Termination, Separation, Mourning and Saying good bye

"To attach, to separate from, to internalise and to identify with"

This weekend will be the last of this course we did together for two years. So to say goodbye to you after this course, invites me to reflect on that which lies behind us and that which is yet to be expected. It is about saying goodbye; without this, no new perspectives can be opened up, there is no future and neither is there a past. Today, it is about saying goodbye without getting lost, and this not only means to separate, but also to internalise and to identify with. This lecture will be about termination, about separation and mourning about internalisation and identifying with. It is about us, you and me but also about terminating the treatment with our patients

A. To attach, to separate, to internalise and to identify with

To train and to be trained

What happens during a training? According to Bion, it is about 'learning by experience'(1962). During the training, we acquire a new, professional identity. It is about 'changing', in thinking, feeling and doing. The whole of mental functioning is involved. During the training, it is about learning to bear what we couldn't bear before, and to learn how to handle multiple processes, such as identification with and separating from. People identify with new objects and internalise these, they adjust other inner objects or even say goodbye to them. We identify with our teachers, our supervisors and our therapists. We identify with them, but, eventually, we seem to leave them behind, seem to, because, in a special way, we take them with us inside, to make sure we won't forget them.

In such processes, we need the other to identify with, we need the ability to "make use of the other". Others, on the other hand, also offer themselves up to identify with and they need to have the ability to be made use of. It is on the basis of such processes that our thinking, feeling and doing start to move and to change. To develop is to separate, to internalise in order to individuate. It is about connecting with others without losing ourselves. It is about being able to be ourself without losing the other. It is about the quality of the inter personal functioning; this is how we have subscribed it in the DSM-5.

Otto

When Otto came in for treatment he was in his late twenties, and had been trying for some years to finish his studies, in which he didn't succeed because, next to his studies he also had a demanding job and was very active in the student society.

His complaint was that he felt empty and depressed, and was very anxious. Intimate relationships were extremely scary and he tries, in these, to maintain a distance, in which he doesn't really succeed**, *"the closer I am to someone, the more I start sweating, I am panicking, get a feeling of falling apart, everything happens to me and I have no grip at all, and at the same time I feel this urge to be close to someone without it making me happy"*.** His relationships were short, as soon as the intimacy increased, the contact had to be broken, and in this way, a pattern of on/off relationships came into being. When the panic increased, he would start to drift, and would find himself after some time in a place he didn't know, and not knowing how he had got there. Otto is a replacement child in the sense that he was born very soon after a sister died very young of a medical disease. In the parental house there are still a number of silent witnesses to this sister's presence. Otto's acting out behaviour is extreme, he regularly undertakes dangerous survival trips or intensive risky trips into high mountains. The anxiety appears to be mainly fusion anxiety and his tolerance for fear is absolutely minimal. His self-image is very low and there is great uncertainty about his sexual identity. Continually, there is a basic feeling of insecurity present and he has to be very active in order to be able to control his panic and fears. In the anamnesis a number of mini psychotic episodes occur. He perceives himself as fragmented and says about himself: ***"I am a collection of bones, held together by a bag, sometimes I think it will open and everything will fall out... and that is panic, chaos, a big black hole inside".*** At another moment, he says: ***"I am an amoeba that will disappear in the other's body if we have sex".***

Separation and mourning

In Psychoanalytic treatment, from the beginning it was about separation. That was the immense revolution of Rank writing his book about the trauma of birth, which was in fact about the first huge separation in life. By that he was criticizing Freuds emphasis on the oedipal conflict. We also find the theme in the work of Ferenczi and later Balint. But also the myth of Oedipus is primarily about the separation from the mother object and secondly

about the rivalry with father. And this very same theme we find in "Totem and Taboo" (1913), the sons leaving mother and marrying a partner from outside, and so incest was prevented.
However, no separation without mourning. Working through the reality of being separated, working through the absence of the beloved other, in short: working through the anxiety that goes with separation is the beginning of mental functioning. Mental functioning and mourning go together. No goodbye without mourning, this goes for my leaving as a teacher, but also for you saying goodbye to the course. It certainly also goes for our patients when they end their therapy and say goodbye to their therapist.
This is the theme of 'Mourning and Melancholia'(1917). In this, Freud describes the painful process of mourning and the separation between the self and the object. In mourning, it is about the realisation that the other has his own life, and is not your possession. That is what it is about in a treatment, but also in a training. In both cases, it is about learning to function autonomously, to know that you are related to the other, but that you are not the other, and that you are a being that has his own life. To mourn means to be able to have a relationship with an object that is not really there. The ability to mourn opens up the ability to symbolise or to build up mental representations.
Our feeling of having our own identity we get from identification with various people around us. We discover ourselves through the images that look at us from the eyes of others, that meet us. Such images are not replicas of ourselves, but it is more about the relationship that we have with the one looking at us and who has a place for us in his/her mind. This looking at us may be a loving look, or an unhappy or angry look. We mirror love but also hate, we mirror the relational context.

Primary identification

Identification is part of the earliest emotional tie we enter into with the other, wrote Freud in 'Group psychology and the Analysis of the Ego'(1921). Our character, he wrote, is partly determined by memory-trails of our earliest identifications. In 'Civilization and its Discontents' (1930) Freud introduced what he called the "Oceanic Feeling"; such a feeling has to do with a non-solvable relatedness, without limits and with a kind of eternity experience. Without naming this explicitly, he points with this to the early tie between mother and child. It is about the primary identification in which there is not yet differentiation between the self and the object/the mother. It is because of this that Winnicott says there is no mother without a child, and no child exists without a mother. It is

the baby that is actively seeking the mirroring eyes of the mother, it is the baby that actively provokes the mother to respond further. It is the mother who carries her child emotionally and, by doing this, represents a world that the child 'cannot fall out of' (Freud 1930). In terms of Melanie Klein: it is the mother who contains what the child cannot yet contain, because she identifies with her child (Notes on some Schizoid Mechanisms; 1946). With this, Klein introduces the concept of projective identification. Later on, Bion will give a more interactional meaning to this concept. The helpless, impotent child tries to get an emotional response in the mother through both verbal and non-verbal behaviour. An adequately receptive or sensitive mother will permit this and let her child use her in that sense. On the grounds of her reverie, the mother gives meaning to the physical and sensory experiences of the child and through thinking turns them into mental representations, in other words, the mother digests, detoxifies the material into things that can be borne, transforms beta elements into alpha elements. The child will store these experiences in his Mind, so in the future, he will be able to go through similar experiences without the presence of the mother, and with this, the 'capacity to be alone' comes into being.

It is important that the child can, in the presence of the other, the mother, still retain his sense of self and, in the absence of the other, retain the sense of the other. Development, thinking and creating mental space is facilitated by the absence of the object. The concept of primary identification by Freud is similar to the internalising of the mother as surrounding by Winnicott. Internalising has to do with the transformation of external aspects of object relational involvement in inner metal representations. Identification is a special aspect of the process of internalising which is important when building inner mental representations. Identification is related to a specific connection between the self and the object. It is a way of protecting the object. At the same time, the process of identification makes it possible that such things as separation, differentiation, autonomy and enduring loss can come into being. And this also creates more space to be conscious of an independent external reality which we have no control over, but of which we are, in a sense, dependent.

Differentiation of Self and Object

Separation, identification and differentiation help the small child to take the step from the phase Jose Bleger (1967/2013) calls, in his book "Symbiosis and Ambiguity", the phase of the primitive undifferentiated-ness to the phase of the paranoid schizoid position. This is a step in which the original concurrence of Self and the Other is broken and there begins a certain measure of differentiation between the Self and the Other. In that phase of primitive

undifferentiated-ness, symbiosis and autism exist next to each other in narcissistically coloured relational patterns. In that symbiosis, the child puts a part of his Mind into the external world. In autism, the movement is pointed inward. Both movements take place within the small child. The Ego is not yet well-defined but more of a deliquescent entity. The ego is still a 'factual ego', which means the ego only exists in doing, the action, there is not yet space for interiority and experiencing. The ego is a 'bodily Ego'. The ego is part of a bigger whole of which it is not yet separated. The primary setting has a symbiotic function, there is concrete behaviour and not yet a symbolising function. There is the need of symbiosis and, at the same time, the need to escape this. The Self is not yet a somatic Self and the Psychological Self is not yet born. The small child will, in the interaction with the primary objects, learn to understand the language of its own body and to understand the meaning of it. Along the way, there will be space for reflection, and behaviour will become less impulsive and more thoughtful. From the phase of being undifferentiated comes the splitting which is characteristic for the paranoid-schizoid position. In short: on the way to differentiation between the Self and the Other.

Inter-personal functioning: intimacy/relatedness and self determination

In the development, it is about the quality of the inter-personal functioning. The quality of the inter-personal functioning goes hand in hand with the differentiation between the Self and the Other. It is always about alternating between the individual who knows himself to be related with the other and on the other hand a withdrawal in himself. It is about finding a balance between being with the other without losing oneself, and to be with oneself without losing the other. This is what we call to be 'safely attached'. If the balance shifts to the emphasis on relatedness with the other, the emphasis lies more with the preoccupied attachment, and part of the autonomy is handed in. If the balance shifts to the side of the autonomy, relatedness is handed in and the emphasis is more on autonomy.

Pathology is seen the moment that, because of a failing attachment history, people hand in either the need for autonomy or the need for relatedness. Pathology always has to do with the quality of inter-personal functioning and therefore with the way in which the Self and the Object are differentiated from each other.

Development-oriented treatment

Developing, to find an adequate balance between connecting with the other and to learn to experience oneself as a steering and autonomous agent, this is what it is about within

psychoanalytic treatment. It is the treatment session itself in which the change or development takes place. The treatment session is therefore not the place from where we are looking out to how the change is coming about elsewhere. The therapist offers himself as a new primary object, for identification and internalisation. The patient must be able to use the therapist as a new primary object and the therapist must be able to be used as an object for internalisation and identification. The therapist is, to the patient, a new and, hopefully, safer attachment object. In the therapeutic relationship the inner working model (the attachment representation) of the patient (and that of the therapist) is provoked and thereby becomes manifest, in order to be revised. In treatment it is about the primary aspects of the relationship, and about inner conflicts that repeat themselves in the transference.

On the one hand, it is about the curative aspect of the relationship itself, and on the other, it is about the importance of the interpretation. It is about the motherly, but also about the fatherly aspect.

- It is about optimising the mental process and in that, it is about working through the procedurally memorised processes that do not occur consciously. So, this is not about the (dynamic) unconscious but about the not-conscious.
- Next to that, it is about working through conflicting mental representations which have been kept in the dynamic unconscious through the mechanism of repression.

It is important to consider that the unconscious is not something which is stored somewhere in the depths. The unconscious is not something which was previously determined and previously existing in a specific place. Not like photographs, neatly placed into albums, waiting in a cellar until they are taken upstairs. The unconscious generates itself through the development, and in that development the drives are of great importance. To be clear: drives mark the border between the biological and the psychological, it is about mental representation. These are the motor that constitute the unconscious. It is not about two drives, the sexual and the aggressive one, but about ONE drive with two different extremities: relatedness and autonomy.

Blatt (2008)says that a psychotherapeutic treatment is like a compacted conglomeration of what happens in the normal development of the individual. In a normal development, people organise their experiences on the basis of the measure that mirrors their need for

relatedness or autonomy. People fixate this in cognitive-affective schemas or what we call inner working models. These are procedurally memorised structures, which have to do with the complex interactions between the self and the other. These inner working models function as organising principles and interpret and select the experiences people have. This implies that both empathic failure of the surroundings as well as experiences of separations are assimilated in these inner working models. This assimilation of experiences in the inner working model is done through internalising, or we could say the 'process of internalising of object relational involvements'. In treatment, it is about revising or adjusting the dysfunctional aspects of these inner working models or introjections. In other words: psychotherapy is a revision workplace to repair dysfunctional aspects of the mental representations that the person has built about himself and the other. It is these mental representations that present themselves within the therapeutic relationship. Psychotherapy is intervening in the cycle of attachment-separation-internalisation, it is about match, mismatch and repairing the mismatch. The revision of the inner working model or the cognitive-affective schemas leads to a more coherent self and a stronger identity. Non-adequate internalisations which limit the functioning are revised and in their stead, more adequate representations about the self and the other have come into being. During this, the therapist functions as a new attachment object. Apart from that, the patient can, in the relationship with his therapist, have new experiences which can further develop the already existing adequate but only partially developed internalisations.

Both patient and therapist bring their own inner working models into the treatment. With this, both are looking for an optimal balance between the need for autonomy and involvement. The working model of both will determine the nature of the therapeutic relationship, and this makes the therapeutic relationship a construction of both patient and therapist. Within the relationship with his therapist, the patient has the chance to experience an alternative inner working model and to test how safe and reliable this new perspective is. Here, too, it is about having a corrective emotional experience with a new and safer attachment object.

An essential part of the treatment is the experience of the patient that he is, just like the therapist, an autonomous person, and with this, he should become conscious to the fact that there is life without the treatment and without the therapist. The process of separation is explicitly experienced, this separation process is an essential part of the treatment and it

facilitates the process of internalisation. In earlier stages of the treatment, internalising is also an issue, but mainly from the (relative) certainty that the therapist is present. At the end of the treatment this is different: then there is the perspective that patient and therapist will separate at some point. Hopefully, knowing that the patient is able to have an adequate relationship with an object that is no longer present in the reality but which he will take with him in his inner world. The treatment itself is the place in which the change takes place. It is important that the therapist is alert to the fact that what happens within the treatment setting generally also happens in the world outside the treatment. If he doesn't, and he doesn't facilitate this enough, then he keeps the patient in what Fonagy calls the 'pretend mode' and by doing so he neglects to help the patient grow towards the reflective mode. If that happens, this means the therapist doesn't have enough regards for the need for autonomy of the patient, next to his need for relatedness. In short: the therapist then fails in adequate sensitivity.

Otto: The Treatment

In the treatment, Otto slowly learns to recognize the mechanisms he uses to keep his fears, sadness and anger controllable. He is learning to verbalize his inner chaos, and slowly he becomes less active and he starts to reflect about himself, and there is space for such a thing as an inner self. During the analysis, Otto starts a relationship and because the therapist continually connects Otto's behaviour with the underlying motive, there was developing a space to communicate less and less through 'acting' and 'behaviour', and more and more through 'talking'. The therapist is able to create an adequate holding environment, in which balancing between adequate distance and intimacy is all-important. Otto perceives intimacy which is too empathic as a provocation to a threatening symbiosis as he had experienced in his latency with his father who would take him to bed and then tell him stories in which the borders between fantasy and reality would become vague to him. ***"It was all very scary, the persons from the stories would come into my bedroom, walking over my blankets and across the wallpaper, and I didn't know whether they were real or they were shadows because my father would gesticulate with his hands ... horrible... ... I was all fear, this is where the thought about me being bones started".*** Next to offering adequate holding and connecting behaviour to feelings and underlying motives, the therapist aimed to structure and cognitive clarifications. With that, implicitly he functioned as an extern, observing ego for Otto, hoping and expecting Otto to adopt

this, which eventually did happen. Next to that, his attention was mainly on the here and now between Otto and himself, and he translated the things Otto brought to the therapy about his experiences outside the treatment into what the consequences of these things were for what was happening between them in the analysis, that is, in Otto's perception. In short, it was more about working through the here and now situation than about building up genetic reconstructions. Especially the fears were given a lot of attention, aggression and anger were interpreted as manifestations of anxiety. Slowly but surely, Otto was increasingly able to reveal himself and build up an inner world. The fear became less and less diffuse and got a 'face' of its own. He would 'have scared feelings' much more than 'be scared'. By the end of the treatment, Otto had a relationship, he had graduated and was hired, after a severe selection-procedure, for a specialist training in his own (legal) field.

B. Termination in Psychoanalytical Treatment

Introduction

Termination in Psychoanalytical Treatment can be related to disruption of the process and is at that time related to more or less a failure. It can be related to a temporarily discontinuation because of different reasons for example leaving for going abroad. At last it can be related to the fact that the targets of the Psychoanalytical Treatment are more or less achieved.

The last will be the main issue in the second part of this paper. This means that ending the analysis implies the agreement of both the patient and the therapist and that termination of the psychoanalytic process is related to accomplishing the aims of Psychoanalytical Treatment.

There is quite a discussion about what should be the aim of Psychoanalytical Treatment. But when we want to discuss the issue of termination of Psychoanalytical Treatment we should have our ideas about the criteria to end the treatment.

- In his introductory lectures on psychoanalysis (1915/1917) Freud related a successful Psychoanalytical Treatment to the ability to love and work, to create

satisfying relationships on different levels of intimacy. At that moment the patient would have the possibility to develop relations at the level of take and give and not only at the level of wishful thinking. To be related to someone else without loosing yourself and to be with your self without loosing the other, that would be the target of Psychoanalytical Treatment. Psychoanalytical Treatment is about the creation of mature relations with your self and with others.

- In his new introductory lectures on psychoanalysis (1933) Freud stated as the goal in Psychoanalytical Treatment: “To make the unconscious conscious” or “Where Id was Ego shall be”. It is about what Fonagy (1999) calls “Mentalization”. In the analytical treatment the therapist and the patient should mentalize the unmentalized.

- In “Analysis terminable and interminable”(1937) Freud reformulated the target of Psychoanalytical Treatment into “secure the best possible conditions for the functioning of the Ego”, when that would be realized the analysis would have accomplished its task. By this Freud stated that Psychoanalytical Treatment should create a new balance within the inner structure of the Ego.

Central in Freud’s ideas about what Psychoanalytic treatment should be is the concept of intersubjectivity, as in whole development, more specifically focused on the treatment situation; it is about the psychoanalytic couple: the patient and the therapist. The purpose of the treatment is not to bring the past, which is forgotten, back into the memory and to reconstruct ‘forgotten’, so called objective experiences. It is not about the **past**, but about the way the patient perceives the other and interacts with him influenced by the past, so psychoanalytical treatment is about the **here and now** in favour of the **future**.

In the treatment, implicit structures are reactivated in the here and now. These implicit structures, built up from the past have come into being and were consolidated in an extremely complex manner, in which both nature and nurture played a part: things like how the patient was treated by his primary care givers, how he responded to that and the way in which the parent-objects responded to the reaction of their child, and the fantasies the child had in this context. All this takes place within the context of a specific attachment relationship. It is the quality of this attachment relationship that regulates how and what of all these is internalised and consolidated in the implicit procedural memory.

In short, it is not about an objective reality, but about a subjective psychic functioning. It is this psychic functioning that has to be explored, and, if necessary, revisited, in the treatment. This revision happens, because the differences between the implicit model of the patient and the mental states of the therapist in the here and now are dealt with, within the context of a new attachment relationship. New experiences in interpersonal relationships are acquired. The patient will experience that things are not necessarily what he perceives them to be, and then a new, alternative way of seeing comes into being, and within the patient there is room for experiencing alternative possibilities. He will start to realise that he has his thoughts about the other, just as the other has thoughts about him, without the other annexing him or he the other. This is what we call reflective functioning. The process of mentalization is regained, in the sense of developing and recognizing mental states in oneself and in the other. So Psychoanalytical Treatment is deeply connected with the concept of change that is why we now will elaborate the concept of change

Psychoanalytical Treatment and Change

Psychoanalytical Treatment aims for change, and not only that, but a specific form of change, not so much on the level of the reduction of symptoms but on the level of the underlying structure. Traditionally Psychoanalytical Treatment claims that it leads to structural change. The question is, however, whether this is the case, and **what** changes, and what the cause of this change is. Is there such a thing as structural change, not to be confused with the reduction of symptoms, and what do we consider to be structural change, what is structural about it? Are all the changes we see during a psychoanalytic treatment structural?

In the past, psychotherapists were more focused upon the development of theories about the character, and about how symptomatology or pathology came into being. Nowadays, the focus has shifted to the **how** and **what** of the process of change. Much more than before, the purpose of psychoanalytic treatment has become: how to bring about or facilitate the transformation of a destructive internal working model into a more productive one. In this context I would like to refer to “Psychic structure and Psychic change” (1993), a collection of essays in honour of R.S. Wallerstein. In present-day terms: Psychoanalytic treatment and Psychoanalytical Treatment aims for a change in the way the mind is functioning; psychoanalytical forms of treatment aims for a change in the mode of mental functioning.

Structural Change: from Interpretation to Relationship

Although the concept of structural change does not occur in any of Freud's writings, he did indeed develop a theory about change. His first theory about change was related to the topographical model: "Where Id was Ego shall be". The return to consciousness of material that had been repressed earlier (wishes and memories) was seen as curative. The second change-theory was related to the structural model in which concepts as Id; Ego and Superego played an important part. Before we go deeper into the concept of structural change, it is important to define what we mean by 'structural'.

- Rapaport (1957) defined structures as 'quasi permanent organisations' and later (Rapaport and Gill 1959) as 'configurations with a slow rate of change'. In Rapaport and Gill's opinion, psychic structures are relatively stable and permanent and, in a way, resistant against change. Those psychic structures are the mental functioning and the way the mind is functioning in a person is relatively permanent and stable even with a borderline personality disorder.

What is meant by structural change depends on what the aim of a psychoanalytic treatment is. When it is assumed that after a successful treatment, the patient is able to have more constructive solutions for his core-conflicts at his disposal there will be a problem. The idea that new solutions will take the **place** of old ones is incorrect, it is much more related to the possibility to make use of alternative solutions.

- Anna Freud was of the opinion that in spite of the newly found solutions, the underlying conflicts remained. She, too, was alive to the relative changeability of people. The thought at the time was that these new solutions were arrived at through the beneficial effect of the instrument of interpretation. A crucial question that should be asked here, is whether this new solution now takes the place of the old one, or that the new solution should be seen, as it were, as an alternative 'next' to the old solution. These days, we assume that the latter is the case: they co-exist. In short: how structural is structural change, and what the treatment needs to focus on, in order for change to be structural.

- Sandler and Sandler (1993) are of the opinion that structural change occurs during the development, and they see the psychoanalytic process as an intervention in the development, with the aim of creating new structures, and, especially, a new structural organisation. During a successful psychoanalytic process, old structures or solutions are inhibited and new structures or solutions are reinforced. This process of inhibiting and reinforcing is what is called "working through". In other words: the new does not take the place of the old. With the introduction of the 'development metaphor", Sandler and Sandler have placed themselves far from the image of the anonymous and neutral psychotherapist who arranges to be used like a "blank screen". Far away, also, from the thought that the patient projects his fantasies **on** or **in** the anonymous therapist who reflects these projections by means of interpretations and thus renders them harmless, after which he returns them to the patient.

Increasingly, it is about the relationship and about the psychoanalytical working therapists who, through counter-transference, knows himself to be involved in it. The therapist not only needs to make contact with the mental states of the patient, but also with his own, not only must he reflect about what the patient brings in and tries to actualise within the relationship with the therapist, but also about his own perceptions and behaviour. It is up to the therapist to create a climate of safety, acceptance and tolerance so the patient can increasingly identify with the accepting, safe and tolerating aspects of the person of the therapist. It's about creating a safe attachment representation, by mentalizing in the treatment itself; in the here and now, the unsafe attachment representation of the patient. By doing this, the patient has become familiar with a new form of object-relational involvement that is corrective towards the older object-relational dyad. Change within the psychoanalytic process, therefore, does not only occur on the basis of the interpretations of underlying experiences, but just as much as a result of being offering an adequate holding environment. Both relationship and interpretation are important.

- Kris (1993) and N. Treurniet (1993) concur with this when they show that the distinction between supportive and expressive is misleading. Interpretation can be very supportive, and the offering of support is an important part of an adequate expressive therapy. It will be obvious that it is not about support in itself, but about functional support. Wallerstein (1986), too, shows in his monumental "Forty-two

lives in Treatment" that supportive treatment can certainly lead to structural changes and that expressive therapy is not the only form of treatment that can claim this. Support is necessary for creating a safe attachment representation which facilitates the development of a representational world; in other words for developing a "mind". Wallerstein found in his research that the more supportive the psychoanalytical treatment was the better the result was. Furthermore, Treurniet (1993) points out the importance of the psychoanalytic setting as a 'containing' one (Winnicott 1965), which he connects to the concept of the 'background-mother' (Modell 1990: the containing transference) and the difference with the 'object-mother' (Modell 1990: the iconic transference).

- Rangell (1993), as well, rejects the causal relationship between change and interpretation. In psychoanalytic therapy, it is about more than just interpretation, interpretation is necessary but, in itself, not enough. In other words, no support without insight, and no insight without support. The therapist functions, in the treatment, as a new object which can give the patient a new, hopefully corrective, experience through which his development can be resumed where earlier it had come to a standstill. Rangell (1993) made the statement that a successful psychoanalytic treatment makes the patient become his own therapist. By this, he means that the patient identifies with his therapist and internalises him, so that in the end, he will treat himself the way his therapist treated him. Although actually, it is not so much the therapist who is internalised, but the way he treats the patient.

It is within the affective context of the treatment that a new object-relational dyad is built up and consolidated in the implicit memory; in other words, a new attachment representation is developed, which not so much writes away the old one, but sits next to it, as an alternative. This change, on the basis of introjection of, or identification with, is what can be called a structural change. Talking about change we first see change at the level of the symptoms based on the positive transference later on there will be change on the level of the personality related to the process of internalisation.

Structural Change: Mentalising and Mental Representations

In the above discussion about structural change, it was mainly about what produces change: either the instrument of interpretation, or the quality of the relationship, or the interaction

between these two. In the latter case, it is about how the interaction between both aspects should be seen. The old controversy between Freud (interpretation)and Ferenczi (relation) is still alive.

Fonagy and Target (1993; 1995; 1996) distinguish between two kinds of pathology, one which is the result of conflicting mental representations and one, which results from dysfunctional mental processing.

People with serious personality pathology, or, in terms of Kernberg, people with structural pathology, inhibit the working and further development of the process on the grounds of which mentalising becomes possible. They are not able to take a third position, which means to reflect about themselves and about others, they cannot adequately use the symbolic functions of language and cannot give meaning to behaviour of themselves or of others. Their ability to think in terms of intentions, opinions and feelings is inhibited. Such people '**know'**, they do not have '**opinions'** (Britton, 1995). To have an opinion means you know that it can also be different, that there is room for alternative possibilities, that pros and cons can be weighed. This is what adequate 'reflective functioning' means, to function, as Fonagy says, in 'reflective mode', where 'equivalent mode' and 'pretend mode' are integrated.

With people who '**know'** this 'reflective functioning' has remained behind, they lack the inner space to "play" with words, they function at the level of the 'equivalent mode', what is inside is outside, everything that is thought, exists in the outer world, too.

In other words, it is about the difference between personality pathology in terms of the DSM-IV and neurotic pathology. People with that type of personality pathology are characterised by dysfunctional "mental processing", that is, an inadequate mentalizing ability, their reflective functioning fails, and they are unable to build up inner mental representations of the outer world, others and themselves. Patients with neurotic problems, on the other hand, are able to develop inner representations, but these are conflicting because the patient is unable to integrate contrary object representations. Psychoanalytically spoken this is a different type of personality pathology. The capacity to develop mental representations is present but some aspects are not mentalized, which results in conflicting mental representations. With all this, we have to realise that mental processing itself cannot be perceived directly; it is through the inadequate quality of the mental representations that the failing of the mental process shows itself. This is why

Fonagy sees 'change' on several levels. On the one hand, at the level of conflicting mental representations, on the other, at the level of "mental processing". Change at these levels is what can be called structural change.

Structural Change: Memory

Finally, it is important to return once more to the difference between 'interpretation' and 'relationship'. Earlier, we talked about the fact that inner working models, early object-relational dyads which are consolidated in the implicit memory, like other skills such as driving a car, playing the piano and, important for us Dutch people, ice skating, are consolidated, and this in a procedural way. The working of the implicit memory is not verbally mediated, it is about characteristic skills and certain characteristic manners. In this implicit memory, it is more about 'behaviour' than about 'memories'. Next to this, there is the explicit memory, in which facts, knowledge and one's own biography are filed. This explicit memory is verbally mediated and can indeed be remembered. However, it is the quality of the context that determines how and what and in what way something is consolidated in the explicit memory. This also goes for remembering. What and how something can be remembered is determined by the actual emotional context. It is the actual context that activates and colours the memory. Remembering demands stimulation and facilitation. In short: it is not about an objective reality, but about subjective psychological functioning. Newly acquired relational skills and ways of interacting with others arrive into the implicit memory by way of the explicit memory. First, you play the piano with your head, later; you play the piano with your hands. When that happens, your hands '**know'** how to play, better than your head does. Structural change is born within the implicit memory system, where our characteristic ways of interacting are consolidated. Psychoanalytic treatment is not about rediscovering forgotten memories from the past and removing repression, but about restructuring implicit inner working models in an emotionally safe context. Through this, it is possible for biographical memories to come into consciousness. In other words, to be able to remember is not the **cause** of the change, but the **result** of it as Fonagy says. Therefore, before there can be a question of structural change, there needs to be a relational context, in which the therapist offers himself as a new attachment object. This new attachment object must, contrary to the earlier primary care givers, be safe enough for the patient to attach to again, for him to develop a safe attachment representation. Structural change means a revision of the inner working model, and is mediated by a new safe attachment in the here and now within the treatment. We

should realise that structural change can only be deduced from the reduction of complaints and symptoms, and cannot be perceived directly.

Termination and Transference

Psychoanalytical Treatment aims for change by provoking and after that working through the transference neurosis. Traditionally it is said that Psychoanalytical Treatment will be terminated when the transference neurosis between the therapist and his patient will be worked through, let us examine this issue for a moment.

Both Freud and Ferenczi were intensely focussed on what was going on within the relationship between patient and psychotherapist.

- Freud was focusing more on the transferential aspect of the relation in the Psychoanalytical Treatment while Ferenczi was focussing on the developmental aspect. Both are there at the same time but in neurotic pathology the transferential aspect is in the foreground while in case of structural pathology the developmental aspect is in the foreground.
- Ferenczi aimed at revitalising early experiences, with the help of an active, emphatic, accepting technique. His aim was not primarily the reconstruction of the forgotten childhood, as Freud wanted to do, but to give the patient a lived-through corrective experience in the here and now.

In other words: with Ferenczi, the transference vaporized in the real aspect of the therapeutic relationship. With Freud, on the other hand, at least in his writings, the real relationship vaporized in the transference. The discussion between Freud and Ferenczi was about the importance of the real relationship and the transference; this was how it was then, and, in some ways, it is still like that.

At first, Freud considered transference to be a characteristic way of acting in which early childhood wishes, developed in the relationship with the primary carers, were transferred from the carer-objects to the person of the therapist. The concept of “displacement” was central in this. Freud wrestled, in his writings about techniques, with the question of whether transference was a form of resistance against the process or the re-experience of a crucial inner object relationship. Next to that, he was confronted with the question of

whether transference was purely a repetition of what had occurred previously (1915) or whether it was a new shape of old conflicts (1917).

It can be said that transference contains two aspects, namely the aspect of "**repetition**" and of "**reparation**". Patients aim to repeat old object relationships in the present, hoping this new version will be different from the old one, in other words, they want both reparation and a corrective experience. In the interactional psychoanalysis, "transference" is considered to be a mutual construction of this specific patient and this specific therapist (Gill 1994; Mitchell 1997;).

From neurosciences we have learned that transference reactions are not merely determined by experiences from the past, they are activated by things that happen in the present. Occurrences from the past have been registered in the implicit or the explicit memory system. These systems are embedded in neural circuits. To remember or to activate these neural circuits demands a memory password and it is the nature and the colour of this password that determines the nature and the colour of the memory. Next to this, these circuits are mutually connected. The actual behaviour of the therapist or actual occurrences in the psychoanalytic process determine the nature and the colour of the transference reactions that happen. Transference always has a plausible basis in the here and now of the analytic situation. In other words: "transference" always occurs within a certain actual context. There is not so much **a** transference, but many with many affectively coloured faces. A specific occurrence in the present hooks up with various neurologically registered networks through which specific occurrences or aspects of occurrences become connected. Transference manifests itself in the moment that aspects of the psychoanalytic relationship activate networks (which exist in a potential condition of activation) through which conscious and unconscious perceptions, emotions, desires, expectations and behaviours are activated. Such networks can be functional but certainly also dysfunctional, and if the latter is the case, they need exploring and working through. In transference, both the implicit procedural memory and the explicit autobiographic memory, but also affective reactions or implicit resistance mechanisms can be activated. In the psychoanalytic treatment, patients develop, within the relationship with their therapist, new behaviours which will eventually be absorbed in new associative neural networks, which can be activated both within the treatment setting and without it. In other words: in the psychoanalytic treatment, slowly

new object relational patterns are being developed and internalized, which will finally be registered in implicit networks.

Everything that is connected with the psychoanalytic setting activates specific memories or experiences of the patient. Because memories are registered in associative networks which do or do not activate each other, one memory recalls another. It is the actuality of the psychoanalytic relationship which makes the patient remember, consciously and unconsciously, earlier implicitly or explicitly registered experiences. The psychoanalytic treatment does not end with working through transference (Westen and Gabbard 2001) Psychoanalytic treatments are about the actuality of the treatment relationship in which present and previous experiences are integrated within less dysfunctional behaviour patterns.

Otto: Follow-up

In a follow-up interview, a couple of years after termination of the analysis, Otto says that he came in for treatment with as his main complaint "***an overpowering feeling of threat, fear, inferiority and a sort of general feeling of extreme unease. It was all very vague and not very concrete, not any of it really had a face"*****.** Now, years after the analysis, he knows the same feelings but, he says**:** ***"I gave them different words, they are less vague, they mainly have to do with my father and my dead sister, it has all become more real and controllable".*** This also goes for the relationship with his partner (the same one he had when he finished the analysis), the fear of intimacy is still there, but a lot less, they can handle it better, together, and this also goes for his need for distance. In his job, too, he is doing well, and he is able to enjoy it very much. The inner chaos has disappeared, his anxieties have, as he says, ***"been given a face"*****.** With this, Otto means that fears have been connected to inner mental images, and there is an inner world through which he no longer 'is' his anxieties. Or, in other words, the panic has disappeared and he no longer **is** afraid but he **has** scared feelings. About his therapist, Otto says that during the treatment, he was afraid to fantasize about him, that has only started when, some time ago, he heard that his therapist had gotten a new job, from that time he could give him 'space of his own'. When talking about how he perceived his therapist he says *"**distant but not cold, rather: involved, that feeling that he was involved was really important to me, just like the feeling that he was enjoying the analysis, the puzzling and the looking for what things meant, I, too, got that more and more,***

which gave a sense of like-mindedness, especially when the therapy when through a difficult phase". As a result of the treatment, Otto started to look at his life in a different way: ***"first it was all very diffuse, I started to realize how much I had missed, which made me sad. There were images about my childhood, for example, but they did not impress me as meaningful. It was like a book of which the pages had fallen out, but in the analysis, we put them back the right way, and then it turned out that I didn't understand the grammar, and only when I started to, things acquired significance. Actually, I used to be terribly frightened; now, no matter what, I realize what it is about, it was the starting-point of a development, of looking for what was behind things, I found out that something was wrong".***

Otto was, thanks to the therapy, able to build up an inner mental space through which his life acquired a face, mental representations were developed because, within the treatment, the therapist focused on un-mentalized aspects in Otto's inner world, through which reflective functioning became possible and his identity grew, and he is now able to plan and organize his life adequately. Next to this, he is able to, better than before, feel emotions without being them, and he doesn't need to communicate through acting. He is better able to separate himself from the people around him and he can live with a relationship and no longer has to break it up because of panic when there is a conflict.

C. Conclusion

- Terminating psychoanalytical treatment is related to attachment, separation, internalisation, mentalization and structural change. It is about being able to have a relation with someone who is not actually there. It is about making use of the object and letting making use of. It is about leaving without getting lost.

- Structural change is about change in mental processing, about solving conflicts between mental representations, is about the revision of implicit working models and is facilitated by a change to a more safe attachment representation.

- In Psychoanalytical Treatment the therapist offers him/herself as a new primary object which is safer than the old one. By this he/she is creating a situation by which the internal working model will be provoked and could be changed as happened with Otto.

- Terminating psychoanalytical treatment is related to mentalization and by that to structural change. It is about creating alternative ways of perceiving.

- When the patient is able to handle him/herself in the same way his/her therapist is handling him/her the end is there. The idea of working through the transferential neurosis is no longer a realistic issue regarding new views about transference.

- Termination in psychoanalytic treatment asks for identification, Internalization and after that for separation and mourning

It's all about building up new relational patterns and storing them in a procedural way in the implicit memory system. It is about attachment and separation, about internalisation and identification, about relation and interpretation.

Good bye and thank you for everything.

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