Mentalization, insightfulness, and therapeutic action

The importance of mental organization

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Continuing debates over the relative importance of the role of interpretation leading to insight versus the relationship with the analyst as contributing to structural change are based on traditional definitions of insight as gaining knowledge of unconscious content. This definition inevitably privileges verbal interpretation as self-knowledge becomes equated with understanding the contents of the mind. It is suggested that a way out of this debate is to redefine insight as a process, one that is called insightfulness. This term builds on concepts such as mentalization, or theory of mind, and suggests that patients present with difficulties being able to fully mentalize. Awareness of repudiated content will usually accompany the attainment of insightfulness. But the point of insightfulness is to regain access to inhibited or repudiated mentalization, not to specific content, per se. Emphasizing the process of insightfulness integrates the importance of the relationship with the analyst with the facilitation of insightfulness. A variety of interventions help patients gain the capacity to reflect upon and become aware of the intricate workings of their minds, of which verbal interpretation is only one. For example, often it seems less important to focus on a particular conflict than to show interest in our patients’ minds. Furthermore, analysands develop insightfulness by becoming interested in and observing our minds in action. Because the mind originates in bodily experience, mental functioning will always fluctuate between action modes of experiencing and expressing and verbal, symbolic modes. The analyst’s role becomes making the patient aware of regressions to action modes, understanding the reasons for doing so, and subordinating this tendency to the verbal, symbolic mode. All mental functions work better and facilitate greater self-regulation when they work in abstract, symbolic ways. Psychopathology can be understood as failing to develop or losing the symbolic level of organization, either in circumscribed areas or more ubiquitously. And mutative action occurs through helping our patients attain or regain the symbolic level in regard to all mental functions. Such work is best accomplished in the transference. The concept of transference of defense is expanded to all mental structure, so that transference is seen as the interpersonalization of mental structure. That is, patients transfer their mental structure, including their various levels of mentalizing, into the analytic interaction. The analyst observes all levels of the patient’s mental functioning and intervenes to raise them to a symbolic one. At times, this will require action interpretations, allowing oneself to be pulled into an enactment with the patient that is then reprocessed at a verbal, symbolic level. Such actions are not corrective emotional experiences but are interpretations and confrontations of the patient’s transferred mental organization at a level affectively and cognitively consistent with the level of communication. Nonetheless, the goal becomes raising the communication to a symbolic level as being able to reflect symbolically on all aspects of one’s mind with a minimum of restriction is the greatest guarantee of mental health.

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Although some believe there is increasing convergence about analytic technique in today’s pluralistic world (Wallerstein, 2002), it remains common to find divergence about what is mutative in psychoanalytic technique. This disagreement generally occurs about the relative, if not exclusive, roles of either interpretation leading to insight or the relationship between analyst and analysand leading to change.

From the late 70s a number of writers have shifted the emphasis from structural change as the focus of therapeutic action to the transaction between patient and analyst as a curative experience, and the early mother–child relationship as the most appropriate analogue for the therapeutic encounter. (Fonagy, 1999, p. 8)

Too often, these perspectives are seen as mutually exclusive, despite the acknowledgment by many that both insight and relationship are necessary for change to occur (Gabbard and Westen, 2003). For example, modern-day Freudians often dismiss relational thinking and technique as ignoring the importance of mental structure and internal conflict (Sugarman, 1995). They believe that focusing on the interaction forces one to become interpersonal (Aron, 1996). And relational analysts, too, often caricature contemporary Freudians as failing to realize or acknowledge the importance of their relationship with the patient as contributing to analytic change. As Aron says, ‘Relational analysts generally believe what is most important is that patients have a new experience rooted in a new relationship’ (1996, p. 214). At other times, an artificial separation between the patient–analyst relationship and interpretation leading to insight is emphasized. This approach is usually formulated along the lines that both the relationship and insight bring about analytic change, but in an additive fashion. That is, one must have both a good relationship with the patient (e.g. therapeutic alliance) and insight for change to occur. Or certain changes occur via insight and others occur through the relationship modifying procedural memories, being internalized, etc.

This distinction between insight and relationship needs to be reconsidered. It will be suggested that the experience with the analyst and insight are two aspects of the same phenomenon (Aron, 1996). A possible solution to this artificial distinction is to correct a more fundamental false dichotomy about the nature of insight and to emphasize the importance of mental structure in understanding the nature of therapeutic action in psychoanalytic technique. Attending to underlying mental organization in understanding how we help patients to change may mitigate the tendency of relational and Freudian analysts to talk past each other (Smith, 2001).

An important, and not always appreciated, assumption implicit in the structural model is that psychopathology arises from mental functions not working optimally (Hartmann, 1955; Rapaport, 1967). That is, both symptoms and character traits for which our patients seek treatment involve subtle or not so subtle disruptions in mental functioning (affect regulation, narcissistic regulation, self- and object-constancy, etc.). These disruptions involve either the active inhibition of key psychological functions or the failure of these functions to develop fully because of either very early conflict, trauma, or constitutional limitations—or the intrusion/disruption/coloring by conflicted content on otherwise adequately developed functions. From this perspective, psychoanalysis cures, in part, by remobilizing and
reintegrating these disrupted psychological functions. It does this through helping patients to learn about their minds, or what Spezzano calls character: ‘Gradually the analyst can help the patient talk about the affects he is expressing in the transference and what he is doing in the relationship to contain and regulate feelings he cannot tolerate (defense, resistance, and character)’ (1993, p. 207). The more our patients’ conscious self-knowledge is expanded, the greater control they develop over mental functioning. The progressive movement from reflexive, psychological functioning to reflective, conscious control is marked by a shift from concrete to abstract mental functioning and an expansion of the mind (Aron, 1993). Self-reflection and the ability to use words to think about and communicate one’s inner processes help to alleviate the need for the problematic symptoms or character traits our patients use in their desperate attempts to maintain homeostatic equilibrium (Spezzano, 1993; Shapiro, 2000). This is the essence of structural change (Busch, 1995a, 1999).

Therapeutic action

The process of insightfulness

It appears that the traditional dichotomy of insight versus relation is based on a reversal of figure and ground about the nature and role of insight in causing intrapsychic change in psychoanalysis. Traditional definitions of insight have revolved around patients gaining emotional and intellectual awareness of the unconscious mental content thought to be contributing to whatever clinical phenomena are in question. Only recently have attempts been made by modern Freudians to correct the developmental lag in technique that follows from an overemphasis on mental content (Busch, 1995a, 1999; Gray, 1994). Until recently, analysands have been expected to develop access to their own thoughts and feelings, and to realize that these thoughts and feelings both arise from past experiences and currently contribute to troublesome symptoms, inhibitions, emotions, behavior, or character traits. Verbal interpretations of unconscious content (impulses, defenses, or prohibitions and ideals) have traditionally been accorded a privileged status in imparting insight and criticized by relational analysts for being too cognitive and failing to realize the importance of the patient–analyst interaction. This prioritizing of verbal interpretation is not surprising if one equates the attainment of self-knowledge with understanding the contents of the mind’s functions.

But accepting this definition of insight, and its overvaluation of verbal interpretation, carries with it serious problems for psychoanalytic technique. First and foremost is the attribution of excessive authority to the interpreting analyst. Both Busch (1995a, 1999) and Renik (1993a, 1995) are concerned about this tendency, and each takes pains to analyze in a way designed to reduce patients being put in a position of having to acquiesce to the omniscient analyst who imparts knowledge of their mental contents to them. To be sure, each works in very different ways to counteract this tendency. Nonetheless, they are both aware that it is an all too common element of traditional psychoanalytic technique; in fact, it is almost inevitable so long as one adheres to the traditional definition of insight with its implication that unconscious content needs to be unearthed or decoded and brought to patients’
awareness. It has led a host of interpersonal and relational analysts to suggest other technical modifications to reduce it (e.g. Aron, 1996; Hoffman, 1983; Levenson, 1972, 1998; Spezzano, 1993; Summers, 2001).

Another problem with this traditional definition, the one that occupies most of this paper, is its failure to account for the importance of the mind’s formal organization. It is here that figure and ground have become reversed. To the degree that psychopathology arises from the mind failing to fully and successfully utilize its crucial, stable functions in the service of self-regulation, the guiding principle of analytic technique needs to be remobilizing and reintegrating these functions. That is, the goal is to expand the mind’s activity to include all its mental functions working optimally and harmoniously. Most analysts believe that this is best accomplished by helping our patients to consciously experience and expound on all their inner workings with a minimum of restriction. It is this ability to consciously reflect on their minds’ workings in all their complexity, more than awareness of content, that promotes the mental mastery or self-regulation we regard as psychoanalytic cure. But it seems that our traditional and not-reflected-upon acceptance of insight into unconscious mental content (likely a residue of Freud’s topographic model) has led us to reverse figure and ground in our attempts to understand how psychoanalysis brings about change. This confusion continues to confound our efforts to define psychoanalytic technique. For example, Bleiberg has recently distinguished promoting mentalization as a separate technique from psychoanalysis proper:

> Psychoanalysis opens pathways to the experience of repudiated affects. In contrast, helping patients who are prone to inhibiting mentalizing in the face of threatening internal cues requires that they learn to use their ideational capacity to modulate their emotional experience. (2003, p. 219)

Once one realizes that the emphasis needs to be on expanding the mind’s conscious access to its workings, it seems more useful to speak of what has elsewhere been called promoting insightfulness (Sugarman, 2003a) or insighting (Abrams, 1996; Boesky, 1990). These terms are synonymous with Mayes and Cohen’s (1996) ideas about theory of mind and Fonagy and colleagues’ (Fonagy and Target, 1996; Fonagy et al., 2002) concept of mentalization, and suggest that patients come to us unable to fully mentalize. To a greater or lesser degree, they lack access to their inner world and fail to realize its importance in understanding the problems for which they seek help, or that its workings and contents have been affected by developmental experiences. Thus, in psychoanalysis we promote mentalization, which is more usefully called insightfulness or insighting in the psychoanalytic situation. Expanding this mental function is a significant component of therapeutic action. That is, we facilitate our patients’ awareness that they have an internal world, that it arises out of important developmental experiences and fantasies about them, and that it contributes to their emotions, self-esteem, ability to relate to others, etc. For example, an important interpretation early in the analysis of a narcissistically defended man highlighted his proclivity to assume that any thought, fantasy, or emotion of his was simply ‘normal’ rather than to be curious about its deeper meaning. Pursuing this line of inquiry fostered his curiosity, self-reflectiveness, and, eventually, psychological
mindedness. To be sure, dynamic and structural contributors also became evident, particularly his defensive grandiosity and the functions it served. But the important impact of this line of interpretation involved the development of mentalization more than awareness of any particular psychodynamic content. It was the attainment of this mental function that allowed him to realize the relevant dynamics as well as subsequent knowledge of his mental workings. We help our patients gain access to a key psychological function that has been disrupted by conflict and/or trauma more than access to repudiated mental content in psychoanalysis proper. What is mutative in analysis is the facilitation of a mechanism for self-understanding that leads to mental expansion. ‘To be sure, awareness of repudiated content will usually accompany the development of mentalization. But the point of insightfulness is to regain access to inhibited or repudiated mentalization, not to specific content per se’ (Sugarman, 2003a, p. 331). This emphasis on regaining a key psychological function leading to self-knowledge is very similar to Kleinian (Mitrani, 1993, 1995) and relational (Levenson, 1972, 1998; Spezzano, 1993) perspectives. By promoting mentalization, we, in essence, stimulate the immune system of the mind. Analysands are helped to absorb internal and external stressors by mentally processing their effects and elaborating them more (Lecours and Bouchard, 1997).

The promotion of insightfulness

Shifting figure and ground to an emphasis on the process of insightfulness integrates the importance of both the relationship with the analyst and his facilitation of insightfulness instead of artificially distinguishing them. As mentioned above, the idea that we provide insight, with its implication that the analysand is a passive recipient of the unconscious content verbalized by the analyst, must be reformulated. Toward this end, Vygotsky’s concept of the zone of proximal development (ZPD) is valuable (Wilson and Weinstein, 1992a, 1992b, 1996). Promoting the process of insightfulness lends itself to the analogy of a competent tutor teaching a new skill to a neophyte (Wilson and Weinstein, 1996). The ZPD is defined as

…the processes that beget the differences between an analysand’s ability to advantageously make use of the dyadic nature of the clinical situation as contrasted with solitary introspection or self-analysis, in order to acquire insight and capacities that promote self-knowledge and ultimately self-regulation. (1996, p. 171)

Levenson (1998), likewise, talks about the patient learning a new skill through his interaction with the analyst. Through the analytic process and emotional involvement with the analyst, in particular the transference, we create a frame necessary for patients to gradually develop the capacity to reflect upon and become aware of the intricate workings of their minds.

Developing this frame and promoting insightfulness occur through a variety of interventions, of which verbal interpretation is only one. Interventions such as helping patients to recognize their emotions and their triggers to promote affect-regulation, or confirming that they are genuinely valued or not forgotten outside sessions to promote narcissistic regulation and/or a sense of self-constancy, are just as crucial to the promotion of insightfulness as verbal interpretation of mental
content. Thus, defining insightfulness as gaining a theory of mind transforms our focus into a complex array of technical strategies used by the analyst to foster the development of this important process. Insightfulness is insightfulness; acceptance of the importance of this process makes it logically untenable to designate verbal interpretations as the essence of analysis and interventions via action or the relationship as something else—either just therapeutic or just unfortunate parameters necessary to allow the real work of analysis to occur. Any intervention by the analyst that promotes patients’ abilities to see, understand, and integrate (both cognitively and emotionally) the workings of their minds is functionally the same. Aron draws the same conclusion from a relational perspective: ‘If what is thought to be transformative is not only insight but new forms of engagement, if relationship is privileged along with interpretation … then why limit our interpretations only to formal interventions?’ (1996, pp. 213–4).

Our relationship with our patients, at certain points or around certain issues, can potentiate their capacity for insightfulness as much (and sometimes more) than any verbal interpretation. Often it seems less important whatever psychological function, conflict, or issue is focused on than the fact that we are genuinely interested in their minds. Many patients do not realize the importance of their own minds without some interactive guidance from one who is important to them. For this reason, one can be a relatively active analyst, raising questions, pointing out discrepancies, etc. in an attempt to focus patients on their minds’ functioning. Just as with young children, development of self-reflection is stimulated by love, not just frustration. Put another way, the analyst’s interventions facilitate an environment where the aim is to know, in a relationship with someone interested in knowing (Miller, 2000). Our patients internalize our awareness of them as thinking selves. Furthermore, our analysands develop insightfulness by becoming interested in and observing our minds in action. Self-definition and self-regulation improve as our patients develop or expand thinking selves out of the interaction with the containing analyst. Ogden (1982, 1994) has made a similar point over the last two decades with his emphasis on projective identification and the need for the analyst to ‘make available to the patient in a slightly modified form that which was already his but had been formerly unusable for purposes of integration and psychological growth’ (1982, p. 40). After all, we bring more developed and sophisticated psychological skills to the analytic interaction. Our words and the ensuing verbal dialogue encourage self-observation, expand the emotional repertoire, and create a field for the externalization of patients’ intrapsychic conflicts to be explored (Wilson and Weinstein, 1996).

This is not to say that verbal interpretations are unimportant to the attainment of insightfulness. After all, analysis is a form of self-inquiry with the aim of accessing what has been unrecognized by patients and putting together the discovered elements of mental activity in a new way. Language is an essential (but not exclusive) tool in this process of self-inquiry, with its goal of making as much mental activity as possible available to conscious, symbolic processing. Unfortunately, our traditional ways of interpreting to patients are based on the assumption that bringing their internal conflicts to awareness will allow the eventual modification of the compromise formations many analysts believe cause analysands’ difficulties. This approach
implies that it is awareness of particular mental contents (e.g. wishes, defenses, prohibitions, or ideals) that is essential for patients to recognize.

Instead we should interpret in such a way that patients become aware of their minds at work: ‘this model is more concerned with the ways in which the experience is transformed and with the shape of its expression than with its content’ (Lecours and Bouchard, 1997, p. 861). That is the point of Busch’s (1995a, 1999) emphasis on working with the conscious ego. To put it another way, we help our patients exercise specific functions in relationship to one another. Our analytic frame allows a host of functions (affect-regulation, narcissistic regulation, self- and object-constancy, etc.) to emerge and be subjected to self-reflection and integration, for example. Thus, the point of verbal interpretation is to draw patients’ attention to these various mental functions as they occur and interact in the analytic relationship. Mental content remains important because it provides a focus for the mind to observe itself in action. We may draw patients’ attention to their avoidance of aggressive thoughts, for example. The goal, however, is not so much to explore the aggressive or defensive fantasies per se, at least not initially. It is to facilitate a greater capacity for self-understanding through all the means discussed above. We want our patients to see their minds functioning as it happens and to realize the importance of doing so. To be sure, we will want to later explore the details of why their minds function in this way around such specific issues. But, even then, the point of this exploration is not to make the unconscious conscious or to promote ego ascendancy over the id. It is to promote our patients’ mentalization. Being able to reflect on all aspects of one’s mind with a minimum of restriction is the greatest guarantee of mental health (Busch, 1995a, 1999; Kris, 1990; Marty, 1990).

The importance of mental organization

Technical strategies, then, follow from our understanding of the importance of mental organization, how it develops, and what facilitates or impedes its development. There is a good deal of agreement between cognitive researchers and psychoanalysts that the mind’s earliest origins are in the body (Altman, 2002; Aron, 1993; Bucci, 2002; Fonagy et al., 1993, 2002; Freedman, 1977; Lecours and Bouchard, 1997; Levenson, 1998; Piaget, 1947; Ross, 2003; Santostefano, 1977; Stern, 2002; Sugarman and Jaffe, 1990; Wolff, 1960). Regardless of whether one speaks of a body ego, procedural systems, or sensorimotor thinking, the essential point is ‘the central role of body action in the early formation of psychic structure’ (Freedman, 1977, p. 112). The mind, its processes, and its functions become progressively more organized as development proceeds. Although there is some disagreement about whether the mind originates in action or in earlier physiological, proprioceptive, and kinesthetic processes, and about the number of stages before arriving at abstract symbolizing, all agree that the most mature and effective form of mental organization is the symbolic one, and that mental organization exists along this somatic-symbolizing continuum. All psychological functions seem to work better and facilitate greater self-regulation when they work in symbolic ways. Affect-regulation, for example, improves as one moves from psychosomatic discharge
or action to verbal symbolization as a means of experiencing, modulating, and expressing emotion (Herzog, 2001; Mayes and Cohen, 1993; Mitriani, 1993, 1995; Sugarman, 2003b, 2003c, 2004). So does narcissistic regulation, self-reflectiveness, the stabilizing of self- and object-representations, etc. Using a visual schema, the developmental continuum from body to symbolizing can be thought of as moving from left to right. Psychopathology can then be recast as failing to develop or losing the symbolic level of organization, either in circumscribed areas or more ubiquitously: what Herzog (2001) calls a shift to the left.

Another important feature of this developmental continuum of mental organization is the fact that earlier modes of organization never disappear. Instead they are subordinated to and integrated within more advanced modes of organization (Sandler and Joffe, 1967; Santostefano, 1977; Talvitie and Ihanus, 2002). Regression, as an explanation of psychopathology, must shift its emphasis using this perspective. Traditional explanations of psychopathology have either emphasized drive regression (i.e. oedipal to pre-oedipal), in essence using mental content as an explanatory concept, or ego weakness, that is, relying on abstract, metapsychological constructs. We can better understand psychopathology, as well as better focus our interventions with patients, by tracking the ebb and flow of symbolizing versus de-symbolizing as they occur within the analytic encounter (Lasky, 2002). One might argue that action is ubiquitous in the analytic interaction (Aron, 1996; Boesky, 1990; Ellman and Moskowitz, 1998; Jacobs, 1986, 1991; Levenson, 1972; McLaughlin, 1981; Ogden, 1982) and that the discrepancy between words and action is an important surface.

One patient, for example, would become enraged, virtually shouting as he expressed anger over various perceived slights by me, such as charging him for missed sessions. My attempts to draw his attention to the intensity of his anger would be met by hurt and frustration that I did not give him credit for knowing that his perceptions were distorted by dynamic conflicts and appreciate that he was just sharing his feelings as I had asked him to do. His first association would usually be that my failure to appreciate this fact meant that I did not see his entirety, instead emphasizing one small part of him out of context because of my biases against him. He would then draw the parallel to his maternal grandfather whose love he could never gain. I would find myself irritated with the intransigence of this masochistic defense. Silently exploring my irritation, I realized it was a response to feeling helpless in the face of his rigidly and aggressively held position as victim. Realizing how controlling and sadistic he was being toward me allowed me to gradually illuminate the grandiosity that lay beneath it. That is, feeling hurt and misunderstood allowed him to feel that he could treat me however he wished so long as he was analyzing and understanding it. Laborious focus on such interactions over the first two years of his analysis allowed him gradually to realize his tendency to enact and analyze simultaneously, its repercussions elsewhere in his life, and its meaning in his mental organization, in particular the grandiosity that colored so much of his behavior.

In essence, ontogeny is recapitulated in the analytic interaction and we should be able to track shifts along the developmental continuum through which patients experience and demonstrate the organization of their minds. Increasingly, developmental research is drawing our attention both to the existence and importance of
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Implicit, procedural, action-based knowledge systems, and to their emergence in the clinical situation with neurotically organized patients, not just those whose minds are more primitively organized. The distinction is not black and white (Aron, 1996). Hence, the use of words to enact more than simply to communicate indicates an inhibition of symbolic communication. For some reason, at that moment, the patient has lost the ability to experience, reflect upon, and communicate the workings of his mind in a purely abstract, symbolic fashion. He will either enact in a more gross fashion or use his words to do so more subtly. As Busch (1995b) has emphasized, our analytic approach when confronted with a regression from symbolizing to action by patients should generally be to draw their attention to this regression in their ability to think and reflect symbolically, not to the unconscious content being expressed by the action. In this way, we make the discrepancy between words and action a surface that can be studied.

Promoting insightfulness means that we strive to help our patients to think about and reflect on their minds in the most developmentally advanced ways. There is a developmental line of insightfulness (Sugarman, 2003a) that parallels developmental dimensions of mentalization (Lecours and Bouchard, 1997). Conscious self-reflective insightfulness, with its implication of an ego split between experiencing and observing (Sterba, 1934), is the end point of this developmental line. We may need to meet patients at the level of mental organization in operation around whatever we are focusing upon; but our goal is to promote more advanced levels of mental functioning. Some disagreement exists about the way to do this and the degree to which it is possible or even optimal. For example, some argue that optimal functioning and self-regulation require an easy but controllable ebb and flow between levels of mentalization (Lecours and Bouchard, 1997), while others argue for the value of subordinating as much mentalizing as possible to the verbal, symbolic mode (Altman, 2002; Ross, 2003). And some believe that implicit, procedural, or action modes of knowing can be directly reflected upon (Ross, 2003) and subordinated to explicit, declarative, and symbolic mentalization (Lecours and Bouchard, 1997; Santostefano, 1977), while others argue that it is impossible to subject these earlier modes of organization directly to mature insightfulness (Talvitie and Ihanus, 2002) or that primitive mentalizing cannot be literally superseded by mature mentalizing so that, instead, one should aim to integrate the action mode, not replace it (Bucci, 2002). Resolving these subtle disagreements can await further research. At this point it seems prudent to study all modes of mental functioning as they emerge in the analytic process while striving to analyze them using the verbal, symbolic mode. ‘When we say that psychoanalytic treatment creates or restores symbolizing, we really mean that treatment fosters accurate abstractions and a fluid process of symbolizing’ (Friedman, 2002, p. 211).

Implications for analytic technique

The importance of transference

Implicit in the approach to analysis being advocated is the centrality of the relationship between patient and analyst, that is, transference in the broad sense.
Transference is ubiquitous in all relationships; what makes psychoanalysis unique is our reflecting upon and exploring it in the context of the relationship where it is occurring. This broad or global definition includes more than the classical emphasis on the displacement or projection of early object ties on to the person of the analyst. This phenomenon certainly occurs in the analytic situation as well as all object relationships. Too often, though, we forget another aspect of transference—transference of defense—first articulated by Anna Freud (1936) and more recently emphasized by Gill (1982) and Gray (1994). But many aspects of the mind’s organization become transferred, not just object ties or defense. This fact has led Silk (2004, personal communication) to define transference as the interpersonalization of mental structure. Wolstein views transference similarly from a relational perspective when he defines it as the ‘integrative and unitary phenomena of the total personality in the active field of experience’ (1959, pp. 18–9).

The analytic process can be viewed as an interpersonal interaction with certain formal constraints (frequency, schedule, the couch, payment, etc.), which is designed for the sole purpose of allowing one party (the patient) to transfer elements of his mental organization into the relationship so that both parties can observe and study these transference phenomena with the goal of helping the patient to modify elements of his mental functioning. Levenson (1995) similarly describes the psychoanalytic process as a frame that the analyst initiates. To be sure, analysts will also find themselves transferring elements of their internal structure, hence the inevitability of countertransference. And this can be useful. But the goal of analysis is always modification of patients’ internal organization (Bachant and Adler, 1997; White, 1996; Wilson and Weinstein, 1996). Because both parties’ minds are organized in the manner discussed above, so that action-oriented, preverbal experiencing and communication is always active and present, even if subordinated to verbal, symbolic modes, there will always be some impetus to actualize the transference (Aron, 1996; Boesky, 1982; Ogden, 1982; White, 1996) and countertransference (Renik, 1993b; Tansey and Burke, 1989). Externalization of internal structure is the means by which individuals render experience safe and predictable while at the same time subjecting aspects of their inner world to possible modifying feedback that can then be reinternalized (Bachant and Adler, 1997).

To the degree that psychological structure becomes interpersonalized, it follows that patients will interpersonalize their various modes of mentalizing. That is, developmentally less advanced modes of mental organization will be manifested as well as more advanced ones. We will have the opportunity to see our patients’ minds in process, at all levels of stratification, as well as the issues being communicated at each level: for example, the above-mentioned patient who would enact his grandiose demands in the guise of analyzing and reflecting upon his negative transference. To the degree that patients’ minds involve a hierarchy of modes of mentalization, it is inevitable that action will be part of their communication. Freud (1914, 1915) observed this clinical fact a number of years before he articulated the structural model that helps us to understand why it is so. No patient’s mind is organized at only a symbolic level. This is the point of those who emphasize the importance of procedural, nonverbal, or action-based knowledge as well as those who emphasize the
importance of interaction. Analysts who attend only to verbal aspects of transference fail to help patients to gain insightfulness into all aspects of their mental functioning. The question becomes how to gain awareness of procedural knowledge, and how best to help our patients become aware of, and integrate or subordinate it to symbolic knowledge. Ogden (1982) has used the concept of projective identification toward this end, while other relational thinkers find countertransference a useful avenue (Tansey and Burke, 1989). Freudian analysts have traditionally referred to it as developmental help or something other than psychoanalysis proper (Bleiberg, 2003; Fonagy, 1999). ‘Developmental help facilitates a better synthesis of developmentally acquired organizations which were pathologically established’ (Daldin, 1994, p. 523). However, it is becoming far more common to accept that experience or knowledge organized at less symbolic levels can be worked with analytically (Altman, 2002; Friedman, 2002; Lecours and Bouchard, 1997; Process of Change Study Group [PCSG], 1998; Ross, 2003; Santostefano, 1977; Talvitie and Ihanus, 2002).

The failure by some to include work on pre- or nonverbal issues under the rubric of analysis involves more than adherence to the traditional definition of insight into content. Another factor likely has to do with the common tendency to only recognize such modes of experiencing and communicating after they have resonated with the analyst’s own less symbolic modes of organization. Patients who have difficulty mentalizing abstractly, so that they communicate via action, tend to trigger countertransference reactions, including the loss of one’s own ability to mentalize abstractly (Bleiberg, 2003). Renik’s (1993b) observation that countertransference enactments cannot be recognized until one is already in them seems true much of the time. Often we are unable to realize that our patients are communicating via action until we, too, are doing so. It is likely our discomfort with this common occurrence that leads some to prefer adhering to an ideal that prioritizes only verbal, symbolic communication between patient and analyst as genuine analysis. Accepting that our minds, too, are organized hierarchically, and that action modes remain potentially present, no matter how well analyzed we are, may make analysts more sanguine with this fact of analytic life. Such acceptance does not have to imply a laissez-faire attitude or a dismissal of the importance of eventually processing the material in a symbolic mode.

**Action interpretations**

This fact does raise a question about the most effective manner of promoting insightfulness into an issue being communicated nonverbally, however. To the degree that the formative experiences and conflicts contributing to that issue may only be known to the patient at an implicit or procedural level, will a verbal, symbolic intervention that aims instantly at engaging patients’ conscious, symbolic capacities have the affective immediacy necessary to promote insightfulness? At times, an action interpretation might be more effective in drawing patients’ minds to how and what they are communicating. Ogden makes a similar point with regard to projective identification being used as a means of communication: ‘For parts of our work with more disturbed patients, verbal interpretations will play a relatively small role’ (1982, p. 41). Increasingly, analysts are finding that this holds true for neurotic
patients, also. With children, setting a limit on aggressive behavior can be viewed as a confrontation and interpretation of defensive omnipotence surrounding aggressive impulses at a level of abstraction consistent with the child’s concrete mental organization (Sugarman, 2003c). It is often necessary to intervene at this level first before the child can be helped to develop more abstract levels of insightfulness. The same can be said of some adults. This seems to be what Stern (PCSG, 1998) has in mind with his concept of moments of meeting. But his idea that such enactments, in and of themselves, reorganize patients’ implicit, procedural knowledge does not sufficiently consider the complex, intrapsychic impact of the interaction on patients’ mental organizations. Love or empathy, while important, are not usually enough to explain structural change. Rather, such interventions seem more usefully viewed as action interpretations, preliminary to verbal, symbolic ones, with the goal remaining eventual conscious, verbal insightfulness. This approach is consistent with Santostefano: ‘In phasing-in interventions, the goal would be to facilitate therapeutic progression from action without thought to thought without action, so that all modes (action, fantasy, and language) are available’ (1977, pp. 352–3).

A clinical example of such an action interpretation occurred in the analysis of a middle-aged, masochistic woman in the fourth year of a five-sessions-per-week analysis. Plaintive complaints that she had never been loved or appreciated by her parents because she lacked sufficient physical beauty, social poise, or intellectual talent had been a regular part of her analysis. Similar complaints about previous lovers and therapists had also been a regular theme over the years. The only respite from this pervasive experience of feeling not good enough had occurred with two of her previous therapists who had blurred certain interpersonal boundaries in ways that allowed the patient to feel special. Not surprisingly, a central aspect of the transference had been her wish that I do so also, preferably by gratifying various sexual fantasies. Only the physical act of sex would prove I cared and found her attractive. My failure to do so, and my interest in exploring her belief that only actions, not words, conveyed affection and approval, resulted in disappointment, hurt, and anger, despite her intellectual understanding of my refusal to gratify her wishes. Over the first four years of the analysis, we made steady but slow progress in understanding the meanings and functions of her belief that she was simply too unattractive for me or any other man to care about. Nonetheless, she remained adamant that my caring was ‘only’ professional and devoid of personal interest because, otherwise, I would demonstrate it in the manner she prescribed. That is, she could acknowledge that she seemed to have a need to see me as uncaring and herself as unlovable. But this awareness remained only intellectual, failed to incite much curiosity, and did not lead to greater awareness of the meanings that these beliefs had for her.

In that context, I returned from a break to find that she had experienced a sudden, frightening, and potentially serious medical problem while I was away. However, she had recovered so quickly that her physician believed her illness had been a fluke event. Within a week of resuming sessions, she had to be hospitalized for similar symptoms. This hospitalization lasted a week because of difficulty in diagnosing the exact nature of the problem and then deciding upon a treatment. During that week, I checked in with her on the phone daily, and visited her in the hospital twice, each
a short visit. The medical problem was eventually treated satisfactorily, she was discharged, and we resumed regular sessions. At the time I did not reflect much on my behavior. It just seemed the right thing to do. Only in retrospect did I realize that I was involved in an enactment and responding to some nonverbal communication of the panic she was experiencing. Thus, such action interpretations are likely part of what Aron (1996) means when he emphasizes that the patient meeting with an authentic response from the analyst is an intervention in its own right.

We discussed her reactions to my calls and visits, and she showed no apparent fantasy or reaction beyond feeling appreciative that I had been available to her at a time of anxiety. But she was subsequently struck by her continued insistence that I did not really care about her when she resumed her analytic work. My actions seemed more difficult for her to minimize and she herself became curious as to why she continued to feel so unloved in the face of what she felt had been my going beyond the call of duty in visiting her. Grudgingly, she acknowledged that I must care more than she seemed willing to allow herself to feel and proved amenable to trying to understand her insistence that I did not. For the first time, she stepped back and emotionally, not just intellectually, experienced those feelings as ego alien. I was able to use this discrepancy and newfound perspective to deepen previous work about how she used her complaints to maintain an omnipotent fantasy of being able to have anything she wanted so long as she wished for it enough. She remembered believing as a child that wishing for something hard enough and long enough would make it happen. Furthermore, refusing to accept that I and others cared masked a belief that unconditional loving or caring was still realistically available for her. She was genuinely shocked when I explained that unconditional love was something that happened sometimes between certain parents and children. But it was unrealistic as an adult. Sadly, she realized that she had always felt that so long as she avoided ‘settling’ for my care, which involved limitations, she could still believe that one day someone would love her unconditionally. She had only to hope long enough. We talked about how her previous therapists had iatrogenically reinforced this fantasy with their boundary violations. Similarly, her complaints helped her to avoid her rage about the limits to my caring. Feeling mistreated led to depression and self-directed criticisms instead of anger toward me. She talked of feeling afraid to feel her anger because it would destroy all her positive feelings toward me and leave her feeling alone. Feeling unloved also let her feel her anger was justified and caused by me, not by her narcissistic wishes. She also gained greater awareness of the intensity of the neediness obscured by her angry and disappointed complaints. Over time she noted that she was never satisfied by any of her friends or family, always emphasizing what they did not do for her. All this newfound self-knowledge led gradually to improved relationships outside the analysis, greater self-acceptance, and improved affect tolerance.

Thus, I would view my calls and visits as a confrontation and interpretation of her defensive use of magical thinking: that, in essence, she was not omnipotent, she could not have everything she wanted and that there were limits to how much I cared. The interpretation could only be processed in an action context wherein she was given some of what she wanted, but not everything. Levenson seems to have the same thing in mind
when he says, ‘When interpretation works, I believe it is because it is reflecting on a felt experience’ (1998, p. 244). Verbal interpretations alone had never promoted the sort of symbolic insightfulness she showed after these actions. She finally realized that she would remain hungry and lonely so long as she failed to face and modify the ways in which her mind dealt with aggressive, narcissistic, and dependent longings, guilt and shame over them, as well as projection and externalization. Certainly I partially gratified her wish to feel special, her magical thinking, and her omnipotent fantasies with these actions, just as her previous therapists had. But (in contrast to her previous therapies) the gratification was both insufficient to alter her masochistic complaints and it was then subjected over time to verbal, symbolic processing. The interpretation did not remain at an action level. Only the fact that it was processed in a symbolic manner allowed the expansion of her ability to mentalize. Ultimately, it is necessary for patients to gain abstract insightfulness and be able to reflect on their minds using verbal symbols in order to develop a sense of subjective agency in regard to them (Altman, 2002). Until this patient was able to expand my action interpretation and reflect on it abstractly, she continued to feel a helpless victim; symbolically organized insightfulness facilitated her sense of herself as an active agent. Action interpretations play an important and necessary role in promoting insightfulness. But in the end, the talking cure remains the talking cure (Busch, 2004).

Where is the neighborhood?

Intervening ‘in the neighborhood’ (Busch, 1993) acquires additional meaning from this perspective. ‘Outside the neighborhood’ now means much more than the unconscious content that is unavailable to patients’ conscious egos. Such neighborhood boundaries remain relevant when patients are interacting with us in primarily a verbal, symbolic mode. But the neighborhood is expanded greatly when patients’ interactions and communications fluctuate between various modes. Moving patients from left to right so that full mentalization is acquired requires that we accurately read and intervene by meeting our patients’ minds where they are.

The idea that there is something therapeutic about the therapist’s containment of the patient’s projective identifications is based upon an interpersonal conception of psychological growth: one learns from … another person on the basis of interactions in which the projector ultimately takes back … an aspect of himself that has been integrated and slightly modified by the recipient. (Ogden, 1982, p. 40)

Bouchard and Lecours make a similar point about the importance of intervening using the same form (level) of mentalization as the patient.

The ‘putting into form’ must engage the specific internal structure and integrity of the presently observed, considered and actualized process: words filled with meaning (interpretations) in response to symbolic … thinking; words as ‘play’, joined with tone of voice, posture and facial expression to meet unmentalized sensations and excitations, and primary mental representations. (2004, p. 889)

Ideally, this will involve retaining our own abstract abilities and drawing our patients’ attention to departures from experiencing and communicating in verbal, symbolic ways. Even when we are able to do this, we may, as discussed above, find such interventions
lack the emotional immediacy to facilitate insightfulness. And, of course, we are often unable to maintain our own abilities to mentalize abstractly at such moments. But, regardless of the mode in which we begin the work, the promotion of insightfulness dictates that we facilitate our patients’ abilities to verbally recognize regressions in their minds’ ways of functioning, and to explore and understand how and why these regressions occur. Until the tendency to regress to action and the reasons for it are understood, it will continue to occur around whatever new thought, emotion, or conflict stimulates it. This work is the structural parallel to Gray’s (1994) emphasis on attending to shifts in patients’ associations when dealing with dynamic conflict.

The difficulty in this exploration of shifts in modes of mental functioning is that the reasons giving rise to it are often unavailable at a verbal level, not because they are repressed but because they simply are not organized at a symbolic, abstract level. It is likely this difficulty that leads some (Talvitie and Ihanus, 2002) to argue that implicit knowledge cannot be made conscious. In contrast, Ross argues that ‘the derivatives of what has long been procedurally felt only in sensorimotor or emotional form become, through later associative processes, ever more subject to and “known” by declarative memory’ (2003, p. 69). The question becomes how to bring this about. Many of the interventions that some have regarded as ‘only’ promoting mentalization (Bleiberg, 2003) or developmental help (Daldin, 1994) become relevant here. For example, observing, labeling, and communicating patients’ internal states promotes mature insightfulness. Showing a patient who has difficulty recognizing, tolerating, or modulating anxiety that he regresses to behavioral externalizations to avoid the conscious experience of that emotion can be a crucial first step in knowing and thinking about his anxiety and his difficulties with it, so that he can eventually think about it at a verbal, symbolic level. Often, just emotionally engaging and accepting a patient’s anxiety is a crucial first step toward symbolic insightfulness. In this way the patient comes to recognize his use of action modes of experiencing as a defense. The reasons for his anxiety or his difficulty regulating it must await the patient being able to manage it, and fantasies or memories associated with it, at a consistently verbal, symbolic level.

This work occurs best in the transference because it is far easier for patients who regress to concrete, action modes of thinking and feeling to observe such shifts when they are occurring in the room. At these times, the regressions have an emotional immediacy and a cognitive tangibility that is missing when working outside the transference. Furthermore, the relationship between patient and analyst is crucial in helping patients learn to consistently experience and communicate abstractly. Action and interaction are key contributors to mentalization (Aron, 1996; Levenson, 1972). Satisfactory interaction with the analyst is necessary to develop awareness of a mind characterized by interacting and conflicting processes and functions. Only through being willful can awareness of willing develop; internal agency requires feeling an agent vis-à-vis another.

For these reasons, it is important to intervene in a way that helps patients to understand how and why we choose to say and do what we say and do. We must spell out the links in how we arrived at a particular intervention. At times this will involve explaining the logic of our thinking (Busch, 1995a, 1999) and tying it to the patients’ words and actions. But, at other times, particularly around regressions
in modes of mentalizing, it may be necessary to disclose our own emotional reactions (Renik, 1995). After all, it is often our countertransference feelings and actions that draw our attention to the enactment in the room. Our emotional reaction may be necessary in helping some patients recognize and be curious about their use of action and its impact on others. In these instances, self-disclosure seems important. Patients learn mentalization, in part, by observing our minds in action (Sugarman, 2003a). Hence it is incumbent upon us, at times, to make our minds available for analysands to see and experience. This can be done in a disciplined way without the anything-goes mentality that many fear when they hear the term ‘self-disclosure’.

For example, one young man in analysis for a variety of psychosomatic issues was embroiled in a long-standing battle with his analyst over raising his fee because of his improved financial situation. Despite consistent and sensitive analysis of the many factors contributing to his reluctance to raise the fee, he continued to avoid doing so. In this context the patient suggested raising the fee per session by reducing the frequency of weekly sessions from five to four. His associations led to remembering his mother often failing to give presents while acting as though she were (e.g. presenting him with his weekly allowance as though it was a birthday gift). At this point the patient realized that he was sadistically withholding from the analyst as his mother had done to him and negotiated a reasonable fee.

Soon, the patient began a session wondering whether the analyst would wish him a happy birthday as it was his birthday. This analyst was not unwilling to interact in this way because she feared being overly gratifying. But, in this case, she did not feel any spontaneous desire to do so. Instead she felt that she should do so just to avoid the patient’s anger. She chose not to say anything and to attend to her unusual reaction as the session progressed to other themes without the patient commenting on her silence. The patient began the next session talking of a number of situations that had angered him. At that point, the analyst interpreted his displacement and he admitted feeling angry that the analyst had not wished him a happy birthday. The analyst then reminded the patient that the birthday wish had come up soon after realizing his mother’s withholding and disclosed that she had felt she should gratify his wish just to avoid his anger. She asked if he had ever felt that way with his mother. He responded, ‘all the time’ and provided numerous examples. This work led to him gaining greater awareness of how much he identified with his mother, in particular, her proclivity to sadistically bully others while feeling the victim.

To be sure, there were probably other ways for the patient to have gained self-knowledge of his subtle use of action to coerce others. But the analyst chose to make a countertransference self-disclosure that improved the patient’s ability to reflect on himself. One could argue that seeing his impact on the containing analyst had an emotional immediacy that made it easier for this highly somatic patient to mentalize his inner world (Mitrani, 1993).

**Conclusion**

Clarifying that we help our patients change by promoting a process of insightfulness has the potential to reduce the unfortunate tendency to artificially separate
interpretation from the relationship with the analyst as the mutative factor in the psychoanalytic process. Central to this technical approach is the importance of attending to the formal organization of patients’ minds, as key mental structures and modes of mental functioning are manifested in the interaction between patient and analyst. This emphasis on facilitating a process of insightfulness, with its goal of helping patients achieve and maintain a stable ability to mentalize, wherein key mental functions, not just contents, are subjected to self-reflection and affective-cognitive self-knowledge, reverses figure and ground and the traditional emphasis on knowing just unconscious mental content.

This approach is based on the idea that ‘mentalization accounts for a continual, never-ending transformation of psychic contents through the multiplication and organization of representations. This permits the emergence of mental contents and structures of increasingly higher levels of complexity, leading to symbolization and abstraction’ (Lecours and Bouchard, 1997, p. 857). Our technical challenge becomes how to promote this process. Most patients show either circumscribed inhibitions of this process or a failure to have attained advanced modes because of early developmental interferences. A variety of benefits accrue from patients gaining insightfulness at an abstract-symbolic level of functioning (Bram and Gabbard, 2001). Self–other boundaries are strengthened as patients gain a cognitive-affective awareness that they have differentiated and conflicted minds that affect their behavior, and that others do also. Empathy improves with the realization that others’ minds may be organized and function in different ways, or contain different feelings and beliefs. Interpersonal interactions are more easily understood and navigated by patients who can mentalize symbolically. Relationships feel safer as patients come to realize that others’ actions are dictated by their mental functioning. Reality testing is facilitated, separation-individuation is promoted, and the primacy of secondary-process thinking is enhanced by symbolic mentalization. Finally, affect regulation is improved so that emotions can serve a signal function and not be experienced as overwhelming.

Promoting insightfulness improves self-regulation because patients’ minds are better able to maintain homeostatic equilibrium as both their functions and contents become subject to conscious self-reflection and symbolic processing. Thus, patients’ sense of self-as-agent are expanded. It should be noted that the role of the past has not been mentioned in this discussion of insightfulness. That is because this perspective does not emphasize the recovery of memories of the past as a crucial element in mutative action. Epistemological questions can be raised regarding whether it is even possible to do this with ‘memories’ of the past. Regardless, learning to mentalize symbolically seems most easily accomplished in the interactional field (Aron, 1996; Levenson, 1972; White, 1996) as patients transfer the organization and contents of their minds into it. Certainly memories from the past usually emerge as patients gain greater access to the workings of their minds. But this is a by-product of good analytic work, it is not essential to structural change. Some patients do need us to help them to understand regressions to or fixations at action modes of experiencing and communicating in terms of their pasts. These explanations are often necessary because patients can feel such shame or anxiety about their actions.
being seen and put into words. Their shame or anxiety needs to be assuaged before they can reflect more abstractly on the action. Some would argue that such shame or anxiety should be explored verbally instead of bypassed, i.e. Paul Gray (1994). In theory, this approach would be optimal. But some patients’ shame or anxiety is experienced at such a concrete, action level that similarly concrete interventions may be necessary. Thus, the point of the genetic reconstructions that are sometimes necessary is not to help patients change by becoming aware of previously repressed mental content. Instead, it is a nonverbal confrontation that shame and/or anxiety are not necessary because their actions are understandable and containable. Hence, the impact lies with the analyst’s nonverbal communication, not the content of his reconstruction, except insofar as the content is necessary to catch our patients’ attention. Once again, technical interventions are guided by the dictate to promote symbolic insightfulness. This requires greater openness to ways of intervening with patients and deeper thinking into the impact of our interventions. So long as we maintain a commitment to freeing up our patients’ mental processes, the more likely we are to transform and liberate their symbolic capacities (Friedman, 2002).

Translations of summary


982 ALAN SUGARMAN
Mentalización, capacidad de insight y acción terapéutica: la importancia de la organización mental.

El debate actual entre la importancia de la interpretación, entendida como promotora de insight, y la relación analista/paciente, entendida como el factor del cambio estructural, se funda en la clásica concepción del insight como conocimiento de contenidos inconscientes. Esta definición invariablemente privilegia la interpretación verbal, en la medida en que el autoconocimiento es equiparado a la comprensión de los contenidos psíquicos. Se sugiere que una manera de salir de este debate es redifiniendo el insight como proceso, denominado capacidad de insight (insightfulness). Este término implica conceptos como mentalización o teoría de la mente, y sugiere una dificultad en los pacientes para acceder a una mentalización completa. La toma de conciencia del material rechazado suele acompañarse de la obtención de la capacidad de insight. Pero el objetivo de esta última no es tanto el conocimiento en sí mismo de contenidos específicos sino la posibilidad de acceder de nuevo a una mentalización inhibida o repudiada. Hacer hincapié en el proceso de capacidad de insight integra la importancia de la relación analista/paciente con la facilitación de la capacidad de insight a través de la interpretación. Diferentes tipos de intervención ayudan a los pacientes a adquirir la capacidad de tomar conciencia de los intrincados funcionamientos de su mente y de reflexionar sobre ello. La interpretación verbal constituye solo uno de los diferentes tipos de intervención. Por ejemplo, a menudo parece ser menos importante concentrarse en un conflicto particular que mostrar interés por la mente del paciente. Además el analizando adquiere la capacidad de insight desarrollando un interés por el funcionamiento de la mente del analista y aprendiendo a observarlo. Debido a que la mente se origina a partir de experiencias corporales, el funcionamiento mental siempre fluctuará entre modos de acción basados en la experiencia y modos de expresión verbales y simbólicos. El rol del analista permite al paciente tomar conciencia de las regresiones a modos de acción más que a maneras de expresión verbal, de comprender las razones, y de subordinar esta tendencia a la modalidad verbal y simbólica. Todas las funciones mentales trabajan mejor y facilitan una mayor autorregulación cuando funcionan de manera abstracta y simbólica. La psicopatología puede entenderse como un fracaso en el desarrollo o como la pérdida del nivel simbólico de organización, ya sea en áreas circunscritas o de forma más global. El cambio en el paciente se realiza al consentir a este último alcanzar o reencontrar el nivel simbólico en todas las funciones mentales. Dicho trabajo se logra mejor en la transferencia. El concepto de transferencia como defensa se extiende a toda la estructura mental de manera que la transferencia es vista como la interpersonalización de la estructura mental. Es decir, los pacientes transfieren su estructura mental, incluidos sus diversos niveles de mentalización, en la interacción analítica. El analista observa todos los niveles del funcionamiento mental del paciente e interviene para elevarlos hasta un nivel simbólico. A veces esto requerirá interpretaciones actuadas (actions interpretations), dejándose arrastrar a la actuación ( enactment) con el paciente, la cual luego será reprocesada en el plano verbal simbólico. En estos casos no se trata de experiencias emocionales correctivas sino de verdaderas y propias acciones destinadas a interpretar y a afrontar la organización mental del paciente en la transferencia. El nivel afectivo y cognitivo de estas acciones corresponde al de la comunicación del paciente; sin embargo su objetivo final es el de conducir esta comunicación a nivel simbólico. La capacidad de reflexionar simbólicamente sobre cualquier aspecto de la mente con un grado mínimo de restricciones es de hecho la mejor garantía de salud mental.

Mentalisation, plénitude d'insight et action thérapeutique : l'importance de l'organisation mentale.

Les débats continus sur l’importance du rôle de l’interprétation menant à l’insight versus la relation à l’analyste dans leurs contributions respectives au changement structural sont basés sur les définitions traditionnelles de l’insight en tant que gain de connaissance sur les contenus inconscients. Cette définition privilégie inévitablement l’interprétation verbale, et la connaissance de soi devient équivalente à la compréhension des contenus de l’esprit. L’auteur suggère qu’un moyen de sortir de ce débat est de redéfinir l’insight comme un processus, appelé plénitude d’insight. Ce terme repose sur des concepts comme la mentalisation ou la théorie de l’esprit et implique que les patients présentent des difficultés dans la capacité à mentaliser pleinement. La conscience des contenus répudiés s’accompagne habituellement de la conquête de la plénitude d’insight. Mais le but de la plénitude d’insight est de regagner l’accès à la
Mentalizzazione, pienezza di insight e azione terapeutica: L’importanza dell’organizzazione mentale. Il dibattito attuale che mette a confronto l’importanza dell’interpretazione, vista come promotrice di insight, con l’importanza del rapporto analista-paziente, visto come fattore di cambiamento strutturale, si fonda sulla classica concezione dell’insight come conoscenza di contenuti inconsci. Questa definizione privilegia inevitabilmente l’interpretazione verbale poiché la conoscenza di sé viene equiparata alla comprensione di contenuti psichici. Viene qui suggerito che un modo per uscire da questo dibattito sia una ridefinizione di insight in quanto processo, meglio denominato come pienezza di insight. Questo termine implica concetti come quello di mentalizzazione o teoria della mente e suggerisce una difficoltà dei pazienti a raggiungere una mentalizzazione completa. La presa di coscienza del materiale ripudiato si accompagna generalmente al raggiungimento della facoltà di insight. Ma lo scopo di quest’ultima non è tanto la conoscenza in sé di contenuti specifici, quanto la possibilità di accedere nuovamente a una mentalizzazione inibita o ripudiata. L’accento sull’insight come processo integra l’importanza del rapporto analista-paziente con la facilitazione della facoltà di insight mediante l’interpretazione. Svariati tipi di intervento, consentono ai pazienti di acquisire la capacità di prendere coscienza sugli intricati funzionamenti della loro mente e di rifletterci sopra. L’interpretazione verbale costituisce soltanto uno fra questi interventi. Per esempio, è spesso meno importante concentrarsi su un conflitto particolare che mostrare interesse per la mente del paziente. Inoltre l’analizzando acquisisce la facoltà di insight sviluppando un interesse per la mente dell’analista all’opera e imparando ad osservarla. Poiché la mente ha origine da esperienze corporali, il funzionamento mentale è destinato a fluttuare tra modalità di sentire e di esprimersi mediante azioni e modalità verbali e simboliche. Il ruolo dell’analista diventa quello di permettere al paziente di prendere coscienza delle regresseioni ai modi dell’azione, di comprendere le ragioni e di subordinare questa tendenza al modo verbale e simbolico. Qualsiasi funzione mentale è più agevolata e facilita una maggiore autoregolazione quando sono all’opera secondo modalità simboliche e astratte. La psicopatologia può infatti essere considerata come mancato sviluppo o perdita del livello simbolico di organizzazione, in aree circonscritte o più ubiquitarie. Il cambiamento nel paziente si realizza consentendo a quest’ultimo di raggiungere o ritrovare il livello simbolico in tutte le funzioni mentali. Tale lavoro si svolge al meglio nel transfert. Il concetto di transfert come difesa viene esteso a tutta la struttura mentale, di modo che il transfert viene visto come l’interpersonalizzazione della struttura mentale. Vale a dire che i pazienti trasferiscono la loro...
struttura mentale, compresi i vari livelli di mentalizzazione nell’interazione analitica. L’analista osserva tutti i livelli del funzionamento mentale del paziente e interviene per innalzarli a livello simbolico. Talvolta ciò richiederà interpretazioni-azioni, in cui l’analista si lascia coinvolgere in un enactment con il paziente. L’enactment viene successivamente riprocessato a livello verbale e simbolico. Tali azioni non sono esperienze emotive correttive ma sono volte a interpretare e ad affrontare l’organizzazione mentale che il paziente ha trasferito ad un livello coerente – sul piano affettivo e cognitivo - con il livello della comunicazione. Tuttavia il loro obiettivo finale è quello di innalzare questa comunicazione a livello simbolico. La capacità di riflettere simbolicamente su ogni aspetto della mente, con un grado minimo di restrizioni è infatti la maggiore garanzia di salute mentale.

References


