

# Response to Soren Ekstrom

By Jean Knox

The most urgent and vital task facing the whole depth psychology profession today is a reevaluation of our theoretical frameworks and the ways in which these shape our clinical practice. The urgency arises partly from the explosion of scientific discoveries about the nature of the human mind and brain, research findings which challenge some of the fundamental ideas of both analytical psychology and psychoanalysis and whose sound empirical basis means that they cannot be ignored. Clinical outcome studies also cast doubt on the assumption that there is a correlation between the analyst's theoretical model and his or her clinical effectiveness. Furthermore, new frameworks have been developed which help us to identify the developmental building blocks of conscious and unconscious meaning and their interpersonal roots. All of these therefore offer us new perspectives on the analytic process.

Soren Ekstrom is one of a number of analytical psychologists who are rising to the challenges presented by this wealth of new information. In a previous paper published in the *Journal of Analytical Psychology*, he highlighted the "cacophony of theories" which, he argued, conceal the relational and nar-

rative aspects of the analytic encounter (Ekstrom, 2002). In this paper he continues his exploration of the contribution that cognitive models can make to our understanding of the human psyche and then shows that this scientific understanding can be integrated with the narrative and interpersonal aspects of analytic work. The scientific and the hermeneutic do not need to be seen as contradictory, but instead the meaning-making process can itself become the object of scientific study. Soren directly addresses this issue, exploring the ways in which "recent findings in cognitive science may be integrated into the older models from various psychoanalytic theories so that the distinctly dyadic and relational qualities of treatments may be accounted for."

The dilemma, which faces every practising analyst and psychotherapist, is that our clinical work requires both a highly developed hermeneutic understanding—a capacity to relate to and explore the subjective meaning of a patient's conscious and unconscious communications—and also a reasonable grasp of the current scientific evidence about the information-processing mechanisms that underpin subjective experience and meaning. The art of being an analyst requires us to attend to the intuitive, poetic, symbolic narrative that emerges in an analytic session. It is an art which requires years of personal analysis, training, and supervision to nurture the capacity to resonate with the multiple and sometimes contradictory threads of the patient's narrative. It also requires a deeply ingrained respect

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for the symbolic process. For example, analysts who enter into sexual relationships with their patients not only abuse such a patient physically but are also engaging in a fundamental violation of the fragile co-construction of a symbolic space, a psychological abuse which may destroy the last hope that patient has of finding the symbolic "holding" that is a prerequisite for individuation.

However the art of sensitive responsiveness to a patient's subjective experience is necessary but not sufficient for clinical practice because our interpretations are shaped not only by the patient's material but also by the theoretical models that we draw on to understand that material. Unfortunately, both psychoanalysis and analytical psychology have insulated themselves for too long from the influence of empirical research in the evolving disciplines of developmental psychology, cognitive science, neuroscience, and attachment theory. Psychodynamic models have therefore become increasingly out of touch with the wealth of recent experimental evidence that provides new insights into the ways in which the human mind registers, stores, and accesses information about the world around us. Psychodynamic psychotherapists of all orientations were, until recently, mainly content to remain largely ignorant of the huge strides made by cognitive scientists in understanding the workings of the human mind. Many therapists to this day even seem proud of their ignorance of these other areas of study. They argue that the analytic session is itself a sufficient research tool and that therapists share their clinical experience and evidence with one another in seminars and in published clinical papers, believing that this provides accumulating knowledge about the human mind and the way it works.

However, Fonagy and Tallandini-Shallice (1993) have challenged this argument, pointing out the inherent bias of this approach in that analysts interpret what they find in the clinical session in the light of their preexisting expectations, assumptions, and theoretical orientation. This "enumerative inductivism," the finding of ever more examples consistent with the model being used, is essentially flawed in that its subjectivity means that it is an approach which is not capable of eliminating false positive observations; psychotherapists and analysts who rely on this method for their understanding of the human psyche have no means of modifying or discarding their theories once they have been accepted as plausible.

This diversity of theoretical models may be acceptable from a postmodern perspective, but it may be the source of considerable problems in the clinical situation. The absence of any objective criteria for testing psychodynamic models also provides an epistemological breeding ground in which multiple and competing theories about the development and functioning of the human psyche can emerge, as analysts construct new models to understand the clinical phenomena they encounter in the consulting room. The problem which then arises is that, as theories multiply, it becomes less and less possible for analysts to agree amongst themselves about the nature of the events taking place in an analytic session; the bias produced by the analyst's expectations reaches a point where no objective observation of fact is possible. For example, one American research project asked analysts to rate a transcript of an analytic session to see whether, in their view, an analytic process had been established. The alarming outcome of this study was

that the raters, all experienced analysts, could not complete the task because they could not even agree on the criteria for evaluating whether an analytic process (AP) was taking place in the session. Analysts agreed that it was a vital part of the analytic process, but there was “no meaningful consensual definition of the term AP among a group of training and supervising analysts from the Columbia Center for Psychoanalytic Training and Research” (Vaughan et al., 1997, p. 964).

If it is not even possible to agree on what constitutes the fundamental process in analytic therapy, there can be no hope of demonstrating that any therapeutic gain may result from that process rather than from other nonspecific factors, such as the intensity of sessions; there is also no hope of investigating the relative merits of different theoretical models in bringing about the analytic process if analysts cannot even agree on whether an analytic process is taking place. It therefore may not be possible to make a judgement about the validity of one model of psychic reality over another on clinical grounds in that all models may be clinically useful and appear to account for psychic change at different times.

Soren Ekstrom highlights the dangerous consequences of this situation for analytic training programs, in which “futile attempts are spent teaching an ever-increasing number of theoretical formulations of only secondary importance to how treatments progress,” and suggests that this leads to fruitless attempts to establish the correctness of one or other of these formulations whilst neglecting the vital task of drawing on other areas of knowledge to help us establish what it is that effective analysts have in common.

Part of the problem is that some psychoanalysts still strongly resist what they consider to be a dangerous encroachment of knowledge from other fields of enquiry. André Green (2001), for example, has recently suggested that observation cannot tell us anything about intrapsychic processes that truly characterize the subject’s experience and argues that

*the analytic setting provides an opportunity to observe and participate in a unique form of mental functioning, which is the only way through which the analytic state of mind can be experienced, integrated and tested, year after year, day after day, hour after hour. (pp. 71-72)*

Some of the roots of this attitude lie in the history of the psychoanalytic movement. Hamilton (1996) points out that the close connection between hypnosis and transference led Freud and his colleagues strenuously to avoid any possible accusation that suggestion might be a causal factor in bringing about change in analysis, an important point in the light of Soren’s exploration of the experience of trancelike hypnotic states in both analyst and patient. Hamilton writes:

*Since Freud, psychoanalysts have made concerted efforts to purify the field and their professional lives of this unwelcome “contaminant.” Ultimately these efforts have meant that some psychoanalytic practitioners have attempted to rid the psychoanalytic encounter of its relational—that is, emotional or affective—properties. (1996, p. 23)*

Hamilton concludes that this attempt to “study humans as if they were not human beings but, rather, mental structures, underlying principles, biological forces or affective outbursts” has

led psychoanalysts to introduce a whole set of “extra ‘non-analytic’ ideas, such as the ‘real relationship,’ the holding environment, ‘parameters,’ supportive techniques, to account for what most of them find themselves doing and saying, their theories notwithstanding.” These techniques are seen as necessary deviations from the pure analytic method, and by defining them as extra-analytic, the core concepts of analytic technique are somehow preserved.

It is this model which provides the focus for Soren Ekstrom’s critique of psychoanalytic theory and practice. Soren suggests that

*until recently scant attention was given to describing how the analyst retains and otherwise processes the information from each patient. The assumption, it seems, has been that the significant phenomena in analytic treatments are determined by the patient’s state of mind, rather independently of how the analyst structures the encounter via his or her way of remembering and ascribing meaning to the relational data. The analyst’s contribution has been viewed as primarily a question of techniques.*

Soren goes on to suggest that the analyst’s dynamically evolving memory makes a crucial contribution to the dyadic process in therapy and to treatment outcome. He acknowledges that some psychoanalysts, such as Thomas Ogden, have fully recognized the dyadic nature of the analytic relationship and explicitly place their own memories and reveries at the heart of their work. However, I think that he gives the impression that that this view is still very much outside the mainstream when he writes that the prevailing models give pride of place to techniques or procedures in producing a good outcome.

My own perception is that there have been major developments of the kind Soren describes both in the more traditional and in the newer psychoanalytic models, such as the relational school of psychoanalysis, as well as in attachment-based psychoanalytic approaches. Sandler and Dreher (1996) have given a detailed historical account of the changes that have taken place within Freudian theory and practice in terms of the goals for change in psychoanalysis and have concluded that “a desirable outcome of analysis will vary from one patient to another, and is not capable of being encompassed by one definition or measured by one single criterion” (p. 114).

Furthermore, the relational school and attachment-based therapies place the relationship with the analyst at the heart of the analytic experience and consider that the analytic process is one in which the analyst’s own contribution is seen as a vital part of the co-creation of new experience. In this approach, technique, in the form of interpretation, is not the gold standard of analytic technique; indeed, it may even be counterproductive at times, according to the late Stephen Mitchell, one of whose last publications was his response to a *Journal of Analytical Psychology* questionnaire designed and edited by the Journal’s U.S. editor, Joe Cambrey. Mitchell (2002) emphasized the fact that

*there is no way for the analyst not to act, and, in one way or another, to re-enact as well. What is crucial is a continual self-reflection on the dense, multiple reverberations of the past in the present and a commitment to forms of interaction that seem most enhancing to the patient’s developing vitality and sense of freedom. (p. 87)*

An increasing number of psychoanalysts are moving towards an acceptance of a constructive component in analytic work, recognizing that interpretations cannot focus purely on the overcoming of repression. For example, one of the foremost psychoanalytic researchers, Robert Emde (1999) concurs with this view, writing that

*over the course of its history... psychoanalytic thinking has increasingly taken into account the importance of the complexities of meaning and of integrative processes—both in practice and in the wider arenas of theory. We are not just analysing, reducing, deconstructing and dying. We are as much concerned with integration, connecting and putting together as we are with analysis. (p. 317)*

This perspective fundamentally challenges the classical psychoanalytic perspective that the central (and even the only) function of analysis is to use classical techniques in order to overcome repression by the interpretation of defences and of unconscious fantasy. Even more relevant to Soren's focus on the key contribution of the analyst's narrative memory is a paper presented by Owen Renik at the conference held by the Journal of Analytical Psychology in Merida, Mexico, in 1999, in which he described analytic work, a significant part of which involved the analyst presenting the patient with ideas she had not previously considered. His analytic method included classical techniques, but there were also times when he saw the need to offer a model of his own mind at work in order to help his patient to begin to develop her own. Renik (2000) wrote:

*If pre-existing thoughts are discovered in analysis, they are of course, the patient's*

*thoughts; whereas if thoughts are newly created in analysis they are necessarily co-authored by patient and analyst...very often the most important thing that happens in analysis is that the patient is presented with new thoughts to consider—not thoughts of the patient's which he or she has been motivated to keep unconscious, not memories of pre-verbal experiences which needed verbal presentation in order to reach consciousness but thoughts that the patient has never previously encountered. (p. 7)*

Statements such as these either explicitly acknowledge or implicitly suggest that the analyst is constantly engaged in a process of self-reflection. They also allow for an active role on the part of the analyst in contributing his or her own material that is often explicitly acknowledged as such, a model that resonates with Soren's focus on the importance of the stories that analysts construct in order to remember and find meaning in their patient's narratives.

In contrast to early psychoanalytic theory, Jungian theory recognized the relational aspects of therapy from the start. Jung was adamant that an effective analysis required the analyst to be affected and altered as well as the patient. Jung's view was that analysis is a dialectical process "in which the doctor, as a person, participates just as much as the patient" (1951, p. 116). This was the basis of Jung's view that the analyst must first have had a thorough training analysis himself; and although he was under no illusion that this would be "an absolutely certain means of dispelling illusions and projections," he argued that it would at least develop the capacity for self-criticism. He went on to suggest that "a good half of every treatment that probes at all deeply consists in the doc-

tor's examining of himself, for only what he can put right in himself can he hope to put right in the patient."

### **Implicit and Explicit Aspects of Analytic Work.**

However, these insights have not previously been used to explore the active role of the analyst's own narrative constructions, and Soren's exploration of this offers a valuable extension of the interpersonal aspect of theory in analytical psychology and psychoanalysis.

Soren's paper also breaks new ground in offering a detailed exploration of the different types of narrative which analysts construct during a session, shortly afterwards, and in the longer-term evaluation of a patient's analysis.

However, I would draw readers' attention to a paper by Michael Fordham (1995), who has also pointed out the analyst's constructive role in a review of Robert Langs's book *The Therapeutic Interaction*, writing that "when he (the analyst) has collected enough information he will develop a 'silent hypothesis' which he then, continuing to listen, tests or modifies in relation to his patient's associations until a 'sense of fit' arises" (p. 207). Fordham also emphasizes the dialectical nature of analysis in this review, a position far from the theory-bound model which Soren criticizes.

I would like to offer some additional reflections, in terms of the information processing that might underpin and link these different types of narrative and so explain their differing uses at different times in relation to the analyst's understanding of the patient's material. Soren asks:

*Are there in fact particular states in which we access meaning and implicit beliefs? How do we encode such information for long-term storage and how do we help our patients to encode experiences which were based on the state of reverie?*

Daniel Stern (2002) in a lecture coined the term "sloppiness" to describe the rather vague and imprecise nature of the analytic process and the analyst's attention to the patient's material, which has also, of course, traditionally been termed "free-floating attention." In my own clinical experience, one of the surest signs that an unconscious analytic dialogue has been established is when a patient remarks in passing that he or she knows that what we talk about in the sessions feels important and is having an impact but cannot remember the details of what has been said. Soren also highlights this as a feature of the analyst's experience in sessions, writing that "we rarely remember what actually triggered a response from us and who initiated a particular exchange, the patient or ourselves."

I would suggest that these features of the analytic work demonstrate that much of analytic work centers on implicit memory processes for both patient and analyst. The key feature of implicit memories is that they are unconscious, abstract, and generalized patterns or models, not consciously accessible and lacking specific episodic details. The analyst's training, centered on their own analysis, develops their capacity to "tune in" to implicit levels of relationship, screening out surface detail. The analyst's reverie, occasional sleepiness, and heightened suggestibility, all of which Soren mentions, are all indications that the analysis is functioning at this unconscious implicit level.

Johnson-Laird (1991) highlights the key feature of the way information is encoded and stored in implicit memory, coining the term “mental model” (p. 484). The “internal working models” of attachment theory are mental models specifically concerned with self-other relationships and can be thought of as implicit unconscious narratives, of extraordinary power, partly because they are so difficult to access consciously and explicitly. Soren demonstrates beautifully the implicit nature of the analytic experience but does not specifically draw on the concept of the analyst’s internal working models, which are implicitly constructed and modified to form a basis for the analytic work with each separate patient. Initially the analyst draws extensively on the internal working models built up from his or her own past experience, drawing on his or her own analysis and supervised work and previous experience with patients, but as the analysis proceeds, new internal working models are constructed by both analyst and patient—as Soren says, “New experiences are constantly incorporated into our already established understanding.”

Soren describes the ways in which the analyst gradually elaborates more explicit narratives, which suggests to me that a process Annette Karmiloff-Smith has identified as “representational redescription” may be at work. This process consists of a series of stages in which information is re-encoded into ever more explicit format, eventually emerging as concepts which can be expressed in language. As Annette Karmiloff-Smith (1992) says, “This pervasive process of representational redescription gives rise to the manipulability and flexibility of the human repre-

sentational system” (p. 186). It is a process that allows knowledge to become increasingly accessible to different parts of the cognitive system, so that consciousness itself can be seen to be an emergent property of the constantly reiterated process of representational redescription. Although she offers this primarily as a developmental model, she also suggests that it underpins the mastering of complex procedural skills in adult life as well, which initially can only be learnt implicitly but can later be re-encoded and described in language. This is a fundamental feature of analytic work—so often we struggle for months or years with implicit awareness about a patient and then suddenly find the words to describe what we, and often the patient, already know. An implicit narrative can gradually become explicit.

However, the danger that Soren highlights is that sometimes the new stories, which I suggest are conscious accounts of new unconscious internal working models, are forced into the straitjacket of an orthodox analytic theory that in reality they do not fit. The impact of research in other fields has provided a major impetus for review of our analytic stories, so that a greater openness to new models should develop if we take note of this kind of information.

### ***Attachment Theory and The Analyst’s Narratives.***

There is one particular field of study that has focused on empirical appraisal of subjective meaning and interpersonal relationship, namely, that of attachment theory. Soren’s paper does not make direct reference to this model, in spite of the fact that attachment theory fulfils the task of unifying the subjective narrative and hermeneu-

tic aspects of analysis with an objective, empirical approach that uses “ideologically neutral” tools to identify the effective factors in therapy. There are two crucial concepts from attachment theory that seem highly relevant to Soren’s paper, those of the “internal working model” and “reflective function.” I have already indicated some of the ways in which the concept of the internal working model, which is essentially a form of implicit memory, can guide our understanding of the analytic process, and I will now say more about reflective function, a term which describes the awareness of oneself and others as psychological and emotional beings as well as physical objects.

Reflective function depends upon the creation of adequate internal working models of mental functioning in all its aspects, including emotions, intentions, and desires as well as thoughts; one might say that reflective function requires the construction of internal working models of internal working models. Mary Main’s research with the Adult Attachment Interview has shown that reflective function underpins the capacity to give a coherent and reflective account of one’s own life. Reflective function can be measured (Fonagy, 1995, pp. 250-251). It is the most significant and compelling evidence of adult security and the most predictive of infant security; reflective function demonstrates that a person has formed internally consistent working models of relationships in which the behavior of key attachment figures can be experienced as an empathic response to one’s needs, and so, consistent, meaningful, and containing.

For reflective function to develop, the infant has to internalize the parent as someone with a mental image of the

infant, a parent who sees the infant as someone with a mind and emotions. It is the parent’s mental representation of the infant which is internalized, allowing the infant to find himself in the other. If the parent fails in this respect, the version of itself that the infant encounters in the parent’s mind is that of a physical object rather than a person with a mind of his own. Under these circumstances, it is difficult to see how an infant could experience himself as a reflective being.

In a forthcoming publication (Knox, in press) I explore the various aspects of mental functioning which combine together to create reflective function. One such feature is the psychological links that give stories their meaning. One of the defining features of any narrative is that it links events in a meaningful way through the desires and intentions of the people who play the various roles in the story, whether fictional or not. In any narrative it is minds which are the agents of change, giving rise to decisions, choices, and actions which produce effects and which link events into a coherent structure. Without mental agency, there would be no story, no meaningful thread tying events together, and those events would appear random and meaningless.

This capacity of reflective function to link experiences in a meaningful way is a crucial part of human psychological development and is intuitively nurtured by parents in the early development of their children as much, for example, as the nurturing of language itself. One of the key functions of stories is to facilitate the child’s understanding of this link between what goes on in people’s minds and the practical consequences, a process that developmental psychologists have come to rec-

ognize as vital. Stories allow a child to explore the possibilities for future events and so to investigate how the choices that people make influence events (Bruner, 1986; Emde, 1999).

Holmes has coined the term “narrative competence” to describe this ability to make sense of experiences and has investigated a range of deficits in the development of narrative capacity, linking these with differing patterns of insecure attachment. Holmes (2001) also highlights the fact that narrative is a dialogue: “There is always another to whom the Self is telling his or her story, even if in adults this takes the form of an internal dialogue” (p. 85). This dialogue is also itself a constructive process of increasing complexity in which a story is created first by one person and is then taken over and re-told on a new level by the other. This “narrative dialogue” continues throughout development, from the earliest moments of an infant’s life, and plays a central role in psychotherapeutic dialogue. Bion’s concept of “reverie” describes the mother’s role in creating a narrative that she can use to give meaning to her infant’s various behaviors, interpreting them as meaningful communications. At this stage the mother holds the storyline and the infant gradually internalizes the meaningful links that she has made for him. In this way he gradually acquires the awareness of his own mind, with its feelings and thoughts, and the sense of his mind as an agent of change, because when he wants something, his mother produces it.

This process whereby the narrative initially belongs to the parent and then is taken over by the child is also mirrored in the analytic dialogue. Our analytic theories are narratives that we construct so that we can provide an analytic rever-

ie which allows us to find meaning in our patients’ verbal and nonverbal communications when the patients themselves cannot yet do so. A successful analytic narrative is one that can become meaningful to our patients so that they can take it over, use it for themselves, and adapt it to establish their own sense of psychic causality, of the link between intrapsychic experiences and the external world. Holmes describes the psychotherapist’s role in this respect as that of an “assistant autobiographer,” whose role is to find stories that correspond to experience. This role starts in the assessment interview, where the therapist will “use her narrative competence to help the patient shape the story into a more coherent pattern.” He suggests that the patient then gradually “learns to build up a ‘story-telling function,’ which takes experience from ‘below’ and, in the light of overall meanings ‘from above’ (which can be seen as themselves stored or condensed stories) supplied by the therapist, fashions a new narrative about her self and her world” (Holmes, 2001, p. 85). Soren’s paper highlights the contribution of the therapist’s own narratives to this process.

In addition to its essential role in the construction of narrative, I would suggest that the concept of reflective function also offers a metatheoretical framework that may explain the research finding to which Soren refers, that the therapeutic effect of analysis does not seem to depend on the theoretical model the analyst uses. This could be the case if what matters in analysis is the fact that the analyst consistently finds meaning in behavior (enactments) that the patient himself or herself does not yet realize are meaningful. When, as Michael Fordham (1996) described in an account of a

clinical session, he attributed psychological intentionality to a patient's polishing his glasses, interpreting this as his wish to see more clearly, he was doing what mothers do with small infants (p. 193). He was helping the patient to construct an image of himself as a person with desires and intentions, which the analyst could recognize through the patient's actions.

It may well be true that, as Schafer (1999) has suggested, the analyst needs a consistent theoretical framework within which to process and find meaning in the patient's communications; on the other hand, for the patient the most fundamental requirement is for an analyst whose theoretical model allows that analyst to see meaning and intentionality in the patient. In other words, it is crucial for our patients that analysts constantly nurture and develop our own reflective function—our own capacities for empathy and symbolic awareness are the fundamental analytic tools we can offer. It probably does not matter too much whether the analyst's interpretations about the patient's intentions are entirely accurate; indeed, the analyst's inaccuracies, if not too great, may help the patient discover himself what his intentions are, just as a baby corrects a mother's small misattunements. Marvin et al. (2002) have conducted detailed studies, with rated video tapes, of parents' interactions with their infants as part of a 20-week parent education and psychotherapy intervention designed to shift patterns of attachment in high-risk parent-infant dyads. One of their conclusions is that smooth interactions between parents and their children are often disrupted and need repair, as Bowlby (1969) himself suggested. Marvin et al. suggest that it is this ability to repair disruption that is the essence of secure attachment, not the

lack of disruptions, and that repair requires a clear understanding and responsiveness to each other's signals. This disruption and repair process in infancy is mirrored in the analytic process in later life, and it depends on the analyst's reflective function, his or her attentiveness and sensitive responsiveness to the feedback from the patient. If the analyst's theoretical framework is one which encompasses a reasonable degree of understanding of the patient's psychological need for this kind of mutually responsive relationship, then the patient will feel contained. It is the patient's need to be understood, in the sense of being held in mind, that the analyst needs to understand and convey by the nature of his or her interpretations. The extent to which the analyst's theoretical model is compatible with the patient's need to be related to as a person, with a mind of his or her own, may be the key determinant in relation to the effectiveness of the analyst's interpretations. The analyst may believe that his or her interpretations are effective because they identify some specific unconscious conflict, whereas it may be, in reality, the analyst's constant search for unconscious meaning in the patient's communications which is the effective agent of change. Support for this view comes from research which demonstrates that successful therapy is accompanied by an increase in reflective function in the patient (Fonagy, 1995, p. 267).

The analyst's demonstration of his or her own reflective function seems therefore to be increasingly recognized as a vital part of analytic technique. I would argue that the attachment-theory model of the creation of new internal working models that contain representations of reflective function offers the most comprehensive and cogent expla-

nation for this aspect of analytic effectiveness, regardless of the theoretical framework which the analyst consciously uses. The factors which predict positive therapeutic outcome, identified by Luborsky et al., Strupp, and others, can all be seen as manifestations of the analyst's reflective function (the patient's experience of a helping alliance and the therapist's ability to understand the patient) and the capacity of the analyst to help the patient gradually develop his or her own reflective function (the patient's level of self-understanding and decrease in the pervasiveness of conflicts). In attachment theory, internalization is the key mechanism for change, and this underpins the fifth factor, the therapist's ability to assist in internalizing gains. The patient draws on the experience of the analyst's reflective function and empathy to gradually construct new internal working models of self in relation to other that include a greater awareness of mental and emotional sensitivities and needs in oneself and others.

The process of change in analysis is thus the end result of a complex interaction of factors. It is a learning process in that new patterns of relationship in analysis are internalized and used to create new unconscious patterns of expectations about future interpersonal experience. It is an integrating process in which representations and unconscious narratives are woven together into a coherent and unified sense of identity. It is also a developmental process in which primitive psychic structures provide a scaffolding that patterns and integrates new experience, allowing the gradual emergence of explicit knowledge and self-awareness.

I certainly agree with Soren that the analyst plays an active role in this

process and that the nature of this contribution is ripe for empirical and theoretical examination. I myself find the overarching framework of attachment theory to be particularly useful in exploring the analyst's active contribution to therapeutic effectiveness. Some readers might argue that attachment theory and the concept of reflective function are simply additions to the cacophony of analytic theories; however, I would suggest that this is far from the case in that they offer a higher order of explanation that focuses not on the nature of unconscious content but on mental processes, in particular the construction of symbolic meaning through interpersonal relationship.

I have not attempted to cover all the issues raised by Soren in this stimulating paper but have linked them to ideas that I have been exploring. I welcome this opportunity to contribute to the kind of scientifically informed review of the models we use, a process of review that I also hope to stimulate in the *Journal of Analytical Psychology*, and I hope that this exchange will encourage other analytical psychologists to investigate these issues further.

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