FORMING AND TRANSFORMING SELF-EXPERIENCE

JAMES L. FOSHAGE, Ph.D.

This article addresses the formation and transformation of self-experience with a central emphasis on therapeutic change. Focusing on motivation and organization of experience and their emergence within the analyst-patient dyadic system, the author develops a theory of therapeutic action that involves two fundamental pathways of analytic change that operate in tandem: the explicit mutually exploratory/reflective avenue to therapeutic change and the co-creation of new relational experience.

Keywords: exploratory/reflective processing; listening/experiencing perspectives; motivation; nature/nurture; new relational experience; organization of experience; systems theory; therapeutic action

Central to all self psychological models has been the concept of self, the topic of this conference. Kohut (1984) posited a “nuclear self and its program of action,” an intrinsic design unique to each individual that develops within self/object matrices. Contemporary self psychological and intersubjective theorists have shifted to a more phenomenological term, sense of self, which focuses on the experience of

James L. Fosshage, Ph.D., is Founding President of The International Association for Psychoanalytic Self Psychology. He is Co-Founder and Board Director of the National Institute for the Psychotherapies (New York City), Founding Faculty of the Institute for the Psychoanalytic Study of Subjectivity (New York City), and Clinical Professor of Psychology and Co-Founder of Relational Track, New York University Postdoctoral Program of Psychotherapy and Psychoanalysis.

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selfhood as it is constituted out of lived experience within intersubjective or relational systems. While Kohut’s (1984) conception of self emphasizes both constitutional and relational origins of the self, the phenomenological formulation essentially bypasses the nature/nurture issue.

While systems theory has significantly contributed to our understanding of development (e.g., the explanation of “newly emergent properties”), it has not resolved the nature/nurture issue (Fosshage, 2011a). Thelen and Smith (1994), the authors of the seminal text in the application of systems theory to the development of cognition, raised a most cogent question in their last chapter: What does the baby bring into the system? Current advances in cognitive science; neuroscience; human biology and genome research; and infant, attachment, and dream research are providing evidence with increasing specificity of the exceedingly complex systems interplay of constitutional and environmental elements in development. We can now say that with an assortment of temperament dispositions, evolution-derived “biases” or “values” (Edelman, 1987, 1989, 1992), self and interactive regulatory capacities, strength of motives, and physical and cognitive capacities, babies develop through experience within a complex array of relational systems. While it is true that “all of us are much more human than otherwise” (Sullivan, 1953, p. 32), it is also true that each baby is unique, each family system is unique, and each child’s experiential world is unique. These findings position us as clinicians to respect more fully the uniqueness of the two individuals forming the analytic dyad (that is the basis for Bacal and Carlton’s, 2011, specificity theory).

The question before this panel is, “How do we facilitate positive change in a patient’s sense of self?” It is the essential question for psychoanalysis as a psychotherapeutic treatment. Let us first approach this question through taking a brief historical review and then elucidating where we are now with regard to a contemporary theory of therapeutic action, including a specific focus on some of the more difficult problems with regard to change.

In his evolving theory of self psychology, Kohut (1971, 1977) posited that the self developed within a self/selfobject matrix. He initially viewed narcissistic patients and, later, all patients seeking treatment as suffering from various arrests in the development of the self. In the beginning of treatment, Kohut found that patients were often defensive or protective as they anticipated that past hurts would be but repeated in the analytic relationship. The interpretive lifting of these “transference resistances” subsequently enabled patients to experience selfobject needs and, in turn, establish selfobject transferences. Kohut (1977, 1984) focused on the subsequent rupture and repair cycles of selfobject transferences, the mainstay of his theory of therapeutic action. The ruptures, in his view, were triggered by the analyst’s empathic failures. Interpretation of these failures—that is, the restoration of empathic understanding through explanation—repaired the ruptures and restored the needed selfobject connection. During “optimal” ruptures, Kohut (1984) hypothesized that patients internalize the selfobject functions, previously co-created with the analyst, as well as learn that ruptures are reparable, all facilitating the development of self, including the capacity to maintain selfobject connections and, implicitly, the capacity to self-regulate.

In 1959, Kohut updated psychoanalytic epistemology from positivistic to relativistic science in his seminal formulation of the empathic mode of observation. For some time, however, the primary mode of intervention remained interpretation, the sine qua non of the classical method. Subsequently, Kohut (1977) realized that the analyst cannot simply be an interpreting computer but had to be sufficiently “empathically responsive” to enable the patient to establish and make use of the analyst as a selfobject. Empathic responsiveness fundamentally departed from the classical analyst’s blank screen, neutral, and anonymous stance and contributed to the future development of what became the revolutionary intersubjective or “relational turn” in psychoanalysis. In How Does Analysis Cure?, Kohut (1984) expanded his theory of therapeutic action beyond interpretation of rupture—repair cycles, and posited that ongoing selfobject experience within the analytic relationship also contributes to the development of the self. This contributed to the contemporary emphasis on new relational experience.

Within Kohut’s (1977, 1984) model of the self, the self either developed or not. The question emerged as to what happened to the negative experiences of selfobject failure. Are they registered or organized into a different sort of self-structure? The conceptual shift from Kohut’s “self” to the phenomenology of “a sense of self” made it possible to recognize that negative experience does get organized into a negative self-structure; that is, a negative sense of self—a structure very different from Kohut’s self (Artwood and Stolorow, 1997). Our common human struggles with negative feelings and images about our selves, which we all know too well, lent more than ample empirical verification.

Now the scene has become more complex. Psychoanalytic treatment must address and find ways to extricate the patient from devitalizing negative self-feelings and images in order to foster development of a more
vital, positive sense of self. In addition, Kohut (1984) concluded that change did not primarily occur within the "cognitive sphere per se," but more within the relational experience of the selfobject connection with the analyst, a connection that required the analyst to be far more emotionally and expressively involved than previously conceived. Together with these changes was the ongoing epistemological shift from objectivism to constructivism that dethroned the analyst from the perch of objectivity and, while maintaining the asymmetry of the analytic relationship, leveled the playing field between analyst and patient in terms of subjective "knowing." The subsequent full emergence of the relational turn, and, more recently, the integration of systems theory, has made it clear that the analyst and patient form an intricately complex interactive dyadic system in which each participant, implicitly and explicitly, variably co-creates experience with one another.

To address how we facilitate changes in a patient’s sense of self within the psychoanalytic arena, I (for the purposes of this discussion) focus on two key factors, motivation and organization of experience, which play pivotal roles in the formation and transformation of a person’s sense of self. I touch on listening/experiencing perspectives and their contribution to understanding the complexity of the patient–analyst interaction and, finally, delineate my theory of therapeutic action.

**Motivation**

We know that motivation plays a central role in our lives, for motives are primary in “directing” and giving meaning to our thoughts and actions. Motives or intentions (equivalent terms) refer to an experiential sense of desiring and choosing goals and taking action to achieve these goals (Lichtenberg, 1989, 2002; Boston Change Process Study Group [BCPSG], 2008). Successful action evokes positive affect and a sense of personal agency. In our daily lives we experience within a kaleidoscope of shifting desires, urges, aims, and strivings emergent within various contexts and relational systems. Cognitive scientists (Brunner, 1986, 1990, 2002) assert that motives are the “basic mental unit” for understanding human behavior. The BCPSG considers parsing human behavior into motives is “an innate mental tendency necessary for adaptation in a social world of other motivated beings” (2008, p. 129). “Intention detection centers” in the brain have been identified that are activated when a person infers an intention of another person (Ruby and Decety, 2001). Lichtenberg, Lachmann, and Fosshage (1992, 1996, 2002, 2010) viewed sensing and identifying on a moment-to-moment basis a patient’s motivational priorities to be pivotal in gaining empathic entry into a patient’s experiential world, what the BCPSG (2008) called tracking the “intention unfolding process” (p. 131).

Clinically important is the observation of “an inherent tendency in human beings to grow or develop, meaning to expand in function, to self-organize with increasing complexity in keeping with basic and evolving motivational values or preferences” (Fosshage, 2011a, p. 96). This inherent tendency has been variously conceptualized as a striving to self-actualize (Goldstein, 1939; Jung, 1953; Winnicott, 1965; Maslow, 1968; Kohut, 1984), effectance motivation (White, 1959; Greenberg, 1991), destiny drive (Bollas, 1989), expansion of function (Ghent, 2002), and developmental motivation (Fosshage, 2011a). Whether conceptualized as an inherent tendency or as an overarching developmental motivation, it is central in our lives and provides the motivational momentum and overall direction for psychoanalytic work. In the clinical encounter, Kohut (see Miller, 1985) discovered that sensing and articulating what a patient is striving toward increases understanding, as well as implicitly supports these strivings. This self psychological emphasis stands in marked contrast to the ego psychological emphasis on resistance and defense and has become referred to as the “leading” or “forward edge” of the material (Lachmann, 2008; Tolpin, 2002).

In their delineation of cognitive development from a systems perspective, Thelen and Smith (1994) concluded that, when observing from “the view from below” (i.e., at a microscopic level), development occurs in nonlinear fits and starts and is messy; yet, observations from “the view from above” (i.e., over longer time intervals) reveal that development occurs in a more linear fashion and is marked “progressive or directional” (p. xiv). The current psychoanalytic literature utilizing systems theory emphasizes, almost exclusively, Thelen and Smith’s observation from “the view from below” of the nonlinearity of development and neglects Thelen and Smith’s observation from “the view from above” of developmental linearity. In keeping with these findings and those of neuroscience, cognitive science, and motivational theory concerning a developmental trajectory, Fosshage (2011a) proposed that “the shifting priorities and strengths of motivational values and preferences substantially contribute on a moment-to-moment basis to an individual’s developmental direction...
each momentary actualization of intention or motivational preference within an affirming relational context contributes incrementally to a sense of agency and vitality" (p. 96).1

Why am I emphasizing the concept of developmental direction? Simply put, the recognition and actualization of intentions provides a fundamental emotional anchor in our lives and creates an overall sense of direction. When an emotional moment is sufficiently in keeping with one’s motivational values and direction, that moment is experienced at a feeling level as authentic and vitalizing (Fosshage, 2011a, p. 97). These developmental processes, likewise, serve as a beacon for analyst and patient and the analytic work.

**Organization of Experience**

It is commonly accepted that we human beings, as well as other animals, organize our experience to negotiate our lives and adapt to changing contexts. Organization of experience, occurring throughout waking and sleeping, is primary in the formation, composition and transformation of selfhood. A host of variables contribute to our moment-to-moment organizations of experience, including motivations, perceptions, affects, thoughts, actions, past experience, established organizations, temperament, events, and relational interactions and context.

Learning and memory processes are organizations of experience. Psychoanalysts have tended to be averse to the term, learning, equating it with explanations of behavior in terms of learned stimulus–response connections. Earlier studies of classical and operant conditioning viewed the animal as a black box, and failed to include how the animal mediated these connections. Now, the mediating black box has been opened up and animals are seen as having affects, motivations and organizing and memory processes (see Panksepp, 1998), all of which variously affect learning. When I read current scientific studies of animals, I can now recognize my Siberian huskies, for they, I can assure you, impress me daily with their powerful intentions, affects, and memories that impact the immediate context and what is learned. Cognitive scientists now view operant and classical conditioning as extremely complex learning processes.

We refer to *implicit and explicit thematic experiential learning* that variably shapes current and future perceptions, reactions, and actions as organizing patterns (Piaget, 1954; Wachtel, 1980; Stolorow and Lachmann, 1984–1985; Stolorow, Brandchaft, and Atwood, 1987; Fosshage, 1994, 1997b; Lichtenberg et al., 1996), expectancies (Lichtenberg et al., 1996, 2002, 2010) and attitudes. How do these organizing patterns function? We establish *expectancies* on the basis of lived experience that, in turn, dispose us to attend selectively to cues that correspond with those expectancies, to attribute meanings to those cues that correspond with the expectancies, and to interact, often implicitly, in a manner that confirms the original expectancies (Fosshage, 1994). These organizing patterns are essential for adaptively negotiating our lives in ever changing relational contexts and fundamentally contribute to a sense of self, a sense of others, and a sense of being in the world.

In my view, learning, although generally underappreciated amongst psychoanalysts, is primary in all relational models of development and pathogenesis. It offers, for example, a parsimonious explanation of intractability of attitudes. In contrast to the common assumptions of ego psychology, object relations, and self psychology that the patient, respectively, is “resisting change,” “holding on to object ties,” or “holding on to selfobject tics,” to explain to a patient that the intractability of a self-percept is related to learning based on, for example, endless repetitions within a family context, makes for an easily understood and palatable explanation. To suggest also that a patient is currently “holding on” to the attitude to maintain an object or selfobject tie, while at times accurate, can more easily sound accusative and increases considerably the complexity of the change process.

**Transference**

The organizing *model of transference* (a host of contributors, including Wachtel, 1980; Hoffman, 1983; Stolorow and Lachmann, 1984–1985; Fosshage, 1994; Lichtenberg et al., 1996) refers to the primary organizing patterns with which the analysand constructs and assimilates his or her experiential world, including but not limited to the analytic relationship. Primary organizing patterns can be based on devitalizing or vitalizing experience, and can emanate from strivings for needed or hoped for experience.

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1Borrowing from Chomsky's (1968, 1995) work on a constitutionally based foundation for learning language, what he calls "linguistic deep structure," some authors—for example, Ogden (1986), Slavin and Kriegman (1992), and Gentile (1998)—use the concept of deep structure to refer to the constitutionally based foundation for developmental trajectories.
A central analytic task is to help patients become reflectively aware of devitalizing, constricting, organizing patterns (attitudes) and their experiential origins, enabling patients to gradually suspend and deactivate when they have been triggered. In addition, we pick up patients' hoped-for experiences, as well as reinforce patients' vitalizing organizations.

Psychoanalysis, in my view, has generally suffered from an analyst-centric focus, assuming, at its most extreme, that the content of a patient's communications "always" or "usually" apply to the analyst (Gill, 1982, 1984; Langs, 1973). The literature is replete with examples that, in my view, are simply bewildering. I (Fosshage, 1994) suggested that differentiating between content and process of communicating to understand which applies to the analyst and analytic relationship solves this conundrum. This differentiation then enables us to focus on and understand the relational context in which an organizing pattern is activated, be it the analytic or any other relationship.

Conceptualizing organizations of experience importantly provides a more complex understanding of selfobject ruptures. Ruptures occur not just when an empathic failure occurs, but when a traumatic organizing pattern is activated. Repair in depth requires understanding of both the analyst's and patient's respective contributions.

LISTENING/EXPERIENCING PERSPECTIVES

Kohut (1959, 1982) taught us about the importance of understanding a patient from within the patient's frame of reference, the empathic mode of perceiving (see also Schwaber, 1981, 1998). Is the empathic mode of listening and understanding sufficient? Does it utilize all the information that we garner in a relationship? What if we experience a patient as walling us out, arrogant, loving, or hostile based on how it feels to be "an other" in a relationship with the patient, what I have called the other-centered listening/experiencing perspective (Fosshage, 1995, 1997a, 2003a, 2011c). This perspective can reveal a patient's interactive or relational patterns (procedures) or changes in those patterns. It, of course, can also reveal our idiosyncratic experience of relationships. In understanding a patient-analyst interaction, sequences of empathic inquiry into the patient's experience, followed by incorporation of the analyst's other-centered experience, assists patients in understanding their inner experience, as well as their contributions to relational experience.

What if a patient experiences an analyst's disapproval, anger, or love and inquires about it? Recognition of the analyst-patient relational context and its co-creation and complexity precludes an attempt to remain exclusively within a mode of empathic inquiry. Such moments require, instead, an analyst's self-reflection, what I call the analyst's self-perspective, in an attempt to understand the analyst's experience, the ingredients of the co-created interaction, and the analyst's open investigation and response to the patient. While the empathic mode provides an overall guide to analytic work, the other-centered and analyst's self-perspectives are required in an effort to ferret out who's contributing what to the analyst-patient interaction.

TWO FUNDAMENTAL PATHWAYS TO THERAPEUTIC CHANGE

Beginning with Freud and Ferenczi, two major pathways to therapeutic change have been variably emphasized throughout the history of psychoanalysis: interpretation/insight and new relational experience. In 1991, Clyman, borrowing from cognitive science, extended implicit procedural memory to the learning of relational patterns subsequently, in 1998, made famous by the BCPSG (Stern et al., 1998) as "implicit relational knowing." The BCPSG argued that the implicit memory system uses an entirely different format for encoding, processing and remembering, what they call enactive representations, which, in their view, rarely get translated into explicit verbal symbolic thinking. The BCPSG asserted that change occurs primarily at the implicit level, diminishing the importance of the exploratory/reflective pathway of change.

In contrast, I (Fosshage, 2005, 2011b) argued that two pathways of change are pivotal and, moreover, work in tandem. Cognitive scientists generally agree that imagistic symbolic capacity is available at birth and is utilized by both the implicit and explicit systems of processing and memory (Paiwio, 1971, 1986, 2007; Bucci, 1985, 1997; Rovee-Collier, Hayne, and Colombo, 2000). Later, with the arrival of language, both systems use imagistic and verbal symbolic encoding that, I argue, increases the fluidity between the implicit (unconscious) and explicit (conscious). What this means is that implicit relational knowing, I believe, is more accessible to consciousness through exploratory/reflective work than the BCPSG believes.

I, thus, have proposed two fundamental pathways of analytic change (Fosshage, 2003a, 2003b, 2005, 2011b). The first is the explicit mutually exploratory/reflective avenue to therapeutic change. While this corresponds
with the traditional psychoanalytic focus on interpretation and insight, relational approaches at large emphasize a more collaborative exploratory process that expands reflective awareness. Primary is engendering reflective awareness of devitalizing self and self-with-other images and their origins that gradually empowers us to intercede and deactivate these problematic patterns.

While self psychologists especially have learned the importance of understanding from within the patient's experiential world, we, to reiterate, cannot remain "exclusively" (Kohut, 1984, p. 182) within the patient's perspective. To increase reflective awareness of organizing patterns requires input from us that falls outside the patient's perspective. For example, asking questions like, "Have you felt that way before in your life?" "When did you begin to feel that way about yourself?" implicitly introduce a developmental, learning perspective that undermine the "felt reality" of a negative percept.

What if a patient feels rejected by the analyst? We first live in the attributions of the transference (Lichtenberg et al., 1996, 2002) to hear and fill out the patient's experience. We ferret out and acknowledge what from the patient's perspective is our contribution to the patient's experience. If the analysis stops here, however, the patient could easily remain convinced that the analyst indeed felt rejecting for the analyst has said nothing to the contrary.

What if the analyst momentarily felt rejecting of the patient? Using this other-centered experience to explore the interaction can reveal a patient's interpersonal impact, or, of course, an analyst's idiosyncratic reaction.

What if the analyst's experience is dissonant with the patient's attribution—in this instance, feeling loving, rather than rejecting, of the patient? At some point during the exploration, we might inquire, when not asked, if the patient would like to know what the analyst was feeling toward the patient. Revelations such as this illuminate the patient–analyst respective contributions to the patient's experience.

These processes of exploration and understanding of the patient–analyst experience simultaneously contribute to new relational experience, the second fundamental avenue of change. This, of course, is but one of many types of new relational experience. Others range, for example, from co-created moments when a patient feels seen, known, affirmed, supported, cared for, loved, and moments of camaraderie, togetherness, and mutual reciprocity. New, vitalizing experiences often occur at implicit

procedural levels; yet, periodic explicit focus amplifies and integrates new experience. New relational experience gradually establishes new percepts, a vitalized sense of self, and more effective relational procedures.

**Conclusion**

Based on developmental research, cognitive science, systems theory, and motivational theory and research, we can conclude that there is "an inherent tendency in human beings to grow or develop, meaning to expand in function, to self-organize with increasing complexity in keeping with basic and evolving motivational values or preferences" (Fosshage, 2011a, p. 96). Whether conceptualized as an inherent tendency or as an overarching developmental motivation, it is central in our lives and provides the motivational momentum and overall direction for psychoanalytic work.

In addition, I have suggested that the shifting priorities and strengths of intentions create, on a moment-to-moment basis, a developmental direction. Recognition and actualization of intentions emotionally anchors us, creates a sense of direction, and serves as a beacon for analyst and patient in their analytic work.

How is a patient's sense of self transformed within a psychoanalytic process? I believe that analytic change occurs along two fundamental, interrelated pathways: explicit reflective exploratory work and new implicit and explicit relational experience. Rather than change taking place primarily through exploration, the traditional focus, or primarily through implicit relational learning, a more recent proposal, I emphasize the interplay between the implicit and explicit systems for therapeutic change. While reflective exploratory work and relational experience usually work in tandem, their relative balance varies from moment to moment. When implicit procedural knowledge and explicit attitudes are accessible to reflective consciousness, then reflective exploratory work, along with new implicit and explicit relational experience, facilitates psychological transformation. In contrast, when implicit procedural knowledge remains inaccessible to consciousness, the primary avenue of change is new implicit relational experience. In both situations, the requirement of new relational experience implicates the magnitude of the analyst's participation and the importance of the analyst's explicit attitudes and implicit procedural relating in co-creating with the patient's transformative self-experience.
References


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Traducción del Resumen

Este artículo aborda la formación y transformación de la experiencia de uno mismo con especial énfasis en el cambio terapéutico. Al centrarse en la motivación y organización de la experiencia y su emergencia dentro del sistema didáctico analista/paciente, el autor desarrolla una teoría sobre la acción terapéutica que implica dos caminos principales para el cambio terapéutico que operan conjuntamente: la vía explícita mutuamente exploradora/reflectiva y la co-creación de una nueva experiencia relacional.

Cet article étudie la formation et la transformation de l'expérience de soi en mettant l'accent sur le changement thérapeutique. En centralisant son attention sur la motivation et l'organisation de l'expérience ainsi que sur leur émergence à l'intérieur du système didactique analyste/patient, l'auteur développe une théorie de l'action thérapeutique qui implique deux voies fondamentales du changement analytique opérant en tandem: l'avenir d'exploration/éclairage mutuel explicite vers un changement thérapeutique et la co-création de nouvelles expériences relationnelles.

L'articolo verte sulla formazione e trasformazione dell'esperienza di sé concentrando l'attenzione sul cambiamento terapeutico. Mettendo a fuoco la motivazione e l'organizzazione dell'esperienza e il loro emergere all'interno del sistema didattico paziente/analista, l'autore sviluppa una teoria dell'azione terapeutica che implica due percorsi fondamentali del cambiamento analitico che operano in tandem: la strada di una esplicita esplorazione riflessiva reciproca verso il cambiamento terapeutico e la co-creazione di una nuova esperienza relazionale.