Some reflections on the therapeutic action of psychoanalytic therapy

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Sidney Blatt deserves several Festschrifts. His stature in the field is almost unique. His capacity to bridge the world of Yale psychology (one of the most highly cited departments of psychology in the world) and the world of psychoanalysis leaves all of us with a brilliantly lighted path to follow. In this tribute to his work, we will look at some of our ideas on the nature of therapeutic change, a topic to which Sid devoted considerable attention throughout his career. His pivotal paper with Behrends (Blatt and Behrends 1987) has been a guiding inspiration in our pursuit of a developmental model of psychic change. His most recent writings with Ken Levy (Levy and Blatt 1999; Levy, Blatt, and Shaver 1998) on attachment and with John Auerbach on self-reflexivity (Auerbach and Blatt 1996, 2001) have brought us particularly close. His paper with Blass on attachment and separateness (Blatt and Blass 1990) has helped many in the field to organize their ideas about developmental psychoanalytic approaches and was one of the core influences on our recent monograph (Fonagy and Target 2003). We have had the opportunity to work with Sid as a teacher, and his work in that context, as we suspect in the clinical, is a masterly bridging of the dialectic interaction between the two developmental lines, attachment and separateness, to which he has drawn attention. He is able at once to provide impetus for independence while offering himself as generously as any teacher ever has, as a resource, as an example, and as an ideal. We have learned an enormous amount from Sid Blatt, from his writings, but even more from his approach to his subject matter, characterized by commitment, dignity, enthusiasm, open-mindedness and generosity. He has given all of us so much and deserves so much more than we are able to give him in return.

It would be a brave or foolhardy person who would announce a definitive model of therapeutic action. In this chapter, we shall present a personal heuristic that helps us understand how patients progress through psychoanalytic treatment. Obviously, it is our hope that the distinctions identified may be useful beyond providing signposts to everyday clinical work, but the basic objective is not one of adding a new theory to an already overburdened literature. Rather, it is to link characteristic aspects of change to phases of an analytic process and to distinguish some putative psychological components of the process of change in psychoanalysis that might be helpful in our attempts at defining with greater rigor what a psychoanalytic process is.

We shall distinguish three types of psychic change linked to each other loosely across the course of treatment, each working through a focus on the relationship with the therapist. They are: (a) intersubjective shifts, (b) changes of mental processes, and (c) changes in mental representations. To illustrate these three types of change, we would like to introduce a patient whom one of us saw in analysis some years ago: Mr. A.

Introducing Mr. A

Mr. A started his analysis in a rage of which Kohut (1972) himself would have been proud. The couch was invented to humiliate and belittle people who needed help. The analyst's silence was a deliberate mockery. My talking about “working together” on his problems was a calculated insult. I wanted to work “on him” or more likely “in him.” Working with him suggested a partnership that was clearly a million miles from his perception of my intention in recommending the couch. His assessment with Professor X had been civilized and urbane, whilst he could tell that I was a secondrater who lived in the shadows of great men. The paper tissue on the pillow provided a magnet around which the iron filings of his shame and sense of being ridiculed were all aligned. Did I think that he would infect my other patients? Did I think he had head lice? Or, even worse, did I delude myself into some pathetic medical identity by the pretense of sterile conditions?

I knew nothing about Mr. A at this stage, except that he was 32 and well to do. The referral was from a very senior colleague who had seen and liked him and who had pressured me to take him, sight unseen. He came late for his initial interview and said very little about his background, except that his childhood had led to his suffering from anxiety and depression and that he frequently felt an overwhelming sense of inadequacy in competitive relationships with other men.

I was relatively inexperienced; who was I to say that Professor X was wrong in suggesting that Mr. A would be a good case for me to learn to work independently as an analyst. In fact, I recall feeling extremely grateful to my senior colleague after the referral. By the end of Mr. A’s first session, however, I
was extremely angry with both Mr. A and my senior colleague. In fact I had a formulation. My senior colleague had exactly the same narcissistic problems as Mr. A, so naturally he saw him as a charming man. I would have been happy to leave them both to enjoy the other’s company.

For the best part of a whole year of five times weekly analysis, Mr. A kept me in such a furious state. I managed some interpretive work with him, but I found it hard to keep my wish to punish him at bay. One Friday session he was particularly boastful, listing the properties he owned and suggesting that my consulting room could be moved, with advantage, to one of his large houses, which was situated in a neighborhood where many successful psychiatrists practiced. I managed an interpretation about him wanting me close to him over the weekend and also under his control, so he could avoid the humiliation of having to miss me. In response, he assured me that, if that had indeed been his intention, then he would simply have bought the house I was in. But in reality, he was quite fed up with my monotonous whining, was grateful for the respite, and had considered extending it by taking an unscheduled break early the coming week. I persisted in what I realized at the time to be an easily deflected approach. “You are frightened of the helplessness which allowing yourself to become attached to someone faces you with. You don’t need to have complete control and buy this house as long as you can arrange to come and go as you please.” He responded, hitting hard: “Look, if you could afford to buy this house, then you would not be renting one of its shabbiest rooms. Just because you can’t, there is no point in your getting irritated, just because you know I could.”

This kind of repartee was typical of my work with him. Working on his experiences in the here and now came naturally to Mr. A, as there appeared to be few people besides himself in whom he was interested. I began to think of him as Teflon man because none of my attempts to reach him appeared to stick. I repeatedly tried to address his sense of shame and vulnerability, which, I believed, partly motivated his defensive behavior. He seemed unable to hear my comments and often, quite rudely, would start talking in the middle of carefully sculptured interventions. He would make me feel alternately enfeebled and angry, and at some level, I was deeply puzzled as to why he was coming.

At this point, I should explain Mr. A’s relevance to a discourse on therapeutic action because it is clear little useful analytic work was being done. The challenge that Mr. A set psychoanalytic scholarship, going far beyond my shabby consulting room, was the improvement in his personal happiness and relationships that accompanied our attempt at starting a psychoanalytic process. By the end of treatment, his depression disappeared, his anxieties receded, his collaboration with his male colleagues, including his competitors, improved; he even started what sounded like a reasonable relationship with a woman who was his equal-a radical change from his previous attachments to prostitutes or to the uneducated women he had described as "scrubbers." We would speculate that cases of unaccountable improvement, such as Mr. A, are perhaps more common than psychoanalytic reports of successful treatments might lead us to suspect. But even if there were just one Mr. A, the benefit he gained from his less than adequate treatment might justify scrutiny.

**Outcome and process aims**

One approach to such a case, perhaps most characteristic of the French school of psychoanalysis, might be that symptomatic improvement is a largely irrelevant aspect of the therapeutic action of psychoanalysis. However, already in 1965, Wallerstein noted that, whilst analysts adopted a therapeutic stance that Bion (1967) later characterized as without memory or desire, behind this lay the dramatic ambition fundamentally to alter the patient’s personality organization. A lack of concern with clinical outcome seems curious at a time when evidence-based medicine (Kerridge, Lowe and Henry 1998; Sackett et al. 1996) is forcing all mental health practitioners to state their therapeutic goals and the expected outcome of their interventions.

Our position is that it is inappropriate to dismiss symptomatic improvement as irrelevant, particularly because most patients come with precisely this concern. It should also be acknowledged, however, that Mr. A’s analysis, despite considerable symptomatic improvement, categorically failed to achieve any of the ambitious goals that psychoanalytic authors have specified. These are normally termed process aims and are to be distinguished from outcome aims (Kennedy and Moran 1991). What the experience with Mr. A appeared to demonstrate was that process and outcome aims of psychoanalytic therapy were at best loosely coupled and at worst unrelated to one another. Yet if our theory of pathology is to be considered truly comprehensive, improvements that are not specific to the psychoanalytic experience should be accommodated as readily as those changes that we believe ourselves to have instigated. I believe the concept of intersubjective shifts accounts for some of these cases of unexplained improvement.
Intersubjective shifts

The lack of a stable sense of self is a central difficulty for narcissistic patients, particularly at the borderline end of this spectrum. By contrast, reflective function is essential to self-organization (Fonagy et al. 2002). Reflective function, we believe, is the psychological process that maintains our intentional stance—Dennett’s (1978) phrase for the interpretation of behavior in terms of underlying mental states (beliefs, desires, wishes, feelings, thoughts, etc.). The symbolic representation of mental states may be seen as a prerequisite for a sense of identity; they form the core of a sense of psychological self (see Figure 12.1a). As Cavell (1993) has thoughtfully demonstrated, selfknowing self-states do not arise intrinsically from within the mind. They are internalized from the other who knows and mirrors the self. At the core of all our selves, then, is an image our object created of us as intentional beings (see Figure 12.1b). For example, Gergely and Watson’s (1996) theory of the development of affective understanding posits that infants’ understanding of their own emotional experience depends on contingent, marked mirroring by the mother. Infants understand what they are feeling by looking at the mother’s face and seeing the emotion there that they feel. They know that they, and not mother, feel it because the mother marks her expression of the affect, clearly designating it as not ”real.” Recently Auerbach and Blatt (2001) have also advanced the notion that attunement of the caregiver to the infant creates an experience of intersubjectivity that, in normal development, helps in integrating transitional fantasy with realistic cognition.

In Mr. A’s case, parental self-absorption probably precluded the development of an authentic, organic self-image built around internalized representations of self-states. His mother was the only parent of any adult patient I have treated who attempted to come to her son’s sessions. One day, she simply turned up at the reception desk of my consulting rooms. The receptionist, accustomed to the peculiarities of a psychoanalytic practice, phoned my office in confusion, saying: “Oh, Peter, I don’t know what to do! A Mrs. A is here, determined to see you. She says you have her child in treatment. She can’t mean Mr. A, can she?” My curiosity drove me downstairs to meet her. When denied access to my consulting room, she insisted on telling me in the hallway about her failed third marriage, which in her view was undoubtedly upsetting her son. I had to draw on all the reserves my analytic training had equipped me with to maintain what passed for neutrality and yet assert the privacy of Mr. A’s analytic treatment.

If, as indeed we suspect was the case for Mr. A, the maternal object is unable or unwilling to reflect the child’s internal state, or projects her own internal state onto the child, intentional states will not be symbolically bound, and the developmental basis of the self-structure will be absent (see Figure 12.1c). Thus, Köös and Gergely (2001) found that babies whose attachment will be disorganized at 12 months are more likely to look at themselves in the mirror than at their mothers at six months of age, when these two are offered as alternatives. The weakness of a self-image not reinforced by adequate mirroring leaves the child with affect that remains unlabored and confusing—presumably what Bion (1962) considered unmetabolized or uncontained. The building blocks of reflective function, mentalized self-states, are absent. The turmoil that results will make the child even more desperate to seek closeness, to find some organizing structure for his affect, in whatever form this might be available. The child will be willing to take in reflections from the object that do not map onto anything within his own experience. This will lead to the internalization of representations of the parent’s state, rather than of a usable version of the child’s own experience. Such internalizations create an alien experience within the self that is based on representations of the other within the self. There may be similarities here to the “alien objects” that Britton (1998) has described on the basis of clinical work with patients such as these.

Figure 12.1a The experience of emotion, such as fear or anxiety, is a second-order representation of the primary representations of constitutional self-states

Figure 12.1b Constitutional self-states are symbolically bound by the internalization of the object’s mirroring displays

Figure 12.1c In cases of neglect or abuse, the secondary representation of self-states is not created, and affects are perceived as unmetabolized self-states

Figure 12.1 A schematic representation of the development of the experience of affect

Source: Based on Gergely and Watson, 1996
Once internalized, the alien presence interferes with the relationship between thought and identity: Ideas or feelings are experienced as one’s own that do not seem to belong to the self. The alien self destroys the coherence of self or identity, a coherence that the intentional stance demands. The experience of consistency can be restored only by constant and intense projection. There is ample evidence for this process in the attachment literature. Children with a history of disorganized attachment to the parent have been shown to develop a pattern of controlling behavior towards their attachment figures. I believe that what we are seeing here is the child’s desperately projecting the alien parts of the self back into the parent, forcing the parent to enact the feelings that create incongruence within the child’s self-structure. Understanding this process is vital clinically because, in contrast to the neurotic case, the projection is motivated not by superego pressures but by the need to reestablish the continuity of self-experience.

People like Mr. A are reachable, we believe, only at the moment when their externalization of the alien other is felt to be complete. It is this externalization process, and the window of opportunity it offers, that we refer to as an intersubjective shift. The difficulty is that these are not the

Figure 12.2 The process of changing intersubjective representational shifts. The analyst needs to see and create a coherent representation of the patient's “true-self” beyond, but concurrently with, countertransference enactments

moments when one is likely to function effectively as an analyst. Bateman (1998) described the same phenomenon sensitively in the context of Rosenfeld’s (1964) distinction between thick-skinned and thin-skinned narcissistic personalities and argued that narcissistic individuals alternate between thick-skinned (derogatory and grandiose) and thin-skinned (vulnerable and self-loathing) states. He shows that interpretive work can be done with such patients only at the dangerous moments when they are in movement from one state to the other. We think that what Bateman describes is the successful externalization of the alien self (the derogatory or self-hating self). The externalization of the persecutory object within the self leaves the patient able to attend and even experience concern. If we look at them in the context of an attachment relationship, such patients adopt the caregiving component of the controlling-caregiving pattern referred to above. Having externalized the alien part of the self, into the parent, they can then try to look after it, still in a very bossy and controlling way. The analyst, faced with a more sophisticated version of this process, needs to be in a dual functioning mode, to infer and create a coherent representation of the patient's true self, separate from but concurrently with any countertransference enactment (see Figure 12.2). However, this is where therapy often fails, because as soon as patients hear anything other than what they projected onto the analytic object, they must once again be on the alert. They might be risking the return of the laboriously ejected introject.

Changes in mental processes and the recovery of reflective function

Strangely, whilst psychoanalysts have long recognized that all mind is representation, they have been curiously uninterested in the mechanisms that generate and organize these: mental processes. Mental representations are the products of mental processes; a mental process is the violin from which the melody of mental representation originates.

The notion that mental processes are as vulnerable to the vicissitudes of conflict as mental representation is implicit in many psychoanalytic writings. We believe that patients with severe personality disorder inhibit one particular aspect of the normal development of mental processes—their reflective function (Fonagy and Target 1997). This is the psychological process that maintains our intentional stance. Patients with inhibited reflective function have little reliable access to an accurate picture of their own mental experiences, their representational worlds. In intense relationships that reevoke the attachment context, they inhibit the capacity to recognize thoughts and feelings, instead responding to them within one of two early modes of experience of psychic reality: psychic equivalence, in which internal states are mapped onto external reality and assumed to reflect it faithfully, or pretend, in which all states of mind are treated as completely separate from everyday reality. They either are gripped by thoughts, as though they were reality, or experience them as utterly inconsequential. Without the capacity to mentalize, they are unable to take a step back and to respond flexibly and adaptively to the symbolic, meaningful qualities of other people’s behavior. Instead, they find themselves caught in fixed patterns of attribution, rigid stereotypes of response, nonsymbolic, instrumental use of affect-mental patterns that are not amenable to either reflection or modulation. They inhibit their capacity to think about thoughts and feelings in themselves and in others, prototypically as an adaptation to severe or chronic maltreatment.
Mr. A, as a vulnerable child, confronted with an undoubtedly intrusive and probably extremely self-preoccupied mother, could not bear to develop a coherent image of his own mental state that could have served as the basis for an understanding of others. Although apparently somewhat reflective, his rigidity betrayed his incapacity truly to reason with mental states. The rigidity that imbued his representational world was one of the most striking aspects of Mr. A's treatment. His tendency to hold on to a specific point of view went far beyond that which might be associated with habitual patterns of defense. Like other patients, Mr. A organized the analytic relationship to conform to his unconscious expectations. But, for Mr. A, these expectations were experienced with the full force of reality, and alternative ways of viewing things were either dismissed out of hand or entered into in superficial and meaningless ways. Equally striking was that a lack of consistency between representations apparently caused little distress. The object, cherished as the source of salvation one day, could become the source of damnation the next. And thus his entire representational system seemed both in constant flux and immutable to lasting change.

Britton's (1995) distinction between knowledge and belief is helpful here. Mr. A did not believe in his superiority—he knew it. Belief entails uncertainty and the knowledge that a mental state is just a way of constructing experience, not reality itself. Mr. A's knowledge, however, existed only when reinforced by an external reality. He would constantly seek evidence and assurances of his superiority, which having been obtained almost immediately became valueless and effectively nonexistent. More evidence would be demanded. The mere state of knowledge had no permanence; as with infants, his sense of himself was ephemeral. He lived in a world of psychic equivalence (Fonagy 1995; Fonagy and Target 1996; Target and Fonagy 1996), where he believed whatever he thought actually did exist in the physical world. And all that existed in the physical world, Mr. A had certain knowledge of. Although this is perhaps normal for the child of three or four, the persistence of the psychic equivalence mode of relating is a major complication in the establishment of normal object relations. The perception of a reaction in the other is tantamount to its presence, without room for doubt, uncertainty and thus the possibility of alternative understandings.

It is psychic equivalence that reveals the alien self. Normally, mentalized self-narratives obscure the discontinuities of self-organization. Mr. A's intersubjective shifts were triggered by his inability to integrate his alien self-states into a coherent narrative. Forcing the analyst to enact remained the only route to the experience of self-coherence. The psychic equivalence mode of functioning precludes normal interpretative analytic work. Beyond the usual conceptualization of resistance, the requirement of isomorphism between internal and external leaves no room for an alternative analytic perspective. This formulation of course begs the question of how change may be achieved. In our view, change can happen solely through the revival of reflective function.

**What brings about change in reflective function?**

Mr. A did eventually show change in terms of process aims (his reflective function), as well as outcome aims (feeling better outside analysis). Change was slow and was clearly marked by an initial worsening of his depression as he became increasingly aware of undesirable aspects of his personality. There was no specific point that could be marked with the prefix of “turning.” No clever interpretations were made that could be singled out as delivering the change. Yet there was change, perhaps most noticeable in the change of atmosphere of the sessions. After three years of hard work, it became possible to talk with Teflon man.

The ongoing discussions on therapeutic action have generally acknowledged that the psychic change in individuals who manifest developmental deviations, impairments, deficits, or underlying structural deficiencies fits poorly with the neurotic model of therapeutic action. From the late 1970s, many writers have shifted the emphasis from structural change as the focus of therapeutic action to the transaction between patient and analyst as a curative experience and to the early mother-child relationship as the most appropriate analogue for the therapeutic encounter. Developmental processes are invoked by those who link therapeutic action to the holding environment (Modell 1976), separation-individuation (Blatt and Behrends 1987; Stolorow and Lachmann 1978), a sense of union with the primary object (Loewald 1979), social referencing (Viederman 1991), empathy (Emde 1990), or other aspects of developmental processes (Goodman 1977; Schlessinger and Robbins 1983). Recently, Blatt and Auerbach (2000) discussed the complexities of a naïve developmental view in attempting to understand long-term therapeutic change, its quantity, its quality and the patient's resistance.
These developmental models cannot give a satisfactory account of therapeutic action with the difficult patient. Abrams (1990) makes the obvious point that the developmental sequences in psychoanalysis and the biological constraints imposed on normal development make for discrepancies that should invalidate the developmental metaphor. Mayes and Spence (1994) make the important but counterintuitive observation that the developmental metaphor applies more to relatively well-endowed adults who historically probably had the benefit of the kind of caregiving experiences that reemerge in the transference, whilst the group of patients with whom these metaphors are most often used simply do not have the capacities that might make the developmental metaphor applicable.

So what was it that caused a shift in Mr. A’s psychic reality? We do not believe there is a single answer to this question. We believe that reflective processes are enhanced by work in the transference, work that highlights differences in perspective between self and other. The transference also focuses the patient on the analyst’s mental state as he tries to conceive of the patient’s beliefs and desires. The repeated experience of finding himself in the mind of his therapist not only enhances self-representation but also removes the patient’s fear of looking. Believing, as opposed to knowing, now allows uncertainty, rather than reliance on rigidity, and ultimately allows vulnerability, from which grandiosity can only afford momentary protection.

In what we believe to be an appropriate use of the developmental metaphor, the analyst performs the function of the object who enters into the child’s pretend play, creating a transitional sphere of relatedness. Here hard to bear thoughts and emotions may be played with while also experienced as real; the phobic avoidance of mentalization gradually and tentatively gives way to reflective function. More generally, a degree of flexibility and mutual adaptation is required between patient and analyst. The principal aim of the process must be to make the world of feelings and ideas safe for the patient. Optimally, the patient’s mental work recapitulates that of the analyst. The analyst’s thinking, even if initially neither understood nor appreciated by the patient, continually challenges the patient’s mind, stimulating a need to conceive of ideas in new ways. What is crucial, then, is the active engagement of one mind with another, inconceivable without empathy, holding, and containment. In our view, attachment to the therapist is the necessary condition that permits the mental proximity that is the essential precondition for this type of change. Yet none of these is directly responsible for the therapeutic action. This leads us on to discussion of our third concept-representational change.

**Representational change**

It is only when mental processes have been to some measure freed that change in representational structure is possible. Technically, this is a key stumbling block for beginning clinicians who understandably aim to modify specific representations as soon as their insights permit. Mr. A’s analysis illustrates representational change. As the analysis progressed, his picture of himself in dreams gradually shifted from an empty palace of the beginning of the analysis to a frightened mouse in its third year and, two years later, at the end of the analysis, to a man with a physical handicap. Perhaps most striking was the way his images of past figures were revised. He had almost never discussed his parents in his analysis in the first year without denigration but in the second year discovered his father as someone he admired for his tenacity and fairmindedness. A frequently recalled episode where he had felt humiliated and ridiculed by a grandfather who had played a trick on him gradually took on a far more benign coloring. He now experienced this episode as illustrating the man’s wish to surprise and tease him, rather than mock and humiliate. We could summarize such representational changes under three categories:

1. **Self**, object, and relationship representations acquired enhanced integrity and coherence.
2. Person representations were increasingly seen in relationship to one another, rather than as isolated figures. Ultimately Mr. A could talk about father and mother as having a marriage in which each parent had a separate mind, with feelings and ideas.
3. Finally, totally new object representations emerged. We may say that Mr. A’s representational system was restructured so that previously isolated, incompatible and unelaborated representations of the mental states of self and object ceased to be pathogens.

By creating and elaborating a mental world for his internal objects, these could change from part objects to whole structures. Understanding the other in mental state terms requires integrating assumed intentions in a coherent manner. The initial solution for the child, given the imperative to arrive at coherent object representations, is to split the representation of the other into several coherent subsets of intentions (Gergely 1997), primarily an idealized identity and a persecutory one. Splitting enables the individual to create mentalized images of others, but these are inaccurate and oversimplified and allow for only an illusion of mentalized interpersonal interchange. Further development of reflective function normally leads to an integration of these partial representations. The hopelessness of this task in the face of a deficit in reflective capacity may be seen as the direct cause of the permanent fragmentation of the internal world of such patients. The recovery of reflective function, and its active use within the analysis, enabled Mr. A to integrate his representations, so that his objects could have conflicted motives and yet retain their coherence.
**What brings about representational change?**

What aspect of psychoanalysis brings about these changes in representational structure? It is widely recognized that insight is not enough and that something akin to Loewald's (1960) real object is necessary to explain change. The primacy of the verbal in psychoanalysis has obscured the appreciation that representational structures change not only through insight but also through the experience of the other with the self, whether the other is speaking or not.

The dichotomy between interpretive insight on the one hand and relationship-generated change on the other, however, is probably false (Blatt and Behrends 1987). It is based on a confusion of means and ends. Verbal communications by the analyst may change representational structures in the patient's mind, and we may, if we wish, talk of such changes as insight as long as the term is restricted to the mental states that are experienced as motivating behavior in self and other. However, as has become increasingly accepted (Fonagy et al. 1993), the new relationship with the analyst, as much as interpretations, readily leads to psychic change via the modification of representational structures. We know from infant research that, as we observe the behavior of another, even from our earliest days, we automatically interpret, infer mental states, and restructure and potentially enrich our representations of how we see self and other interacting (Gergely and Watson 1996; Stern 1998). By analogy, the patient observing the analyst is not simply unthinkingly internalizing an experience; what patients benefit from are the constant inferences that they make about the analyst's internal world. The perception of the analyst as having empathy (Emde 1990) or healing intentions (Stone 1961) may bring about changes in object representations through the same mechanism of change as interpretations. Thus there is no clear dividing line between interpretation and new relationship as the means by which therapeutic change is achieved.

So our brief answer to the question, is it the relationship or is it the interpretation, would be, "It is both."

**What changes in representational change?**

Schematic models of therapeutic change (Abrams 1987; Joffe and Sandler 1969; Sandler and Joffe 1969) attribute therapeutic action to changes in long-term memory that underpin the representational system. However, it seems fair to say that, although the aims of psychoanalysis (Sandler and Dreher 1997) have been greatly elaborated since Freud's original model of undoing repression and recovering memory into consciousness (Breuer and Freud 1895), these advances have not brought with them an updating of the role of memory in the therapeutic process.

Solms and Turnbull (2002) have argued that infantile amnesia is a function not of repression but of the immaturity of the neural structures underpinning autobiographical memory before four years of age. But if infants do not have autobiographical memory, does this mean that early experience has no impact on us? There is now overwhelming evidence that there are at least two forms of memory. Relational experiences during the period of infantile amnesia are remembered in an implicit, procedural way.

We have described before (Fonagy 1999) the distinction cognitive science (Cohen 1984; Cohen and Squire 1980) now makes between two memory systems, both of which have important functions in psychoanalytic treatment. Declarative or explicit memory is involved with the conscious retrieval of information about the past whereas the procedural or implicit memory system contains the kind of content-independent information that is involved in acquiring general skills like playing the piano or driving. Declarative memory relates to remembering events and information. The aspect of declarative memory that we, as analysts, have been most concerned with is autobiographical memory, high in self-reference and frequently accompanied by personal interpretation (Conway 1996).

Clyman (1991) was perhaps the first to suggest explicitly adopting the distinction between procedural and declarative memory for use within psychoanalytic models of normal and pathological development. He proposed that the procedural, rather than the declarative, memory system may be involved in the transmission of early experience into adult personality.

Even earlier, Crittenden (1990) suggested that Bowlby's notion of internal working models may be best understood in terms of procedural knowledge. More recently, a group of psychoanalysts working in Boston, including Daniel Stern, Ed Tronick, Karlen Lyons-Ruth, Alexander Morgan and Alexie Harrison, have been working intensively to integrate the concept of procedural memory with ideas about the therapeutic process (Stern 1998).
In agreement with these authors, we believe that experiences contributing to internal representations of object relationships are not, by and large, stored in declarative memory. The extent to which episodes of interaction with the caregiver may be remembered (encoded and stored in autobiographical memory) may be incidental in the development of internal representations of relationships. What lies at the root of interpersonal problems, the transference relationship, and quite possibly all aspects of the personality that we loosely denote with the term unconscious, is a set of procedures or implicit memories of interactional experience. These may be represented as self-other-affect triads, as Otto Kernberg (1988) has suggested, as a network of unconscious expectations, as Bowlby (1988) conceived, or simply as emergent properties of the nervous system that abstract invariant information through the tendency of neurons to survive together if activated together (Edelman 1987; Stern 1994). They are generic memories or scripts (Nelson 1993) where the child's predominant experience of a relationship is retained. Individual experiences that have contributed to this mental model may or may not be stored elsewhere, but in either case, the model is now autonomous, no longer dependent on the experiences that have contributed to it. The models exist nonconsciously as procedures that organize interpersonal behavior but are not consciously accessible to the individual unless attention is specifically directed to them.

So where is therapeutic action—in procedural (implicit) memory or in declarative (autobiographical) memory? In our view, memories of past experience can no longer be considered relevant to therapeutic action. Psychic change occurs as a function of a shift of emphasis between different mental models of relationship; this change leads to a change in the procedures one uses in living with oneself and with others. Hence, therapeutic action is predominantly in the procedural memory system, rather than in relatively superficial changes in autobiographical memory. The term superficial is used advisedly here because, it is our contention, experiences constructed in autobiographical memory are more likely to be inaccurate than accurate. Undoubtedly, recovered autobiographical memories will contain the essence of a wide range of events, distilled into a configuration represented within that mental model. In that sense, the autobiographical memory is true. It is true to the model of a particular experience-of-being-with (Stern 1994). However, such a model may be profoundly distorted by fantasies and other intrapsychic experiences. The recovered memory is the outcome not of an undoing of repression but rather of a process of active construction.

In other words, analysands work backwards, pulling together elements of early experience consistent with freshly discovered perceptions of themselves in relation to others. It is not surprising, then, that memories from adolescence and latency will dominate a patient's material despite our conviction that earlier experiences were the formative ones. The mental model uncovered by the patient in analysis is likely to have been generated by early experiences that antedate the development of autobiographical memory and therefore will never be retrieved.

Of course, it is also possible that just as procedural memory may activate specific elements within the autobiographical memory system, so might newly found awareness of a particular experience influence the way an individual experiences himself or herself in relation to others. However, the patient's recovery of an autobiographical memory, like the analyst's delivery of a single interpretation, is highly unlikely in itself to be enough to facilitate change without the accompanying context of a reshaping of a way-of-experiencing-the-other. Conversely, given the neurophysiological evidence that the emotional charge associated with experiences stored subcortically cannot change without cortical involvement (LeDoux 1995), bringing such implicit structures of self-other relationships into conscious focus through the exploration of memories, transference dynamics, and interpretations seems not only desirable but arguably a critical component of therapeutic action.

Bringing it all together

We have outlined three modes of psychic change that may occur in psychoanalytic treatment. These three modes may be differentiated on at least four levels (see Table 12.1): (a) their descriptions; (b) the particular mental processes the analyst will aim to engage in each case; (c) the respective impact that each mode will have on symptomatology; and (d) the techniques that are most pertinent to accomplish the analyst's process aims in that phase of treatment.

Initially, in the treatment of personality disordered individuals, we are most likely to encounter intersubjective shifts. Descriptively, these are defensive strategies that enable the patient to establish coherent self-states by externalizing alien parts of the self onto the therapist. From the point of view of infant research, we can recognize these as flaws in the self-structure that result from misattunement, common in all our histories. The therapy offers an opportunity to increase self-coherence by externalization. As a consequence, symptom reduction is likely to result. The analyst must permit such
externalizations in order for the therapy to be tolerable to the patient and seek precisely these moments for interpretation, not of the

Table 12.1 The three modes of psychic change

<table>
<thead>
<tr>
<th>Description</th>
<th>Process aim</th>
<th>Impact on symptoms</th>
<th>Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intersubjective shifts</td>
<td>Allow intersubjective shifts to make therapy tolerable for patient</td>
<td>Improvement</td>
<td>Dual functioning; see patient beyond enactment; human generosity</td>
</tr>
<tr>
<td>Disinhibition of mental processes</td>
<td>Move away from equivalence</td>
<td>Worsening</td>
<td>Coherent approach; focus on mental states; availability of analyst’s mind</td>
</tr>
<tr>
<td>Representational change</td>
<td>Changing the representation of the patient’s picture of the mental world of self and object</td>
<td>Improvement</td>
<td>Exploration of current object relationship; relationship experienced in the transference</td>
</tr>
</tbody>
</table>

The second, concurrent, phase entails the disinhibition of mental processes, particularly of reflective capacity—mental processes that have been defensively inhibited as part of an attempt at adaptation to suboptimal internal and external environments. The clinical aim here is a move away from the infantile duality of psychic equivalence and pretend modes of functioning that antedate reflectiveness and toward engagement of the patient’s mind in forms of mental activity that have felt dangerous in the past, such as playing with ideas and different points of view. A complicating aspect of this phase is the almost inevitable worsening of the patient’s symptoms. The revitalization of mental processes inevitably induces a heightening of conflicts, which bring with them regression and compromise formation. With consistency and coherence of approach, it is possible for patients to build increasingly clear experiences of their own minds, thereby replacing their defensive disruption of their own thinking and the analyst’s access to it. Patients experience an intense hunger for understanding the ways that minds function; they learn this not so much from the specific comments of the analyst but rather through the observation of the analyst’s developing a coherent model of their minds-through the experience of a mind’s having their mind in mind.

Finally, representational change is the reorganization or restructuring of the representational system. With neurotic patients, this may be all that is required. And because therapists tend to come to the profession with reasonably intact minds, we are often tempted to assume that the patient on the couch also requires no more. Knowledge of infant research alerts one to the primitive mechanisms that may be active even in neurotic, and relatively intact, patients. But representational change will all too readily be reversed unless it becomes integrated with changes at the level of implicit memory. Both self- and other representation may need to alter, and this can be done effectively only in the here and now. Changes in the perception of important others will surely follow.

Conclusion

We have described three phases of a prototypical psychoanalytic treatment. These phases, whilst theoretically coherent as presented, may indeed emerge in a different order in particular treatments. The deepest level of a patient’s pathology tends to emerge only as the therapeutic relationship intensifies. As early relationship representations are activated in the intensified transference, the patient’s capacity to represent self and other as feeling and thinking beings can appear to fail, and an analytic process characterized by representational change comes to be dominated by intersubjective shifts.

Some further qualifications are in order. Permanent symptomatic improvements should be an inevitable consequence of these steps being followed. Yet process-outcome research clearly demonstrates that close associations between observed process and subsequent outcome are by no means inevitable and
may be quite rare (Fonagy et al. 1999). These studies are sobering reminders that our understanding of factors relevant to therapeutic benefit remains limited. In this context, we should remember that this model was proposed as a simple heuristic.

Perhaps the only assertion we can make with confidence is that psychoanalysis creates an interpersonal encounter where the psychoanalyst's mentalistic elaborative stance helps the patient to find himself in the therapist's mind and to integrate this image as part of his sense of self. In this process, there will be a gradual but inevitable transformation of a non-reflective mode of experiencing the internal world that forces an equation of internal and external reality to one where the internal world is treated with more circumspection and respect, as separate and qualitatively different from physical reality. This, we believe, is our inheritance from Freud and is what we should cherish in our daily work with our patients.

Notes

1 This chapter is a tribute to Sidney Blatt, who has overseen in a benevolent way the growth of both our scientific careers. We are indebted to him and delight in being able to contribute to this fitting tribute to one of the great clinician scientists. The chapter also owes a great deal to the editorial talents of Dr. Elizabeth Allison, for whom Mr. A. represents as much of a formative experience as to his analyst.

2 The analyst was Peter Fonagy. Throughout this chapter, the case will be discussed in the first person.

References


