

Dyadic Processes and the Analyst's Learning: Three Models for Analytic Memory

By Soren R. Ekstrom, Ph.D.

Abstract

The often neglected role that the analyst's memory plays in psychotherapeutic treatments is the topic of this article. Based on recent findings in cognitive science, the author proposes that how analysts remember will determine their theoretical and technical stances. Since it involves the creation and use of narratives, the analyst's memory is continuously evolving, and it is aided by certain generic master-narratives. However, these narratives do not represent discrete procedures, which can be disseminated in theoretical formulations, but a dynamic system of memory-driven skills. Acquired in previous dyadic interactions, they are both similar enough to produce certain stable attitudes and, at the same time, unique enough to require highly individualized indexing.

Keywords: Analyst's memory, narratives, depth psychology, cognitive science, analytic techniques, outcome studies, reverie, induction.

This paper introduces three models for how analysts think. Broadly speaking, this thinking will be defined as having to do with how analysts process information specific to each therapeutic encounter, i.e., how analysts remember in order to understand.

The paper consists of eight different sections. The first is an introduction to three cognitive models discussed in the latter part. The second section is a

review of some of the literature of how analysts think and ways they process each analytic encounter. The third section introduces the more recent explanations of analytic theory as being narrative rather than strictly scientific. Sections four, five, and six describe the three cognitive models proposed in the paper, while the seventh section compares the proposed models with the findings from psychotherapy outcome research. The eighth and final section summarizes the discussions and the three models.

I. INTRODUCTION

Three Cognitive Models

The first model, *story matching*, opens up new ways of viewing therapeutic interactions. In previous models, the focus was on the patient's process and the patient's learning, while the analyst's role to a large extent was viewed as static. The understanding that emerges from looking at therapy interactions as being based on narratives changes this. From this new perspective, we use indices to activate our own story-based memories when relating our understanding to a patient's narration. In the process we keep building a more and more complex memory system of a particularly expert nature.

The second model, *arousal reinforced encoding*, is a direct translation of findings in cognitive science. It allows us to take into account the emotional state of the analyst when he or

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she is processing experiences with a patient. By stressing the consolidation of memory encoding as critical to recall, it also explains aspects of the analyst's later processing as central to the entire outcome of a treatment.

The third model, *reverie and induction*, has its roots in hypnotism. Both Freud and Jung abandoned this method. They found that the suggestibility of patients made the method too unreliable and led to short-lived pseudo-cures. However, recent memory research has renewed interest in how certain aspects of the hypnotic experience dovetail with central memory functions. From this point of view, analysts may in fact train themselves to be in semi-trances, high in absorption but weakly encoded, in order to deeply experience what the patient's inner world is like. In so doing, however, difficulties inherent in these hypnotic states must be compensated for.

The Critical Role of the Analyst's Memory

As I will show in reviewing some of the analytic literature, depth psychological models¹ persistently overlook the significance of the analyst's memory. This is particularly evident in how treatments are described. As a rule, the focus is on the patient, his or her diagnosis, transference, or developmental history. 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 particular way of remembering and ascribing meaning to the relational data. The analyst's

contribution has been viewed as primarily a question of techniques.

According to the prevailing models, with their roots in medicine, these techniques or procedures—also called *specific factors* (Strupp, 1986)—are what matters in achieving good outcomes. The way future analysts are trained makes this especially apparent. Too often, futile efforts are spent teaching an ever increasing number of theoretical formulations of only secondary importance to how treatments progress (Kirsner, 2001). Fruitless arguments about the correctness of one or the other of these formulations also dominate our scientific communications (Bornstein, 2001). And last but not least, we have neglected to find ways to establish what effective analysts have in common and how they develop their unique abilities.

The models proposed in this paper open radically new ways to understand these issues. By emphasizing the critical role played by the analyst's dynamically evolving memory, they demonstrate how misleading and incomplete procedural explanations are. Without taking memory into account, we have no way to establish how analysts contribute to the dyadic processes in treatments.

The three models address several other concerns. One is how recent findings in cognitive science can be integrated into the older models from various psychoanalytic theories so that the distinctly dyadic and relational qualities of treatments can be better accounted for. Another concern is the growing awareness from years of psychotherapy research that factors related to the analyst's contribution may be most essential to treatment success, more so than the application of a particular method.

My own experience tells me that how I process information during a ses-

sion, immediately after it, and when I review an entire treatment differ considerably. Still, they all have to do with how I think and how well I remember in order to understand each patient and his or her process. My performance as an analyst, I must assume, depends on how my memory is being used and how I can continually update it. More precisely, what I will call *analytic memory* (and how it functions) appears to be central to the entire treatment process.

II. THE ANALYTIC LITERATURE

Winnicott: What We Say We Do

Few contributions to the analytic literature deal with how analysts use their memory.² In terms of how analysts think, the discussions generally focus on theoretical formulations and their resulting techniques. Occasionally, however, analysts also reveal how they would like to be known to think and the particular context for this thinking.

For our review three contributions have been selected. The first two are by D. W. Winnicott and C. G. Jung and address technique formulations from two different perspectives. The third and more recent, a paper by Joseph Cambray, clarifies some of the differences between the two previous contributions. This is done by differentiating between how analysts process their experiences in their interactions with patients and when they later reflect on them.

As many analysts before him, D. W. Winnicott (1960), in his paper "Countertransference," equates his thinking with technique. He claims that "a professional attitude, a technique, separates him from his patient" and that the professional attitude is necessary in order to allow for "the patient's need to idealize the doctor, and to fall in love with him, to dream" (p.

160). He goes on to say that technique is "*the work he does with his mind*" (italics in original) and that he thinks of himself as "working with easy but conscious mental effort," which means that "ideas and feelings come to mind, but these are well examined and sifted before an interpretation is made" (p. 161).

Winnicott's emphasis on professionalism and separateness—his declaration of intent, so to speak—seems to describe one aspect of analytic attitudes: as analysts we rely on certain stable approaches. Without a cohesive set of attitudes, it would be impossible to do what we do day in and day out. Not that these attitudes remain fixed, but a sign of competence is not having to ask ourselves what something means and how to respond in every situation we are faced with.

Dating back to Freud (1954), such stable attitudes have been equated with therapeutic techniques. However, this ignores that we are dealing with a highly subjective sense of consistency that has more to do with how our memory works than with the precision of what we do. What we remember from a given session is highly selective, and much of our involvement is forgotten soon, if not immediately, after it occurred. Only certain things are retained, and we rarely remember what actually triggered a response from us and who initiated a particular exchange, the patient or ourselves. Even when a patient tells us the expected, we often listen for what is not overtly stated.

Our memory is, in other words, both fragile and selective. So if it were true that we relied exclusively on a given set of attitudes or techniques, this would only permit some very static approaches to practicing, a view that clearly is at odds with experience. In reality, our aim

is to be affected by each person we see and to listen for the unexpected, the not-yet-spoken, what is in-between the lines or expressed nonverbally. We are thus confronted with new situations, new ways of seeing and believing every day. And in spite of how little we remember, we seem able to convey to each patient that we know the most critical information about them.

On the basis of this evidence, we must conclude that our attitudes, as much as they remain stable, undergo continuous changes, even when we fail to take notice of these changes. The fact of the matter is that, when discussing technique, we are still dealing with personal attitudes with a great deal of variance between clinicians and between what the same clinician does with different patients (Teyber & McClure, 2001).

We may safely assume that our more stable attitudes were formed by situations to which repeated exposure occurred—thus our sense of something validated, technical. At the same time, relevant new experiences are constantly incorporated into our already established understanding. In essence, information from a particular patient must be made to agree with our theoretical frames. Common depth-psychological models have no answers to this conundrum.

Jung: Learning from Our Failures

Jung's writings on the topic are quite different from Winnicott's. Describing himself as having "deviationist views," he takes a contrarian stance and focuses on certain experiences that seem to be emblematic to the analytic profession.³ He says:

The extraordinary diversity of individual life necessitates constant modifications of theory which are often applied uncon-

sciously by the doctor himself, although in principle they may not accord with his theoretical creed. (Jung, 1929, para. 78)

This no doubt is another part of the equation: needing to modify our responses in ways that contradict theoretical stances. Many of these modifications occur unconsciously but may be justified by particular needs of the patient. When made conscious, they can usually be confirmed by the patient as a response to something about him or her.

What Jung articulates may in fact be an essential mechanism in dynamically evolving memory (Schank, 1999). Through repeated experiences of modifying and refining, analysts add new elements to their skill arsenal. Only when analysts fail to do so, will new learning be inhibited and a fault or unconscious blind spot develop.

Jung further argues that rigid adherence to established technique may in itself produce treatment failure by ignoring the patient's uniquely individual traits. In this context, he discusses instances of prematurely terminated treatments when a deeper reexamination of assumptions was called for. He concludes that, in such instances, the analyst must do some soul-searching, or face a sense of lost competence.

Since such critical review can only occur after the fact, we are now dealing with how to process failures. To Jung, the ability to do so is essential. He writes:

In my psychotherapeutic practice of nearly thirty years I have met with a fair number of failures which made a far deeper impression on me than my successes. Anybody can have successes in psychotherapy, starting with the primitive medicine-man and faith-healer. The psychotherapist learns little or nothing from his successes, for they chiefly confirm him in his mistakes. But failures

are priceless experiences because they not only open the way to a better truth but force us to modify our views and methods. (Jung, 1929, para. 73)

This type of dynamic learning presupposes a high degree of flexibility and openness to continuous learning. As Jung correctly asserts, not only do we need to have some fairly stable attitudes as to how we approach our work, we also need to allow for surprises—and beyond those, we need to be able to process failures and mistakes. We must in other words rely on a meaning-oriented thinking, what Jung (1928) calls a *teleological approach*, which presupposes subjective and objective, as well as introspective and receptive attitudes.

Cambray: Remembering In Session and After

That the analyst's thinking has many components is described with great clarity by Joseph Cambray (2001) in a recent article in the *Journal of Analytical Psychology* (vol. 46, pp. 275-303). While comparing two particular approaches, the Freudian *reverie* and the Jungian *amplification*, he also reveals the considerable difference between how he experienced certain interactions while they took place and when he later reflected on them.

The data for his discoveries come from an experiment he designed for the last day before a vacation, with himself as participant observer, thus both the subject of the study and the observer/researcher. The idea behind it was as follows:

By exploring the multiple images that emerge with notable frequency during the course of numerous analytic hours through a single working day, an analyst can gain a

perspective on what is being constellated in the analytic process with that analyst at just that time. The relevance of such data to the understanding of the analyst's countertransference should be obvious. (Cambray, 2001, p. 286)

In particular his personal involvement, as it played itself out in all the sessions of the day of his experiment, now came into clear focus as a type of day residue. However, as Cambray carefully points out, this became apparent only upon reflection. He writes:

Developing the capacity to identify work with countertransference enactments starts with acknowledging them as metacommunications. In the recent analytic literature they have been detected via self-observation of somatic or non-linguistic channels, and have been proven to offer valuable refinement of the analytic instrument. While they presage new awareness, the occurrence of such enactments is revealed only after the event through reflection. (Cambray, 2001, p. 292)

The fundamental difference between an analyst's thinking in the session, and after it, when reflecting over the experience, leads Cambray to recommend ongoing self-analysis. Especially when an amplification "feels too rational or intellectually abstract" and "indicates a lacuna in the personal, subjective relation to the analysand's narrative" would be imperative (p. 291).

To Cambray, processing in sessions is by necessity intuitive. It needs to be based on attunement to the patient's psyche as well as to one's own internal responses. The thinking after sessions is more extensive. Thus it often restores a sense of personal boundaries and what belongs to self is being reclaimed.

The intensely emotional involvement in sessions does not permit such recoveries (Levine, 1994).

Three Stages of Thinking

In reviewing what these analysts have to say about their thinking, three things stand out:

- 1) *Analysts need to develop stable attitudes to their work, ways of thinking that reflect healing and helpful approaches to patients. Whether they are called techniques or common approaches, they constitute a highly personal set of skills and attitudes.*
- 2) *Analysts will do things that surprise themselves and that contradict their general views of how to go about their work. Such experiences will eventually call for a modification of analytic attitudes, i.e., thinking, usually in the form of reflection after certain sessions.*
- 3) *Analysts have a need to review, modify, and change their attitudes as the result of experiences from treatment failures and impasses. Such critical review of a more extensive character must rely on a somewhat different thinking than what is used in sessions or immediately following them.*

Together these three components form a distinct way of processing in that they define the kind of thinking that analysts do by noticing when it occurs, during interactions with a patient or after. As a whole, the three stages also represent a particular way of learning and using memory.

III. NEWER PERPSECITVES ON THEORY

Introduction of Narrative Explanations

The kinds of thinking done in sessions and after them are the obvious part of the analyst's involvement in treatment processes. But receptivity

and ability to process complex interactions may not be enough to secure confident participation in the treatment process. Our everyday attitudes may also need certain narrative explanations. We are fond of calling them theories. Freud, Jung, Klein, Kohut—we have many different names for these analytic formulations, and we insist that, thanks to our chosen theory, we are able to do the work effectively.

Although theoretical formulations clearly originate in the analytic literature, they most likely found their particular personal meaning when we first tried to understand ourselves. Thus they go back to our own personal analysis (Levine, 1994). But do they remain the same even after years of practicing? All indications are that they undergo changes and become highly individualized with time (Fabricius, 1995). As dynamically evolving narratives, they are soon bound to be our own special version of Freud, Jung, Klein, etc.

The question, then, is why theoretical formulations are not abandoned all together. They certainly appear rather insignificant when processing immediate experiences with patients (Cambray, 2001). However, they resurface when we later legitimize each patient-involvement. At that point, they seem to serve the purpose of offering a uniform story to which all treatments attach. Because of their rather generic nature, we are also able to identify these master narratives with a certain school of thought and its particular terminology.

This may be one reason for the cacophony of theories about analysis (Ekstrom, 2002). As theories they are hardly open to scientific testing, and as skeleton stories, to borrow from Schank's (1990) work mentioned later,

they often conceal rather than reveal what occurred in an individual treatment. What they seem to be are well-edited stories, condensations meant to lend credibility to our work when presented to the public or our colleagues. Rather than capturing our interactions with a patient, they tend to leave out our own involvement while offering explanations for the patient's pain and afflictions.

But therein also lies the danger of these broadly based narratives: they may appear to be objective descriptions of the particular procedures used. As James Hillman (1975/1983) observes, even when attempting to describe our work with a particular patient, the traditional case history is a genre of fiction constructed around certain narrative formulas.

From Scientific Validation to Master Narratives

Roy Schafer (1981) was one of the first to propose that analytic theories in reality are master narratives, broad interpretative structures that serve as overall guides to the analyst's understanding. Freud's theories, he found, translate into two such narratives: one of the beast, the other of the machine. The beast story, according to Schafer, explains how the infant, also called the *id*, must endure the frustrations having to grow up into a civilized world, away from nature. The machine story, on the other hand, is Freud's metapsychology, a vision of human nature seen through the lenses of nineteenth-century laboratories in physiology and neuroanatomy. According to this tale, the mind is a closed system, an apparatus which needs the force of instincts to function (Schafer, 1981, pp. 26-29).

Schafer argues these archetypal stories have been "mythologically

enshrined" (p. 28). The fact that other psychoanalytic variants have developed over the years proves that we are dealing with narratives, not scientific theories. He writes:

That Freud's beast and machine are indeed narrative structures and are not dictated by the data is shown by the fact that other psychoanalysts have developed their own accounts, each with more or less a different beginning, course and ending. (Schafer, 1981, p. 29)

Other such narrative structures mentioned are self psychology, as developed by Heinz Kohut, and object relations theory, as developed by Melanie Klein (Schafer, 1981, p. 29). A certain reading of Jung would also add the story of a child's secret connection to God as revealed in dreams and visions about searching for eternal life (Jung, 1962).

Yet other narrative structures than those mentioned by Schafer can be read into the writings of Freud or Jung. Kohut (1980), for one, read Freud as describing the problems of what he calls "guilty man," and Hillman (1971) has shown us several ways of reading Jung, including as a tale of obsessive monotheism.

Since Schafer's paper, narratives have become a popular way to explain a variety of phenomena in analysis. Most, if not all, have used it to justify established theory (Spence, 1982; Sharpe, 1987; Hanly, 1992). Marshall Edelson (1992) illustrates how the narrative meaning can be attached to patients' fantasies using traditional Freudian theory, and Coline Covington (1995) details the role of narratives in analytic interpretations from a Jungian/Kleinian perspective. Robert Winer (1992) looks at case reporting as a type of narrative fiction,

possibly inspired by Hillman's (1975/1983) early explorations of the topic. He is also hinting at the possibility that we are discussing dynamically evolving memory structures of a highly individualized nature and that each practitioner creates and recreates his or her master story (Winer, 1992, pp. 85-89). From that vantage point, there are certainly many other master narratives in use, with different plots, different characters. Some may be combinations of the ones already mentioned, others may stake out entirely new narrative grounds.

The particulars of these master stories may be far less significant than the fact that analysts develop them for a particular purpose. Although a very similar set of terms is being used, such as *psyche*, *the unconscious*, *transference*, *countertransference*, etc., the terms themselves tell us very little about the particular events attached to them.

Scholars of literary fiction, where the interest in narratives first surfaced, stress this point. They also look upon narratives as having ever-evolving discursive versions. According to Jonathan Culler (1981), a scholar in comparative literature, notions of how "one thing leads to another" and "how something came about" will inevitably change as new experiences make it necessary to modify or expand on a story. He writes:

Scientific explanation makes sense of things by placing them under laws—whenever a and b obtains, c will occur—but life is generally not like that. It follows not a scientific logic of cause and effect but the logic of story, where to understand is to conceive of how one thing leads to another, how something might have come about: how Maggie ended up selling software in Singapore, how George's father came to give him a car. (Culler, 1997, pp. 83-84)

In line with memory research, Culler (1981) proposes that a narrative is the structure which underlies any particular instance of presenting a series of events, events which can be identified as "something which exists prior to and independent of narrative presentation and which the narrative then reports" (p. 171).

IV. THE FIRST COGNITIVE MODEL *Stories for Remembering and Understanding*

That thinking during and after sessions, and upon reviewing entire treatments, is part of a general learning process now appears confirmed by developments in cognitive psychology. Roger Schank, a cognitive psychologist and director of the Institute for Learning Sciences at Northwestern University, proposes that much of what we experience will be memorized as stories. In *Tell Me a Story*, Schank (1990) points out that, by creating stories about our experiences, we condense them into "a story-size chunk that can be told in a reasonable amount of time" (p. 115). In so doing, the original experience becomes coherent. By making intelligent use of indices to our stories, storage is possible that is much more complete than a simple, event-based kind. The more complex the data and decisions, the more we have to make new stories or update old ones.

Schank's original contribution was in the field of artificial intelligence and had to do with data structures he and his team called *scripts*, structures which they viewed as distinct human memory structures (Schank & Abelson, 1977). In a later review, Schank (1990) defines scripts as "a set of expectations about what will happen next in a well-understood situation" (p. 7).

In *Tell Me a Story*, Schank turned his attention to stories as another memory structure. He found that they are of particular utility when trying to understand the meaning of stories of others. Since stories deal with beliefs rather than factual details, how they are created had to be of particular significance. He writes:

We need to tell someone else a story that describes our experience because the process of creating the story also creates the memory structure that will contain the gist of the story for the rest of our lives. Talking is remembering. It seems odd, at first, that this should be true....But telling a story isn't rehearsal, it is creation. The act of creating is a memorable experience in itself. (Schank, 1990, p. 115)

Creating narratives by telling them to others thus aids us in remembering and making meaning of what happened, and once a story is created, it can be repeatedly reused. This arrangement makes reconstruction of missing or loosely connected details easier than creating a new story each time.

Stories are also involved in how we listen to someone else's stories. According to Schank, listening makes us review our own private storage of stories in order to find a fitting response (1990, p. 59). How well we understand others will greatly depend on how they perceive the stories we retrieve in response to theirs. He proposes that this retrieval occurs by extracting indices, labels we keep attaching to the original story.

To Schank, two activities are particularly significant when it comes to using our stories: the occurrence of something unexpected, and being reminded. In *Dynamic Memory* (Schank,

1982), the main emphasis is on how learning depends on what he calls *expectation failure* and our attempt to explain that failure by further indexing our stories. He bases this idea on the fact that we take particular notice every time the expected does *not* happen. Without consciously having to decide, a new index will be created so that any future occurrence of this circumstance can be accounted for. To Schank, this means that, paradoxically, "we process new experiences in terms of prior experiences, and our memories change as a result" (1999, p. x).

The other memory mechanism involved in the use of stories is what he calls *reminding*. Schank expands this notion in a revised version of the earlier work on dynamic memory. Since no two stories are exactly alike, retrieval must take place by searching for stories with similar features. Listening to others, story matching takes place when we are reminded of a story of our own which is similar enough. He writes:

When we process events as they happen, we need to find particular episodes in memory that are closely related to the current input we are processing. But how do we define relatedness? What does it mean for one experience to be like another? Under what labels, using what indices, do we look for related episodes? The phenomenon of reminding sheds light on both the problem of retrieval and our ability to learn. (Schank, 1999, p. 21)

Analytic Expertise and Stories

Schank's innovative ideas about how we understand others have obvious and immediate application to how we as analysts use our memory to perceive, to learn, and to communicate. His models illustrate how intimately remembering,

learning, and understanding are connected. Being an analyst is, in this perspective, a continuous learning process in which we train ourselves to become the carriers of many stories, many search-indices. In so doing we train a particular kind of memory which is dynamic and meaning-determined. Schank describes such expert memory as follows:

What is an expert? An expert, for our purposes here, is someone who has a great many stories to tell in particular area of knowledge and who has those stories indexed well enough to find the right one at the right time. (1990, p. 109)

Our particular area of knowledge is an understanding of the stories of others to be about their pain and their desires, their psychological deficits but also their strengths. Accordingly, our first priority is being attentive and interested so that we can obtain as much of the relevant information as possible. We do so by being reminded. Our second concern is how to hold on to that information, verbal as well as nonverbal. In order to do so, our own stories have to be used and reused. With each treatment, certain unexpected data will also surface and new indexing to the basic stories will be gained.

Our capacity to listen analytically, then, begins in our personal analysis, with the exploration of our own lives. As Mahoney (2001) suggests, particular paradigms allow analysts-in-training to create and to tell stories later to be used when listening to patients. With these as a base, further stories and indices give rise to yet other sets. In working with training supervisors, still others are added.

The stories we accumulate are also our way of remembering from session

to session and processing what happened with a particular patient. Every new patient activates several sets and forces us to create more search-indices. The search for what fits is particularly strong in the initial phase of each treatment, but as soon we have retrieved a useful set, we can also begin the creation of a story that is particular to the person—and a relationship is established.

Without searching through a mental warehouse of stories, we would not be able to understand and relate. But we need a plot line, a narrative template, to organize all this material. And it is here that our favorite theories come in handy, whether they come from case presentations, technique formulations, or from formulations by the pioneers of analysis. What we call theory is in fact our own personal compilation from all these sources and becomes a reusable template for what to expect.

As stories, these compilations, what Schank (1990, pp. 147-170) calls *story skeletons*, are quite general, but they do provide us with ways to validate what we are doing. That the names we give them often are borrowed from one or several academic disciplines—biology, social psychology, neuroscience, etc.—does not make them more reliable; they have simply found scientific-sounding names.

V. THE SECOND COGNITIVE MODEL

How Emotion Helps Memory Encoding

Arousal and emotion also seem to play an important role in how we as analysts remember things. More than a century ago William James (1890/1981) observed that certain impressions may be “so exciting emotionally as almost to leave a *scar* on the cerebral tissue” (p.

630). His hypothesis about the neurochemical nature of memory storage now appears confirmed by research. James McGaugh (1995), of the Center for Neurobiology of Learning and Memory at University of California at Irvine, studies how encoding of information is reinforced experimentally. He writes as follows about these results: "This evidence suggests the possibility that emotional arousal may enhance memory by activating systems involved in regulating the storage of newly acquired information" (McGaugh, 1995, p. 256).

From a neurobiological perspective, McGaugh views all memory as potentially distorted because, first of all, a great deal of information initially encoded in short-term memory will be lost or damaged. In the passing of time, some memories will weaken and fragment. Briefly experienced events seem especially vulnerable to forgetting or distortion. Daniel Schacter of Harvard University, in his most recent presentation of the research, *Seven Deadly Sins of Memory* (2001), describes these types of problems in terms of omission, weakening of encoding over time, attention failure, misattribution, suggestibility, bias, and persistence.

What these researchers are able to show is that different parts of our memories are stored in different parts of the brain and that the common notions of distinct entities, whole chunks of photographic or cinematic memory, is false. According to Schacter (1995), the current understanding instead suggests that "the subjective experience of remembering does not correspond in any simple way to the reawakening or reactivation of a dormant picture in the mind." (p. 24). "Rather," he continues, "information available in the present retrieval environment combines with stored information

to yield an emergent pattern of activity that we experience as 'memory'."

To a considerable degree, the accuracy of our memories depends upon their strength, and according to McGaugh (1995), "We are generally quite accurate in remembering well-rehearsed and often recalled information" (p. 255). A critical element in how strongly encoded an event becomes is the type of attention given during the follow-up of the experience. McGaugh writes:

The hypothesis that memory traces are initially fragile and subsequently become consolidated is strongly supported by clinical as well as experimental findings indicating that retention is impaired by conditions, such as brain trauma, electrical stimulation of the brain, or drugs, that interfere with normal brain functioning shortly after learning. (1995, p. 256)

Paradoxically, such consolidation, unless interfered with, is aided by arousal. In other words, while arousal may disturb attention at the moment of an initial experience, McGaugh suggests that it strengthens the ability to make experiences memorable (pp. 265-266). McGaugh also suggests that the most appropriate understanding of memory is that each act of remembering creates new memories of old experiences. What we are dealing with, in other words, is not only how a certain experience was encoded and stored, but the particular circumstances present in the actual situation when something is remembered.

When translated to the analytic situation, this means that as analysts we keep reusing already stored information with each patient. Schank's narrative model, described above, refers to this process as indexing, the creation of ever

more complex searchkeys to already formed narratives. To be strongly encoded, particularly new experiences require emotional responses. In other words, in order to remember certain experiences with each patient, encoding is aided by the degree of attention and emotional participation they elicit. At any point in a treatment when the expected fails to occur, we create additional indices to our stories by noticing and paying special attention.

This understanding also means that our entire memory is a dynamically evolving and changing system. In this regard, recommendations by others will have very little impact. It is from our own experiences that we form the memory structures we need. Particularly meaningful and arousing interactions with patients reinforce these basic schemata.

VI. THE THIRD COGNITIVE MODEL *The Reevaluation of Mutual Influence*

Another component of what analysts do in sessions is responding to the particulars of the patient's moods and feelings. Much has been written about this aspect of being an analyst: the kind of permeable presence and openness to induction that is required in order to relate to a given patient (Racker, 1968; Jacobs, 1993).

Jung, for one, understood the ability to be affected by a patient to be critical. He writes:

If I wish to treat another individual psychologically at all, I must for better or for worse give up all pretensions to superior knowledge, all authority and desire to influence. I must perforce adopt a dialectical procedure consisting in a comparison of our mutual findings. But this becomes possible only if I give the other person a chance to play his hand to the full, unhampered by my assump-

tions. In this way his system is geared to mine and acts upon it; my reaction is the only thing with which I as an individual can legitimately confront my patient. (Jung, 1935, para. 2, emphasis added)

As Sonu Shamdasani (2001) points out, Jung was at the same time unwilling to recommend any technique based on conscious suggestion, any intentional influencing of patient, either by pretending to have superior knowledge or assertion of authority. Jung's experience with hypnosis as a hospital psychiatrist had warned him against relying on data from patients under the influence of suggestion, and this included "all strictly technical methods, because these invariably assume that all individuals are alike" (Jung, 1935, para. 3). The dialectical procedure, outlined in the quote above, was to him "absolutely necessary since it alone is scientifically responsible" (ibid.).

Since the 1980s much of psychoanalytic theory has come to view transference and countertransference as intersubjective phenomena, thus moving closer to Jung's understanding (Cambray, 2001).⁴ However, the caution against using countertransference as a technique has not been part of this change. In common psychoanalytic parlance, the attitude Jung described in 1935 is usually called *induced countertransference* or *objective countertransference* (Gill, 1982; Ulanov, 1982, citing Winnicott, 1949). As such it has become an accepted approach used by most analysts (Mitchell, 1988).

The problem with this new use is that it tends to ignore the analyst's contribution to the dyadic experience. In an article critical of this trend, Morris Eagle (2001) warns that again "we assume that all feelings and thoughts

that emerge in [the analyst's] experience necessarily, and in any simple, uncomplicated way, reflect what is going on in the patient's inner world" (p. 36). He reminds us that this may be just another way to regard everything in the treatment as reflecting something about the patient.

What many of the new definitions of basic dyadic dynamics do not address is the role of the analyst's learning. An exception perhaps is the formulation by Thomas Ogden (1997), who suggests that what he calls *reverie* is the important ingredient in the analyst's processing of patient-induced feelings. Referring to Freud's (1913) comment that "while I listen, I resign myself to the control of my unconscious thoughts" (p. 354), Ogden argues that such reverie has always been an unspoken reason for the psychoanalytic use of the couch (Freud in fact refers to the couch as "a vestige of the hypnotic method" [ibid.]). To Ogden, "a necessary condition for the conduct of analysis" is that both analyst and patient "gain access to a state of reverie" (1997, p. 114).

A Cognitive Model for Understanding Induction

Implicit in his argument is that as analysts we enter trance-like states, a type of autosuggestive reverie that heightens the experience of dyadic interaction while screening out its larger context. It also implies that we permit similar states to occur in our patients. As David Spiegel (1995) of Stanford University Medical School notices, one of the characteristics of such states is an unusual degree of "absorption." He writes:

Absorption is an immersion in a central experience at the expense of contextual ori-

entation....Tellegen, the originator of the term, describes it as "total" attention, involving a full commitment of available perceptual, motoric, imaginative, and ideational resources to a unified representation of the attentional object." (Spiegel, 1995, p. 130)

Spiegel defines hypnosis as "aroused, attentive, focused concentration with relative constriction of peripheral awareness" (p. 129) and divides hypnotic states into three components: absorption, dissociation, and suggestibility. Of these three, absorption may come very close to how most analysts describe their attention in certain sessions or parts of certain sessions. Most likely, this is what Ogden (1997) has in mind when stating that the analyst "renders his own unconscious receptive to the unconscious of the analysand" (p.113).

It is also possible that analysts experience moments of the other two hypnotic states, dissociation and suggestibility. According to Spiegel, each of them affects memory. He writes:

One can conceptualize these components of hypnotic experience as having specific corresponding effects on the three main components of memory processing: encoding, storage, and retrieval. Absorption, narrowing of the focus of attention, can have particular effects on encoding problems, dissociation on storage, and suggestibility on the process of retrieval. (Spiegel, 1995, p. 131)

It seems quite feasible that as analysts we do process patient-induced feelings by training ourselves to use a high degree of absorption. Such semi-trances carry encoding liabilities, however. The high absorption of what transpired in a session will necessitate further processing afterwards in order that the many intense impressions from the

encounters may find proper and enduring memory storage.

In fact, as Spiegel points out, all three hypnotic states would require some type of further processing in order not to distort memory. Dissociation, which carries the burden of memory being split off into different identities or alters, is a condition usually associated with trauma (Spiegel, 1995; Schacter, 1996). Analysts working with patients suffering from the aftermath of such events would no doubt be vulnerable to such states (Pearlman & Saakvitne, 1995).

The third state, suggestibility, cannot be ruled out either. It is possible that our selective recollection of certain sessions, certain interactions, may in fact be due to this problematic aspect of memory retrieval. Analysts ascribing to relational theories appear particularly open to this possibility. Lewis Aron (1996) relates instances of the analyst's sleepiness to suggestibility and induced countertransference. Stephen Mitchell (1988), referring to Black (1987), concludes that "the analyst becomes the various figures in the analysand's relational matrix, taking on their attributes and assuming their voices" (p. 296). The ability to be permeable to that extent would certainly depend on a high degree of absorption in the patient's experiences, even a state of high suggestibility.

Reverie and Cognitive Structures

The current understanding of hypnotic states poses the question of how the three components of memory, described by Spiegel (1995) as encoding, storage, and retrieval, correspond to the three stages of the analyst's thinking outlined earlier in this paper. Is it possible that, in both instances, we are looking at particular ways of maximizing and continuously training the aspects of

memory which have to do with understanding others? If this is the case, the analyst's way of processing ought to have strong appeal for researchers trying to understand certain types of learning often overlooked when investigating memory functions. 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 a state of reverie?

As analysts we rely on being able to remember not only in order to take a patient's history and monitor mood changes from session to session. It is our way of processing, of using and building the skills necessary for what we do. As Schank's (1990, 1999) works illustrate, this means that we are continuously developing stories and indices to them. In so doing, we are creating cognitive structures which we are able to call upon when we listen to our patients.

VII. SUPPORTIVE OUTCOME RESEARCH

No Specific Factors, No Particular Technique

In looking for support in research on psychotherapy, outcome studies are the most specific source. This research now appears to have reached a point where the analyst/therapist, not methods and techniques, are becoming the focus. With such a focus, the memory of individual analysts should finally be given its deserved attention.

After many years of often large-scale projects, there is certainly no clear-cut proof about the superiority of one paradigm over another. Robert Wallerstein (2001), one of the senior researchers in the field, points out that

the research is now entering a fourth generation and that many of the projects are coordinated and operating with more sophisticated tools. These tools are also ideologically neutral and focus on the dyadic nature of analytic therapies as a series of relational interactions (Strupp & Binder 1984; Miller et al., 1993).

Research particularly focused on psychoanalysis has so far established that strictly analytic treatments often fared less well than those which had strong supportive elements and that the success rate upon termination was not dependent on whether the traditional psychoanalytic goal of conflict resolution was reached or not (Wallerstein, 2001). Fanciful theoretical formulations, as well as recommended techniques, may imply certain attitudes. They do not seem to capture what happens in a successful treatment, or an unsuccessful one, for that matter.

In describing the experiences of the Penn Project, Lester Luborsky and his team conclude that no particular measure, before or after treatment, predicts outcome (Luborsky et al., 1988, p. 310). However, they assume that five factors must be particularly relevant when looking at the outcome with groups of patients (p. 271):

- 1) *The patient's experience of a helping alliance.*
- 2) *The therapist's ability to understand the patient.*
- 3) *The patient's level of self-understanding.*
- 4) *The patient's decrease in the pervasiveness of conflicts.*
- 5) *The therapist's as well as the patient's ability to assist in internalizing gains.*

These factors again point to the crucial role played by the analyst/ther-

apist/. Of the five described by Luborsky and his team, at least three have directly to do with the skills of the analyst/therapist (nos. 1, 2, 5), and in the case of the other two (nos. 3 and 4) it is clear that the skills of the analyst/therapist play a critical role.

In a specific analysis of the data about therapists and if they vary in effectiveness, Luborsky, Crits-Christoph, and McLellan (1986) conclude:

- 1) *There is considerable difference between therapists in their average success.*
- 2) *There is also considerable variability in outcome within the caseload of individual therapists.*
- 3) *There is little support for the widely held view that certain therapists are best at certain kinds of patients.*
- 4) *Variations in success rate typically have more to do with the therapists than with the type of treatment.*

Hans Strupp (1986), lead researcher for the Vanderbilt Psychotherapy Project, agrees that the search for what he calls *specific factors* has been a failure. He writes:

All contemporary theories of psychotherapy are based on the supposition that particular procedures or techniques associated with theory are uniquely effective in producing therapeutic change. By the same token, the theories either ignore or give short shrift to those elements that may be common to all psychotherapy. (Strupp, 1986, p. 514)

At the same time, Strupp warns against assuming that this failure calls into question the legitimacy of psychotherapy as a profession: knowledge, training, professional experience, and skills do still matter. The question remains, however, what this profes-

sional competence is based on and how analysts develop it. The studies so far do not address it.

Medical Model or Common Factors

In a more recent meta-analysis of several past studies, Hyun-nie Ahn and Bruce Wampold (2001) of the University of Wisconsin are more definitive. Research looking for the best theoretical ingredients is to them futile. Their analysis instead supports what they call *the common factors model*, factors such as a charged and confiding relationship, the active participation of both parties, and a rationale that gives a plausible explanation for the patient's symptoms and is consistent with his or her worldview (Wampold et al., 2001, p. 268). Particularly important is the ability of the analyst/therapist to establish a therapeutic alliance. They write:

The research evidence supports the notion that the benefits of counseling or psychotherapy are derived from common factors. For example, it has been shown that the therapeutic alliance, measured at an early stage, accounts for a significant portion of the variability in treatment outcomes. (Ahn & Wampold, 2001, p. 255)

To Wampold et al. (2001) this also means that the traditional medical model for treatments is put into question. Assuming that a sufficient psychological explanation for mental disorders exists, the medical model posits that, when the analyst administers ingredients derived from it, change will occur (p. 268). Their analysis found no support for such assumptions. Instead they conclude that the now available outcome data favored a contextual model that is based on mutual factors.

Similar views are expressed by

Edward Teyber and Faith McClure (2001), two psychotherapy researchers from California State University, San Bernardino, in the most recent *Handbook of Psychological Change*. They write:

It is time to drop the uniformity myth and better address the contribution of the individual therapist to treatment outcome. Comparative studies of psychotherapy outcome consistently find that therapy modalities are relatively equivalent in effecting client change. In contrast, there is considerable support for the view that the individual therapist's attributes, attitudes, and actions (e.g., interpersonal skills, countertransference propensities, and personality) match or override the effect of particular techniques. (Teyber & McClure, 2001, p. 80)

As a result of this shift, Wampold et al. (2001) assert that treatment protocols and other devices lack research evidence. They may appear scientific and may be required for experimental control in the research context, but in their findings, they could also "cause ruptures in the alliance, and consequently, poor outcome" (p. 255).

Frank and Frank (1991) agree with this assessment. To them, there is perhaps only one reason for why theory still may have some value, albeit a very indirect one:

In general, commitment to the theory keeps the therapist willing to take on new patients even after disappointments with others, and willing to try multiple techniques within the theory if one particular one is not effective. (Frank & Frank, 1991, p. 161)

VIII. SUMMARY

The Power of Cognitive Models

In exploring questions about the nature of analysts' thinking, this paper

proposes that we are dealing with several components, all relevant to how analysts process their experiences of treatments.

The kinds of processing that we do in a session, post-session, and when reviewing treatments appear to augment each other. While the processing in sessions seems to involve a heightened state of absorption, at least at some point in the treatment process the other two are significant in that they aid the encoding of information from each session. What differentiates the processing after each session from the review of entire treatments, or treatments up to the present time, seems to be the former's lack of generalizations and references to theory. The latter, on the other hand, seems to involve how we revise previously held notions and how we modify attitudes as the result of failure to understand particular aspects of a patient.

In order to establish what type of learning process these components represent, three models are suggested. All three make the understanding of memory of critical importance. This was the inevitable consequence of using data and conceptual models from recent cognitive research, models that approximate how the brain, as it is now understood, remembers—i.e., how it encodes, stores, and recalls—experiences.

The explanatory power of these newer models also brings into sharp relief the problems inherent in depth psychological concepts. Although still the basis for much of our theoretical discussion, depth psychology is in many respects founded on outdated knowledge, and without the now available data from cognitive science about how information is encoded, stored, and recalled, the powerful use of memory exhibited by the individual analyst clearly will elude us.

As with all other memory, the analyst's must be viewed as evolving in the continuous processing of information. What we are dealing with are not discrete procedures, which can be disseminated in theoretical formulations, but a sophisticated and interactive system of memory-driven skills. Acquired in dyadic interactions that are both similar enough to produce certain stable attitudes and, at the same time, unique enough to require highly individualized indexing, these skills are the result of a specialized and evolving memory.

The shortcomings of depth psychological models have for a long time obscured this fact. As Jerome Kagan (1998) of Harvard University notices, we often falsely assume that psychological processes generalize broadly by ignoring the agent being studied or the context in which the subject acts. So have proponents for analytic models, in relying on individual analysts' narrative formulations about what may be expected to occur in treatments, assumed that these formulations are the basis for specific techniques that apply to all analytic relationships.

Research on psychotherapy outcomes has found no support for the presence of such specific factors. By having developed into certain paradigms or "schools," the skeleton stories or master narratives that analysts develop to aid their memory may seem to indicate the presence of theory-determined methods. However, the various paradigmatic narratives or theories poorly describe what analysts do or did with individual patients. How each treatment, each session, and each interaction is remembered and understood by individual analysts, on the other hand, has everything to do with what analysts do. When we understand more

about this type of memory, how it functions and how, optimally, it is maintained, we may also have some long-sought answers about what produces good outcomes.

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Notes

- 1) In this paper, the terms “depth psychologies” and “psychoanalysis,” as well as “depth psychological models” and “psychoanalytic models,” all refer to common elements in the theories of Freud, Jung, object relations, and self psychology, among others.
- 2) Freud’s technique papers (*Collected Papers*, vol. 2), surprisingly, are a poor source for how analysts think, since Freud’s own thinking processes in sessions and after are hardly mentioned. Jung is somewhat more forthcoming, but even in his papers on the practice of analysis (*CW 16*), first-person accounts are rare. More detailed accounts are Racker (1968), Searles (1979), and Jacobs (1993).
- 3) Jung’s views on the topic did not seem to change, and in his autobiography, *Memories, Dreams, Reflections* (1962, p. 131), he pretty much repeats the same understanding.
- 4) Morris Eagle (2001), in a recent critical article, traces this change to the writings of Gill (1982). See also Levine (1994).

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