it replicate the client’s wounding. Both the therapist’s being and doing, their therapeutic understanding and interventions, may be received by the client’s unconscious as an enactment (i.e. the “repeated” relationship).

So the paradox at the heart of therapeutic action, in my view, hinges around the notion of enactment (Soth, 2008): “the therapeutic healing of the ‘wounding’ is inseparable from the enactment of the ‘wounding’ in and via therapy.” Therapy works – i.e. transformation in therapy occurs – via enactment and its containment.

A similar recognition is implicit in Little’s formulation of the therapist equidistant position between the needed and the repeated relationship, to create the space for the ‘required’ relationship.

The paradigm shift towards enactment

Whilst the likelihood – and historically later: the inevitability - of ‘countertransference enactments’ (or what used to be called ‘acting-in’ on the part of the therapist) has been recognised within psychoanalysis for some decades, this was always considered a danger to be avoided, precisely because it was correctly intuited as counter-therapeutic. However, that enactment is necessary for therapeutic action, i.e. essential to the way therapy does its work, and that therapeutic transformation paradoxically relies on the apparently counter-therapeutic nature of enactment, is a significant quantum leap beyond these long-standing psychoanalytic recognitions.
In my view, therefore, the success of the integrative-relational project — whether in TA as proposed by Little, or in other approaches — depends decisively on our capacity to take the notion of enactment far enough, towards that paradoxical position which then becomes the relational knife edge that constitutes the secure base of the impossible profession.

The relational movement, as it has haphazardly coalesced over the last 20 years, does not approach this central paradox in any agreed or coherent fashion. In order to clarify this ambiguous territory, we can ask the question:

Is the notion of 'enactment' an extension of a transference-countertransference perspective, or does it constitute a paradigm shift?

“Many contemporary theorists believe that the outcome of therapy is related to the successful elaboration and re-evaluation of patterns of relating that become accessible through the analysis of the transference-countertransference matrix (Sandler & Sandler, 1997; Lemma, 2003).”

But one can subscribe to this statement, and beyond it to the notion of enactment, both from a one-and-a-half as well as from a two-person psychology, and Little acknowledges this fuzziness which Stark herself is confused about:

“Although at times some of what I describe sounds more like a one- or one-and-a-half person psychology, at other times a two-person psychology (Stark, 1999), I see the two-person position as a holding frame in which the work occurs. In Stark’s conceptualisation Model 3 (2 person psychology), which emphasises engagement and relationship, 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 the client’s perspective, ‘enactment’ can remain merely a further elaboration of traditional transference-countertransference notions within a one-and-a-half person psychology. The question that delineates the paradigm shift focuses on the therapist within enactment: to what extent does the therapist go unconscious, lose their therapeutic position, and what degree of that kind of ‘failure’ is acceptable, necessary, inevitable, conducive, productive?

The relational field, as homogenous and agreed as it appears on some important issues (especially in their opposition to classical analysis, drive theory and one-person psychology), falls into distinct camps around this question. When we look at the wide variety of psychoanalytic writers quoted in Little’s paper, (Kernberg, Maroda, Mann, Stolorow, Davies, Aron, Bollas), they would inhabit and advocate profoundly diverse and contradictory positions on this question, and they are far from agreed on this delicate matter.

Ambivalence about the central notion of enactment What we find throughout the relational movement are diverse and contradictory notions of enactment, surrounded by a variety of underlying ambivalences when it comes to surrendering to enactment, embracing the inherent paradox as well as how to recover from enactment. We can refine this fundamental bone of contention in the relational movement into more specific questions:

• To what degree can the therapist sustain loss of their therapeutic position within the enactment dynamic?
• How does the therapist process, handle, reflect upon and engage with their countertransference experience when caught in the enactment?
• How does this translate into therapeutic responses which enable recovery from enactment (or, in attachment language: repair of the rupture)?

I have suggested elsewhere (Soth 2005) that the traditional verbal-reflective bias of the ‘talking therapies’ imposes severe limitations on our capacity for surviving and recovering from enactment. One of the perennial ambivalences around enactment manifests in the reliance on traditional mind-over-body assumptions. If the relational transformation does occur, as Little declares, on the level of implicit unconscious processing, then how does one as a therapist mindfully attend to one’s own implicit unconscious processes?

“This entails working mindfully with unconscious processes through the transference-countertransference matrix aiming to have ‘one foot in and one foot out’.”

I guess we all appreciate the old adage: the problem with the unconscious is that it is unconscious. Now somehow, in practice, we do manage this conundrum as therapists all the time, because the unconscious is not like an on/off electrical switch. But appealing to the therapist’s mindful awareness of the unconscious still boils down to Freud’s ‘making the unconscious conscious’ (or ‘where Id was, there Ego shall be’).

But this still leaves out what from a bodymind and neuroscience perspective may be the most important factors in therapeutic action, which Little also hints at:

“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 interpretations and include other experiences that are transformative, and are not explicit, as described by the Boston Change Process Study Group (BCPSG, 2010) as non-interpretive mechanisms.”
Whilst there is increasing acknowledgement of implicit relational knowing (i.e. pre-reflexive and body-to-body) throughout the therapeutic field - and although relational TA emphasises these non-conscious and unconscious processes - there is in practice an experiential, conceptual and technical dearth when it comes to specifying these “other experiences”, that are “not explicit” and “non-interpretive”.

**Conclusion**

Enactment represents a paradigm shift into a two-person psychology framework to the extent that we can get beyond the reflective bias of the ‘talking therapies’ and into these spontaneous bodymind processes. It is therefore my suggestion that an embodied understanding of enactment from within the enactment - as systemic bodymind parallel processes – profoundly enhances our chances for its transformative containment (Soth 2005, 2008). This would imply that our therapeutic responses would not need to remain limited to reflective, narrative and interpretive techniques.

But extending beyond these traditional pillars of the ‘talking therapies’ requires profound changes across the therapeutic field: in how we process our bodymind experience and countertransference as therapists, how we support ourselves within the therapeutic position, what concepts and terminology we rely upon and ultimately how we train future generations of therapists. As a first step, we need to catch up with the wounds of our diverse traditions and their historical origins, on all levels from underlying paradigms to theory and technique. In this process, we can use the contradictions between the various traditions to challenge each other in their dogmatisms – so an integrative perspective becomes necessary as a second step. The third step then is a thorough re-formulation of our traditional models from a relational two-and-many-people perspective, grounded in 21st-century embodied, integral, systemic, non-linear paradigms. It is my conviction that the paradoxical nature of enactment will be seen to constitute a central foundation of any such formulation.

**References:**

Gomez, L. (2004) Humanistic or psychodynamic - what is the difference and do we have to make a choice? Self & Society Vol. 31 No.6 Feb/Mar 2004
Soth, M. (2004) Integrating humanistic techniques into a transference-countertransference perspective - A Response to ‘Humanistic or psychodynamic - what is the difference and do we have to make a choice?’ by Lavinia Gomez, Self & Society, 32(1), Apr./May 2004, p. 44 – 52