From Psyche to Memory: Cognitive Science and the Analyst’s Memory

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Abstract

How analysts remember has long been an ignored aspect of depth psychology and analytic thinking. Yet, convincing data from psychotherapy research now shows that contributions by the individual therapist, his or her attributes, attitudes, and actions, are more significant in predicting outcome than particular techniques. Similarly, the view among psychoanalysts is increasingly that competent handling of countertransference will allow deeper and more direct access to the patient’s experiences. A relational and dyadic perspective on the treatment process seems to be emerging. Still, without taking the analyst’s memory into account, this perspective lacks a critical dimension and will remain one-sidedly patient-focused and formulaic. Based on findings in branches of cognitive science, this article explores two models for the analyst’s memory. The first model comes from research on the role narratives play in memory and applies these findings to analytic narratives. The second model offers ways to understand induced countertransference reactions. As reveries, hypnotic states with a high degree of absorption in the patient’s experiences, these reactions are seen as the first stage in how analysts develop a particular interpretative memory.

Keywords

Cognitive science, depth psychology, implicit and explicit memory, narratives, analytic memory, countertransference, hypnotic states.

Introduction

Why Memory?

Due to discoveries in brain research over the last twenty to thirty years many of the formulations about unconscious mental life presented by Freud and Jung now seem validated by neurophysiological findings (Solms & Turnbull, 2002). This development is in many ways encouraging for those of us in the helping professions.
However, the new findings also challenge some of our established theories. What Henri Ellenberger (1970) calls “the discovery of the unconscious,” the idea that the human psyche has layers of unconscious components, rests on inductions from patients in psychotherapy and observations by analysts as participant observers, not on specific findings about how the brain participates in mental life.

Both Freud and Jung assumed that these neural manifestations of the unconscious could be inferred. In fact, Freud’s career began with his ambitious Project for a Scientific Psychology (1895), in which he attempted to establish a neurological explanation of psychology (Sulloway, 1979). Most of his later understanding of the unconscious can be traced to this abandoned and much later discovered opus. Jung, on his part, made clear that the unconscious could only be deduced introspectively and proposed hypothetically, and he suggested that a laboratory and objective methods would be needed to establish how things really are in an unconscious condition (Jung, 1935).

The new definitions of how the mind works thus focus specifically on memory and learning and are based on findings that trillions of synapses, which make the brain’s cells and neural networks communicate, are modified by experience. This distinct characteristic, often called synaptic plasticity, may now be viewed as “innately determined” (LeDoux, 2002, p. 9).

These findings also establish that much of what occurs in the human brain is beyond the immediate awareness of the person. In fact, the research in the various branches of cognitive science has led to what Campbell Perry and Jean-Roch Laurence (1984) describe as a rediscovery among researchers of the unconscious.

Two Contributions from Cognitive Science

No such sense of rediscovery can be detected in the psychoanalytic community in regards to memory. Hardly mentioned by Freud and Jung, memory continues to be a neglected function, especially as it concerns the analyst. However, there are two areas in particular where findings in cognitive science offer ways to more fully understand the analyst’s contribution to successful treatments. The first has to do with research on the role narratives play in memory. This research, conducted in the fields of computational modeling and artificial intelligence, offers a strikingly different approach to how the understanding of others is developed and maintained (Nadeau, 1992; Lakoff & Johnson, 1999).

The second area of research may give us a fresh and different way to understand countertransference reactions, an aspect of treatment which recent contributors to psychoanalysis have found more and more significant (Racker, 1968; Gill, 1982; Ulanov, 1982). The notion of induced countertransference especially warrants a closer scrutiny in the light of the findings in cognitive science about problems with retrieval in states of high concentration and absorption (Spiegel, 1995).

I have described some of this research in a previous paper, so here I will take the opportunity to further develop two models previously suggested (Ekstrom, 2002b). First, however, we need to define what we mean by “memory” and summarize what today is known about how it functions. We also need to take a look at the established approaches to the analyst’s contributions to the treatment process in most of the schools of analysis.
Memory and the New Unconscious

To Joseph LeDoux (2002), of New York University’s Center for Neural Sciences, the discovery of synaptic plasticity means that many psychological and behavioral functions are mediated by cells joined by synapses and working together. A fairly universal mechanism is, in other words, responsible for how most memory is formed (LeDoux, 1998). The highly dynamic process of synapses being changed by experience can also be said to be responsible for our sense of self. Who we are, our individual self, is thus to LeDoux (2002) the result of what he calls “the particular patterns of synaptic connections in an individual’s brain and the information encoded by these connections” (p. 3).

LeDoux concurs, however, that much of how what happens to our experiences occurs without our explicit awareness. What makes us the individuals we are belongs mainly in this latter category. Distinction thus has to be made between two aspects of the self. Only the first, explicit aspect, involves self-awareness (p. 27). By contrast, the implicit self is “all other aspects of who we are that are not immediately available to consciousness, either because they are by nature inaccessible, or because they are accessible but not being accessed at the moment” (pp. 27–28).²

In practical terms, then, findings about synaptic change restate depth psychology in terms of how conscious and unconscious memory is being formed. Since the production of synaptic connections can be viewed as part of the process of encoding information into memory, what we learn from our experiences is stored for future reference. But how well this storage is organized and retained depends on a variety of factors, not the least emotion or affect. Like attention and arousal, emotions must be viewed as playing a central role in how certain experiences become dissociated and hidden, as it were, or reinforced and available for long-term use (Wilkinson, 2004).

Memory, then, can be defined as “the way the brain is affected by experience and then subsequently alters its future responses” (Siegel, 1999, p. 24). A person’s experiential history, his or her learning, is thus reflected in the structure of his or her brain.

The Fragility of Recall

Cognitive researchers have also shed much light on the fragile nature of memory, especially when it comes to being able to recall exact details and sequence of events (Loftus, 1981; Schacter, 1996). On the basis of this research, Daniel Schacter of Harvard University categorically rejects the idea of distinct entities, whole chunks of photographic or cinematic memory. He writes:

The subjective experience of remembering does not correspond in any simple way to the reawakening or reactivation of a dormant picture in the mind. Rather, information available in the present retrieval environment combines with stored information to yield an emergent pattern of activity that we experience as “memory” (Schacter, 1995, p. 24).
In neurophysiological terms, this means that different parts of our memories are stored in different parts of the brain. A memory, according to Schacter, is always a recreation, a piecing together from many sources.

Especially when it comes to detecting and defending against threat, arousal has been found to be a critical factor, since it tends to monopolize brain resources, thus making the further processing and consolidation limited, if not impossible. The learning and memory structures from such states reflect, among other things, the negative impact of childhood trauma (LeDoux, 2002, p. 322).

But emotion may also have another and unexpected effect when it comes to the follow-up or consolidation of memory. While arousal may disturb attention at the moment of an initial experience, it seems to strengthen the ability to make experiences memorable (McGaugh, 1995, pp. 265–266).3

The most appropriate understanding of memory, then, is that each act of remembering creates new memories of old experiences (Schank, 1990). 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. Some of this process may occur consciously, but, again, much of it happens without our awareness or involving our intent.

**The Analyst’s Memory**

*Remembering in Order to Understand*

In this perspective, the analyst’s memory will have to be regarded as dynamic and evolving. How an analyst thinks, feels, and perceives, both in the sessions and after, is determined by his or her memory. It is what aids the processing of new information specific to each therapeutic encounter. In short, analysts remember in order to understand.

But the analyst’s memory is not merely a passive process. It functions in a relational context and it develops from doing, that is, from what analysts do: listening, being reminded, and storing, on the one hand, and recalling, processing, and interpreting on the other. And since its focus is on meaning and beliefs—and psychotherapy or analysis is about meaning-making and the formation of structures which allow integration of otherwise fragmented memories—the analyst’s memory is a critical ingredient in the outcome of any psychotherapeutic treatment.

The depth psychological models do not account for this fact. Instead, a one-sided emphasis on the patient and on correct technique has endured even though, as I will show later in this paper, extensive psychotherapy research has found no proof for such “particular ingredients” (Strupp, 1986). One particular technique or another means little when it comes to good and effective outcome (Norcross, 2002). Instead much of the research points to the fact that the individual therapist, his or her skills, has much more of an impact (Teyber & McClure, 2001).

In fact, technique varies widely between analysts and can never stay the same. If we were to rely on technique, only a static and predictable approach to practicing would be the result, a view that clearly is at odds with experience. New experiences and new understanding need to be incorporated every day. And since only a small portion of what has been said in a session will be remembered, the analyst must rely on what is also remembered unconsciously, so a great deal of
what occurs in a session involves not only the patient’s unconscious but the analyst’s as well (Mitchell, 1993).

What the Analyst Brings

These conclusions are born out by psychotherapy research. In a recent review of data from a multitude of studies, Lambert & Barley (2002) arrive at the following estimates for what variables are responsible for psychological change:

- 40% is due to extratherapeutic factors such as severity of the disorder, the length of its persistence, if a personality disorder is present (comorbidity of Axis I), and, on the positive side, quality of social support.
- 30% is due to what researchers call “common factors,” i.e., client-perceived relationship factors and the therapeutic alliance. Today they are viewed as the most significant factor and include the analyst’s contribution as a major component. Bordin (1976, 1989) defined the “therapeutic alliance” as consisting of three elements: 1) tasks, or the behaviors and processes within the therapy session that constitute the actual work of therapy (both the therapist and the client must view these tasks as important and relevant for a strong therapeutic alliance to exist), 2) goals, or the objectives that both parties endorse and value, and, finally, 3) bonds, or the positive interpersonal attachment between therapist and client of mutual trust, confidence, and acceptance.
- 15% is due to expectancy or “the placebo effect”, i.e., as in drug trials, a percentage of patients improve solely by being involved in some type of case management.
- 15% is due to therapeutic techniques and can be attributed to a somewhat greater effectiveness of techniques or treatment protocols with certain types of disorders. Included in this group were phobic disorders, sexual disorders, agoraphobia, and OCD.

Like several researchers before them, Lambert and Barley found psychotherapy overall successful in treating most psychological disorders and estimate that 80 percent of patients were better off than control groups upon termination. In some studies therapists with more than six years experience seem to have more success and in others some therapists seem to have more success with difficult cases, while some had good success with certain types of clients, but the overall picture is now that there are certain factors in how the therapist or analyst is perceived that matters the most (Norcross, 2002).

My Own Experience

In my own experience, memory plays a critical role in how well I am able to help someone. How I perform in a given treatment appears to depend on how I am able to update my memory and integrate the patient information to a much larger extent than I was taught to believe in my training.

However, my memory of each patient’s process is based on both conscious and unconscious knowledge and relies on a type of recollection that is specific to what I do as an analyst. Although personal experiences outside of my practice
sometimes enter my mind in the beginning of a treatment, most of the memory material seems to come from previous treatments and, to a lesser extent, case presentations and other psychoanalytic literature. And once a therapeutic alliance has been established with a given patient, most memory associations appear to be connected to what I have experienced with the same individual patient.

My experience also tells me that my memory is aided by what I do after a session. Processing during a session, immediately after it, and when reviewing whole treatments differs considerably and seems to call upon different functions, different ways of using my memory. As I explore the nature of the analyst’s memory more in detail, this difference will guide much of what I will review in the research literature, and findings in the cognitive sciences may shed some further light on this phenomenon.

Remembering During and After

The use of certain routines for consolidating memory is not particular to analysts, but it becomes clear upon some reflection that reviewing what was experienced in a session or sessions is an integral part of the training of analysts. In fact, analysts continue this type of routine, be it with a supervisor or in private, by making notes or simply trying to “digest” what happened in a particularly intense session.

The difference between processing that goes on in a session, with a patient, and when later reflecting over it, points to the use of a process that involves several steps. What happens in sessions is intuitive and based on attunement to the patient’s psyche as well as to one’s own internal responses. The thinking after sessions is more extensive and often restores a sense of personal boundaries: what belongs to self can be reclaimed, something the intensely emotional involvement in sessions does not permit (Levine, 1994).

This fact has been described by Joseph Cambray (2001) in connection with an experiment of recording and reviewing all sessions for the last day before a vacation. Cambray found considerable difference between how he experienced certain interactions while they took place and when he later reflected on them. In particular his personal involvement, as it played itself out in all the sessions of the day of his experiment, came into clear focus only afterwards as a type of day residue. However, as Cambray carefully points out, upon reflection, when his countertransferences could be acknowledged as metacommunication presaging new awareness, distinctly different and relevant details surfaced (Cambray, 2001, p. 292).

The fundamental difference between his thinking in the session, with a patient, and when later reflecting over it, 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” (p. 291).

The importance of reviewing was succinctly articulated already in 1929 by C. G. Jung. He did so at a time when therapeutic technique seemed to be the only credible explanation for the analyst’s involvement—Freud’s (1912–1915) technique papers were first published only a decade earlier. Jung focuses on certain experiences that today seem emblematic to the analytic profession, the often
unconscious overrides of theory and the risk of psychological blind spots when avoiding serious reflection and modification in the face of therapeutic failures (Jung, 1929).

In the light of present understanding in cognitive science, what Jung articulates is an essential mechanism in dynamically evolving memory (Schank, 1999). Through repeated experiences of modifying and refining, analysts add new elements to their skill arsenal. However, when they fail to do so, new learning will be inhibited, and a fault or unconscious blind spot may develop.

**Master Narratives and Analytic Theory**

Another key to how analysts remember may be found in these confusing and often contradictory theoretical statements. The various analytic formulations that are the basis for division between schools of psychoanalysis no longer, if ever, explain how analysis actually works and how analysts become effective (Ekstrom, 2002a). Instead they have by now created a cacophony of theories which have little or no bearing on outcome.

The understanding of paradigmatic formulations has no doubt gone through a radical adjustment from how they were initially perceived (Mitchell, 1993). No more is a claim of scientific truth feasible, but rather, theoretical constructs are in most of the literature viewed as helpful narratives, a set of beliefs or explanations which emerge in connection with the analyst's own training analysis and in interpreting his or her life experiences and personality (Schafer, 1992). All indications are also that they continue to undergo changes and become highly individualized for each practitioner with time (Fabricius, 1995). However, even analysts who proclaim to be eclectic or integrative rely on some type of theoretical construct as a general guidepost for their work (Norcross & Goldfried, 2003).

One reason for this contradiction may be found in a need for legitimacy and support. While paradigmatic formulations appear rather insignificant when processing immediate experiences with patients, they take central stage when analysts later explain their involvement with patients (Winer, 1994). At that point, they seem to serve the purpose of offering a uniform story to which all treatments can be attached. Because of their generic nature, peers will recognize these formulations as representing a certain school of thought and its particular terminology.

In spite of the now obvious conclusion that theoretical formulations have little to do with scientific attitude or truth, they must emanate from broad-based narratives which analysts develop and continue to develop (Spence, 1982). As Schafer (1981) suggests, they become *master narratives*, individualized versions of Freud, Jung, Klein, etc., and as such they serve as aids to memory, even if their impact on actual treatments is limited.

**First Cognitive Model**

**Narratives as Memory**

Cognitive research now appears to confirm that such master narratives are part of memory. Even though the exact neurophysiological pathways remain uncertain, several researchers conclude that narratives must serve as important memory structures (Bruner, 1990; Schore, 1994; Siegel, 1999). Since memory is gen-
erally divided into three kinds in reference to its anatomical pathways—explicit or declarative (episodic and semantic), emotional, and implicit or procedural—it is assumed that narratives operate partially along pathways that are implicit or unconscious and partially along pathways that are explicit or conscious (Squire, 1987; Eichenbaum & Bodkin, 2000). Siegel (1999) concludes that, especially in autobiographical narratives, the unconscious aspects can be traced to mental models or summations of repeated experiences, which are retained in implicit memory.

The emergence of narratives can be linked to the acquisition of language. By age four, children appear ready to use autobiographic narratives to string together memories of many events. As perhaps the most significant cognitive achievement in childhood, verbal sharing of an experience with others now serves as a reinstatement and memory can be preserved (Nelson, 2000). As a result, skills for social participation develop, as well as the necessary means for self-reflection.

As Jeremy Holmes (2001) shows, narratives may also reflect enduring attachment styles “by the ways in which people talk about their lives, their past and in particular their relationships and associated mental pain” (p. 7). Attachment failures in early childhood affect what he and other developmental psychologists call narrative competence. Holmes defines such competence as “consciousness about our own mental life” and suggests that it translates into “a psychological equivalent of immunological competence” (p. 4). This narrative ability also has broad ramifications for the mental health of the person. In finding such competence through psychotherapy, persons with previous attachment failures may in fact build the necessary new structures for overcoming these failures (Holmes, 2001; Siegel, 1999).

Scholars of literature, less encumbered by having to locate specific neural pathways, have shown the broad use of narratives in everyday living. Culler (1997) 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. (pp. 83–84)

This distinction between scientific logic and logic of story seems to be confirmed by Howard Eichenbaum and Alexander Bodkin (2000). Researching the effects of certain brain lesions, they conclude that the implicit nature of narratives may be due to how our experiences are encoded. Certain experiences are processed using one type of pathway and involving particular regions of the brain. Others are processed along other routes. According to their research, the processing leading to knowledge involves radically different regions of the brain than processing leading to belief.5

We may thus safely claim that narrative structures such as belief, autobiography, script, and story occupy unique positions in the human mind. Without them, we would not be able to ascribe meaning to our experiences, maintain a
coherent sense of self, make inferences, or understand the experiences of others. Psychotherapy in particular must rely on these kinds of memory structures, both in the patient and in the analyst.

**The Efficiency of Stories**

Roger Schank (1990), a cognitive psychologist and director of the Institute for Learning Sciences at Northwestern University, 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 experiences become coherent. And by making intelligent use of indices to our stories, more complete storage is possible than if relying on 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, he defines scripts as “a set of expectations about what will happen next in a well-understood situation” (Schank, 1990, p. 7). He also found that when it comes to understanding meanings and motives for actions, we use the more idiosyncratic structure of stories rather than the simpler scripts or memory packets through which we make predictions (Schank, 1999).

Two phenomena in particular are thought to be involved in the activation of 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. In our attempts to explain that failure, our mind creates indices. Without consciously having to decide, the new index will account for the circumstance we experienced and add it to the story for future use. Paradoxically, we process new experiences in terms of prior experiences, and our memories change as a result (Schank, 1990).

This also means that when we hear someone else’s story, our mind searches for a story of our own that may remind us of what we just heard. Schank (1999) expands on this principle 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, a match is assumed when we feel reminded of a story of our own.

But how do we know that our story is the same or similar to the one we heard? To Schank (1999), this is where beliefs come in. If we can construct a belief to go with the story we just heard, most likely we will find a story of our own that relates to this belief. We have connected to a story in our memory and we have done so by juxtaposing another person’s beliefs, made evident by his or her statements or actions, with our own. In the process, an index for future use is created. For instance, if person X is telling a story which seems to proclaim a belief in the blessings of free competition, we are reminded of a story that illustrates our own belief about free competition, a story that tells us what our experiences of it have come to mean.

Indexing may not be limited to beliefs, however. A story can have numerous indices and indices of many kinds. Location, attitudes, quandaries, decisions, or
conclusions may also serve this function, so a story can have an almost endless amount of uses (Schank, 1999).

The Analyst’s Narratives

We may safely assume that analytic interpretations and what traditionally has been called *technique* also serve this indexing function. Through training and experience, analysts seem especially focused on their creation. In interacting with patients presenting a wide array of traits and problems, new interpretative possibilities are continually being discovered. The understanding of narratives and indexing may in fact explain how this type of analytic memory develops.

The findings of Schank’s cognitive research thus have obvious application to what analysts do, how they contribute to each psychotherapeutic relationship, and how they train their memory to perceive, process, and communicate with patients. Some of Schank’s findings have broad application to all those in human services, others seem important in understanding analysts in particular, especially since most previous attempts leave much to be desired.

Analysts are in a continuous learning process to train their memory to become the carrier of many stories, many search indices. In so doing, a particular kind of memory is being learned that is dynamic and meaning-determined. Schank (1990) describes such an 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 a particular area of knowledge and who has those stories indexed well enough to find the right one at the right time. (p. 109)

The particular expertise of analysts comes from learning stories and indices which can be used when relating to stories of others, stories about their pain and their desires, their strengths and their psychological deficits. By being reminded and extracting indices to a learned storage of stories, the benefit of developing an intricate system of indices to these stories is, at the same time, being reaped. With each treatment, certain unexpected data will surface and with it, new indexing.

But this expertise is also about how to provide the environment for new autobiography to be created, new stories to be told and remembered. For this to occur, analysts need to remember more explicitly what their patients have related from session to session. Accordingly, the first priority for analysts is being attentive and interested so that as much of the relevant information as possible can be retained. This information, in turn, needs to be encoded in specific semantic memory. Siegel (1999) suggests that permanent explicit memory happens through a process called “cortical consolidation” and requires “a nonconscious activation or rehearsal process” (p. 37). Schank (1999) points out that when we update our knowledge base, our explicit memory, only certain information is retained while previous incidents of a similar nature may be forgotten. This phenomenon points to a need to review and reflect in order to remember explicit aspects of the experiences with each patient. It also appears to explain why analysts have a hard time remembering what happened in the session before last and the sequence leading up to it.
What is remembered from session to session is, at the same time, dependent on the stories that get activated (Schank, 1999). Every new patient activates several stories and forces the creation of more search indices. The search for fitting stories is particularly strong in the initial phase of each treatment, but as soon as a useful set has been retrieved, the analyst can also begin the process of accumulating explicit, event-based memory. Before the activation of particular stories, the ability to relate, retain, and communicate will remain shallow.

The capacity for this type of listening and attention begins in the personal analysis, with the exploration of the analyst’s own life and the stories created about his or her life. As Mahoney (2001) suggests, particular paradigms allow analysts-in-training to create 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 yet others are added.

These narratives, initially tied to an autobiographical narrative, provide the necessary plot line, a narrative template, which organizes the analyst’s memory. An amalgamation of favorite theories, case presentations, technique formulations, and descriptions by the pioneers of analysis eventually occurs. What we call theory is in fact a personal compilation from all these sources and becomes a reusable template for what to expect. Schank (1990, pp. 147–170) calls such compilations story skeletons. They are quite general, but they do provide ways to validate what analysts do.

Narrating Treatments

The names given to these story skeletons or master narratives are often borrowed from one or several academic disciplines—biology, social psychology, neuroscience, etc. It could be argued that these conventions are rather illusory in that they do not make the stories more scientific or more reliable than if poetic or simply descriptive names had been used.

As memory aids, theory formulations nevertheless ought to meet certain standards. As Jean Knox (2003) points out in her recent book, when a need to go beyond descriptive language presents itself, analysts need to look for formulations which do not contradict current scientific knowledge. Especially findings in the various branches of cognitive science, developmental psychology, and psychotherapy research need to be consulted.

In hindsight, the first generations of analysts made the mistake of assuming that they could formulate a reliable theory to explain the causes for all psychological disorders (Shorter, 1997). In order to give credibility to what they discovered with their patients, they theorized in broad terms, always with the intrapsychic dynamics of the patient in mind (Winer, 1994). The result was a set of generalizations instead of a language describing what happened in therapeutic encounters (Schafer, 1983).

The problem with this approach is that it ignores the fact that analysts experience different relational patterns with each patient. The powerful impact of transference and countertransference, for instance, determines how an analyst interacts with patients in a certain relationship, even in a certain phase of it (Beebe, 1984).

As a result, case reports and analytic formulations too often describe patients as if they inhabit monadic bubbles: on the one hand, they are supposed to be dri-
ven by an unconscious which only the analyst, as the expert, has access to; on the other hand, they are thought capable of the most outrageous distortions in how they view the analyst, the person with whom they are in dialogue.

The only meaningful way to describe therapy interactions is as two-way communication: as patient narratives, analyst narratives and, more tentatively, as therapeutic narratives (Winer, 1994). Deemphasizing hypothetical explanations and developing common formats for describing the relational events experienced with each patient would help to establish the latter as having a higher degree of accuracy than at the present.

The Patient’s Narratives

Applying an understanding of narrative structures to the psychotherapy process leads to a radically new understanding also of the patient’s experiences. The task of giving a coherent, livable, and adequate story about one’s own life is quite complex and, as Jerome Bruner (2002) of Harvard University points out, inevitably involves pleasing an audience. He writes:

Telling others about oneself is, then, no simple matter. It depends on what we think they ought to be like—or what selves in general ought to be like. Nor do our calculations end when we come to telling ourselves about ourselves. Our self-directed self-making narratives early come to express what we think others expect us to be like. Without much awareness of it, we develop a decorum for telling ourselves about ourselves: how to be frank with ourselves, how not to offend others. (Bruner, 2002, p. 66)

Patients’ initial stories no doubt express this wish to please and to follow decorum. Not only is there a desire to be interesting to the analyst, still very much a stranger, and to have his or her attention. The stories being activated often reflect how the patient as a child wished to please a parent. Thus the initial disclosures date back to when storytelling was first learned and are stories meant to prove goodness and loyalty or stories demanding attention by being the vehicles for tales of failure, rejection, and despair.

In the long run, this is not the kind of story the patient favors and finds meaningful (Ulanov, 1982). But since humans to a great extent rely on knowledge and belief already learned, it is easier to tell old stories than to create new ones. As Schank (1999) points out, creating new stories involves more of an effort, and only by attempting to tell someone else about new and recent experiences will a new story be memorized. For this to occur, the patient must have concluded that the old stories no longer offer a good-enough fit. He or she must also have concluded that there are important new experiences to convey. So even if the patient’s first set of stories are met with appreciation by the analyst, an eagerness, or at least a willingness, to tell new stories is a necessary condition for psychological change to occur.

In this perspective, successful therapy depends on the creation of a cohesive new story, a story which can span over a longer time and encompass previously unintegrated memory. The inability to remember and make connections means
that the sense of self never becomes embodied (Covington, 1995). So inevitably the patient is placed in the uncomfortable role of having to create a new story from many old ones, previously seen as unrelated or nonexistent. The sense of integration and meaning comes from the placement of the characters or actors in the patient’s autobiography within an overall configuration, the “plot” (Bruner, 1990).

Second Cognitive Model

Mutual Influence as Implicit Learning

In order to relate fully to a given patient, analysts rely on being able to respond to the particulars of his or her moods and feeling. This permeable presence and openness to induction has increasingly become an important concern in the analytic literature. The trend is to view the analyst’s contribution to the analytic process in terms of a broadly understood use of countertransference reactions (Mitchell, 1988). Analysts, according to this view, use their involuntary reactions to a patient for more in-depth information, since these reactions, upon further reflection, can be traced back to the patient’s unconscious (Winnicott 1960; Levine, 1994).

This was not exactly how the pioneers in psychoanalysis used the term. Freud, for instance, regarded countertransference as something the analyst needed to recognize and overcome, but it soon became apparent that distinguishing between what happens in the analyst’s mind and what happens in the patient’s was difficult if not impossible (Fine, 1979). However, traditional psychoanalysis offered few other theoretical constructs for the unconscious influence that the patient’s state of mind has on the analyst. Thus the term “induced countertransference” soon became the common approach (Winnicott, 1960; Mitchell, 1988).

Without taking the analyst’s memory into account, this way of describing mutual influence seems quite awkward and, as Morris Eagle (2001) points out, tends to create yet another layer of technical recommendations. Instead of a one-sided emphasis on being able to detect and understand the patient’s transference, analysts are now the expert judges of what their own reactions mean for the patient.

The lack of clear formulations about mutual influence has been traced to the early experiences by Freud and Jung with hypnosis and the prohibitions both men left about undue suggestion (Shamdasani, 2001). However, since the 1980s, many psychoanalysts, in embracing an understanding of transference and countertransference as intersubjective phenomena, have moved closer to an acknowledgement of mutual influence as an inseparable part of psychotherapeutic treatments. The problem with the new understanding is that it tends to ignore the analyst’s contribution to the dyadic experience. In Eagle’s (2001) words, “We assume that all feelings and thoughts that emerge in your experience necessarily, and in any simple, uncomplicated way, reflect what is going on in the patient’s inner world” (p. 36). This may be just another way to regard everything in the treatment as reflecting something about the patient.

Reverie and Memory

A different approach to induction and dyadic dynamics can be found in the formulations of Thomas Ogden (1997). He suggests that what he calls reverie is the important ingredient in the analyst’s processing of patient-induced feelings.
Referring to a statement of Freud’s (1913), Ogden claims that “a necessary condition for the conduct of analysis” is that both analyst and analysand “gain access to a state of reverie” (p. 114), thus advocating for mutual states of altered consciousness. Implicit in his argument is that analysts enter trancelike states, a type of autosuggestive reverie which heightens the experience of dyadic interaction while screening out its larger context. In so doing, he or she would also enable the patient to accept reveries as the means towards integration.

As David Spiegel (1995) of Stanford University Medical School notes, one of the characteristics of such states is an unusual degree of absorption, what he terms “an immersion in a central experience at the expense of contextual orientation” (p. 130). Such a state is to Spiegel part of hypnosis—“aroused, attentive, focused concentration with relative constriction of peripheral awareness” (p. 129).

Spiegel differentiates between three different components or hypnotic states: absorption, dissociation, and suggestibility. He argues that these components have specific corresponding effects on the three main components of memory processing: encoding, storage, and retrieval. Absorption, as a narrowing of the focus of attention, causes problems with encoding, dissociation with storage, and suggestibility with the process of retrieval.

Allan Hobson (2001), of the Neurophysiology Laboratory of Massachusetts Mental Health Center and a sleep researcher, compares hypnotic states with REM sleep. He writes:

Because recent memory is disenabled in both states, it is not surprising that orientation to time, place, and person is impaired in hypnotic trance and dreaming. That this process is considerably more floridly deranged in dreaming may possibly be due to the more extreme changes in neuromodulatory balance that occur in REM sleep. (Hobson, 2001, p. 101)

To Hobson, the similarities between dreaming, psychosis, and hypnotic states indicate an analogy between these altered states, although the brain mechanism may be quite different in each. What they do have in common is problems with memory encoding and consolidation. Altered states thus affect implicit memory structures while more or less circumventing the common pathways for episodic and semantic memory (Knox, 2003).

This is probably what Ogden (1997) had in mind when stating that the analyst “renders his own unconscious receptive to the unconscious of the analysand” (p. 113). To him, analysts appear to enter into one of these altered states when processing patient-induced feelings, and we can conclude that these reveries are associated with a high degree of hypnotic 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.

Since all three hypnotic states mentioned by Spiegel require some type of further processing to become part of regular explicit memory, Ogden’s term reverie may also implicate dissociation and suggestibility. Dissociation, which carries the burden of memory being split-off into different identities or alters, is a condi-
tion 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, will lead to selective recollection of certain sessions, certain interactions. Analysts of the relational school appear particularly open to this possibility. Lewis Aron (1996) relates instances of the analyst’s sleepiness to suggestibility and induced countertransference. Stephen Mitchell (1988) concludes that the analyst in the course of a treatment becomes the various figures in the analysand’s relational matrix, “taking on their attributes and assuming their voices” (p. 296). Such capacity for subordination of one’s own personality requires more than passive absorption in the patient’s experiences: a state of hypnotic suggestibility.

Conclusions

The Nature of the Analyst’s Memory

Based on cognitive research on memory, I have outlined two perspectives on the analyst’s contribution to psychotherapy treatments. The first has to do with the role of narrative structures in general memory and how these findings translate into a more detailed understanding of how analysts use their memory. I am suggesting that competence as an analyst depends on the capacity to train a certain type of memory. This type of memory is based on narratives which are updated and expanded via indexing (Schank, 1999). When considering the indexing analysts learn, we seem to be dealing with narratives that are interpretive, perhaps constituting a particular kind of interpretative memory.

The second perspective presents a cognitive understanding of what in the more current psychoanalytic literature is being called induced countertransference. Since processing in sessions involves periods of intense attunement to the patient’s moods and feelings, analysts appear to enter into certain hypnotic states, or reveries, when they are particularly open to induction (Ogden, 1997). Such attunement allows for a high degree of absorption in the patient’s experiences but carries problems with encoding and consolidation.

When periods of reverie are considered, induced countertransference may best be understood as a type of learning that relies on implicit memory. However, like all implicit learning, such experiences only become part of long-term and explicit memory with further processing. The analyst’s memory must thus be based on several stages of learning. One such stage occurs during sessions, another immediately after them, and a third when reviewing whole treatments. Attunement to the patient’s moods and feelings is only the initial element in how analysts remember.

Psyche versus Memory

In examining the two aspects of the analyst’s memory, narratives and reveries, I also touch upon areas where new research conflicts with or alters basic conceptions in depth psychology. From the beginning, as the name indicates, depth psychology hypothesized the existence of unconscious influences on human behavior, and these influences were viewed as part of a larger totality, the psyche, with common roots in all humans (Ellenberger, 1970; Millon, 2004). The model is
one of deep-seated drives or complexes, more or less hidden and resistant in nature but nevertheless affecting consciousness in many indirect ways. It describes the human mind as struggling with its past, with its darker impulses, and with needs to restore a sense of self due to fragmentation and dissociation.

Cognitive science and the research on memory introduce a different picture. In this model, the creation and alteration of memory, even when it is going on unconsciously, happens as experiences are processed via different pathways of the brain, different neural networks. In this model, the mind is no longer split or layered but dependent on several regions of the brain functioning together (LeDoux, 1998; Damasio, 1994). Any memory or perception is an assembly from many sources, and the human mind is viewed as an organism specifically geared towards remembering in order for the person—and the species—better to be able to survive (Siegel, 1999).

The findings of the various branches of cognitive science will no doubt change analytic theory, a process that already appears to have begun (Cozolino, 2002; Solms & Turnbull, 2002). However, cognitive science is not a clinical theory. In spite of being a burgeoning field of research, it has shown scant interest in psychotherapy. Hopefully, this will change, as there are several phenomena in clinical practice worthy of cognitive research. The analyst’s memory, and the kind of learning it represents, ought to be one of them. Not only does it appear to be a form of expert memory central to the analyst’s contribution to effective treatments, but how analysts remember may also give important clues to how understanding of others actually comes about.

Notes
1) The project was abandoned by Freud. It was first published posthumously in 1977.
2) This description of the self echoes much of what C. G. Jung (1950, 1954) stated on the basis of his theory of archetypes in that it proposes that a sense of selfhood or wholeness is implicit for every person. As Jean Knox (2003), my colleague in England, shows, Jung’s archetypal theory has sometimes been interpreted to mean that archetypes are innate, biological entities “hard-wired in the genes [and] providing a set of instructions to the mind as well as to the body” (p. 24). LeDoux’s formulation differs clearly in this regard and comes much closer to yet another interpretation of the archetypal theory proposed by Knox in the same book. In this reading, borrowing from recent formulations in developmental psychology, they are “images schemas, with primitive meanings, in the form of spatial patterns rather than words, which emerge in the earliest weeks of life and which underpin metaphorical meanings throughout life” (Knox, 2003, p. 200). As such they seem to correspond to LeDoux’s remark that the self has the character of something “innately determined” (LeDoux, 2002, p. 9).
3) LeDoux (1998) explains this phenomenon as being caused by the difference between two memory networks which need to work in tandem in order for long-term memory to be established. The first of these networks is located in the amygdala and is mainly responsible for reactions to threat. The other is located in the area of the hippocampus. Especially the hippocampal memory has been shown to be vulnerable to high levels of stress, although moderate levels of stress also seem to enhance memory encoding. Without hippocampal participation, no explicit memory will be formed (pp. 240–246).
4) Cambray’s experiment relies on a simple, often ignored but well established research methodology in which he is participant observer, thus both the subject of the study and the observer/researcher (Gay, 1992).
5) Knowledge, as an explicit form of memory, appears to involve the hippocampal area, while belief, using different pathways, creates implicit memory via the neostriatum and the amygdala (Aichenbaum & Bodkin, 2000, p. 177).

6) Morris Eagle (2001), in a recent critical article, traces this change to the writings of Gill (1982). See also, Levine (1994).

7) The quote from Freud (1913), “While I listen, I resign myself to the control of my unconscious thoughts,” appears to support Ogden when he argues that such reverie has always been an unspoken reason for the psychoanalytic use of the couch. In fact, in the same technical paper, Freud refers to the couch as “a vestige of the hypnotic method” (p. 354).

References


