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TRANSFERENCE BASED THERAPY: PSYCHOSEPARATION

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ABSTRACT: This paper presents a form of treatment known as Transference Based Therapy or Psychoseparation. This treatment uses the therapeutic relationship as the primary avenue for achieving psychological change.

It also explains why to date, theoreticians have not been able to explain the tremendous curative power which the therapeutic relationship possesses. Three reasons for this power are given.

INTRODUCTION

Consider these quotations:

> Incidentally, I may remark that it is not only the only mechanism made use of by the analytic method; you all know that far more powerful one which lies in the use of the transference.
>
> Freud (1952)

> The decisive part of the work is carried through by creating—in the relationship to the physician, in the transference—new editions of those early conflicts, in which the patient strives to behave as he originally behaved, while one calls upon all the available forces in his soul to bring him to another decision. The transference is thus the battlefield where all the contending forces must meet.
>
> Freud (1952)

> It soon becomes evident that this fact of transference is a factor of undreamed-of importance—on the one hand an instrument of irreplaceable value and on the other a source of serious dangers.
>
> Freud (1952)

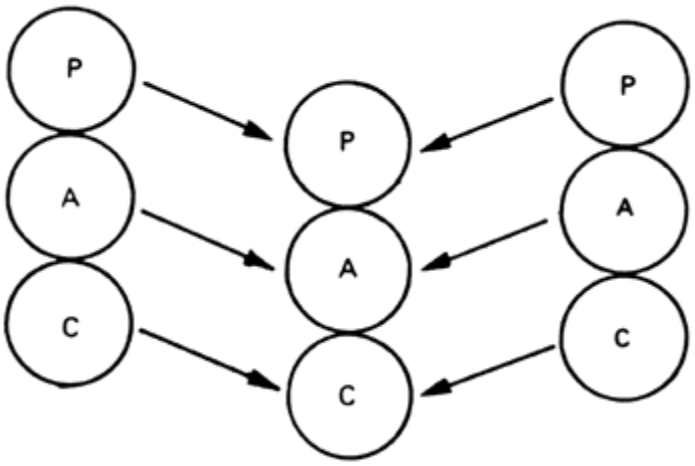
Of all the phenomena that Freud described in his voluminous works, he remained consistent throughout as to the importance of transference in the process of cure. On many other phenomena he changed his position, yet as to the importance of transference, he did not. Of course since Freud, many others have also acknowledged the major role of transference in cure: Carl Jung and Karen Horney to name just two.

However, explanations to date have been inadequate to explain why the transference is so powerful. The usual explanation is summed up by White (1984) in his initial statement on Transference Based Therapy. He states that the therapist must, “Encourage and facilitate the working through of archaic unresolved conflicts, by inviting the client to direct them at the therapist” (p. 86 of 1984 edition; p. 114 of 2000 edition).

This explanation however has been used many times in the past, and it still remains inadequate. Consistently, the transference has been ascribed with tremendous curative power, and the previous explanation does not do it credit. Archaic unresolved conflicts can be worked through with many different types of techniques; yet something else goes on between the therapist and patient that gives the transference that extra power. This paper describes the ‘something else’.

WHAT IS A SCRIPT

Many people believe that the script matrix, as presented in **Figure 1**, represents a script. This is an inaccurate belief.



A Script Matrix:
Representing The Symptoms of a Script.

Figure 1

As indicated in **Figure 1,** the script matrix diagram represents only the symptoms of a script. That is, the counter-injunctions, program and injunctions are only symptoms of the script theme. To deal with them only is to deal with the symptoms only.

In defining a script it is necessary to refer to Eric Berne's early writings. Again, consider two more quotations:

> Scripts belong in the realm of transference phenomena, that is, they are derivatives, or more precisely, adaptations, of infantile reactions and experiences. But a script does not deal with a mere transference reaction or transference situation; it is an attempt to repeat in derivative form, a whole transference drama, often split up into acts, exactly like the theatrical scripts which are intuitive artistic derivatives of these primal dramas of childhood.
>
> Berne (1961)

> The transference consists not merely of a set of interrelated reactions, a transference neurosis, but of a dynamically progressive transference drama, usually containing all the elements and subdivisions of a Greek tragedy. Thus, as previously mentioned, Oedipus comes to life in script analysis not only as a characteristic personality, but as one moving
>
> Berne (1961)

Firstly note how intimately Berne combines transference and script. Such a contention is fully supported here, for as will be suggested later, the way to treat the script (theme) is through the use of transference. Secondly, it is necessary at this point to separate out script symptoms from the script theme. As noted previously, the counter-injunctions, the program and injunctions are script symptoms. With reference to the first quotation, they represent the mere transference reactions or transference situations.

A script theme represents the whole transference drama, it describes the 'preordained destiny' towards which one is inexorably moving. It encompasses one's whole life. It will determine how long one lives, whom one will marry, what job one gets, how many children one will have, how one

thinks, what emotions one has, what illnesses one gets, what one's values are, the chemical constitution of one's blood, one's posture, how one speaks, etc., etc. All of these will combine to direct the individual down one single path to his final destiny. This is a script theme and it is very different from **Figure 1**, the script matrix.

Throughout the history of TA there have been many classification systems of script themes. Berne (1972) provides us with the following classification:

Never script theme	Always script theme
Until script theme	After script theme
Over and over script theme	Open-ended script theme.

Each theme can be fulfilled with a whole variety of injunctions and counter-injunctions. For example, to complete a 'Never' script theme one could use the injunction of 'Don't be a child', or 'Don't think', or 'Don't be close', or even the counter-injunction of 'Be strong'. The injunctions and counter-injunctions do not represent the script theme, but instead are symptoms of the theme (see White [1984] for a more detailed explanation of this).

The script themes are not directly addressed when one uses therapeutic techniques. As a case in point, readers are referred back to the first quotation of Freud's (1952). In that he separates out the therapeutic technique (in that case the analytic method) from the therapeutic relationship. This is a most crucial distinction, as the therapeutic techniques only address the script symptoms, whilst the therapeutic relationship addressed the script theme (see **Figure 2**).

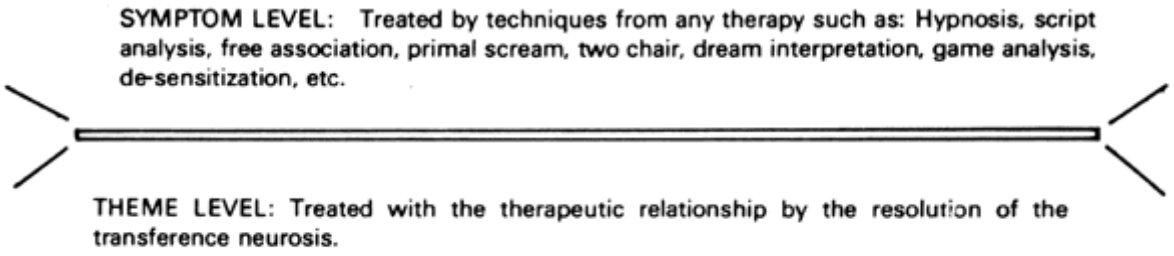


Figure 2

If a therapist is not successfully treating at the theme level, then the client will either exhibit symptom transformation by switching symptoms to fulfil the same theme; or the client will move from an unpleasant neurosis to a pleasant neurosis, where the final outcome of the script theme is less painful or dramatic.

It is often reported that Fritz Perls once said, "80% of patients come to therapy to improve their neuroses". Whether he actually did say this or not, it is not known. However, his figure of 80% seems accurate *if* improving their neuroses refers to the patient changing from unpleasant neuroses to pleasant neuroses. It is also most emphatically stated that such a task is a valid one. Pleasant neuroses are better than unpleasant neuroses. 80% of patients only want this. Changing the script theme involves an enormous upheaval of the patient's life, and most people are not willing to do this.

Why does the transference change the theme, whilst techniques only change the script symptoms? Because through the transference, as will be shown later, the patient has the opportunity to completely repeat their childhood development. Obviously therapeutic techniques cannot do this. The entire repetition allows for the most basic of personality changes to occur: i.e. script theme change.

It is now possible to define the first 'something else', or the first reason why the transference relationship is attributed with such power. It operates not only at the symptom level, but at the

script theme level. Hence, if successful, its effects are far more profound than the effects of the therapeutic techniques.

THE THERAPEUTIC RELATIONSHIP

As this paper is ascribing so much power to the therapeutic or transference relationship, it does seem necessary to define a relationship. As noted by White (1984) a relationship involves transactions plus a great deal more. Berne (1970), defines a relationship only in terms of transactions. **Figure 3** indicates his conception of relationships.

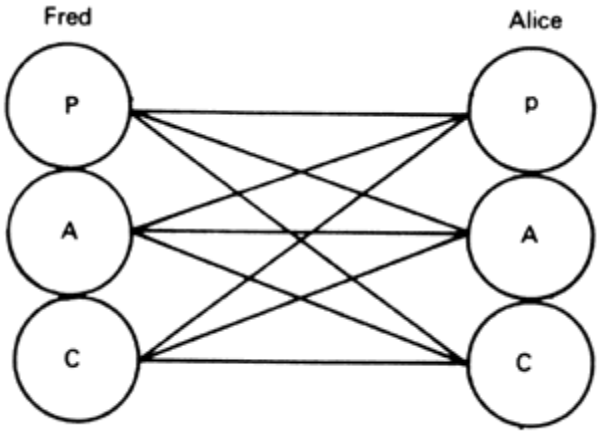


Figure 3. Berne's Relationship Diagram

White (1984) suggests that this is a reductionistic statement about relationships, if one wishes to use it therapeutically. A relationship refers to the individual's entire psychological perception of another. Transactions can chop and change rapidly, whereas the way one psychologically perceives another is a relatively stable phenomenon.

For example, if Fred and Alice were both psychologists, they could have a perception of each other as equals, in terms of their profession and their transacting they could engage in all nine possible transactions. However, what if Alice was Fred's patient? Would they view each other as equals? It is highly unlikely, yet they could still quite easily engage in all nine transactions.

In the second case, Alice would view Fred as a parental or power figure, whilst Fred would view Alice as a dependent or less powerful figure. In the first case Fred and Alice would view each other as equal power figures. In the context of the paper at hand this is what is meant by a relationship. Transactions form only one part of the overall psychological perception of the other.

White (1984) has shown that there are three types of these relationships:

parental/dependent equal/equal dependent/parental.

He has also outlined a series of factors which people commonly use to decide how they will perceive the other. In all the three types of relationships, all nine transactions of **Figure 3** are possible. White (1984) uses the script imago as the relationship diagram (see **Figure 4**).

The transference relationship occurs when the individual perceives the other person as a parental or more powerful figure. This involves an entire psychological outlook, not just a series of transactions. This difference between transactions and relationships has the most crucial implications in therapy.

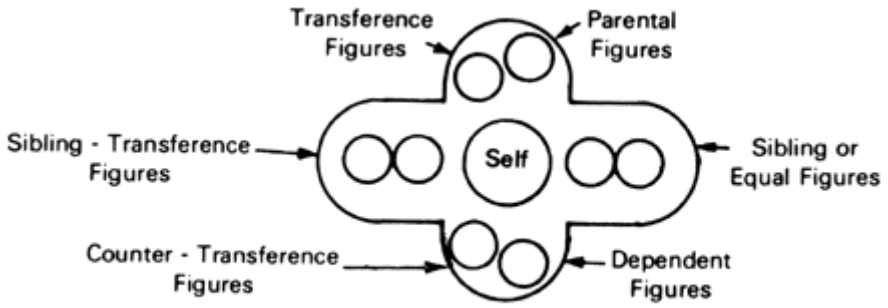


Figure 4. White's Relationship Diagram

For example, if Alice saw Fred as a parental figure, this does not mean that Alice is reliant or dependent on Fred. All it means is that Alice views Fred as having more psychological potency than herself.

A symbiosis only occurs at a transactional level. If Fred and Alice have a parental/dependent relationship in which all nine transactions are used, then no symbiosis exists. As a therapist, if Fred never thinks, feels or does anything for Alice that she can do for herself, then no symbiosis exists, even though Alice views him as a parental figure. It has been suggested that 'symbiosis', as used in the TA literature, refers to both a way of transacting and an overall psychological perception. This is certainly not the case if one examines the definitions of symbiosis. For instance, Schiff (1975) defines symbiosis in ego state and transactional terms only. One could agree that an overall psychological perception is implied from her definition of symbiosis.

If that is the case then this paper would be seen as bringing that implication to the surface, and conceptualizing it in a useable form. Either way, a relationship has two aspects; a way of transacting and an overall psychological perception. The transactional diagram shows the ways of transacting and the script imago shows the overall psychological perceptions.

THE TRIPHASIC SEPARATION/INDIVIDUATION THEORY

We now come to the crux of this paper. Consider Greenacre's (1954) statement: "If two people are repeatedly alone together, some sort of emotional bond will develop between them". This occurs in any relationship and is particularly true for the patient in the therapeutic setting. Often they will form a very strong bond to the therapist. The type and quality of the bond formed will depend on the level of separation the patient gained from their parents in childhood. White's (1985) Triphasic Separation/Individuation Theory is useful in determining what type of bond the patient will form with the clinician. (Note that it can be entirely different from the quality of bond that the clinician develops with the patient.) See **Figure 5** as a summary of the Triphasic Theory.

The patient enters treatment and after a period of time forms an attachment or bond to the therapist. The quality of the attachment, as noted before, will depend on what state the patient is fixated at. If they had problems separating at age 4 then they will bond to the therapist in the same way that a child bonds to its mother, at the Childhood Symbiotic State: see **Figure 5**. If the individual did not successfully resolve the Juvenile Negativistic Stage of adolescence, then they will be fixated at this stage and bond to the therapist in the same way, even though they may be 45 years old.

One can be fixated at any of the stages outlined in **Figure 5**. Those stuck in the symbiotic stages will be 'good' clients who are conforming. Those stuck in the negativistic stages will be the 'bad' clients who are rebellious.

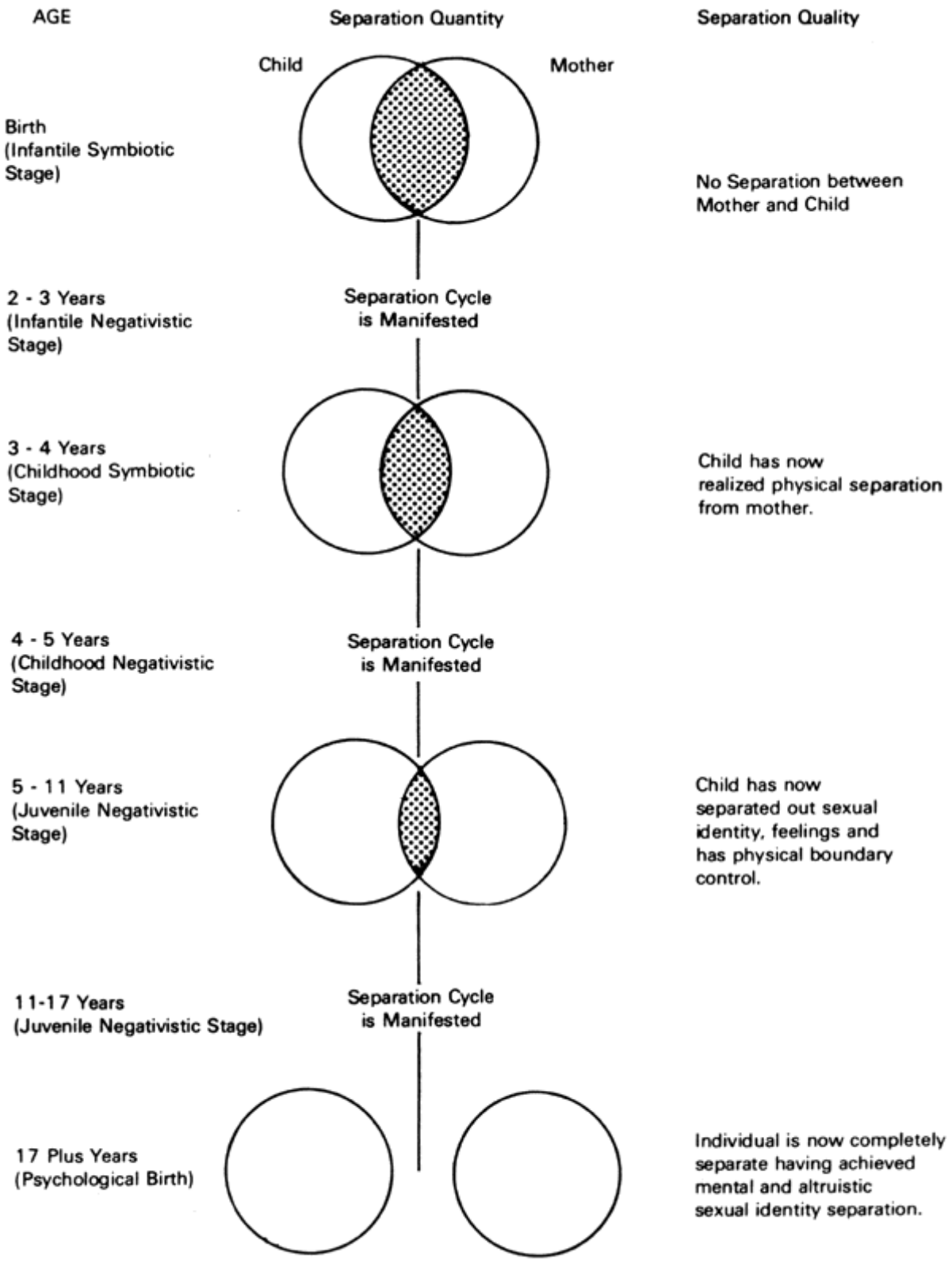

AGE
Separation Quantity
Separation Quality
Child
Mother
Birth
(Infantile Symbiotic
Stage)
No Separation between
Mother and Child
2 - 3 Years
(Infantile Negativistic
Stage)
Separation Cycle
is Manifested
3 - 4 Years
(Childhood Symbiotic
Stage)
Child has now
realized physical separation
from mother.
4 - 5 Years
(Childhood Negativistic
Stage)
Separation Cycle
is Manifested
5 - 11 Years
(Juvenile Negativistic
Stage)
Child has now
separated out sexual
identity, feelings and
has physical boundary
control.
11-17 Years
(Juvenile Negativistic Stage)
Separation Cycle
is Manifested
17 Plus Years
(Psychological Birth)
Individual is now completely
separate having achieved
mental and altruistic
sexual identity separation.

Figure 5

Of course, the individual who as a child successfully passed through all seven stages will have no identity fusion problems with the other person. There will however still be a fusion of identities when they bond to others.

This individual—the autonomous individual—has the ability to easily move in and out of the individual self and the fused identity relationship self. See White (1984) for a further explanation of this.

The person in the individual self has a strong sense of their own identity, they are aware of their own psychological boundaries and do not have their identity fused with the other person's identity. At this point no bond exists (see **Figure 6**).

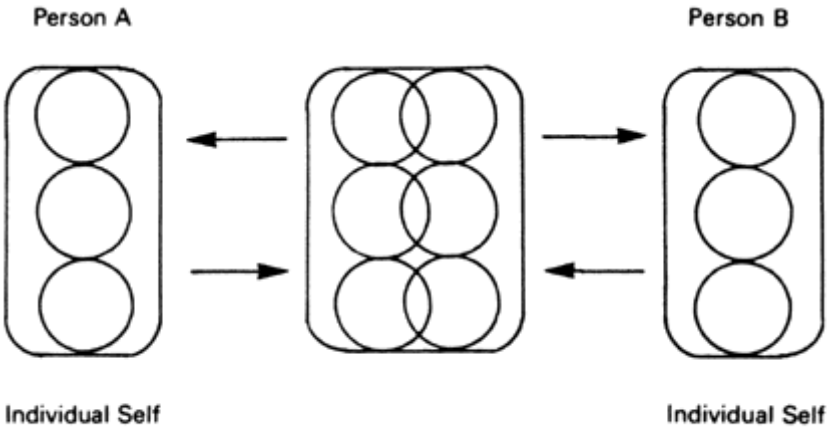


Figure 6.

Those who have not successfully mastered all seven stages of separation/individuation will have difficulty moving between the individual self and relationship self. This occurs most often when the relationship self is painful to that person. For instance the Schizoid person has a great deal of difficulty moving into the relationship self (hence they have the appearance of being isolated). In a case known to this writer, a Schizoid patient feared the relationship self because as a child his mother would cling to him, get him to look after her, and become very anxious when he left the house. He felt enormously drained by her, and found her repulsive. His resultant decision was, "It's too painful to bond, so I never will again". Thus, forming a bond with this patient was very difficult; he eventually did by testing the water many, many times.

ATTACHMENT IN THERAPY

The patient enters treatment, and after a period of time will form an attachment or bond with the therapist. Once this fusion of identity at the fixated point has occurred, then the patient is in a position to get a second chance at completing their psychological development. Without this bond formation, such major developmental advances are not possible. Hence, we arrive at the second 'something else', or the second reason why the transference relationship is endowed with great curative powers—it gives the patient a second chance at normal childhood development. The patient can go over the whole process again and get all the things they missed out on as a child. Consequently the most basic personality structures can be altered by this duplicate developmental approach.

For those patients fixated at a symbiotic stage, the developmental advances begin with the onset of the separation cycle. The client is encouraged to become angry at the therapist in whatever form that may take. When this occurs and the subsequent scare is experienced, the clinician offers reassurance for that scare, and nurturing if applicable. One of the most important factors is consistency and for the therapist not to take the anger personally. This, as Masterson (1978) implies, requires the therapist to be in the possession of a personal maturity.

This separation cycle, indicated by anger and scare reactions, will occur as a matter of course, as has been noted by psychoanalysts for many years. They call it, 'negative transference'. For instance, Freud (1952) in his discussion of the patient's change from positive to negative transference, states:

> "But such fine weather cannot last forever. One day it clouds over. Difficulties arise in the treatment; the patient declares that nothing more occurs to him. He gives the clearest impression of his interest being no longer in the work and of his cheerfully disregarding the instructions given him to say everything that comes into his head and not to give way to any critical obstacle to doing so. He behaves as though he were outside the treatment and as though he had not made this agreement with the doctor. He is evidently occupied with something, but intends to keep it to himself. This is a situation that is dangerous for the treatment. We are unmistakably confronted by a formidable resistance."

This 'formidable resistance' represents the anger part of the separation cycle. The resistance diminishes when the patient is permitted to complete the whole cycle. This is the key to developmental advances.

Those fixated at a negativistic stage are dealt with in a similar fashion to those at the symbiotic stage, although it can be more difficult as the angry feelings may be of a much greater intensity. Also the anger may be nastier, such as is found in passive-aggressive clients. Remaining detached from the anger in these cases is more difficult.

The other facet which must be addressed is the quality of the attachment. This is done by finding out how the patient was psychologically and/or physically abused in their attachments as a child. For instance the schizoid patient mentioned earlier faced the abuse of being made the parent in his relationship with his mother. The patient, through the use of ulterior transactions and games, will unconsciously endeavour to set up the same relationship. The clinician must be aware of this and confront all attempted setups.

Finally, right from the beginning of this form of treatment, it is necessary to highlight three ground rules which are restated periodically throughout treatment. These rules indicate that the relationship between patient and therapist is a most specific one. Firstly, there will never be any sexual relationship between therapist and client. This will obviously never occur during treatment, and will never occur after treatment has ceased. Even if patient and therapist meet 20 years after treatment has finished, no sexual relationship will occur between them. It is a lifelong contract that is written into the treatment contract. Anyone who does not agree with it is not doing Transference Based Treatment.

Secondly, the patient and therapist are not friends. They can feel for each other, care for each other, and even feel an affinity together, but they do not go to the movies together. Friends are an equal/equal relationship, whereas therapist and patient is a parental/dependent relationship. The two do not mix.

Finally, the therapist must like the patient if he is going to engage in this form of treatment. The therapist must be straight in this treatment, and plastic strokes will become obvious if given to the patient. Thus having a dependent figure whom the therapist does not like, is most counter-productive.

To conclude, after going through this therapeutic process a number of times, one is struck by the naturalness of the whole 'adventure'. It is possible to watch the patient grow in front of one's eyes. The boundary of identity issues of thoughts, feelings, sexuality, ideology, etc. all appear one after another and more often than not in their correct order. The clinician never has to suggest them, they come into foreground quite naturally. Fortunately, with adults this duplicate developmental period is far shorter than its original counterpart. So the different stages and phases are easier to recognize. It is truly an exciting adventure to be part of.

PSYCHOSEPARATION IS NOT REPARENTING

It should noted that this therapeutic process of 'Psychoseparation', is very different from the Schiffian techniques of reparenting and parenting. They highlight the need for total or partial decathexis of the Parent ego stage, and the formation of symbiosis with the therapist. This is definitely contraindicated for the mode of treatment described here. In all cases, clients are seen as being personally responsible for their thoughts, feelings and actions. They can rely on the therapist for psychological support, yet under no circumstances does the therapist form a symbiosis with the client.

Again we are confronted with the need to differentiate script imago overall perceptions from symbiotic transactional diagrams. The goal of Transference Based Treatment is to establish a parental/dependent relationship that is transactionally non-symbiotic. In the majority of cases the clinician is placed by the patient into the parental figure slot of the script imago. Thus automatically a parental/dependent relationship exists. The therapeutic goal within this relationship is to make sure that all nine possible transactions occur (see **Figure 5**). If they do not, then a transactional symbiosis does exist along with the parental/dependent relationship. The two possible combinations of relationship and symbiosis are indicated thus:

Reparenting includes—
A parental/dependent relationship with a transactional symbiosis.
Psychoseparation includes—
A parental/dependent relationship without a transactional symbiosis.

Hence the Schiffian reparenting treatment actively encourages transactional symbiosis development, whereas Transference Based Treatment or Psychoseparation actively discourages such symbiosis development.

It is now possible to understand the limitations of Berne's relationship diagram in **Figure 3**. As it only includes transactions, it is restricted to predicting only the absence or presence of a transactional symbiosis between individuals. White's Script Imago relationship diagram **(Figure 4)**, indicates what type of relationship exists outside pure transactions. In Psychoseparation it is necessary to differentiate both diagrams, and use both diagrams.

Historically, both theoreticians and practitioners have failed to make this differentiation. As a recent example, consider the statement by Moiso (1985). He says that in therapy the clinician must accept a pseudo-symbiotic transferential relationship. Within the context of the paper at hand this is obviously not true, for it is clearly obvious that one can have a transferential relationship without any symbiosis. Without making this distinction one is doomed to innumerable problems within the therapeutic relationship. How one makes this differentiation in practice is quite simple. The therapist can establish himself in the patient's parental figure slots by using the seven factors outlined in a previous book by White (1984, Chapter Six). Once this is done, the client has a dependent/parental relationship with the therapist, and a bond has formed. Simultaneously, of course, the therapist must be sure not to permit a transactional symbiosis to form between him and the client. This is done by adopting Goulding and Goulding's (1979) philosophy of personal power. Any attempt by the client to deny personal responsibility is confronted. This mode of therapy involves the therapist establishing himself as the parental figure in the relationship, and not permitting any symbiosis to form. It is a fine line to walk when one begins treating in this way. However, with some practice and supervision, it becomes a task of not great difficulty.

As a consequence of these differences, Reparenting as a treatment aims to replace the patient's Parent ego state with a new Parent ego state. The focus of Transference Based Treatment is bond formation, identity defusion and personal boundary development and control. Obviously, two very different foci of treatment.

THE POWER IS IN THE ATTACHMENT

One may think that this attachment of the patient to clinician is of an inconsequential nature, or that the relationship self is not of a potent nature. These beliefs could not be further from the truth, and it is this that provides the third reason why the transference is so curative.

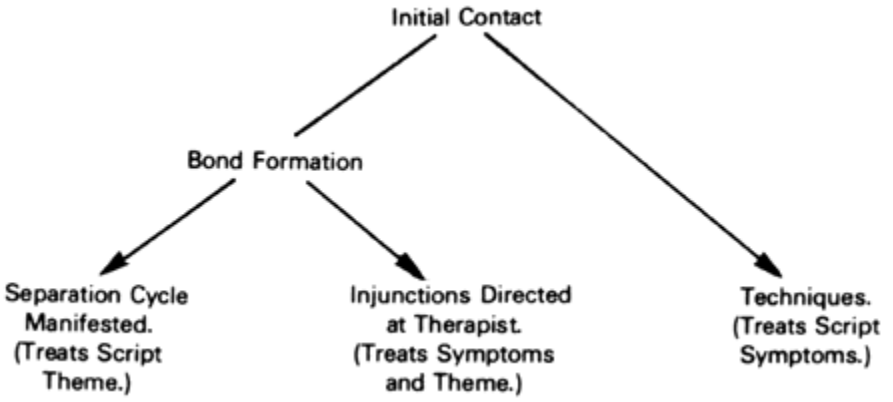
Psychoseparation treatment uses bonding or attachment as a primary tool for altering the script theme. This bond contains extraordinary power and potency, in that it forms a very important part of each individual's psyche. Both Mahler (1965) and Bowlby (1973) have documented this.

They have noted that when an individual has one of their bonds prematurely severed, severe anxiety, panic and anger results. As a case in point of the extreme nature of this anger, consider two examples given by Bowlby (1983). They both refer to cases of matricide by adolescents. The first one is an adolescent, who after murdering his mother exclaimed, "I couldn't stand to have her leave me". The second is of a youth who placed a bomb in his mother's luggage as she was boarding a plane. He later said, "I decided that she would never leave me again".

These two examples are obviously extreme, however, one must never underestimate the power of the bond. And therein lies the third source of power of the transference. As this bond forms such an important and powerful part of the individual's psyche, then when harnessed in Transference Based Therapy, one has a very powerful psychotherapeutic tool.

THE PROCESS SUMMARIZED

The therapeutic effects of this bonding go much deeper and occur in other areas than have been described here. Unfortunately, time and space do not permit of their elucidation. However, at this point it is necessary to summarize the process of Psychoseparation or Transference Based Therapy, thus:



After initial contact is made, one first treats the script symptoms by the use of therapeutic techniques. In time, a bonding attachment inevitably occurs, and then if the patient is willing, they are invited to direct her injunctions at the therapist. The likes, dislikes, resentments and appreciations that the patient had towards their original parents will, as a matter of course, develop against the therapist. These are encouraged and worked through, by having the feelings expressed directly at the therapist.

This direction of the injunctions at the therapist is seen to be effective for two reasons. Firstly, it has been found that confronting an injunction by using a real, psychologically important person in the here and now is most effective. Secondly, the script theme is addressed because such procedures also affect the therapeutic relationship.

The third and most powerful avenue is the separation cycle, for, by following this path, the patient is given a second chance to relive their entire development. As this is not always applicable or useable, sometimes one must rely on the first two only.

INDICATIONS AND CONTRAINDICATIONS

Without a doubt the treatment described in this paper is best suited to those conditions known as the personality disorders (DSM-III nomenclature). This includes conditions such as the Schizoid, Impulsive, Narcissistic, Borderline, Antisocial and Paranoid personality disorders. Personality disorders in this context are characterized as inflexible and maladaptive enduring patterns of perceiving, relating to, and thinking about the environment and oneself. These traits are deeply ingrained in the personality.

It appears that for these deeply ingrained traits to alter, the individual must again go through the developmental process. Hence, we can see the role of bonding and the separation cycle. However this takes time and thus we have a problem with Psychoseparation. In its pure form, it is only useable when the patient and therapist structure their lives so as to permit therapy that will last for an extended period of time.

The other important point to note is that the personality disorders are clearly differentiated from the psychoses. The psychotic individual, by definition, has a gross impairment in reality testing. The personality disordered individual does not have such an impairment. In fact in may cases the reality testing is very good. This is important, for it explains why symbiosis formation has no place in Transference Based Treatment. Psychotics are not capable of dealing with the world and so must rely on someone else to survive. Personality disordered individuals are capable and hence a transactional symbiosis is not necessary.

The other unique feature of this mode of treatment is that it plays a role in every form of psychotherapy. Obviously, every therapist must have some form of relationship with his client and as noted before, when any two individuals spend time together some form of bond will develop between then. Because of the extreme reactions to premature separation, or bond breakdown, even those who do not use relationship based treatment must be aware of what is happening between client and therapist.

Related to this is the notion that any technique from any form of therapy will only be successful if the relationship permits it. For instance, if a patient as a child learned that they could beat their parents by messing up or playing stupid, then they will treat the therapist the same way. All patients know that therapists want to do successful treatment, so the patient may endeavour to beat the therapist by messing up and doing unsuccessful treatment. Techniques will only work if the patient has a parental figure slot in their script imago which says something like 'Parents can help you'. If this does not exist, then the techniques will not work but will be merely used to again show how ineffectual parents are. In these cases, the relationship must be worked with directly and the techniques kept for a later time.

So at any point in therapy the clinician must be aware of the patient's transference issues. More specifically, he must have formally or informally completed the following:

A. Done a script imago analysis.
B. Defined what type of bonding the client will form in relation to the Triphasic Theory.
C. Defined what problems the patient has had with their separation cycle in the past.

To know these three things will greatly facilitate the success of any psychotherapy.

Other clear indications for relationship-based treatment are in the cases of rape victims, incest victims and battered wives. The individual in each of these cases has had their boundaries grossly violated and this results in bonding problems. Psychologically, this person is usually very hesitant to move into a relationship self (see **Figure 6**). As a consequence, the person becomes

isolated. Furthermore, once they finally do form a relationship self, they find it very difficult to move back out to the individual self.

Therefore through this treatment, the patient is given a chance to work out these bonding problems and re-learn how to put up and take down boundaries at will.

The other notable problem in these cases occurs with the belief system which results from being invaded in these most unpleasant ways. These individuals, when they do eventually establish a relationship self find it very difficult to protect themselves from further injustices. They seem to establish the belief: "You can do whatever you want tome, because I am to blame". Consequently, through regressive bonding work this deepest of beliefs can be altered. Of course this form of treatment in these cases must only occur in the later stages of treatment. It is not applicable for the early shock period when the emotional feelings are very pronounced and confused.

Another most advantageous way in which Psychoseparation may be used is in the area of relationship counselling. Most relationship counselling to date has not even addressed the bonding or attachment aspects of relationships. As a consequence, most therapy in this area has been restricted to social control and/or individual script work, e.g. Novey and Novey (1982) and Boyd and Boyd (1981). The script work in these cases involves the patient doing individual work about how they will be in a relationship, then social contracting with the partner about how the relationship will be different. In Psychoseparation the client enters a relationship with the clinician and can work through the relationship attachment problems directly. In this case the patient can do regressive work in the relationship self first hand. Previous relationship counselling involves doing regressive work in the individual self, about the relationship self.

For example, Fred was fixated at the Childhood Symbiotic Stage in his relationship with Alice. This resulted in many problems for both of them. When Alice went away for work Fred would experience separation panic, and Alice found Fred's demands on her smothering. Instead of doing individual script work with Fred about how he will be different with Alice, (and vice versa), through Psychoseparation, Fred could develop the same attachment problems with the therapist. Then with careful management Fred could have a second chance at going through the respective separation cycles, and hence become less clinging to Alice. (This of course rests on the premise that Alice should not be asked to become Fred's therapist.) Traditional relationship counselling does not permit regressive work with attachment problems. Therefore such counselling must be restricted to nonsevere relationship problems only, whereas Psychoseparation can address the more deep-seated relationship problems.

CONCLUSION

This paper asks the question, why does the transference contain such enormous power as a curative agent? Conventional explanations have been inadequate in answering this, and the paper at hand sets about finding a more convincing answer. It comes up with three reasons as to why the transference is so powerful.

Reason 1—The transference relationship attacks the script theme directly, whereas therapeutic techniques only address the script symptoms.

Reason 2—The transference relationship gives the patient a second chance to redo their whole childhood development.

Reason 3—The transference relationship harnesses the extra-ordinary power inherent in psychological bonding and attachment. If handled correctly this power can then be used to fight the power of the script.

Transference Based Therapy or Psychoseparation uses both therapeutic techniques, and the therapeutic relationship to facilitate change. The therapeutic relationship is used at two levels. One, the therapist invites or encourages the patient to direct the injunctions at the therapist. This is found to be more powerful than having the client direct the injunctions at an image or

fantasy. Secondly, if the patient is willing, they can have a second chance at reliving their entire development. This will begin with bond formation at the stage where the patient is fixated. With the onset of the separation cycle they can then move through the normal developmental phases until they reach their psychological birth.

Central to this is the distinction that the clinician must make between relationships and transactions. This is represented by the differences between Berne's relationship diagram in **Figure 3**, and White's relationship diagram in **Figure 4**. From White's diagram it is possible to have a transference relationship without a transactional symbiosis. From Berne's diagram, it is not. This permits the avoidance of many dependency problems, and negative transference problems.

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