CASE EXAMPLE

Internalized Object Relationship as an Advanced Level of Psychodiagnosis

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Abstract

Internalized representations of past relationship experiences, referred to as internalized object relations (IOR), impact how patients perceive and experience their therapist and the therapist's interventions. The ability to identify the internalized object relationship paradigm through which the patient experiences the therapist allows the therapist to formulate interventions that challenge rather than unconsciously enact pathogenic transference dynamics. In this paper, a case example is used to highlight methods for psychodiagnosing internalized object relational roles in the patient-therapist interaction. Further, the authors attempt to demonstrate the utility of incorporating internalized object relations-based formulations in the planning of interventions and assessment of patient responses, and identify areas for further development of internalized object relations concepts in ISTDP theory and technique.

Keywords: ISTDP, Internalized Object Relations, Unconscious Enactment, Transference, Countertransference, Psychodiagnosis, Relational Psychodynamic, Unconscious Identification

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Internalized Object Relations as an Advanced Level of Psychodiagnosis

The psychodiagnostic heuristic commonly used in ISTDP, based upon Malan's (1979) Triangle of Conflict, usually involves evaluating a passage of patient behavior with the question, "Was that feeling, anxiety, or defense?" This heuristic is used for hypothesizing about the meanings of patients' responses to our interventions, and is also used to plan subsequent interventions. When a patient response is coded as defense, therapists are encouraged to ask a further diagnostic question: "Is that a defense against feelings in the patient, or a resistance against emotional contact with the therapist?" (Frederickson, personal communication). This question is designed to help the therapist assess whether the function of the patient's communication is primarily one of resistance in the transference or of character defense (Frederickson, 2013), a defense against the consciousness of some internal emotional experience.

For the purposes of our exposition, it is worth noting that a character defense, by which the patient is thought to defend against something internal, will nonetheless have transference implications. Self-attack, for instance, has interpersonal meaning, if only because it occurs in the context of an interpersonal relationship, the therapy (e.g., Frederickson, 2021). The patient is attacking themselves, and this may defend against a variety of intrapsychic experiences. However, at the interpersonal level, the self-attack can be found to enact a particular way of relating to some "other," casting the therapist in a particular role. These roles may include a passive bystander of an attack, a colluding co-attacker, a fellow failure, a horrified onlooker, etc. Even when a character defense is used to defend against intrapsychic content, it enacts an object relationship in the therapy. The defense makes sense when we view it as a way the patient relates to a transferential image of the therapist. It can be found to communicate implicitly about the patient's unconscious or conscious experience of the therapist, which can, with skillful intervention, become progressively clearer in the session until it becomes verbally explicit, or crystallized (Davanloo, 2000).

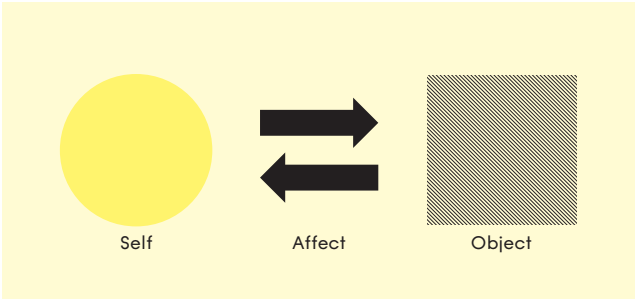
While identifying the defense or resistance qualities of a patient's communications is an essential clinical skill, we will argue that this skill can be enhanced by the additional metacognitive work of conceptualizing the internalized object relation (e.g., Yeomans et al., 2002) that the defenses and resistance represent. From the perspective of internalized object relations (IORs), defenses and resistance do not only keep emotions, memories, and linkages repressed; through their behavioral enactment, repressed aspects of relational learning from the past are also revealed[1]. Dynamic therapists of all stripes view the transference as an opportunity for patients and therapists to recognize and understand lifelong relationship patterns. It is in this sense that some analysts consider transference to be a hopeful, constructive act, and not only a resistance. (Aron & Atlas, 2015; Feiner, 1982; Freud, 1914).

A therapist's ability to not only psychodiagnose the presence of some resistance, but also to hypothesize about what IOR this resistance is designed to enact may lead to clarification of many previously puzzling aspects of transference-countertransference experience and help optimize interventions. Psychodiagnosis of the predominant IOR in the transference-countertransference matrix may also point to necessary adjustments of technical approach, so we will highlight a flexible application of ISTDP interventions tailored to the most-evident IOR in the relationship. We hope to help the reader ask and answer such object relational questions as, "Who do I represent to the patient? Consciously? Unconsciously?" or "Who do they feel themselves to be with me? Consciously? Unconsciously?", "With what kind of figure would these defenses and resistances make perfect sense?" and, "How does their transference to me impact how they experiences my interventions?" so that ultimately, when thinking about what to say next, readers can hypothesize about, "How might this patient, given the transferred IOR through which they perceive me, experience this intervention?"

Defining Internalized Object Relations (IORs)

An internalized object relation (IOR) can be defined as a mental representation, usually implicit and sometimes explicit, of a relationship experience. The constituents of an internalized object relationship are 1) a self-representation, or memory of what it was like to be myself in a past relationship experience, 2) an object representation– an image or experience of some meaningful person from a past relationship, usually in some sort of complementary relation to a self-image, and 3) the affective interpersonal climate between them, including meanings, rules, roles, gratifications, etc. of the relationship (e.g., Yeomans et al., 2002; see figure 1 for a heuristic diagram). For instance, a patient in the midst of a dependent transference may have internalized self and object representations structured around images of 1) an omnipotent caregiver and 2) a perfectly loved and relieved self. A patient suffering from self-attack or fear of criticism may have internalized images of 1) a criticizing other in relation to 2) a dejected, ashamed self. While these images may not be historically accurate (e.g., no parent is actually omnipotent), they depict how the patient felt during childhood experiences.

FIGURE 1: COMPONENTS OF AN INTERNALIZED OBJECT RELATIONSHIP (IOR)



For object relations theorists these internalized images of past experiences are the basis for our explicit and especially implicit models for interpersonal relating, the building blocks of our interpersonal and emotional life. They function as unconscious schemata that influence feeling, perception, and thought (Ogden, 1982). Both self and object roles become aspects of our behavioral repertoire. When in a self-role, we may seek out and even pressure, through projective identification, someone to play the internalized object-role, and vice versa. Most importantly for the purposes of therapy, unconscious IORs form the implicit basis for symptoms, interpersonal problems, and critically, the transference.

These memorialized experiences govern what patients expect from relationships and from therapy. The success or failure of any therapy depends on the clinician's ability to cope with the patient's relationship expectancies and their transferences. Greenberg (1991) has offered parameters for navigating patients' IOR-based relationship expectancies in a way that is sympathetic to the authors: The therapist must be experienced as safe, but not too safe. For Greenberg, if the therapy takes on too great a resemblance to the pathogenic IORs, the patient will either not be adequately challenged ("too safe") or, alternately, experience a traumatic repetition ("too unsafe"). The challenge of navigating this dynamic tension is to find an equidistant position between too safe and unsafe, so that transference can be experienced but not merely re-enacted. The successful execution of this is Greenberg's relational definition of psychoanalytic neutrality. This is a similar strategy to what Davanloo calls "staying out of the shoes" of the pathogenic IOR (e.g., von Korff, 1998, p. 183). The technical recommendations below are all intended to support this goal.

The following case example is taken from a video-recorded initial session with a woman in her late thirties, which took place in-person in 2018 in Washington, DC. The session is presented to show how an internalized object relation emerges from the first moments of an initial session. Annotations are offered to highlight the ways the patient can subtly pressure the therapist into taking a repetitive, collusive, "too safe" or "too unsafe" role, how the therapist can be transiently seduced into a reenactive object relational role, and the ways that patients tend to respond when the therapist awakens from the trance of unconscious enactment and begins to work against it. We will attempt to show how attention to all three channels of communication, verbal and nonverbal signals from the patient, and counter-transferential signals within the therapist, can be used in the process of psychodiagnosis of internalized object relations (cf. Yeomans, et al., 2002).

Clinical example

Therapist: (Joseph): Probably the best thing to do if you want is to let me know what you're wanting to work on together today and maybe going forward.

Patient: Yea, so I know we talked a little bit on the phone, but, uh, (sigh), I'm just kind of struggling with relationships and how to either live with the one I have or move on. I've been struggling pretty much the whole time my husband and I have been married, more because of history, which I can get into in more detail. And it's been really tough, and while I think it's the right thing for me, it's been really tough to stay happy.

Therapist: Mhm.

Her response to the initial prompt contains striated muscle anxiety in the form of a large sigh and then a general, vague description of her situation. The meaning of all this in terms of psychodiagnosis of IOR is not yet clear, but already we can begin to make hypotheses: Did the sigh have to do with the closeness invited by the prompt? Which of her defenses did it interfere with, producing the sigh? Is the vagueness an artifact of some emerging transference image of a figure with whom she had to be vague, or one that was vague with her? Readers may notice their own object-relational hypotheses emerging.

Patient: And in the past year, I have become very close with someone else who I work with (gross motor shift in the chair) who's probably overly patient and kind, and I'm not sure that's the right thing either. So, I'm just kind of struggling with balance, and I think that, it's, it's, stressing me out, trying to figure out (sigh) which way to go. And I haven't taken time off from either of these relationships, so it's been kind of hard to kind of chart out my path. (direct eye contact with the therapist, nods to the therapist, fold hands, expectant look)

She remains quite vague verbally. That having met somebody else is a source of anxiety is strongly suggested by the large shift she makes immediately after speaking about it, and by the sigh

that occurs just before she says "which way to go." She is beginning to reveal a conflict, as suggested by the statements, "which way to go," "hard to chart my path," and the motor shift when she says "someone else." This is all dynamically meaningful and may have transference implications.

But the nonverbal behaviors that emerge toward the end of that sequence are perhaps the most revealing in terms of emerging IOR in the transference: She makes what appears to be an effort to prompt the therapist to speak, and, as we will see, the therapist immediately and compulsively does so. An interpersonal dynamic, driven by the patient's prompting and here abetted by factors in the therapist, begins to emerge.

It is too soon to label the emerging self and object representations. But we can hypothesize that the patient was internally motivated to encourage the therapist to speak, and that the therapist, for unconscious motivations of his own, gratified this. We do not yet know what relationship from either the patient's or therapist's past this dynamic represents, but it is a meaningful interpersonal exchange– a prompter and a prompted one who responds in kind. On this note, the therapist's main affective recollection of this session was the inner pressure to perform well so he might retain this new patient for his recently opened private practice. This aspect of his countertransference likely made the therapist more vulnerable to these enactive pressures.

Upon review of the recording of this session, it seems likely this next intervention reflects more compulsive, pressured discharge than thoughtful, reflective intervening. Even if this "static reflection" appears to be reasonable, it is a product of unconscious anxiety in response to the patient's expectant stare. We can aver that some unconscious interpersonal dance has begun, that unconscious, historical roles from some IOR are being taken up.

Therapist: Okay, so there's kind of concerns about balance and happiness and which way to go in these relationships.
Patient: Yea, (sigh)

Because of the sigh, we can hypothesize that even though the therapist spoke under compulsion, he did not completely enact the transferential role he was then pressured to take. If he had done so, this would have reduced this patient's anxiety, and we would not have seen unconscious anxiety in the body. Though the therapist's intervention was compulsive, it contained implicit encouragement to the patient to share more, which may have had some counterenactive power. Where the patient's expectant gestures say, "You lead," the therapist's prompt may have adequately countered that interpersonal pressure with its implicit invitation to say more.

Patient: I've known my husband for nine years and we've been married for about four. We've had a rocky go of it at parts, but there's been positives as well. I think things are coming back to a positive, but it's not exactly where I want to be. I think I struggle with him as an individual. *(vague)*
Therapist: Hrm
Patient: I do a lot for him. I still do. We took some time apart about six months ago because I was tired of the way I was being treated. But it's sort of come back together without much discussion about why. It's sort of organically come back together. But it hasn't reached the level of positivity where I'm sort of happy that that's where I want to be long-term. *(vague)*
Therapist: Okay.
Patient: So that's, so I think I have a lot of guilt towards this other person ["work husband"] who has become more of a friend long-term, but I have some guilt that I haven't been able to deal with him in the way he probably deserves to be dealt with in a relationship, given how kind he's been.

In terms of process, there is not much additional development in the IOR we hypothesized to be emerging in the therapeutic interaction. We can, however, make use of the content of the patient's speech for a better understanding of her internal object world and the kind of relational expectancies she carries into relationships. We can think of this passage as a kind of "preview of coming attractions" (Frederickson, personal communication): How do we imagine she conceptualizes relationships? "I do a lot for him"; she refers to an implicitly bad way that she was being treated, coming back together "without discussion." This is perhaps a way the vagueness that we see in the therapy plays out in her marriage. She mentions coming back even though she is not sure that this is where she wants to be long term. Then there is an image of someone who is not getting something they deserve, and then a guilty figure who does not give it to them because she is giving to someone else. We encounter themes of one person who gives and one who takes, one who overworks and another who is waited on and perhaps hostile. Then we are presented with an image of sympathy for one who is not getting what they deserve. Interpersonal patterns being discussed in the content of sessions often unconsciously play out in the process (Levenson, 1979), and may already be (see the prompter/prompted dynamic above). We can use these statements as latent clues (cf. Langs, 1989) to wonder about the specifics of the IOR she is transferring into the therapy relationship, what role she is baiting the therapist to take through her silent, expectant prompting. We can begin silently hypothesizing about the transferential "shoes" we may want to stay out of.

Therapist: Oh
Patient: So that's sort of the struggle I guess. So part of it is

not knowing where I want to be. (expectant look, nods to the therapist, folds hands)
Therapist: (10 seconds of silence)
Patient: (folded hands begin clenching)

The therapist waits out this now-recognizable interpersonal prompt, doing what we might call a "not too safe" maneuver (Greenberg, 1991). We can hypothesize that this has the function of countering the prompter/prompted transference resistance. The prompted one does not do what he is prompted to do. There is an increase in striated muscle anxiety evident in the emergence of rhythmic hand clenching, and then we get a fascinating result:

Patient: And so yea, it's not making me feel overwhelmingly sad.

A negation!

Patient: It's making me feel confused, making me feel stressed and out of whack.

And the immediate undoing, more or less, of that negation.

Patient: So I try and do a lot for other people, but I can't get myself past the idea that maybe I shouldn't be doing so much, maybe I should be taking better care of myself

And a whisper from the unconscious! (Abbass, 2015)

Patient: and that's why I felt like I couldn't do it on my own, so I decided I needed some help, get some guidance there. (expectant look)

Much can be gleaned about the emerging IOR paradigm in this last segment of process material, which occurred at 4 minutes and 3 seconds into the session:

The patient again presents her behavioral routine for "passing the conch" to the therapist– the direct eye contact, the encouraging nod, the expectant countenance, and the folded hands all reappear exactly as they did the first time. This appears to be an ingrained, non-conscious, nonverbal repertoire that she does when anxious. This time, the therapist does not immediately respond in accordance with his urge to please, which can be especially prominent with a new patient, and he simply waits for 10 seconds. We can think of this as meeting the patient's passivity with counter-passivity, a nonverbal behavior of the therapist that functions as a pressure upon the patient to be the prime mover (Davanloo, 2000) of the session. As a result, at least in our interpretation of this session, her non-verbal resistance fails and a number of positive signs of response to intervention break through.

First, we see signs of striated muscle tension in the onset of rhythmic hand clenching. Then we see what we hypothesize to be a negation. "It's not making me feel overwhelmingly sad" may be translated as an unconscious confession: "I am feeling overwhelmingly sad". Then we see the rapid un-negating of that negation. Instead of saying what she does not feel, she says what she does feel, and it is not wholly unlike overwhelming sadness. Then there is what we could call a whisper from the unconscious therapeutic alliance [UTA] (Abbass, 2015), in which the patient concisely summarizes her core conflict, a conflict between taking care of others and herself. All in a brief moment, we see four signs of communication from the UTA, all of which may be attributable to just ten seconds of staying "out of the shoes" of the patient's proposed IOR.

At this point in the session, we do not yet know exactly which transferential shoes we are avoiding, but we can hypothesize that by not responding compulsively to her social prompting we are blockading some enactment, eschewing some object relational role. The marked increase in UTA markers further supports this. The therapist gets a little reward for his hard work—and it is hard, anxiety-provoking work not to talk for ten seconds when being prompted to do so by a patient one is trying to impress! Not to mention the prompting from one's own superego!

Immediately following this surge of UTA communications, she makes a statement that alludes to expectations towards the therapist—"I couldn't do it on my own, so I decided I needed some help, get some guidance," followed a moment later by a return of the expectant stare. Here we can see an example of UTA and resistance in conflict within the patient and within the therapy relationship. Within the patient, anxiety and a number of meaningful communications had broken through in response to the last intervention, but then, with the expectant stare, she immediately moves to a gambit to reignite the prompter/prompted IOR, the transference resistance. While the patient's last utterance is not a direct request for guidance, the combination of the verbal and nonverbal communications seems to have meta-communicated to the therapist, "So guide me now!" (Levenson, 1979). Where only a moment ago the therapist had been able to bear his anxiety and counter the patient's interpersonal pressure with silence and waiting, this last statement and expectant stare seems to have further raised his anxiety and triggered his own need to please, thus prompting another compulsive intervention.[2] This demonstrates the way in which both resistance and UTA are co-constructed: behavioral inputs from both participants are required in order to enact the transference resistance, and the enactment will prevent further mobilization of the UTA until the therapist stems his contribution to it, his complementary role-taking. The therapist's next intervention manifestly appears to be directed at getting specifics, but in hindsight it seems more likely to have been a product of compulsion, borne of anxiety:

Therapist: And what is it you're finding you're struggling to do on your own?

Patient: *(sigh)* Um, I don't know. I love my career. I've had a lot of change as far as my career goes, but it's going well, so what I'm struggling with is what do I need to be happy in my personal life? And that's where I'm struggling. I wish it was black and white.

Given the immediate sigh it gets in response, this last intervention may still be thought of as an effective pressure against vagueness or even passivity, insofar as it encourages her to be active; but we note that this is not the result of thoughtful intervention planning. It seems clear from the tape that it came from a compulsive place as a result of her prompting.

Therapist: Oh, yea, that's a very nebulous kind of problem.

This is a further good example of a common problem: When we speak compulsively under the pressure of a transference enactment, the quality of our interventions decreases. Whatever we say under compulsion cannot be effective because it is a participation in the transference enactment, and can only reinforce old ways of relating rather than effectively challenge them. Note the lack of a sigh in the patient's response here.

Patient: Yea

Therapist: Because in some ways it's impossible to know in advance whether a relationship is gonna make you happy.

This is an existential truism or cliché, and may have been intended to address a concern that the patient was seeking some omniscience regarding which of her two partners she should end up with. However, it is more likely that the compulsive pressure the therapist was experiencing, the need to offer something in response to the patient's expectant way of relating, played a determining role in the intervention. The intervention fails to trigger unconscious anxiety because it enacts the transferential role being assigned to the therapist and gratifies the patient's expectant wish.

Patient: Yea, and in some ways it did, but I feel like I've grown as an individual and my husband has been kind of static. I handle a lot of stuff for him, and I could speak up and say we need to divide things more evenly. I'm not saying he doesn't do anything. But I think that's just always been the nature of me is just: do more for people and not (gross motor shift in chair) ask for a lot in return. So I find myself still doing that even though I'm not completely happy.

Here again, the sharp rise of anxiety visible in the gross motor shift and the concise statement of her object relations paradigm– "I do for people and don't ask a lot in return"– is not unlike a "whisper from the UTA", especially in that it directs the therapist back to a more potent focus. Again we can ask, what will this statement mean for the therapy relationship? How can this information, that she tends to overwork in relationships and not get much in return, be used to understand the here-and-now interaction? In what ways is this IOR pattern already emerging? Readers will notice their own hypotheses.

Therapist: Hrm

Patient: Even when we took time apart, I was still doing a lot of stuff.

Therapist: So that's kind of your nature, you're saying. Even though you can see it's making you unhappy, that doesn't make it easy to transform.

Patient: It just adds more to the burden, I think

Therapist: Hrm

Patient: And it's kind of like, well, when do you stop?

Therapist: Hrm

Patient: And I think that's compounding it a bit more and making it tricky to say, "take this time for yourself or take time for somebody else." It's all kind of jumbled (folds hands, expectant look, prompting nods, smile)

Therapist: *(15 seconds of silence)*

So what's happening here, at 7 minutes 24 seconds into the session? A critical observer might aver that the therapist is unconsciously enacting the IOR under discussion by himself withholding while the patient overworks. This is a reasonable hypothesis given the flow of the session and the patient's described history.

At this moment, I (Joseph) recall thinking, "When she looks at me like that, I feel pressured to speak. I'm going to see what happens if I don't speak out of compulsion." I was at that time, and still am, very much under the influence of Leston Havens (e.g., 1986), who had said something like, "Therapy must be free. Nothing therapeutic can happen in the context of compulsion," and Edgar Levenson (1979) who expressed the idea that therapists must resist transformation by finding ways not to be controlled by patients' interpersonal pressures. Though anxious and uneasy with the silence, I tried to implement these ideals and waited those 15 long seconds:

Patient: Yea, it's like, it's kind of weird. I mean, should I kind of go through the backstory of how we got to this point? Like, how should I go about it?

We can think about this moment in many ways, but the one that seems most salient is that it is a moment of maturation of communication (Ekstein & Caruth,1966; Frederickson, 2021; Hewitt,1993; Langs,1989). Communication has "matured" in

the sense that the interpersonal dynamic, this latent IOR, has moved from the enactive realm of behavioral communication to the symbolic realm of language. Where earlier the patient was prompting the therapist to lead through gesture, prosody, pacing, implication, etc., the therapist's failure to compulsively play a complementary role in this yet-undefined IOR for these 15 seconds has successfully pressured the patient to make her transference wish explicit[3]. The transference has evolved from an "unformulated" (Stern, 1983) and unconscious state, and may now be much more available for conscious reflection.

The advantages of this approach will be discussed below, but for now, it may be useful to highlight the fact that the patient has now made her immediate transference explicit, where it was being acted out implicitly before, and this explicitness enables the therapist to confront it explicitly. If the therapist had confronted her expectant stance before this point, e.g., "Are you waiting on me to direct you?" she could have easily responded with denial: "No, I was just thinking, I'm not waiting on you," and the therapist would have no basis to argue. Now the patient no longer has plausible deniability that she is looking to the therapist to direct her (cf. von Korff, 1998). Whereas previously the therapist could only work against the patient's interpersonal pressures implicitly, countering the enactment subtly and without verbally identifying it, now it can be countered more openly. In this way, the "maturation of communication" is similar to Davanloo's (1990) crystallization of resistance in the transference. The following intervention can be thought of as a countering of the patient's projection of will or projection of authority, but at the interpersonal, object-relational level, it may be considered part of a head-on-collision (Davanloo, 2000), namely undoing of the transference, keeping the responsibility with the patient:

Therapist: It's really up to you. Ultimately, the hope is that you'll get what you want out of this, so feel free to just talk about whatever makes sense to you to talk about so that you can get what you want out of this.

The therapist has been working to differentiate himself from the patient's internalized object world up until this point, but he has had to do so in subtle, implicit ways, namely by responding with silence, patience, facial expressions that try to convey interest and encouragement, and his own nodding and nonverbal prompting. Now, the therapist is able to further cement this implicit work of "undoing the transference" with verbal interventions. The word "you" is used six times in the intervention, and it makes the therapist's conscious intentions as clear as possible, providing a contrast to the role the patient's question would put him in if he answered it concretely, e.g., directing the patient.

Patient: Yea ok, so, hrm (sigh), so I have some resentment, and the path of the resentment is that...

In response, the patient thinks and sighs, suggesting the transference resistance has been interrupted, at least for now, and that whatever was defended against by the transference resistance may soon break through—and it does. She uses an emotion word and immediately goes on to describe in detail some of her interpersonal history with her husband. The defense of vagueness is now absent, and we learn the specifics of the problems in her marriage. I will omit the details here, but will share the contours of the object relation they enacted with the hope that this will clarify the nature of the transference resistance she was unconsciously trying to enact with the therapist, the ascendant IOR:

She went on to share that in the first days of their marriage, her husband revealed to her that there was a very specific way he wanted to be pleased, one that required great discomfort and sacrifice from her, and she gave it to him. When the husband pushed her boundaries even further, she still gave him what he wanted, despite her feeling miserable and resentful. Even when she had asserted boundaries the husband broke them, and she remained with him, provided for him, and bent over backward for him in myriad ways. The husband would verbally abuse her if she did not behave as he pleased, sometimes in public, and she tacitly consented to all this by staying in the marriage.

This information may serve to clarify the patient's opening gambits with the therapist and the relative success, as far as the responses to intervention noted above, of some of the therapist's choices. We can hypothesize that this bending-over-backward, people-pleasing, ultimately masochistic pattern was ascendant even in these first eight minutes of this first session– that the patient's expectant waiting, prompting, and requesting guidance from the therapist may represent an unconscious effort to put the therapist in the "husband" position towards her. We can aver that in these moments she was trying to give the therapist opportunities to declare what he wished from her so that she would know how to please and what to submit to.

All aspects of the interaction make more sense in light of the background information the narrative of the marriage provides. We may now figure that her first sigh, in response to the first prompt, occurred because the question was about what she wanted for herself, doing something for herself, a very conflicted premise for her at the time of the first meeting. We may now understand the patient's silent nodding and attentive looking and waiting for the therapist to speak as an example of how she unconsciously and implicitly sets up a relationship in which she baits the other to tell her their needs so she can compulsively pursue those at the expense of her own. This can be characterized as an effort to evoke a masochistic reenactment of the relationship she had with her husband and the one that, we later learned, she watched her father and all her siblings have with her mother. She took this masochistically

caretaking father role in all her previous romantic relationships, and it was also evident in her professional life—everyone became the needy mother. During her 94-session therapy, spread out over four years, this patient began to set and protect more effective boundaries with her husband. When he did not mature along with her, she left the marriage and later married the "work husband". Her initial attraction to him came to be understood as an expression of her longing for a relationship in which she could set limits and still be loved, where masochistic obligation was not required. This longing became less and less conflictual for her over the course of the therapy, leading to major life changes.

Concepts from Weiss and Sampson's (1986) control-mastery theory may provide a useful narrative lens for understanding aspects of this clinical process. Sampson and Weiss propose that patients issue transference tests, especially in the opening phase of therapy. Using various unconscious maneuvers, probes, prompts, and gambits they try, unconsciously, to sort out whether the therapist can be corrupted into a role that will repeat some aspect of the patient's traumatic histories. They unconsciously assess whether the therapist can deal with their subtle pressures in a way that shows the therapist is unlike the figures from their past. In their process research, Sampson and Weiss found that when therapists pass these tests by not enacting the patient's proposed transference role, patients often spontaneously go on, sometimes immediately, to reveal some of the history and meaning of the pattern. Their findings suggest that once we have proved we will not enact the pattern with the patient, the patient may then trust us enough to tell us their history[4].

In this example, we see how the therapist was ultimately able to resist the patient's prompts to take a leading, one-up, "here's how you can please me" mother/husband role through his implicit, nonverbal interventions (silence in response to the patient's pressures that he speak) and his explicitly counter-enactive verbal interventions. We additionally see how the therapist became progressively more conscious of the part of him that might compulsively respond to the patient's enactive pressures.[5] This can be said to have evaded an enactment of the patient's IOR so that it could then be reflected upon and spoken about. The therapist's interventions could be said to have meta-communicated (Wachtel, 1993) his wish not to take on the family role he was being offered (see also the discussion of "acts of freedom" below; Symington, 1983, p. 283).

After the transcript above, the initial session went on to focus on the systematic confrontation of the patient's tendency to submit to treatment she does not want and then resent the person she does this for. There was immense pressure on her to begin to see her own responsibility in the problems with her husband, how she had consented over and over to the way he treated her. This confrontation of her masochism could not be effective if the therapist had taken the patient's bait and unconsciously enacted the very IOR that his later interventions were directed against.

Refining Psychodiagnosis with an Assessment of IOR

We see the emphasis on an object-relational approach as a helpful tool for the augmentation of psychodiagnosis because focus on the emerging and ascendant IOR in a given therapy interaction gives context to the patient's feelings, anxieties, and defenses. In this sense, it can be considered a supraordinate level of psychodiagnosis, in which we use "converging lines of inference from multiple sources" (Schafer, 1954, pp. 142-148, in Tansey & Burke, 2013, p. 112), including verbal content, nonverbal signals and behaviors, and countertransferential experiences (Yeomans, et al., 1992), to form hypotheses about the relationship being invited and/or enacted in the transference/countertransference matrix. Evaluating the clinical experience through this lens, we begin to see anxiety and defenses not merely as responses to feelings, but as implicit representations of relational memories and meanings in the context of a relationship with an important person from the patient's past. This perspective helps us see how the patient's behavior is organized not merely to defend against affect, but, for unconscious and dynamic reasons, to recreate and relive pathogenic relationship experiences. So, though the transference may serve to repress feelings and memories related to certain IORs, it simultaneously expresses these very clearly through the behavioral language of enactment. This is what Feiner (1982, p. 402) called the "healing function" of transference—by unconsciously inviting the therapist to "live through" (Bollas, 1989, p. 252) transferred self and object experiences, patients set the stage to finally have their interpersonal tendencies understood and challenged (see also, Freud, 1914; Aron & Atlas, 2015). From this perspective, transference is a hopeful act, even if an unconscious one.

Work in the transference has been heavily emphasized in ISTDP teaching and training, and process research supports this emphasis (Davanloo, 1990; Town et al, 2013); however, the ability to "work in the transference" is not synonymous with the ability to psychodiagnose the nature of the transference or detect the ascendant IOR. We see these as separate, though interrelated and mutually enhancing skills, and wish to underscore the utility of including both of these skill sets in ISTDP training.

This distinction between "working in the transference" and "psychodiagnosis of the IOR in the transference" reveals an important terminological problem: In ISTDP teaching and writing, we often use the term "working in the transference" or the "T" as shorthand for addressing the therapy interaction, focusing on the here-and-now with the patient. Because of this "the transference" has become synonymous or even interchangeable with "therapeutic relationship.[6]" But this can lead to confusion, as transference, the unconscious investment of the

therapist and the therapy setting with old meanings and expectancies, is only one dimension of the therapeutic relationship. This further underscores the need to differentiate the idea of "working in the T," which usually refers to "addressing the here-and-now relationship," from psychodiagnosis of the ascendant IOR that is influencing the here-and-now relationship. We may learn in our ISTDP training to investigate the feelings and perceptions that the patient has in the relationship, but in order to make good use of the patient's responses we also need to learn how to think about those responses in terms of their transferential, object-relational meaning. We hope that the above transcript analysis has provided some experience of what this moment-by-moment metacognitive process can look like.

Understanding Countertransference Experiences

Metacognizing about IORs as we experience or reflect on clinical sessions can also be helpful for making sense of difficult or uncomfortable experiences with patients. Very often a therapist's first clue to an emergent IOR, or to its unconscious enactment, is an alien feeling or experience in their body. As writers on the subject of projective identification and countertransference have noted (e.g., Ogden, 1992; Grotstein, 1985; Tansey & Burke, 2013), we do not feel quite like ourselves when under the influence of interpersonal pressures from the patient. In the example above, one of the therapist's memories of the session, which can also be inferred from his behavior in the recording, was his anxiety and the rapid, unthinking, compulsive way he was responding to the patient's prompting behaviors in the first minutes. The therapist was unconscious of the possibility that his interventions were in the service of, rather than working against, an IOR enactment. The therapist can be said to have recovered his therapeutic functioning only when he began to reflect upon this anxiety and internally challenge the compulsive pressure to speak. This awakening from the enactive trance helped him begin to effectively work against the enactment. Only then was the therapist able to begin to oscillate between experiencing and reflective modes while with the patient (Ferenczi, 1927, 1988), which transformed his pressured, uncomfortable feelings into a useful source of information about himself, the patient, and their interaction. He could begin to ask himself IOR-related questions to establish an object-relational level of psychodiagnosis: "What is it about this patient that is making me feel this way?" "Is there something about how she is relating to me that makes me feel this need to please, a way she could be said to trigger my native need to please, a way she is getting 'under my skin'?" "What is the role I'm being pressured to take, and what role would that put her in?" "Does that resemble other relationships she has described?" "How can I maintain our conscious alliance, but also not respond in kind to this role pressuring, so that I can learn more of what it's about?"

As we develop hypotheses about the possible IOR paradigms that our uncomfortable countertransference experiences might represent, we can further refine our listening. We can begin to listen to the patient's stories about others and the patient's reactions to us in terms of the IOR we are beginning to define, and we may come to see that the IOR emerging in the transference is the same one wreaking havoc elsewhere in the patient's life. Once patients can see these links between the IOR in the transference and their presenting problems, this can provide a meaningful bridge to develop a conscious alliance for work focused on the therapeutic relationship.

Similarly, when we are confused about the patient's transference to us and finding it difficult to perceive or label the IOR through which they are viewing our relationship, listening for latent or encoded references can be clarifying. Some authors (e.g., Gill & Hoffman, 1982; Langs, 1989) suggest that the stories patients tell about other people in their lives may illuminate the IOR paradigms through which they perceive relationships. They suggest that these stories can provide clues, via displaced references, about the patient's transferential perceptions of the therapist (Langs, 1989) and about unconscious enactments that may already be occurring (Levenson, 1979). An example of this style of listening was demonstrated in the "preview of coming attractions" section in the case above.

Psychodiagnosis of IOR and Crafting of Interventions

The predominant IOR in the therapy relationship affects the patient's perception, cognition, behavior, and the related roles that the therapist may feel pulled to play (Ogden, 1982, 1992). Thus, assessing it can help us plan and tailor interventions that are less likely to enact a too safe or too unsafe (Greenberg, 1991) role in the transference. Here we offer some theoretical background and examples of how psychodiagnosis of the IOR in the transference may help therapists craft interventions that optimally blockade or counter potential unconscious enactments.

Patients experience our interventions in terms of their transference to us, the expectancies and filters through which they see others and the world. They do not experience our communications through a clear window[7]. Instead, they unconsciously shape our words and deeds in ways that fit their systems of interpersonal meaning-making, their IORs.

It is our hope, in calling attention to this, that we will help therapists avoid a problem of clinical thinking that we have termed "the fallacy of immaculate reception" (cf. Orange et al.,1999, p. 386, "the doctrine of immaculate perception"). This is the assumption that patients will hear us as we mean or wish to be heard, rather than through their transferential lens. It entails an omnipotent fantasy that we can control how patients will hear and experience us, which manifests in the idea that careful phrasing and word choice will ensure a par-

ticular hoped-for perception of the therapist. This violates the core psychoanalytic meaning of transference–that our history automatically and unconsciously shapes and becomes a constituent of our present experience of others and relationships. Thus, transference shapes how patients perceive interventions and other aspects of the therapy relationship (e.g., Gill & Hoffman, 1982; Hoffman, 2014). This, to these authors, further underscores the importance of psychodiagnosis of IORs: to understand the patient's current transference perceptions of us, and understand how this will impact the way they hear our words, we must psychodiagnose the internal object relation that shapes and structures their interpersonal perceptions.

This presents a technical challenge: If we believe that the patient will experience us and our communications in terms of their internalized object representations, do we need to adapt our technique to account for this? And if so, how? When an intervention comes to mind, our IOR conceptualization can help us hypothesize about how this patient might experience the intervention, how they might hear it, and what meaning they might make of it (Frederickson, personal communication). Then, we can consider the merits and risks of saying it now: will this intervention enact or help challenge the transference? This psychodiagnosis will not provide an omniscient understanding of the patient. After all, it is a hypothesis. But it may provide a more detailed understanding of the patient, and may thereby optimize intervention.

While some have suggested that this may lead to timidity on the part of the therapist or dilution of the ISTDP model, we argue that this will more likely increase our effectiveness. When therapists intervene with the ascendant IOR in mind, we take into consideration the total context of the relationship, not just a single defense we are addressing or therapeutic process we are trying to facilitate. This continuous attention to the internalized object relation can reduce the risk that an intervention unconsciously enacts the very transference resistance we were consciously hoping to counter.

Further, we suggest that this kind of thinking may call for, support, and encourage a kind of creativity in our practice. We have found that different IOR paradigms call for technical adjustments that may include the eschewing or recasting of certain classic ISTDP intervention forms and the creative addition of non-classic ones, at least for periods of time. This is especially the case when the patient's transferential perceptions of the therapist and their interventions are ego-syntonic.

For instance, in the clinical example above, until the therapist confronts the patient's "projection of will" there is really nothing, aside from the initial prompt, that one would find in any classic ISTDP text. We see the above as an approach that uses ISTDP principles but creatively adapts the intervention formats (namely, pressure) so as not to complement the emerging defensive style of the patient. For instance, we see patient utterances that could be coded as defensive vagueness in the transcript, but no verbal identification of this by the therapist or pressure to specificity, even though those would seem to be the "go-to" interventions for an ISTDP therapist when dealing with that defense. Instead, the primary pressure is silence, which seems to function as an implicit "pressure against" (Abbass, 2015, p. 70) the patient's expectant stance, an indirect (von Korff, 1998), counter-enactive (Havens, 1986; Frederickson, 2021) maneuver that counters the whole emerging transference resistance, as opposed to the single most evident individual defense, the vagueness. We feel this technical approach was preferable to a more "direct" or explicit one in this case because the patient's resistance was unconscious, such that more open confrontation would likely have resulted in misalliance and repetitive enactment of the transference, e.g., the therapist would have stepped into the role of telling the patient how to please him. The end result of this approach is a total collapse of the vagueness, whereas explicit confrontation of the vagueness may have subtly enacted the masochistic IOR and led to a transference repetition and misalliance.

The case example above shows technical adjustments that one may use to avoid certain pitfalls with a people-pleasing, masochistic patient. Here are some examples of other IOR patterns that can impact the transference and may require technical adjustments so as not to enact them:

Passive Patient/Active Therapist[8]

Regarding a passive patient, Kalpin (1994, p. 28) gives the following example: "The therapist may point out passivity but may keep trying to draw out and put words in the mouth of the passive patient." Here we see how the therapist may unconsciously enact the patient's passive/active IOR through their very effort to interfere with it. Frederickson (2013) has suggested that therapists can counterenact unconscious or syntonic passivity with a counter-passivity by the therapist. This would serve to blockade the transference resistance and put massive pressure on the UTA to become the active agent of the therapy. Something like this can be seen in the transcript above.

Depressed Patient/Superegoic Therapist

A depressed patient may experience interventions in terms of their hypercritical view of themselves and their expectations that others will see them the same way. Anything the therapist says can be implicitly or explicitly interpreted as a criticism through the lens of a critic/criticized IOR, and this can lead to iatrogenic depressive feelings and ideas (Frederickson, 2021). One common therapist error with patients in this group would be to use classic defense identification to address syntonic self-attack, "Do you see how you are putting yourself down?" While this is usually intended as an effort to bring awareness, a depressed patient may experience it, through their transferential lens, as an implicit criticism, "Do you see how you are doing yet another thing wrong?" The patient will then feel that ther-

apy is another thing they are messing up, and add "self-attack" to the list of their failings. With very syntonic patients, this can occur no matter how supportively the intervention is phrased. In such cases, therapists will have to consider what interventions they should eschew, and find more implicit or indirect ways to support and encourage self-acceptance.

Compliant Patient/Omniscient Therapist

Compliant patients can hear an omniscient value judgment or agenda in almost any statement of the therapist. They bring an IOR to the relationship that includes an image of self eliciting and submitting to the desires or ideals of an "other" while negating their own. A compliant patient may hear any of the following therapist desires in a simple statement such as, "What feelings are coming up towards me?": "I think emotions are good." "It is important to me that you feel." "Feel these emotions, for doing so is required by the theory I love." "I want you to feel things towards me." They may hear, in a simple resistance identification intervention such as, "Do you notice you are avoiding my gaze?" the implication that, "Maintaining eye contact is good, looking away is bad. Do the good thing now." These more or less standard ISTDP interventions can be experienced by the compliant patient as commands that they will pressure themselves to actualize or please the image they are constructing of the therapist's perceived, and maybe real, desires. Having found an agenda in the therapist's comments, they may come to the next session brimming with stories about emotions they felt, effortfully locking eyes with the therapist; but there will be no signs of unconscious anxiety or increasing UTA communications because these "good" behaviors are artifacts of resistance. With syntonically or unconsciously compliant patients, priority will need to be given to a way of intervening, perhaps somewhat like the one demonstrated in the above transcript, that eschews interventions that could suggest a desire on the part of the therapist. This approach implicitly pressures the patient to make their transference wish, to be told how to please, explicit, so that it can be meaningfully confronted. While no type of intervention can make us omnipotent against the most syntonically compliant patient, who will find a command in our behavior even if we are silent as the grave and hidden from view (Levenson, 2013), we can try to intervene creatively and stay out of those particular shoes as best we can. By doing so, we increase the likelihood that the patient will become conscious of their desperate need for an external agenda, and begin to experience the wishes, memories, feelings, and anxieties that this need defends against.

Defiant Patient/Authoritarian Therapist

Like compliant patients, defiant, argumentative patients may hear even the most collaborative interventions as a command or demand. They will find an authoritarian parental object in the therapist whose agenda they have to defy. Therapists can apply powerful pressure to this resistance by eschewing interventions that betray some agenda on their part, e.g., a wish that the patient should experience her feelings. Once the therapist has given them nothing to defy, the patient will have to face their own conflicts about their will, and be challenged to lead rather than find an external authority with whom they can fight. Therapists may have to resist the patient's powerful pressure on the therapist to actualize an authority role.

Dependent Patient/Omnipotent Therapist

Dependent patients experience relationships in terms of omnipotent saviors and those needing to be magically saved. A dependent patient may experience our interventions as omniscient proclamations. Even when we do not intend to give it, they may divine advice from whatever we say and follow it. To a dependent patient, "What feelings are coming up here towards me?" may be translated to, "If you can figure out the right answer to this question, you'll have the gratification and relief you've always sought." If we fail to detect this transference resistance, a "phase of pressure" or any other treatment process may feel to them like a magic ritual. It will be exciting, maybe for both parties, but go nowhere.

Paranoid Patient/Invading Therapist

Paranoid patients may have relationship memories where they felt invaded or violated, and may, as a result, experience classic pressures as an attempt by the therapist to invade or dominate them. This may lead to the intensification of anxiety and primitive defenses. Counterprojective, counterenactive maneuvers (e.g., Havens,1986, Frederickson, 2021) may help the therapist differentiate themself from an invading, coercive, or seductive image in situations when classic pressures could accidentally put them right in those shoes. These interventions still apply pressure, but it is a subtle, indirect pressure against the patient's paranoid preconceptions instead of a pressure to feeling that could reinforce them. In these situations, it is often the case that it is only through these indirect approaches that emotional intimacy can develop.

We hope these general examples further point to the need for therapists to ask themselves, "Based on his transference to me, how might this patient experience this intervention? How might they squeeze it into their meaning-making system?" Further, in listening to patients' responses, it is important to continue to silently hypothesize about this: "They heard my question as a command (or advice, or judgment). How do I need to adjust my strategy?" "Can I address the way they're hearing my interventions through explicit resistance identification, or will I need to show them implicitly, through my conduct and our experience together (counter-enactively), that they have me confused with some past figure?"

There are some patients who, at least for periods of time, will experience us in ways we do not want or intend to be experienced, and will do so no matter how we conduct ourselves and no matter what we say. No omnipotence is provided by try-

ing to avoid interventions that step right in the shoes. Some patients will put us there whether we wish to be there or not and will do so syntonically. It is also the case that accidentally stepping into the shoes can make great "grist for the mill" and can, when we recover from it, lead to important conversations about the kinds of relationships patients seem to pull for or submit to, and how able they are to seduce others or be seduced into certain roles. At the same time, though, accidental, and especially protracted enactment of a given IOR can take us out "beyond the pale", making for unresolvable, unanalyzable interpersonal experiences, where the therapist's behavior has made them appear to be too much and too irrevocably like the patient's IOR, too unsafe (Greenberg, 1991), resulting in stalemate or termination. Heinrich Racker (1972) describes this dynamic tension between making "grist for the mill" and ending up "out beyond the pale" beautifully:

One might object that this confusion between the analyst and superego [IOR] neither can nor should be avoided, since it represents an essential part of the analysis of transference (of the externalization of internal situations) and since one cannot attain clarity except through confusion. That is true: this confusion cannot and should not be avoided, but we must remember the confusion will also have to be resolved, and that this will be more difficult the more the analyst is already identified in his experience with the analysand's superego and the more these identifications have influenced negatively his interpretations and conduct (p. 342).

We all make mistakes. While some patients possess an unforgiving intolerance for accidental enactment, most therapy dyads will have some amount of resilience so that re-enactive errors can be recovered from. However, we agree with Racker that the more time we spend unconsciously "in the shoes", the more difficult it will be to get out of them in the patient's eyes, and we see this as being another commendation for including some thought about the IORs impinging on the transference/countertransference matrix as we plan interventions and listen to responses from the first moments of the first session. We will argue now for the function and importance of counter-enactment as a means of therapeutic action in ISTDP.

Enactment, Counterenactment, and Therapeutic Action

In the case example above, we see a variety of efforts to "press against" or counter the patient's emerging transference resistance, which in this case helped the therapist stay out of the shoes of a demanding, expectant other that the patient appears to have been implicitly baiting him to take with her own expectant gestures. Evidence for the moment-to-moment and then intermediate-term and long-term effectiveness of this approach was highlighted.

To be effective, our interventions must not merely identify, clarify, press against, and challenge a patient's transference resistance – they must ultimately, in sum, counterenact it (Havens, 1986), blockade it (Davanloo, 2000), or fail totally to reinforce it (Beier & Young, 1966). As we tried to demonstrate in the examples above, it is possible to use many interventions that appear, in their form, to conform to an image of ISTDP, but which fail to conform to the principles of ISTDP in their effect, because they will unconsciously enact the transference resistance which the therapist consciously hopes to interfere with (Joseph, 2024). Here we argue that the approach used in the case example was useful because it countered the patient's ascendant IOR, her proposed transference enactment, by refusing the object role of "the one who desires" while she was in her pathogenic self-role of "the one who enables domination and then resentfully complies." We take the large number of responses that could be coded "from the UTA," even within the brief transcript, as evidence that this strategy successfully interfered with her resistance.

We believe that there is an important statement to be made here about therapeutic action in ISTDP theory. Therapeutic action concerns the questions, "What are the mechanisms of psychological change and growth, and how do these inform the therapeutic interventions and processes that have come to define ISTDP"?

One prevailing theory of therapeutic action in ISTDP has been that the experience of heretofore unconscious feelings about the present and the past drains a pathogenic reservoir (Davanloo, 2000) of guilt. This is a theory of catharsis, of discharge or release. This is usually paired with the twin process of "psychic integration," the cognitive learning process that occurs on the way to and after emotional breakthroughs in which the patient learns about their psychodynamics. The predominant emphasis on catharsis and cognitive learning in our literature may lead to an unintentional omission or underemphasis of the role of unconscious identification in healing[9]. The theory of the therapeutic action of unconscious identification suggests that patients will internalize our way of relating to them and their experience of being with us. Our interactions over time will create a new system of relational memories, new IORs, and may even lead to changes in old ones (Strachey, 1934; Loewald, 1960). As a result of their identification with us, patients will develop new relationship schemata and new interpersonal expectancies, which may be better adapted to their current lives. Conversely, if we unconsciously engage in a repetitive re-enactment of a pathogenic IOR, we accidentally reinforce the old system of relational memories, and fail to challenge patients' pathogenic expectancies and schemata. This can happen if our efforts to "drain the reservoir" conform to the idiom and structure of the patient's pathogenic IOR such that interventions that are meant to provide a new experience become absorbed into an unconscious reenactment.

When we take unconscious identification into consideration, we begin to see the importance of tailoring our work in a way that

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The theory of the therapeutic action of unconscious identification suggests that patients will internalize our way of relating to them and their experience of being with us.

evades, to whatever degree possible, the unconscious or unintentional re-enactment of and resultant reinforcement of these early neurotogenic schema, and instead offers something different. Unconscious identification is a way of conceptualizing the interpersonal educative power of modeling, of being been-with.

When we keep the therapeutic action of unconscious identification in mind we begin to see the importance of the therapist's "acts of freedom" (Symington, 1983, p. 283): Patients, like couples and families, attempt to induct us into their "family system" via pressure to enact the transference. They put the same pressure on the therapist that they themselves likely felt in their childhood. The therapist's refusal of the family role they are assigned in the transference may be the first free act the patient ever observes in response to such interpersonal pressure, the first time they have ever seen someone say "no" to a designated familial role. Maybe they never knew refusal was possible.

Through our conscientious awareness of and refusal to enact transferred IORs, we implicitly teach the patient how to say "no" to their own internalized family demands—their "superegos." Our example sets the stage, through the process of unconscious identification, for increases in the patient's own ability to face the feelings and anxiety that come as they commit the rebellious acts of differentiating from historical IOR patterns. This is an ability they will absolutely need in order to have any success in therapy.

Symington (1983) notes that some internal emotional change in the therapist is often a precondition for the patient's growth. We saw this in the case example above, where the therapist had to become conscious of the enactive pressures he had been unconsciously submitting to, and begin to bear the anxiety that came with refusing the pleasing role, so that the patient could have an experience in therapy that challenged the IOR-derived patterns that had dominated her relationships. According to the theory of unconscious identification, this experience, in which she was not expected to please the therapist and the therapist did not expect himself to please her, may have sewed the first seeds of her own ability to challenge these patterns. Through repeated interactions like this, a new IOR is laid down and practiced through repetition: an image of two people working together, but without masochistic obligation to each other. Moment by moment, session by session, new possibilities for relating emerge.

Conclusion

Therapist and patient relate to each other in terms of internalized representations of past relationships and experiences. We perceive and relate to each other through the biases of these transferential expectancies and filters. Thus, therapists' ability to identify and work with these aspects of the therapy relationship will impact our effectiveness. Throughout this paper, we have tried to show how to understand client responses as manifestations of an enactment of an internalized object relation. And we have described how to use that understanding to tailor our interventions, so that therapists can try to avoid interventions that reinforce rather than counter the transference. We have attempted to encourage a refinement of traditional psychodiagnostic decision-making by including a conceptualization of the emerging or ascendant IOR being transferred into the therapy relationship, and have given our justification for this.

We have defined internalized object relations and given a clinical example demonstrating how the emerging IOR can be tracked and hypothesized about from the first moments of the first session. We have also argued for the clinical utility of psychodiagnosis of IOR, especially its role in helping us identify the transferential role, the "shoes" that the patient is unconsciously offering us, and we have discussed how our conceptualization of the IOR in the transference may help us make technical adjustments so as to consciously challenge rather than unconsciously enact these roles. Finally, we highlighted the therapeutic action of a counterenactive approach: that it results in new unconscious identifications. It is the hope of the authors that the psychodiagnosis of internalized object relations will deepen our understanding of the transference, enactment, and therapeutic process, and that these ideas will have clinical utility for the ISTDP community.

Footnotes

1 This is what the Boston Process of Change Study Group (2002) has called our "implicit relational knowing."

2 This pattern, of blocking the enactment for a few interventions then regressing back into it is frequently evident in presentations and supervision. It may be comparable to a separation-individuation process, with advances into the anxiety and challenge of "not-too-safe" intervening and regressions back into the "too safe", collusive mode.

3 This is a common pattern, that when the therapist fails to respond in a complementary way to the patient's subtle, nonverbal enactive gambits, the patient will then verbalize their enactive wishes more explicitly. This can take anywhere from 10 seconds to a number of sessions depending on patient and therapist factors.

4 This may in some ways resemble Davanloo's (1978) finding that patients will spontaneously make T-P links when the UTA overwhelms the resistance.

5 Ironically, in the transference resistance, the patient was in the mother role, expectantly pressuring the therapist to please her by taking an active, overworking role; but it also became clear that if he had done so, this would have only reversed the pattern: the patient would have then experienced the therapist as an expectant mother whom she had to please.

6 There are even images of the Triangle of Conflict in which the "T" pole represents "Therapist/Transference," as though they are interchangeable.

7 The same is true of how therapists experience their patients.

8 The descriptive labels used in this and the subsequent subheadings are intended as heuristic psychodiagnostic tools to help clinicians understand the internalized object relational roles that may impact the transference and countertransference experience during therapy sessions. Their usage should not be confused with any descriptive, phenomenological diagnoses. They are not meant to describe static traits of either participant, as they are not fixed. Given effective intervening, they may evolve significantly within a session or across multiple sessions.

9 Unconscious identification has been relatively more emphasized in the psychoanalytic literature (e.g., Freud, 1923; Strachey, 1934; Loewald 1960; Searles, 1990), but has not been wholly left out of the ISTDP literature. See, especially, Coughlin's discussions of Alexander and French's "corrective emotional experience" (1996, 2023).

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