

Acceptance Speech on Receiving the 2007 Eric Berne Memorial Award

Helena Hargaden and Charlotte Sills

Abstract

This article expresses appreciation to those responsible for the 2007 Eric Berne Memorial Award to Helena Hargaden and Charlotte Sills and then goes on to review relational psychotherapy in the context of the wider field, including some of the principles and philosophy of the approach. The features of the original theory are summarized in order to locate the work within the rapidly developing field of relational transactional analysis.

We are honored and delighted to receive the Eric Berne Memorial Award and would like to thank our nominators, Charlotte Daellenbach, Elana Leigh, and Kathi Murphy, who cannot be here in body but are here in spirit. We know they are delighted. And we feel very proud as the first British and, in Helena's case, Irish British recipients of this prestigious award.

We feel specially recognized because this award is essentially for our ideas about three domains of transference. In some ways, of course, there is nothing new about articulating varied types of transference. This is commonplace in psychoanalysis, and within transactional analysis there are some excellent contributions on this subject. As far back as 1985, Carlo Moiso brought to transactional analysis the notion of P_2 and P_1 transferences and their different implications.

What is unusual about our domains is that they provide a model for thinking about and working with different realms of transferential phenomena from a relational perspective. That is why we feel so valued by our nominators—because they saw what is different in our work and recognized its contribution to such an extent that Elana Leigh has remodeled her transactional analysis program in Sydney, Australia, to reflect a relational perspective.

We thank, too, our clients, trainees, and supervisees, who inspired us to develop the relational map. We set out to chart the territory of the clinical work that so many transactional analysts were already doing at psychological depth and to provide a theoretical anchor for psychotherapists. It seemed that many of our trainees felt themselves to be in a mess, having somehow jumped off the edge of classical transactional analysis as a humanistic theory into a realm of relatedness for which they had no theoretical language.

There was certainly an echo for us in their experience. Berne seemed to suggest that the deconfusion stage of psychotherapy required psychoanalysis. But once a therapeutic relationship had begun, it seemed odd to say good-bye to our clients and send them on to a psychoanalyst who lived down the road just as they had begun to express their inarticulate speech of the heart! In response to Jack Dusay's (2007) frustration with "words, words, words, and more words," which seemed to be pointed in the direction of the most recent developments in transactional analysis, we would argue that it is not the words but the "wordlessness" of clients' experience that we wanted to address in our work.

We knew that something mysterious and important was going on in the therapy room. Our clients were experiencing and expressing in relationship with us Child ego states or self-states that were the emergence in the present of confused relationships from the past. This was obviously transference, but it seemed more diverse and more complex than could be adequately described by the blanket condition of transference. For instance, we noticed different types of experiences stirred and evoked a variety of self-states in us as therapists. What was happening that one's feelings could fluctuate so widely with different people? What was the meaning of these sorts of relationships? And

how could we think about this theoretically in a way that would be useful to the therapy? Our collaboration began by us tussling with these questions to try and find a way of exploring de-confusion within transactional analysis.

Our discussions and explorations evolved over the years—at Metanoia Institute where we both work and also many a time around one of our kitchen tables, in cafes, or on train journeys. So, perhaps we had better say what we mean by relational transactional analysis. Basically, it is a way of working that prioritizes the relationship between the client and the therapist as the central vehicle for insight and change—meaning that it is through the connection of the person of the therapist and the person of the client in open empathic mutuality and through what they create together that change comes about. Thus, there are two subjectivities in the room, and for change to occur, there must be mutual change: It is a bidirectional approach—therapy is a two-way street. The client’s relationship with himself or herself and with the figures of his or her past and present emerge in the consulting room—as do those of the therapist, and for this reason the therapist is required to have done an in-depth exploration of his or her own internal world.

Relational transactional analysis is also an acknowledgment of and a method to engage with unconscious processes with multiple potential meanings as they emerge. As Meier (1977/1995) said, “The unconscious makes itself known indirectly—and with peculiar effects!” The present adult relationship contains the emergence of the past and also the possibility for the creation of something new, a change at an experiential, relational level rather than at the level of understanding.

When Bill Cornell read *Transactional Analysis: A Relational Perspective* (Hargaden & Sills, 2002) in order to review it for the *Transactional Analysis Journal (TAJ)*, he wrote to us to say, “Hey guys, do you realize that your work is very like the clinical perspective currently being developed by relational psychoanalysts in New York?” (B. Cornell, personal communication, 2002). Bill’s observations turned out to be spot on. When Helena became a member of the International Association of

Relational Psychoanalysis and Psychotherapy (IARPP), she recognized the similarities immediately—this, despite the fact that neither of us had read their material before putting pen to paper! We were influenced and inspired by many theoreticians and practitioners from within and outside transactional analysis, but not these. Some of those within transactional analysis are sitting in this room—for example, those who contributed to the excellent April and July 1991 volumes of the *Transactional Analysis Journal* devoted to transference. Those outside transactional analysis include people from the person-centered approach, object relations, and self psychology.

Last year Helena invited Dr. Anthony Bass, a member of the IARPP board, to teach with her on her relational transactional analysis course in Kent. As part of his preparation, he read our book and said he was struck by the degree to which our approach is compatible with relational psychoanalysis: “It is really surprising to me to see that transactional analysis is alive, well, and developing over there. Most analysts here, and I have checked, are completely oblivious to that fact. When I point out that it has been evolving, and indeed, was way ahead of the curve on multiplicity and self-state work in the framework of adult-parent-child states and so on, people are struck by the fact that we have lost touch with those origins here. I find this quite interesting and will be interested to hear how it took root in England, where multiplicity seems less central in the psychoanalytic groups as far as I can see” (A. Bass, personal communication, 2006).

In a recent issue of *The Script*, Fanita English (2007) said some important things about the episcrypt of transactional analysis and wondered whether embedded in TA might be a legacy of arrogance born out of Eric Berne’s hurt at being rejected by the psychoanalytic establishment. She asked if this had manifested in an unwillingness to “join” and suggested that perhaps this has made transactional analysis somewhat insular, that is, not in dialogue with other psychological and psychotherapeutic approaches. The relational movement in transactional analysis is reflected across the range of professional approaches—in therapy, organi-

zational work, and the arts. Perhaps this could be the sign of a new willingness to belong.

Maybe, also, this rapprochement says something about psychoanalysis becoming less insular. So as psychoanalysis began to recognize what humanistic approaches have known for 50 years about the importance of the face-to-face relationship and the power of the authentic, at the same time humanistic approaches began to acknowledge the importance of psychoanalytic rigor and depth—and the fact that we might not name the unconscious in the same way as psychoanalysts, but that doesn't make it go away!

Thus relational psychotherapy forms a sort of a conceptual bridge between the major forces of psychological thought of the twentieth century. We hope that relational transactional analysis might be providing this bridge for dialogue with other professionals. The comments by Tony Bass and other colleagues across the field have led us to believe that this is so, particularly in the world of psychoanalysis. Indeed, it opens the opportunity for colleagues from across the board to acquaint themselves with rich transactional analysis concepts, such as script (Berne, 1961; Steiner, 1974) and the drama triangle (Karpman, 1968). For instance, a psychoanalytic colleague who works at the Maudsley Hospital in London says that he regularly uses these concepts in his work and that the relational perspective enables him to integrate transactional analysis into his psychoanalytic approach. This is particularly significant for United Kingdom transactional analysts because the national psychotherapeutic body to which we belong (United Kingdom Council for Psychotherapy or UKCP) is facing statutory regulation of the profession; thus, more than ever, we need to be able to have dialogue with other modalities.

We feel that the relational perspective is a type of feminizing of the theory. As we said earlier, a major influence on our work were our clients, trainees, and supervisees, the majority of whom have been women. Women have had a momentous impact on mental health professional practice, entering the profession of psychotherapy—particularly transactional analysis, with its egalitarian approach—in huge numbers. The relational psychologists (originally

Jean Baker Miller and her colleagues at the Stone Center) named relatedness and subjectivity as a valid epistemology and claimed that our understanding of life had been distorted by being created by “only one half of the human species” (Miller, 1986, p. xi). In their critique, these feminists emphasized attachment, relatedness, and empathy as being just as important as independence and challenged the idealization of the masculine ideals of objective science.

It seems to us that the relational perspective provides the possibility for what the Jungians refer to as “*coniunctio*,” which is an archetype for coming together and facilitating deep exploration of the psyche, a process characterized by wordlessness. The union we see in transactional analysis is between feminine and masculine ideals as symbolized through a union between relational perspectives and classical transactional analysis.

When we began to think along these lines, the familiar and much used theoretical concept of ego state diagnosis (Berne, 1961) emerged into our intersubjective space! We thought of the four ways to diagnose, and it seemed that phenomenological and social diagnosis are more obviously reflective of our feminine side because they trust the validity of personal experience and response in both client and therapist, whereas the historical and behavioral are more reflective of classically “masculine” aspects of fact and rationality.

Naturally, the mutuality and transference implications involve both therapist and client in multiple layers of relatedness, and such a way of working brings with it responsibilities. Because of the power inherent in the therapist-client relationship and the particular impact of this when working in the transference domains, we believe that one of the most vital consequences of working relationally is the ethical dimension. This is because the potential evocation, through the transferences, of the client's most primitive longings and yearnings, desires and fantasies of surrender, need to be privileged by the provision of a bounded container, one that allows for the integrity of these experiences to be held in a protective frame and not exposed to outsiders' invasive comments or the therapist's narcissistic acting

out. The therapeutic container needs to provide a safe space in which both therapist and client can take risks and work to the edge of their experiences, thus providing the ingredients necessary for a process of transformation.

We look forward to the continuing evolution of the relational perspective. The *TAJ* and the relational Internet discussion forum (to join, e-mail helenahargaden27@hotmail.com) are full of exciting developments in the relational field, and we have been stimulated and our thinking stretched by many colleagues and friends all over the world.

We have left our most heartfelt thanks to the end, and that is to our editor, encourager, and challenger, the person who was always there for both of us when we were writing *Transactional Analysis: A Relational Perspective* (Hargaden & Sills, 2002), two chapters of which form the basis for this award. Thank you to Keith Tudor, a true friend and colleague. He initiated the series of books, published by Routledge, on *Advancing Theory in Therapy* in order to advance thinking about therapy and to promote dialogue between approaches. *Transactional Analysis: A Relational Perspective* was one of the first volumes in that series. In addition, Keith and his coauthor Graeme Summers are known for their work on cocreativity, and we thank both of them for the lovely creative time we spent together in our writing group, cocreating and being intersubjective like mad, which contributed hugely to the heart and soul of the book!

Autumn 2007

The beginning of this article is the verbatim text of our speech from the 2007 international transactional analysis conference in San Francisco, where we were presented with the Eric Berne Memorial Award. We repeated it here because we wanted to convey the spirit of the moment and the celebratory experience of receiving the award. Having done so, we now wish to present the material for which we were given the award. It is taken from one of our original articles (Hargaden & Sills, 2001). We decided to do this in order to be accurate about the original contribution and its place in the developing field of relational transactional analysis.

If we were writing this article now, we would dwell more on the mutuality of the relational dynamics. Since the publication of our book in 2002, we have developed our thinking further—sometimes separately and sometimes together. We have both been interested in elaborating the significance and implications of the three domains of transference. In addition, Helena has, in particular, continued to explore the significance of the therapist's countertransference and has become more interested in the extent of the bidirectionality of unconscious relatedness, delving deeper into various aspects of the transference domains such as the erotics of relatedness. For her part, Charlotte has been interested in the concept of the "third," the cocreated movement to a new position or relationship that is something other than the sum of its parts. Originally a psychoanalytic term, this notion conveys levels of meaning and possibility that have tendrils in both cognitive and humanistic thought, and Charlotte has been exploring their relevance in a variety of contexts, including the organizational context.

We continue to discuss these areas of interest with each other at times and are beginning to think about a second edition of *Transactional Analysis: A Relational Perspective*, to be published in a few years time. For the moment, we do not wish to rewrite our model and feel the original article speaks for itself. Here are excerpts (pp. 61-65) from our 2001 *TAJ* article entitled "Deconfusion of the Child Ego State: A Relational Perspective."

Step Two: The Transference Relationship

There are many definitions of transference, which, when loosely summarized, suggest that it describes the patient's emotional attitude toward the psychotherapist. In deconfusion, the patient attempts to communicate within the context of the therapeutic relationship unarticulated experience of which she is unaware—that is, reproduce unmet needs and early relationship patterns and experiences in the relationship with the therapist. It is a type of "inarticulate speech of the heart" (Morrison, 1983) that communicates to the therapist through behavior and coded language what cannot be verbalized directly. Many clinicians will recognize the

increasing number of patients who present with this type of disturbance, which can best be understood as a disorder of the self that shows itself most commonly in narcissistic and borderline traits. In this context a useful definition of transference is supplied by Stolorow, Brandchaft, and Atwood (1987): "Transference is conceived . . . as the expression of a universal psychological striving to organize experience and construct meanings" (p. 46).

We view transference as the vehicle by which the therapist finds out about the unconscious aspects of the patient. "The neurological evidence simply suggests that selective absence of emotion is a problem. Well-targeted and well-deployed emotion seems to be a support system without which the edifice of reason cannot operate properly" (Damasio, 1999, p. 43). These findings seem to suggest that it is untenable to separate feelings from emotions, and further, that feelings are inextricably linked to reasoning. Damasio's research on the brain demonstrates how feeling is always present, although not necessarily conscious. Research by Schore (1994) indicates that the links between feelings and thought is developed in right brain-left brain connections. It therefore seems logical to assume that the emotional availability of the therapist is central to an understanding of the unconscious. Understood in this context, the transferential relationship becomes the gateway to the unconscious. Drawing on the work of Menaker (1995), we have identified three domains of transferential phenomenon. We develop Moiso's (1985) transference model to distinguish between the three types of transference as shown in Figure 6.

1. *Introjective Transference (C₀ longings)*: In this type of transference the patient seeks to enter a symbiosis (Schiff et al., 1975) with the therapist to meet developmental needs (C₀). "Introjection is both a defense and a normal developmental process; a defense because it diminishes separation anxiety, a developmental process because it renders the subject increasingly autonomous" (Rycroft, 1995, p. 87). Neuroscientists confirm this perspective when they describe how genetic systems program the development of the brain and are activated and influenced by the quality of the infant/envi-

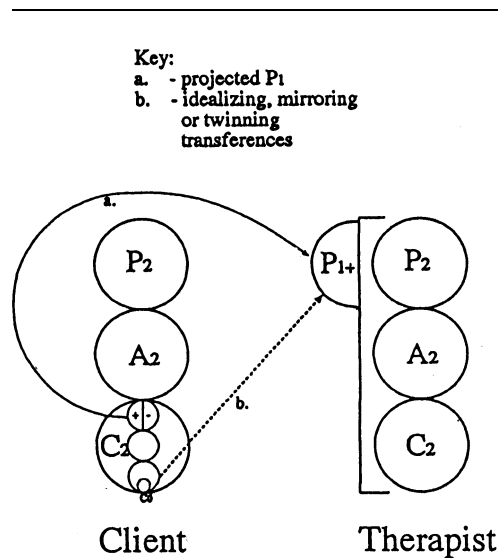


Figure 6
Projective and Introjective Transferences
(Based on Moiso, 1985)

ment relationship. When such a relationship is problematic, the person is left with an undeveloped sense of self because important structures in the brain are left unactivated (Schore, 1994). The undeveloped self is, therefore, unable to be autonomous until certain structures in the brain are activated through the relationship. This neuroscientific research provides us with a context in which to understand the psychological need for a transferential relationship.

Kohut (1971) described the emergence of archaic needs for symbiosis in the therapeutic relationship as selfobject transferences. He understood the development of such transferences as attempts by the patient to get his selfobject needs met. The term selfobject refers to a group of psychological functions that enables a person to maintain self experience. When these needs are thwarted in the infant he will continue as a grown up to try and get these needs met in the environment. They include the following:

Mirror Transference: The mirror transference involves two types of transferring. One is the merger-mirroring transference, a complete first-order symbiosis (Schiff et al., 1975) in

which the therapist is experienced as part of the patient's grandiose self (C_0 and P_0). For such patients, who experience the need for prolonged self-involvement, the therapist's subjectivity can feel, at best, irrelevant and, at worst, an intrusive rupturing of the therapeutic need to be fully and completely heard without interruption.

The other type of mirror transference occurs when the therapist is perceived as separate and the patient seeks her approval and admiration. The patient has a need to be mirrored for something she recognizes as authentic so she feels seen, met, and understood.

Idealizing Transference: If there has been too early a rupture in the child's perception of his powerful adult, this unconscious need to participate in the strength and calm of the "perfect" other will communicate itself in the idealized transference. Such ruptures occur either because circumstances are unfavorable, such as the mother's postpartum depression or a bereavement in the family, or for reasons of parental ineptitude, which can range from misattunement to physical and emotional abuse. A significant amount of therapy involves dealing with some trauma and associated aspects of disassociation. A central feature of posttraumatic stress is that there is a realization that no adult is powerful enough to stop dreadful things from happening: Illusions are shattered. After trauma there is a need to reconstruct illusion: "I'm important, you are omnipotent: The world is a safe place." The idealizing transference enables the patient to occupy a state of illusion, a creation of the Garden of Eden before the Fall. From this position, which in such cases was prematurely interrupted, the patient can be assisted to assimilate a more functional reality. The therapist, of course, must be able to let go of the idealization when the patient is ready. Otherwise the patient is infantilized indefinitely and never learns to deal with the empowering experience of handling betrayal and disillusionment, which ultimately can lead to maturity and the possibility for growth.

Twinship: The twinship transference refers to what might be called fellow feelings, a sense that we are like others. The child wants to "do what mummy does." She wants to identify and

take part in the big world. In this transference domain, the therapist will feel a pull from her patient to affirm a sense of essential sameness. The selfobject need is for the patient to feel validated and to experience a sense of belonging and connectedness so that she can develop her mix of intelligence and talents into usable skills.

2. Projective Transferences (P_1+/P_1-)—The Defensive Transferences: The selfobject transferences do not quite explain the projections of the patient onto the therapist. We think that these features, when displayed in the transference, are better understood in terms of projective or defensive transference. It is, of course, possible for both transferences to overlap. While still wanting merger experiences, the patient may also need the therapist to contain and deal with projections. In this transference domain the patient projects P_1+/P_1- onto the therapist in order to work through unintegrated experiences. "Owing to the influence of Melanie Klein, projection has been accepted as a normal developmental process" (Rycroft, 1995, p. 140).

In a misattuned environment the infant splits between "good" and "bad." "Splitting of both ego and object tends to be linked with denial and projection, the trio constituting a schizoid defence by which parts of the self (and internal objects) are disowned and attributed to objects in the environment" (p. 173). The projective transference is the patient's mechanism for keeping a coherent sense of self while projecting repressed internal conflict onto the therapist. Patients who require this transference often flip back and forth between good and bad. The idealizing aspect of this transference is dissimilar from the idealizing merger transference described earlier in that it usually communicates a significant amount of anxiety to the therapist. She knows only too well that the "love" will turn to "hate."

Faced with a patient's anger, it can be helpful to distinguish between at least two different types of negative transference. A patient may feel angry and enraged because the therapist has unwittingly "missed" him or her, and indeed the therapist may well be at fault. Such ruptures, often seen as mistakes, can be very

beneficial to the therapy since the patient has an opportunity to connect with deep affective experience and express it, for the first time, in the company of a concerned, caring, and even appropriately apologetic other. However, sometimes the negative transference may need to be sustained over a longer period of time to support psychological integration. Winnicott (1949) warned us not to deny our feelings of hate in the countertransference but to find ways to contain them and keep them for interpretation purposes.

If a patient's primary attachment was experienced through hatred, he may have difficulties in attaching securely enough to the therapist to do the work unless he can feel some of that negative charge. This can be a difficult situation for therapists who find it hard to do anything other than feel warm, positive, and sympathetic toward their patients. However, it could be therapeutically ineffective to deny feelings of anger when hatred is attempting to manifest itself in the therapeutic relationship.

3. *Transformational Transferences (C₁) (Projective Identification)* (Figure 7): We refer here to the process of projective identification, particularly as it is defined by Ogden (1992), who amplified Klein's (1986) original concept. Ogden proposed that the infant induces a feeling state in the other that corresponds to a state that he is unable to experience for himself. The recipient allows the induced state to reside within, and by reinternalizing this externally metabolized experience, the infant gains a change in the quality of his experience (Ogden, 1992). In this transference the therapist is required to transform the experience by making it containable and meaningful. This suggests that the patient's core or split-off self is "felt" by the therapist, who finds himself containing and feeling something which is hard to identify as "other" than the patient.

Projective Identification is a concept that addresses the way in which feeling-states corresponding to the unconscious fantasies of one person (the projector) are engendered in and processed by another person (the recipient), that is, the way in which one person makes use of another person to experience and contain an aspect of himself. (Ogden, 1992, p.1)

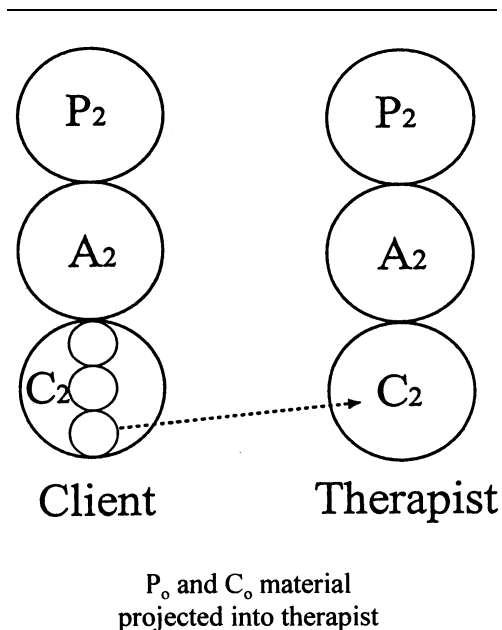


Figure 7
Transformational Transferences

This suggests to us that the therapist must be receptive to feeling something that she experiences as foreign and yet that clamors for her attention.

Step Three: Examination of Countertransference

Case example: A male patient arrived for group and sat in the therapist's chair. The therapist responded by sitting in another seat while containing feelings of apprehension and some anger. The patient looked slightly uncomfortable but began to boast about his newly acquired "power" and how he was now in the "driver's seat." His manner seemed to show contempt toward the therapist, who began to feel powerless, infuriated, and engulfed by rage. As the session evolved, group members challenged the patient's belief that he was gaining power by sitting in the therapist's seat, and the patient began to look defeated. As her own angry feelings subsided, the therapist became aware of feeling powerless and humiliated. Alive to her own distress, the therapist began to

imagine how the patient might have felt as a child in some of the situations that he had described from his past. (There was ample historical evidence for a scenario in which the defiant child had provoked an authority figure and been severely beaten and humiliated as a result.) Becoming aware, too, of the potential for humiliation within the group situation, the therapist intervened to make contact with the hurt, distressed, isolated child hidden underneath the grandiose defense. The client's defense evaporated, and he spoke movingly from an authentic place of a painful sense of worthlessness and a profound need for emotional connection. The scene was now set for further work in deconfusion of the Child.

If we think of the transferential relationship as the interactional field between two people, then the therapist's response within this energy field—commonly known as countertransference—will be significant. Her receptivity to her subjective responses to the patient and her willingness to engage with her experience is a central feature in relational psychotherapy. Such a process necessarily involves a type of introspective musing because information cannot be forced from the unconscious; it only emerges if we allow the space for it.

It is through the transferential process that we as therapists are invited into the unconscious world of our patients. Therefore, a careful examination of our countertransference is vital to the growth and change of mental states within the patient. In the context of a therapeutic relationship the therapist's own primary anxieties will often be provoked. Although this process can feel unsettling and disturbing, it is actually a sign of health in the therapeutic relationship. It may even be the first time that the patient's Child has been able to impact another and have that person remain constant and consistent within the relationship.

It is in this way that our patients seek to use us in order to integrate the unconscious contents of the Child ego state. In therapy this process follows the same rules and functions as those followed in normal child development. He or she is able to deal with the infant's/patient's frustrated feelings or experiences and help the infant/patient to manage them. This is

achieved through a process referred to as "projective identification" (Klein, 1986) but that is also understood by self psychologists (Kohut, 1971) in terms of empathic immersion in oneself in order to understand and help another make sense of his or her experience.

Moiso and Novellino (2000) have argued that in transactional analysis the "enormous methodological and clinical consequences of accepting and working with the transferential and countertransferential dimensions of transactions" (p. 184) have sometimes been neutralized by considering transference as only one dimension of the therapeutic relationship. They point to Berne's original criticism of psychoanalysis as a theory that was too detached from problems of a phenomenological nature. Transactional analysts gained the phenomenology but were often diverted away from the transferential relationship.

We now seek to redress this balance and argue that by making the transferential relationship central to the work, we have access to an exciting and complex emotional dynamic. In accepting the validity of the therapist's emotional life, we have a rich source of data available to us about the nature of the patient's problems. The three transferential domains outlined earlier can be useful in tracking the therapist's countertransference and supporting treatment direction. For reasons of space we do not explore this further except to indicate some of what the therapist may experience in these transferential domains.

1. *Introjective Transference*: When the therapist is required to be introjected or "co-opted," then she can be prey at times to feelings of boredom and even sleepiness. The therapist may find that her own narcissistic needs may get in the way, and unless alert to this countertransferential response, she may insist on her presence in a way that will not be effective in the therapy. If she persists in making interventions, then a Child-Child competition can emerge that is nontherapeutic. At the same time, the therapist will be required to be emotionally attuned so that she is alert to naming and reflecting emotional responses without being intrusive.

2. *Projective Transferences (P₁+/P₁-)—The Defensive Transferences*: These transferences

are more reflective of borderline features and disorders. In extreme cases the therapist will feel as though she is on a roller coaster—up one minute and down the next. In less extreme cases, when she is “up” she will nervously anticipate that the “down” will follow, if not sooner, then later. There is no resting place! The therapist often feels connected with an intense sense of her own vulnerability, since her own primary processes will be stirred up by the volatile interpersonal dynamics. The therapist will often feel under extreme provocation to act out her countertransference, and although apparently calm, she may be tempted to make a particularly “hostile” interpretation under the guise of being “therapeutic.”

3. *Transformational Transferences (C)*: Countertransferential reactions in this domain are diverse and often profound. When the patient projects archaic and unprocessed distress out into the therapeutic environment, the therapist’s primary processes will be mobilized. The previous case study conveys some of this experience.

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