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Rethinking therapeutic action

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Like other core psychoanalytic constructs, the theory of therapeutic action is currently in flux, as theorists of differing persuasions propose different mechanisms. In this article, the authors attempt to integrate developments within and without psychoanalysis to provide a working model of the multifaceted processes involved in producing change in psychoanalysis and psychoanalytic psychotherapy. A theory of therapeutic action must describe both what changes (the aims of treatment) and what strategies are likely to be useful in facilitating those changes (technique). The authors believe that single-mechanism theories of therapeutic action, no matter how complex, are unlikely to prove useful at this point because of the variety of targets of change and the variety of methods useful in effecting change in those targets (such as techniques aimed at altering different kinds of conscious and unconscious processes). Interventions that facilitate change may be classified into one of three categories: those that foster insight, those that make use of various mutative aspects of the treatment relationship and a variety of secondary strategies that can be of tremendous importance. They propose that, in all forms of psychoanalytic treatment, we would be more accurate to speak of the therapeutic actions, rather than action.

Contemporary psychoanalysis is marked by a pluralism unknown in any prior era, and this extends to theories of therapeutic action. We no longer practice in an era in which interpretation is viewed as the exclusive therapeutic arrow in the analyst's quiver. Yet precisely what role insight, toppled off its prior pedestal (Sandler and Dreher, 1996), retains among the range of interpretive and non-interpretive mechanisms of therapeutic action, remains unclear. In this paper we provide a brief overview of recent developments in psychoanalytic theories of therapeutic action. We then attempt to provide an outline of a broader view of what is, or could be, therapeutic.

Evolving concepts of therapeutic action

Loewald was of particular importance in the transition to a broader view of therapeutic action. In his seminal 1960 paper, he noted that the process of change is ‘set in motion not simply by the technical skill of the analyst, but by the fact that the analyst makes himself available for the development of a new “object relationship” between the patient and the analyst …’ (pp. 224-5). Strachey (1934) similarly foreshadowed more recent views in his classic paper on the mutative interpretation, in which he argued that the analyst as a new object is introjected into the patient's superego and thus modifies its harshness.

In attempting to characterize recent trends and controversies, we call attention to three themes running through contemporary psychoanalytic discourse (1) the waning of the ‘interpretation versus relationship’ debate, and the acknowledgment of multiple

modes of therapeutic action; (2) the shift of emphasis from reconstruction to the here-and-now interactions

between analyst and patient; and (3) the importance of negotiating the therapeutic climate.

The acknowledgment of multiple modes of therapeutic action and the waning of the ‘interpretation versus relationship’ debate

The results of the Menninger Psychotherapy Research Project have been influential in pointing to multiple mutative pathways in psychoanalysis and psychoanalytic psychotherapies. In his final report on the Project, Wallerstein (1986) examined the treatments of 42 patients and found that supportive strategies resulted in structural changes just as durable as those brought about by interpretive approaches. Calling attention to our own idealization of insight, Wallerstein noted that interpretive and supportive elements are always intertwined, and supportive or relationship aspects of the treatment should not be denigrated. Blatt's (1992) subsequent reanalysis of the Menninger data suggested that whether patients were classified as primarily ‘introjective’ (preoccupied with establishing and maintaining autonomy and self-definition) or ‘anaclitic’ (preoccupied with issues of relatedness) predicted the extent to which positive outcome was associated with interpretive versus supportive elements of the treatment, respectively. (In many if not most cases, of course, mastery and autonomy on the one hand, and increased capacity for mature and intimate relationships on the other, are both of substantial import to the patient and the treatment.)

In recent years, the either/or polarization of insight through interpretation versus change through experiencing a new kind of relationship has given way to the recognition that these two mechanisms of change operate synergistically in most cases, with greater emphasis on one component for some patients and the other component in others (Cooper, 1989; Jacobs, 1990; Pulver, 1992; Pine, 1998; Gabbard, 2000). There is no longer as sharp a demarcation between interpretive and relational aspects of therapeutic action. Insight into aspects of the relationship itself that are corrective may foster further change, and the content of interpretive comments may at times be less important than the often unconscious meanings, including relational meanings, transmitted in the course of the interpretation (see Pulver, 1992; Stern, 1994; Stern et al., 1998). As Joseph and Anne-Marie Sandler suggested, in a more contemporary elaboration of Strachey's ideas about no-ninterpretive elements of change:

The analyst has to provide, through his interpretations and the way he gives them, an atmosphere of tolerance of the infantile, the perverse and the ridiculous, an atmosphere which the patient can make part of his own attitudes towards himself, which he can internalize along with the understanding he has reached in his joint work with the analyst (1983, p. 423).

Pine (1998) suggests that it is no longer useful to look for a single mode of therapeutic action within psychoanalysis. The mechanisms of change in analysis will always be

individualized according to the characteristics of patient and analyst. Below we suggest how we can both accept a more pluralistic view of mechanisms of therapeutic action while becoming more, rather than less, systematic in our thinking about how change occurs in different patients at different times.

The shift of emphasis from reconstruction to the here-and-now interaction between analyst and patient

Though still useful, reconstruction is now de-emphasized, and we spend less of our time digging for buried relics from the patient's past. Rather, much of our focus is on the way the here-and-now interaction between analyst and patient provides insight into the influence of the patient's past on patterns of conflict and object relations in the present (Arlow, 1987; Gabbard, 1997a). In this respect, one of Freud's masterpieces is his 1914 paper on remembering, repeating and working through. Freud makes the observation that what cannot be remembered will be repeated

in action in the patient's here-and-now behavior with the analyst. This concept was the original meaning, of course, of acting out: the patient's past patterns of internal object relations and the conflicts surrounding those relationships will unfold in front of the analyst's eyes, and no archeological excavation is necessary to unearth them.

A significant addition to Freud's understanding is our current emphasis on enactment, role-responsiveness and the various phenomena that fall under the rubric of projective identification (Gabbard, 1995). We now view the analyst as inevitably pulled into the ‘dance’ the patient recreates within the consulting room—hence the focus on the interactions between analyst and patient in the here-and-now. In this view, transference–countertransference dimensions of the treatment are a primary stage on which the drama of the therapeutic action unfolds, and these enactments are both experienced and interpreted.

From a contemporary point of view, an important aspect of the analyst's role is to help the patient become aware of unconscious patterns expressed in the patient's nonverbal behavior, so that the patient ultimately can gain a sense of mastery and understanding of what is being repeated in one relationship after another (see also Wachtel, 1997). Fonagy and Target (1996) characterize this process as expanding psychic reality by mentalizing, or developing reflective function. A principal mode of therapeutic action involves the patient's increasing ability to perceive himself in the analyst's mind while simultaneously developing a greater sense of the separate subjectivity of the analyst. This model links the interpersonal with the intrapsychic and is intimately related to Benjamin's (1995) notion that intersubjectivity is a developmental achievement in which objects are ultimately replaced by subjects regarded as having a separate internal world from oneself (Gabbard, 1997b).

Although many of the avenues to change described by contemporary theorists involve explicit interventions, conscious mastery of the implicit and repetitive modes of relatedness is often accompanied by changes in non conscious affective and interactive connections described by Lyons-Ruth et al. (1998) as implicit relational knowing. According to Lyons-Ruth and colleagues, changes in implicit relational

knowing may occur in ‘moments of meeting’ between analyst and patient that are neither symbolically/verbally/consciously represented nor dynamically unconscious in the ordinary sense. Yet these moments of meeting can be important in reorganizing procedural and affective experience in a relational context (Stern et al., 1998; Bruschweiler-Stern et al., 2003).

Based on both clinical observation and systematic empirical analysis of transcripts of analytic hours, Jones (1997, 2000) has recently developed an integrative model that takes into account both interpretation and interaction occurring in the relationship, which he terms repetitive interaction structure. In this model therapeutic action occurs in the recognition, experience and understanding by both members of the analytic dyad of a pattern of repetitive interactions.

Negotiating the therapeutic climate

With the demise of any consensually held notion of ‘standard technique’ has come an increasing flexibility in psychoanalytic practice and a recognition of the inevitability—and value—of the negotiation process that takes place in each analytic dyad. Greenberg (1995) refers to this as the interactive matrix, and he argues that the frame itself and the ‘rules’ are varied depending on the specific nature of the analyst's and patient's subjectivities. In his writing on professional boundaries, Gabbard has argued that, to avoid the perils of defensive rigidity, we must conceptualize the analytic boundaries as fluid and related to contextual matters in a particular analytic dyad (Gabbard and Lester, 1995). This change does not mean that ‘anything goes’ in the analytic hour. It does mean, however, that rigid adherence to a technical stance that fails to

meet the patient in an interpersonal ‘space’ comfortable enough for both participants (one that engages the patient in the kind of creative interpersonal negotiation that one hopes to foster in the person's other relationships) can often be as countertherapeutic as ‘wild analysis’.

According to Mitchell, negotiation and mutual adaptation are central to therapeutic action. He notes that:

There is no general solution or technique, because each resolution, by its very nature, must be custom designed. If the patient feels that the analyst is applying a technique or displaying a generic attitude or stance, the analysis cannot possibly work (1997, p. 58).

From this process of entering one another's subjective experiences, what ultimately emerges is what Mitchell calls ‘something new from something old’ (p. 59), which he regards as the central mechanism of therapeutic action. In a similar vein, Hoffman (1994) has emphasized that therapeutic action is inherent in the dialectical tension between throwing away the book and retrieving it.

To summarize, we no longer have a consensus in psychoanalysis about what works and why. In general, the current psychoanalytic scene is witnessing a movement toward greater humility. This humility is reflected in tolerance for uncertainty—in our professional literature as well as in treatment hours. Indeed, for some patients there may be a profoundly mutative effect in the patient's recognition—and at times the analyst's honest disclosure—that the analyst does not know everything and is dependent on a collaborative effort with the patient to figure out what is going on.1

The virtues of a non-defensive attitude toward uncertainty are clear, but so are the dangers inherent in theoretical and therapeutic agnosia. It is useful to acknowledge that we are often sailing without a reliable compass, but it is not useful to be rudderless. In this paper we begin to outline a working model of therapeutic action that integrates theory and data from within as well as outside psychoanalysis—integrating an analytic attitude toward meaning with a systematic attitude toward mechanisms and experimental data from allied disciplines. In so doing, we hope both to describe and place under a broader, more comprehensive umbrella what most of us do when we practice psychoanalysis and psychoanalytic psychotherapy, as well as to consider what we might do if we were to take a more systematic attitude toward the various targets of therapeutic activity that could produce symptomatic and characterological change.

A theory of therapeutic action must describe both what changes (the aims of treatment) and what strategies are likely to be useful in facilitating those changes (techniques). We address each of these in turn, and then conclude with some general implications of thinking this way about therapeutic action. Throughout, we beg the reader's indulgence if the presentation seems at times more like an outline or skeleton of a theory, without some of the connective tissue or clinical and empirical ‘meat’ that usually fleshes out such an argument. Our goal here is to lay out the parameters of a way of thinking about therapeutic action(s), which limitations of space (and, some will conclude, of intellect) prevent us from fleshing out in greater detail.

Before beginning, one caveat is in order. Readers are likely at various points to wonder about the extent to which some of the technical suggestions we are advocating are analytic. We would suggest deferring the question of whether these principles or techniques are analytic and focusing instead on whether they are therapeutic. If the answer to that question is affirmative, the next question is how to integrate them into psychoanalytic or psychotherapeutic practice in a way that is most helpful to the patient. The question of whether something is analytic may

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1 In a paradoxical way, this attitude toward uncertainty in the consulting room is likely to be associated with a more, rather than less scientific attitude within psychoanalysis. Science is first and foremost about framing and testing hypotheses, not about establishing certainty—or its dangerous proxy, the subjective sense of certainty.

at times be useful, but it can, we believe, become a countertransference snare that diverts our attention away from understanding therapeutic action—that is, from understanding what helps people change aspects of their character and problematic compromise formations so that they can live more satisfying lives.

What changes in psychoanalysis?

Distinctions in cognitive neuroscience between implicit and explicit systems that are both functionally and neuroanatomically distinct in many respects converge with Freud's early emphasis on the distinction between conscious and unconscious to suggest two central goals of psychoanalytic forms of treatment. The first and central goal is to alter unconscious associational networks, particularly (a) those that trigger problematic emotional reactions, (b) those that trigger problematic defensive strategies, and (c) those that underlie dysfunctional interpersonal patterns. A second goal of treatment, which the distinction between implicit and explicit processes in cognitive neuroscience has brought into bold relief, involves altering conscious patterns of thought, feeling, motivation and affect regulation. The two goals, and the subgoals that constitute them, often require different types of intervention.

Changing unconscious associational networks

Developments in the cognitive neurosciences have recently placed the importance of altering associational networks on firm ground (Westen and Gabbard, 2002a, 2002b), thanks to the burgeoning literature on implicit memory—memory that is observable in behavior but is not consciously brought to mind (Roediger, 1990; Schacter, 1992, 1995, 1998). Of particular importance from a psychoanalytic point of view is associative memory, a subtype of implicit memory that refers to unconscious links between cognitive, affective and other psychological processes that have become associated through experience. These networks are unconscious whether or not they are conflictual or defended against; we have no access to them, and we are not aware of their state of relative activation or deactivation at any given time, which determines their effects on ongoing mental activity and behavior (such as transference reactions). To the extent that unconscious networks guide most of our thought, feeling and behavior, in most cases they will be the primary focus of therapeutic action.

One central target of associative change, familiar to all analysts, lies in the links between affects and representations. A patient may have feelings of self-loathing associated with a representation of the self as bad, greedy or sexual. Another might associate anger with representations of father figures, or with relational interaction sequences that resemble interactions with his father from childhood, which may trigger defenses, compromise formations or ways of behaving that lead to distress or elicit precisely what the patient fears.

A second and related type of change involves altering the networks that represent unconscious wishes (Brenner, 1982). This has long been a central aim of analytic treatment, such as helping patients who recurrently place themselves into inappropriate relationships understand what they are enacting and develop desires that lead them to more satisfying relationships. However, we are actually short on both theoretical and technical accounts of how to help people change motives that are highly gratifying, if ultimately problematic—and of precisely what happens to the old motives once the person begins to seek more adaptive goals and objects.

A third type of change involves altering the networks that constitute unconscious pathogenic beliefs, such as patients' fears about what will happen if they allow themselves happiness or success, express anger, and so forth (Weiss, 1990). In some cases, the belief may

be more of an implicit, automatic association rather than a fully formed fantasy. For example, a patient may avoid achievement because he harbors an unconscious belief that others will be hurt by his success. Indeed, the affect or affect-regulatory strategy may or may not be connected with a clear fantasy. Approaching the feared object or act may unconsciously trigger anxiety, self-sabotaging actions and related defenses without any implicit or explicit activation of a belief, fear or representation of an incident. From a point of view informed by cognitive neuroscience, the relative functional and neuroanatomical independence of many implicit and explicit expectations is a major reason why insight alone may fail to effect change.

A fourth target of associative change involves defenses and compromise formations. We are here somewhat artificially distinguishing this category from the previous target of unconscious pathogenic beliefs. In fact, many unconscious beliefs have defensive functions and result from, or constitute, compromise formations. Altering defenses has, of course, long been seen as one of the most essential aspects of psychoanalytic treatment, and has been emphasized in recent theories of therapeutic action enunciated by Gray (1990) and Busch (1995). A related target of therapeutic action also emphasized by classical psychoanalysis involves compromise formations, which, once formed, may then be triggered automatically in similar situations or form a prototype or template for future such compromises.

Two points here are worthy of note. First, although we often think of the goals of different schools of psychoanalytic thought as incompatible or incommensurable (e.g. changing problematic compromise formations versus altering the patient's patterns of object relations), most of these goals can be understood in terms of altering unconscious associational networks. For example, changing problematic internal object relations means changing the networks that represent significant others, significant interpersonal situations (self-with-other paradigms), affective reactions to significant others or situations, ways of regulating particular affects in close relationships, and so forth. As we will see, helping patients change enduring internal object relations also means attending to the individual's external relationships in life outside the analysis, which, after all, are the ultimate targets of change involving object relations.

A second point is what it means to alter the functioning of associational networks, and how this relates to the concept of structural change. Whether our goal is to alter motives, pathogenic beliefs or ideas, defenses, compromise formations, or links between affects and representations, change typically involves three processes. The first is a weakening of links between nodes of a network that have been activated together for years or decades, and a general lowering of their level of chronic activation (that is, their tendency to assimilate new experiences and hence to affect ongoing mental activity). According to connectionist models in cognitive

neuroscience, which share many features with the model of associative networks implicitly and explicitly held by Freud (Westen and Gabbard, 2002a), representations are not ‘things’ stored in memory, but connections among mental units (ideas, memories, sensations, affects etc.) that ‘fire together.’ Representations, in this view, are potentials for reactivation—that is, patterns of neural firing that occur under certain conditions based on their prior levels of activation. A representation that plays a powerful and recurrent role in a patient's psychic life (e.g. a representation of self interacting with a critical authority, which leads the patient to interpret relatively benign comments as critical or to ‘strike first’ and rebel) is a potential that has been activated many times before (and perhaps recently, which increases its level of activation) and hence exists in a heightened state of potential.

Thus, associative change means weakening links between mental processes that have become associatively linked. Second, structural changes in associative networks involve creation of new associative linkages, or the strengthening of links that were previously weak.

A treatment that results in structural change does not obliterate or completely replace old networks, which is neurologically impossible under most circumstances. Rather, lasting change requires a relative deactivation of problematic links in activated networks and increased activation of new, more adaptive connections, so that the patient will tend to find new, more adaptive compromise solutions. If circumstances are powerful enough—that is, if they spread enough activation to networks in ‘disrepair’—they can activate ‘regressive’ dynamics in even well-analyzed patients. One would hope, however, that much of the time a patient who has achieved what we think of as structural change would have learned to recognize these dynamics consciously, to understand the meaning of their re-emergence, and to use this conscious knowledge and the capacity for self-analysis to bring them back under control or seek further help.

Thus, from a view that integrates psychoanalytic concepts of affect, motivation and conflict with a connectionist model of representation, structural change is a matter of degree, and depends on several factors. The first is the durability of changes in associative networks in the face of powerful life circumstances that may exert a pull towards old solutions—which in turn depends on the extent to which those circumstances arise, which may or may not be under the patient's control. The second is the extent to which changes in associative networks are pervasive and clinically significant in their impact on previously dysfunctional patterns. The third is the patient's capacity for conscious self-reflection, which allows him to override unconscious dynamics once they are recognized.

In this sense, patients do not either make or fail to make structural change, because there is no single structure. What we call structural change is always relative to a persistent dynamic or pattern that is interfering with the patient's ability to love and work. The extent to which we consider change structural depends on the extent to which it is durable, important to the person's life and capable of coming under conscious control when circumstances activate regressive ‘pulls’ on old networks.

Altering conscious patterns of thought, feeling, motivation and affect regulation

A crucial recognition that is beginning to emerge from the experimental literature on implicit thought, feeling and motivation is that neither conscious nor unconscious processes can be taken for granted from a therapeutic standpoint (Westen, 1999, 2000). Many defenses, for example, likely become routinized, like much of procedural knowledge ('how-to' knowledge, or skills—in this case, procedures for regulating affect unconsciously), at the level of the basal ganglia (subcortical structures increasingly implicated in procedural knowledge) as well as in inhibitory circuits in the ventromedial prefrontal cortex. In contrast, conscious affect regulation strategies (often called coping strategies), such as self-distraction, involve executive functions associated with working memory (momentary memory available for conscious manipulation), which is under control of circuits in the dorsolateral prefrontal cortex as well. The technical strategies that are most likely to produce changes in conscious and unconscious affect regulation strategies may thus at times be different, because they are directed at changing structures that are not only functionally but neuroanatomically distinct. The same can be said for changing conscious thought processes, which may be qualitatively different from unconscious thoughts and fantasies. Aside from altering unconscious associative networks, then, another target of therapeutic action lies in conscious patterns of thought, affect, affect regulation and motivation.

For years we have assumed that the most important interventions target the 'deepest' processes, by which we mean the most deeply unconscious (see Wachtel, 1997). In part, this assumption makes good clinical sense. Clinical experience suggests that focusing primarily on conscious thoughts or feelings (as in cognitive therapy for depression) tends to produce only

short-lived changes, and careful examination of the research basis for such treatments supports this view (Westen and Morrison, 2001). Recent research in cognitive neuroscience suggests why this should be the case: implicit processes are psychologically and neurologically distinct from explicit ones, so that targeting only those processes that reach conscious awareness is likely to leave many important associational networks untouched.

In some respects, however, the relative lack of attention to conscious processes in psychoanalytic writing on both therapeutic action and technique is paradoxical, given Freud's 'implicit' emphasis on the importance of consciousness in his dictum about making the unconscious conscious. Consciousness no doubt evolved because it served a function or functions. A prime function of consciousness is to provide the organism with the capacity to override the 'standard operating procedures' encoded in implicit associational networks and to 'reset' some of the parameters of those networks (the strength of connections among their linked units) through conscious reflection and actions that alter subsequent experience (see Horowitz, 1999). Indeed, experimental research documents show that, when people are not consciously thinking about their motives, they are guided by implicit motives, but when they turn their conscious attention to their motives, their conscious goals—which have very different

developmental correlates and origins—tend to regulate their actions (McClelland et al., 1989). To the extent that conscious and unconscious thoughts, feelings, motives and affect regulation strategies may differ, it stands to reason that a comprehensive therapeutic approach—and a comprehensive theory of therapeutic action—would address conscious as well as unconscious processes. A greater focus on conscious processes is one of the ways we often distinguish between psychoanalysis and psychoanalytic psychotherapy. However, the extent to which we can, and should, address conscious processes even in psychoanalysis is a topic worth careful consideration.

Several kinds of conscious process are worthy of therapeutic attention. First, treatment may target conscious thought processes. One patient, for example, was consumed with thoughts about a man she had hoped would propose and instead spurned her. She spent most of her waking (conscious) moments for the following year ruminating about what she might have said, what he meant when he said particular things, and so forth. Over time, the patient came to understand her tendency to ruminate as a defensive strategy that had once allowed her to cope with the uncertainty of having an intermittently abusive parent. This insight-oriented work aimed at examining the unconscious function of rumination for her, which was tied to its etiology. At the same time, however, the therapist helped her distinguish modes of conscious self-reflection: introspection, aimed at examining experiences in the past or present with an attitude of curiosity, self-exploration and the possibility of change in the future; and rumination, which dwells on the past with an attitude of regret. The former is ultimately likely to lead to a sense of freedom from prior emotional constraints, whereas the latter is likely to ensnare the patient in these constraints further and to perpetuate her anxiety and depression. In fact, this distinction proved very helpful to the patient in regulating spirals of negative affect, as she began to catch herself ruminating and to shift gears by asking herself questions about the functions rumination was serving at those moments (e.g. ‘What am I getting out of this right now?’, ‘What would I be feeling if I weren't ruminating?’, and ‘What is doing this preferable to?’). Indeed, exploration of this conscious dynamic led to a better understanding of a way she was initially using the treatment process in the service of rumination (and hence self-flagellation) rather than change.

As this example suggests, and as empirical research amply documents (Power and Dalgleish, 1997), conscious thoughts can amplify feelings, which can in turn lead people either to undertake or to avoid actions that profoundly affect their lives. This is frequently apparent in patients with self-defeating dynamics, whose conscious attitudes toward themselves, like their

unconscious attitudes, contribute to their failing to obtain or maintain jobs, relationships, and so forth. Despite the lack of an explicit theoretical rationale, we suspect that most analysts and analytic therapists routinely call depressed patients' attention to the way they consciously berate themselves, expect the worst, discount their own abilities, and so forth. Although doing so is unlikely by itself to change unconscious networks, it may well help stop self-defeating spirals and allow patients to make better life decisions, which can in turn impact their future happiness.

A second target of therapeutic action is conscious affect states. Focusing on conscious affect states may involve efforts to alter the frequency or intensity of particular feelings, helping the patient recognize and tolerate contradictory feeling states (e.g. love and hate toward the same person (Kernberg, 1975)), or helping the patient tolerate feelings that are uncomfortable (Krystal, 1977). Much of the time, in fact, patients come in with the explicit goal of reducing aversive emotional states such as anxiety and depression. At other times, however, a therapeutic goal may be to increase, rather than decrease, the consciousness of particular emotions, such as helping a person who is passive and unassertive become aware of anger.

In this respect, an important goal in many treatments is helping patients learn to tolerate affects such as anxiety enough so that they can use them as signals (Siegel and Rosen, 1962). From an evolutionary perspective, the function of affect is to guide thought and behavior in ways that foster adaptation, and a chronic tendency to avoid specific affects or affect in general (as in many obsessive patients) leaves the individual without an essential compass for navigating life, and particularly social life (Westen, 1985, 1997). Bechara et al. (1994) have described the difficulties patients with damage to the amygdala or ventromedial prefrontal cortex often have in trying to make life choices. Although their capacity to think may be intact, their inability to imagine or make use of the affective consequences of their actions renders them, like many psychopaths, unable to make decisions that protect either their own or others' interests.

A third target of therapeutic action is the conscious strategies people use to regulate their affects, typically referred to in the psychological literature as coping strategies. Although we may not always target such processes explicitly, changes in conscious coping strategies often provide an index of change, as when a patient begins to show an increased capacity for using humor to cope with unpleasant realities, particularly about the self. At other times, particularly in patients with severe personality disorders who lack basic affect regulation skills, conscious coping strategies may be an essential, explicit target of therapeutic action (see Westen, 1991; Linehan, 1993). Indeed, this was a central recognition of the ego-psychology of the mid-twentieth century (e.g. Redl and Wineman, 1951).

A final target of therapeutic action is the conscious motives that guide people's behavior when their consciousness is engaged in goal-directed activity. To the extent that these motives are maladaptive or reflect unconscious compromise formations, and to the extent that they may lead people to behave in ways that are ultimately detrimental to their well-being, they should become the target of treatment just as unconscious motives should. More often, of course, our aim is to bring to consciousness motives that are unconscious so the patient can make more informed choices about what he wants to do, what messages he wants to convey etc.

Technique: strategies for fostering therapeutic change

Having provided a first approximation of an outline of the primary targets of therapeutic change, we now turn to a dissection of the technical strategies that may be useful for effecting change. As we hope to show, clearly spelling out the multiplicity of targets of therapeutic action may be useful in calling attention to multiple ways we

could proceed therapeutically at any given time. We focus here on three classes of intervention: those aimed at fostering insight, those that flow from aspects

of the therapeutic relationship, and ‘secondary strategies’ such as exposure and self-disclosure. The first two are central to psychoanalysis proper, while the secondary strategies are more closely linked to psychotherapy, but none should be considered exclusively the province of one or the other.

Fostering insight

The two major techniques for fostering insight, of course, are free association and interpretation. Free association is useful for two primary reasons.2 First, as Freud emphasized, it provides a way of seeing defenses in action, occasionally gaining a glimpse behind them (when the patient is associating relatively freely), and observing the circumstances under which resistance emerges (when the patient is not as able to associate freely). Second, and related, free association allows the patient and analyst to explore and map the patient's implicit networks of association—to work together as cartographers of the mind to create a model of the networks that lead the patient to think, feel and act in the ways he does under various circumstances. Conscious, goal-directed speech can interfere with this process because conscious cognition operates on different principles than unconscious associational thinking. One of the salutary effects of recent developments in the neurosciences is the empirical support they ‘implicitly’ provide for this fundamental psychoanalytic technique.

Interpretation, the second technique, may be directed at any of a number of mental events. These include wishes, fears, fantasies and expectations; defenses and compromise formations; conflicts; transferential patterns; relational patterns observed from patients' narrative descriptions of interpersonal events that do not have direct analogs in the therapeutic relationship; feelings induced in the analyst by the patient's interpersonal pressure; and links between thoughts and feelings or between elements of associational networks that the patient has not recognized or wanted to recognize.

Interpretation that focuses specifically and systematically on transference themes is, of course, one of the hallmarks of psychoanalysis that typically distinguishes it from psychoanalytic psychotherapy. While psychotherapeutic approaches may involve interpretation of transference phenomena, these efforts are often more attenuated, less thoroughgoing and less systematic. Psychoanalysis relies more heavily on an approach that pushes transference understanding to its limits (Gabbard, 2001a; Greenberg, 2001). Through interpretation of transference, analysts help their patients reintegrate aspects of themselves that have been defensively disavowed through projective identification (Steiner, 1989). In this regard, part of the therapeutic action of analytic work is helping patients live within their own skin (Gabbard, 1996) through relentless interpretation of transference phenomena.

The exploration and identification of implicit procedures, such as defensive processes, may at times lead to the uncovering of unconscious (repressed) memories, which Freud once viewed as the major purpose of exploring the past. This is not likely, however, to be a central mode of therapeutic action in most treatments.

‘The relationship’ as a vehicle of therapeutic action

In our overview of current trends in understanding therapeutic action, we noted the wide cceptance of the role of the therapeutic relationship itself in therapeutic action. It is important to pecify, however, which aspects of the relationship influence which targets of therapeutic change.

First, central to contemporary relational views is the notion, which harkens back to the

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2 Free association is a technique without theoretical grounding in some schools of psychoanalysis. From a relational perspective, for example, it is not clear why free association would be useful, since it can be a somewhat solipsistic enterprise, and certainly a socially peculiar form of interaction with a person with whom one hopes to develop a meaningful relationship.

concept of corrective emotional experience, that experiencing a different kind of relationship can be an important avenue for therapeutic change. From the present perspective, much of what this entails is altering networks of association, including the wishes, fears, motives and defensive strategies that may be associatively linked to representations of objects, states or actions.

A second way the relationship can contribute to change is through internalization of function, in which the patient develops the capacity to perform a hitherto external function, as when a patient learns to self-soothe through repeated experiences of soothing by the therapist (e.g. Adler and Buie, 1979). At times this may begin through forming a representation of the therapist that the patient uses consciously when upset and then gradually begins to use automatically and unconsciously. However, internalization of function often does not require the use of a conscious, declarative representation of this sort. Precisely how patients internalize therapeutic ministrations and create procedural memories that can be activated consciously and ultimately unconsciously is worthy of careful thought and research.

A third way the relationship can be therapeutic is when the patient internalizes affective attitudes from the therapist. For many patients, this involves tempering a hypercritical superego, as when the patient begins to internalize the therapist's interested, exploratory stance toward material previously experienced as shameful or otherwise ‘bad’, or when the patient internalizes a more explicitly temperate attitude toward his impulses or actions. This may occur through explicit comments by the therapist as well as through gestures, intonation and other forms of communication that may be registered implicitly or explicitly. To what extent implicit and explicit pathways for therapeutic change contribute to the alteration of enduring associative networks and conscious patterns of mental activity is unclear and again worthy of research.5

A fourth way the relationship can be an active change instrument is through internalization of conscious strategies for self-reflection—that is, when the patient gradually becomes his own analyst. In part, this may occur through simple observational learning processes, although as Fonagy has observed, a crucial avenue for therapeutic change may lie in the patient's increasing capacity to ‘find himself in the therapist's mind’ (1999b, p. 51). All of these aspects of internalization are predicated on development of a therapeutic relationship in which the patient feels safe enough to explore his mind in the presence of an other.

Finally, a central use of the relationship in psychoanalytic forms of treatment lies in the identification of prominent transference-countertransference paradigms. Because many relational patterns reflect implicit procedures and associations, people are frequently unaware of them. In other instances, people are unaware of these patterns because of their conflicts and defenses against knowing. This is an example in which it is useful to distinguish cognitive explanations, in this case regarding the lack of conscious access to implicit procedures, from dynamic explanations, which involve motivation. In the present instance, these appear to be complementary rather than competing explanations.

It should be clear from this discussion that we are not arguing that simply by being different the analyst changes the patient's internal world. The notion that being different can be transformative has an extensive and controversial history in the psychoanalytic literature, going back at least to Strachey's (1934) classic paper on therapeutic action. Strachey stressed that the analyst should avoid any behaviors reminiscent of the ‘bad’ archaic introject because the analyst would then be less distinguishable from that object, and interpretation would be less mutative.

From a more contemporary viewpoint, what is crucial is that the analyst (or analytic situation) is not only different from an object from the past but in some respects similar to it.

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5 A large body of social-psychological research on central (direct, rational) and peripheral (implicit, affective) routes to attitude change may be of some relevance to this question (see Eagly and Chaiken, 1998).

From a connectionist perspective, features of the analyst or the analytic situation must themselves bear enough resemblance to prototypes from the past to activate core networks to be reworked. At times, the patient's activated networks will in turn pull the analyst into enactments that can be crucial for the patient and analyst to understand and transform. For example, in one case, the analyst unwittingly found himself enacting a pattern in which he felt provoked by the patient's cavalier attitude about spending, which was threatening her ability to remain financially solvent, and started to criticize her about her irresponsibility in a way reminiscent of her mother's pervasive criticism of her. By interrupting this complex ‘script’, in which the analyst was drawn into the role of the mother, the analyst helped the patient recognize it, form

new associations to talking openly with an intimate other (being understood rather than criticized or attacked) and develop new compromises to regulate the relevant affects.

Secondary strategies

The primary vehicles of change in psychoanalysis involve the therapeutic relationship and the acquisition of insight or understanding. In psychoanalytic psychotherapy a variety of other avenues of therapeutic action are common. Several secondary strategies can, if used thoughtfully, contribute substantially to meaningful change, including what we normally think of as structural change, and hence should be included in any discussion of therapeutic action. Some of these strategies may (or should) operate in psychoanalysis as well, at least at certain times with certain patients, and may at times be inappropriately dismissed as tangential to the 'real' work of analysis.

The first such class of interventions involves various forms of confrontation that carry implicit or explicit suggestions for change. Freud wrestled from the start with the concern that psychoanalysis involves elements of suggestion, both because he wanted to distinguish psychoanalysis from hypnosis and because he was aware of the limitations of hypnotic cures. Yet suggestion is an inherent part of analytic technique and an inescapable byproduct of the analyst's authority (Levy and Inderbitzin, 1997). For example, many interpretive comments that include confrontive elements call the patient's attention to patterns of behavior, and particularly maladaptive relational patterns, with an implicit or explicit suggestion that the patterns are problematic and may require change (Raphling, 1995). Indeed, the simple act of exploring one set of associations or issues rather than another provides information to the patient about the aspects of his mental life or behavior we consider worthy of attention and, by implication, the aspects that we suspect are giving him trouble and he might want to work on (see Wachtel, 1993). Even as neutral a comment as 'I wonder what it means that …' implies that there is something to be understood that is worth therapeutic attention and that may require change.

Under what conditions we should be explicit or implicit about the patterns we believe are causing our patients trouble (and hence that we hope will change over time) is unclear. However, clinicians may deceive themselves into thinking they are simply freely exploring associations and letting the patient make independent choices when they are in fact structuring the situation in such a way as to make it problematic if the patient does not change course. The danger of making our views explicit to the patient is that the patient may begin to externalize one side of the conflict on to the analyst and perceive the analyst (sometimes with good reason) as controlling or critical. The opposite danger, which can occur when our beliefs are clear but unconscious and defended against because they conflict with our theoretical canon, is that something is indeed happening in the room that involves suggestion and persuasion but cannot be discussed because of the analyst's concerns (and defenses) about being directive—leading to a realm of unacknowledged experience in the analytic dyad.

A second form of intervention not emphasized by most theories of therapeutic action in psychoanalysis is confrontation of dysfunctional beliefs, which can at times be as important as confrontation of problematic behaviors, defenses or compromise formations (Weiss, 1990). Although this is an explicit part of cognitive therapy, analysts regularly use it implicitly or explicitly. Simply exploring a belief or way of viewing the self that the analyst considers worthy of attention is a clue to the patient that the analyst may not agree with the patient's view of how things are. The examination and confrontation of dysfunctional or irrational beliefs is an inevitable component of any good psychotherapy for depression or anxiety, regardless of the theoretical basis for the treatment, because depressed and anxious mood states recruit ways of thinking that perpetuate dysphoria, and hence need to be addressed directly.

A third class of secondary strategies involves efforts to address the patient's conscious problem solving or decision making. We typically associate 'directive' interventions of this kind with the treatment of severe personality disorders who have difficulty with the capacity to mentalize. However, even high-functioning patients can benefit from explicit mutual problem solving. Interventions of this sort, though not classically 'analytic', can have two salutary effects. First, they may help a person make more adaptive life choices, which in turn influence his subsequent choices. For example, one patient who worked in an academic setting was enraged at her department chair, for reasons both real and transferential, and was heading to his office shortly after a session to confront him in ways that would have been disastrous for her career. The clinician interrupted her plan by both exploring the meanings of her anger and intended self-destructive response (which was in part a reparation for her anger) and by problem-solving ways she could address her concerns with her chair that would accomplish her conscious goals without accomplishing some of the less adaptive unconscious ones. The patient went on to interact with her chair in a way that not only got her needs addressed and avoided a career-ending move but also both disconfirmed a deeply entrenched expectation about the disasters that accompany self-assertion and gave her an experience of competence in a kind of confrontation that she would have found unimaginable without explicit 'coaching'. As this example suggests, helping patients problem solve may help them learn to problem solve better in the future, particularly when their affects are strong and their explicit reasoning may be compromised. Of particular note is that this patient did not have a severe personality disorder, and that a 'directive' intervention of this sort was nonetheless extremely useful for her.

A fourth strategy, exposure, is the most robust change mechanism in behavioral treatments, particularly for treating anxiety states. Exposure means presenting the patient with the stimulus or situation that is fear-provoking and inducing him to confront it and continue to confront it until he is no longer anxious—hence breaking, diminishing the strength of or otherwise altering associative links. In the treatment of panic, for example, cognitive-behavioral researchers have had considerable success in addressing the fear of fear that panic patients develop, in which they become hypervigilant for signs that they are getting nervous. This hypervigilance leads, in turn, to amplification of their anxiety and often to further panic attacks (see Barlow, 2002). Experimental evidence suggests that the association between internal states (such as shortness of breath) and anxiety about potential panic can, over time, become wired at subcortical levels (involving the thalamus and amygdala), and that these associative links may not be easily amenable to highly verbal, 'cerebral' treatments

such as psychoanalysis, except to the extent that the patient's insights into his problem lead him to confront what he is afraid of. Analysts from Freud on have noted that, for phobic patients, little progress will be made unless the patient faces the feared situation (Gabbard and Bartlett, 1998).

Evidence on the efficacy of behavioral research using exposure for panic, simple phobias

and obsessive-compulsive disorder (Dutra et al., 2001; Westen and Morrison, 2001) presents challenges that psychoanalysis will need to face in the years ahead. Patients in psychoanalytic treatments manifest avoidance in many areas of their lives (including the networks they avoid while associating on the couch), and avoidance is self-reinforcing (i.e. it keeps anxiety at bay, which in turn reinforces avoidance of thoughts, memories or situations associated with anxiety or other forms of negative affect). An exposure model can be useful in thinking in object-relations terms about affects associated with warded-off representations, as when a depressed patient actively wards off positive self-representations. Many patients with depressive dynamics fear feelings of pride and accomplishment, and actively ward off both the recognition of others and self-recognition. To what extent this is best addressed by exploring the meaning of the defense, inducing the patient to examine and ‘sit with’ positive warded-off self-representations, or some combination of the two, is an open question. For some patients, it may well be that no amount of defense analysis—or only a very long period of defense analysis, during which the patient may persist in symptoms or actions that have irremediable consequences (such as a junior faculty member on a tenure clock who presents for help with a career-threatening writing block)—will overcome the natural tendency to avoid what is threatening, without more active interventions by the therapist.

Many psychoanalytic interventions in fact rely heavily on exposure (Wachtel, 1997). Indeed, psychoanalysis began in large measure as a form of exposure therapy, predicated on the view that exposure to repressed memories (and, later in Freud's thinking, forbidden fantasies) was essential to freeing patients from the chains of their childhoods. The diminution of transference anxieties over time is in part related to exposure as the analysand recognizes that his fears of being criticized or humiliated are unrealistic. As Fonagy and Target (2000) point out, helping patients differentiate belief from fact, and fact from fantasy, is a form of exposure, in which the analyst acknowledges the patient's psychic reality of fear while simultaneously providing an alternative perspective that suggests safety.

A fifth class of ‘secondary’ interventions involves forms of self-disclosure. This can be particularly important for patients whose attachment relationships fostered incoherent working models of relationships—that is, whose attachment figures were so unpredictable that the child could not understand or predict their behavior. In such cases, limited self-disclosure can be essential in helping them learn to understand people better, maintaining their trust, and showing them a different model of emotional expression and intimacy. Judicious self-disclosure may also promote mentalization (Gabbard, 2001b), leading to an enhanced reflective function in the

patient. For example, by sharing a feeling with the patient, the analyst may help the patient see that his perception of how the analyst feels is only a representation, which can be played with and understood.

Discussion of self-disclosure leads to a sixth mode of therapeutic action, namely, affirmation. As Killingmo (1989) has pointed out, patients who have experienced severe childhood trauma may experience the therapist's observations as invalidating the patient's subjective experience in the same way the patient's parents did (see also Linehan, 1993). Notions of acceptance and validation have long been central to theories of therapeutic action outside psychoanalysis (Rogers, 1959), and have begun to gain 'acceptance' in the psychoanalytic literature with their introduction by Kohut (1971). Empathic validation of the patient's perspective, however, must ultimately be complemented by an 'outside' perspective from the analyst that presents a different view (Gabbard, 1997b; Goldberg, 1999).

A final class of secondary strategies involves what we might call facilitative strategies— interventions that help the patient become more comfortable collaborating with the analyst or

therapist to come to understand his inner world. These can range from interjection of the normal social niceties that make anyone comfortable in conversation to the use of humor, educational comments (e.g. explaining to the patient why focusing on what is happening in the room can be useful) and various forms of soothing comments that can be helpful when people are confronting painful, anxiety-provoking or shame-inducing material that they may have kept from awareness—and may otherwise keep from the therapist or analyst—for many years.

Some concluding thoughts

This discussion, telegraphic though it may be, points to several conclusions. Some of these suggest changes in the way we practice, or in the way we conceptualize or fail to conceptualize what we actually do with our patients.

First, there is no single path to, or target of, therapeutic change. We would do well to stop writing about the therapeutic action of psychoanalysis, as if one basic principle accounts for all change, and instead recognize that therapeutic change probably occurs through multiple mechanisms, each of which may be fostered in ways we have not even begun to understand by different techniques.

Second, some principles of change and techniques for eliciting it are likely to be useful for all patients, whereas others are likely to be useful only for some. Any time we are tempted to propose a single formula for change, we should take this as a clue that we are trying to reduce our anxiety about uncertainty by reducing something very complex to something very simple. If we are to advance our theory of therapeutic action, and our techniques for effecting change, we will need to develop more systematically, clinically and empirically grounded models of the domains of functioning that constitute personality (e.g. motivation, cognition, affect, affect

regulation, cognition, object relations) and the ways processes in each of these domains can go awry (Westen, 1998).

Third, the variety of treatment goals and intervention strategies outlined briefly here interact in complex ways that are likely to become more clear if we distinguish them more carefully and avoid single-cause theories of therapeutic action. For example, when insight leads a patient to become less emotionally constricted in intimate relationships and to become more open and vulnerable, other people are likely to respond differently. This, in turn, will change the patient's experience of intimate relationships and lead to further behavioral change (Wachtel, 1997). Behavioral change also leads to changes in the availability of associations, which can be useful for further analytic work.

Fourth, nothing guarantees that the various goals of treatment and techniques useful for facilitating therapeutic change outlined here will be free of elements that are conflicting or at cross purposes, any more than we would expect people's motives to be free from conflict. Less active, exploratory techniques may at time inhibit alterations in associative networks that could come about if the patient were encouraged to confront a feared situation more directly, which might in turn provide analytic access to important associations. On the other hand, more active techniques that foster changes in associative networks may at times interfere with exploration, impede the patient's sense of autonomy, activate oppositional dynamics, lead to countertransferential acting in, and so forth.

A final issue is one of method and epistemology. In psychoanalysis, we write about therapeutic action as if somehow the question of what is therapeutic and how best to help our patients is one that can be settled by logical argument and debate. In fact, it is an empirical question, which can be no more answered by logic and debate than the question of whether one or another treatment for heart disease is more effective. We do not know whether one technical

stance works better than any other, because all we have are competing claims backed up by data cloaked by the privacy of the consulting room. With new technologies for measuring what actually happens in treatment hours (Jones and Pulos, 1993; Ablon and Jones, 1998) and for assessing personality structure (Westen and Shedler, 1999a, 1999b), we are now in the position to discover and measure what clinicians are doing, what changes and what ways of working are associated with better outcomes. Making use of those technologies to refine our theories of what works and for whom—by bringing together large networks of clinicians willing to pool not only their ideas but data from their practices—will be one of the major challenges facing psychoanalysis in its second century, as we attempt to move from arguing about the therapeutic action of psychoanalysis to demonstrating and refining it.

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