Chapter 13

THERAPEUTIC CHANGE: A Summary and Some General Clinical Implications

We now have all the pieces in place. We have a process unit of subjective experience: the present moment. It has a duration and a temporal architecture that permits it to chunk and make sense of experience while it is happening. This results in the experience of being in a lived story as it evolves. The lived story has a beginning, end, affective highpoints, a primitive plot, implied intentions, and, most importantly, a duration with a temporal contour along which the experience forms during its unfolding. This is its temporal dynamic. In short, the present moment is directly lived through in real time. It is undergone in reality as it is happening. It is a direct, temporal experience. It is not an experience once-removed by language or twice-removed by abstraction, explanation, or narrativization. Its formation in real time is crucial.

A therapy session (or any intimate dialogue) is made up of a series of present moments that are driven forward by the desire for intersubjective context and an enlargement of the shared–intersubjective field. Intersubjectivity is a primary motive in this movement. As the dyad moves along, linking together present moments, a new way of being-with-the-other may arise at any step along the way. These new expe-
The present moment enters into awareness but need not enter consciousness all the time. They add to the domain of implicit knowing. This kind of change occurs at the local level. These moments, each lasting only several seconds, accumulate and probably account for the majority of incremental therapeutic change that is slow, progressive, and silent.

Less often, more sensationally and less silently, these relational moves can prepare the ground for the emergence of a special present moment, the *now moment*. This is an emergent property of the moving along process, a process that is unpredictable, sloppy, dynamic, and cocreated—an ideal milieu for the irruption of emergent properties. These special present moments, when they suddenly arise, threaten the status quo of the relationship and challenge the intersubjective field as it has been mutually accepted up until then. These are moments of *kairos*. They test the therapist and the therapy. They set the stage for a crisis that needs some kind of resolution.

The resolution occurs in a different special present moment called a *moment of meeting*. When successful, the moment of meeting is an authentic and well-fitted response to the crisis created by the now moment. It is a moment that implicitly reorganizes the intersubjective field so that it becomes more coherent, and the two people sense an opening up of the relationship, which permits them to explore new areas together implicitly or explicitly. The moment of meeting need not be verbalized to effectuate change. A now moment followed by a moment of meeting is the nodal event that can dramatically change a relationship or the course of a therapy.

Because of their affective charge and import for the immediate future, the now moment and the moment of meeting, focus the participants on the presentness of the moment they are now living. They are both experiencing the unfolding of a piece of reality. They read in the behavior of the other a reflection of their own experience. This provides a form of reentry via another’s mind so that the experience becomes intersubjectively conscious. This opens the door for the experience to be verbalized and narrated and to become a landmark reference point in the narrative history of the treatment.

The question of the mechanism of change now comes up. The reason I put the emphasis on experience and not meaning is as follows. It is my basic assumption that original experiences are laid down (inscribed in memory and in the neural circuitry) in a form that retains the real-time flow of their unfolding. They are a temporal record as well. I assume that these formative memories must be as temporally based as life is when subjectively lived. This is why temporal dynamics have been stressed throughout the book.

If past experiences are to be changed, they must be rewritten or replaced by a new temporal experience occurring in the same time framework. The rewriting must also be lived through with its own temporal dynamics. In contrast, the content of language and narrative is an abstracted experience. It is once-removed from direct experience and shortcircuits its temporal flow. It has different temporal dynamics from direct experience. But it can only rewrite the explicit past, not the implicit experienced past.

One cannot change without altering the functional past—in other words, the past that is activated and now influencing present behavior. The present moment is a “present remembering context” that selects which pieces of the past will be activated and brought into the present, as well as how they will be assembled to best deal with the present situation and influence it.

The present moment changes the functional past (not the historical past as seen from the outside by a third-person) in two ways. First, to the extent that the current present moment
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is a new experience that arises in the moving along process, it will act as a novel present remembering context. As such it will select and assemble never-before-seen or less-used pieces of the past to create a new functional past to bear on the present. The old functional past is not reassembled and not brought forward. It is bypassed, and the new functional past is ready to act on the future. This process must be repeated over and over to strengthen the selection of the particular new functional past and its neural basis. That is why this mode of change is slow, progressive, and silent. The past is, so to speak, replaced by being reassembled differently.

The second way the present moment changes the functional past is by rewriting it and erasing the old record in the course of one experience. Here, I reemphasize that present moments are real experiences lived in real time. Recall the evidence (e.g., the rabbits’ repertoire of odors) that a new experience can rewrite the neural circuitry and phenomenal expression of a previously written and remembered experience. The key notion, again, is a real happening in real time with a temporal dynamic—a lived story that is being rewritten by writing over the old.

It is important to remember that the experience contained in present moments is occurring in parallel with the exchange of language during a session. The two support and influence each other in turns. I am not trying to lessen the importance of language and the explicit in favor of implicit experience. I am trying to call attention to direct and implicit experience because it has been relatively neglected.

With an emphasis on implicit experience rather than explicit content, therapeutic aims shift more to the deepening and enriching of experience and less to the understanding its meaning.

SOME GENERAL CLINICAL IMPLICATIONS

The aim of this book has not been to develop a new clinical approach but rather to suggest a different vision of the clinical process when seen at the momentary, local level. Nonetheless, there are some implications for theory and practice. Where they will eventually lead remains to be seen. My experience and that of the clinicians in the Boston CPSG has been that our clinical sensibilities have been altered by this view in ways that are hard to pin down. Nonetheless, here are some of them.

When we focus at the local level made up of present moments, a different clinical sensibility arises. One becomes more aware of small events, especially nonverbal and implicit events. These also occur in the form of speech acts. They surround and accompany what is being talked about. They make up the parallel implicit agenda. The observer/listener must be attentive to the explicit verbal content and the implicit experience simultaneously. But it is difficult to follow both equally. If one does not believe that they both may have equal value in the treatment. And many approaches do not believe that. However, when the two are given equal weight, it becomes just as reasonable and fruitful to intervene about a small implicit behavior as about a verbalization. And the intervention can be in the implicit domain as well as in the explicit. This greatly increases the spectrum of therapeutic opportunities.

When the flow of a session is thought to be driven by the desire to regulate and enlarge the intersubjective field, some events fall more into the background, particularly the search for explicit meaning (at least for a while). Other hitherto less attended events jump to the foreground, such as the direction in which the intersubjective field is being led. Strategically, it is often initially more important to follow the movement of the intersubjective field toward a place that can permit the
explicit agenda to open up than it is to focus on the production of explicit material en route. The emphasis shifts temporarily from intrapsychic content to intersubjective regulation. Recall the case of Mariah and the amount of time needed to set up the appropriate intersubjective field before any explicit content could even appear. One could easily have focused on her negativity and aggressiveness while moving along, rather than on her working toward an acceptable intersubjective jumping-off place to talk about what was uppermost on her mind.

The same applies to progressions of present moments. The clinical action is likely to be in the sequential shaping of the intersubjective field, as well as or even more than, in the development of explicit content.

In a similar light, the transference-countertransference moves are subordinate to the more overarching regulation of the therapeutic relationship, particularly its intersubjective aspects. Not all acts to define or alter the nature of the therapeutic relationship are primarily transferential, or defensive.

This brings up a larger issue. The point of view developed here suggests the advisability of holding theory at a further distance during the session so that the immediate relationship can be lived more fully. When should interpretations be made or held off in order to stay inside the cocreated dyadic process and wait until it has run a fuller course? This is a question of good timing, which is accounted for in traditional techniques. In practice, however, an interpretation is usually conceived and used as an hypothesis to be tested by the patient and therapist for its truth and heuristic value. That is all very well, but it adds a powerful directional influence on the flow of the moving along process, an influence that comes largely from outside the immediate dyadic process and arises from theory and metapsychology residing only in the therapist's mind. The interpretation-as-hypothesis pulls the therapeutic process into a more asymmetrical relationship with regard to cocreation. It also sets a direction that was not necessarily what was happening at that moment in the process. During and right after the interpretation, the therapist is standing on a very different ground than the patient. They must renegotiate the distance between them while they negotiate the value of the interpretation-as-hypothesis. Yet interpretations must be made when deemed appropriate. The only way around this dilemma is to treat interpretations as potential sloppiness as much as a reasoned (possibly true) hypotheses.

I have the impression that in certain therapeutic schools, very early and frequent interpretations are given. These appear to force the direction of the dyadic process along theoretical lines, leaving unexplored the unique lines intrinsic to the patient.

Attention to the implicit flow of the session has implications for viewing and dealing with the sloppy nature of the therapeutic process, its unpredictability, and its spontaneity. If one accepts that sloppiness is not only necessary but potentially creative, and not necessarily psychodynamically determined but inherent in the moving along process, one treats it differently. First, it does not have to be treated as the breakthrough of unconscious material, like a slip of the tongue or a defensive mishearing or misunderstanding, at least not right away. The clinical question becomes not why that misunderstanding occurred, but where may it lead us, now, that is interesting. Second, the therapist can always double back later and pick up the psychodynamic aspects if they then still seem salient. They usually don’t. Stated otherwise, defense analysis comes second. But this will only happen when there is a full recognition of the scope and potential creativity of sloppiness and unpredictability.

Another implication concerns now moments. Now moments carry a double danger. If not responded to and redirected toward another purpose, they can quickly lead to
The present moment

greater and more disruptive acting in. Additionally, they may provoke anxiety in the therapist, who responds by hiding behind technique which prevents the now moment from bearing much fruit. The acceptance of the now moment as not only a normal event in therapy, but also as a rare creative opportunity, changes the therapists' threshold for this kind of anxiety. This permits him or her to tolerate the situation with enough ease to be more authentic and find a response that is both well fitted to the specific situation and carries the therapists' personal signature. All members of the Boston CPSG have noticed this change within themselves.

Finally, I have emphasized at several points that the approach taken here focuses on experience rather than cognitive meaning. Again fall back on the experience of music, (it could be any of the arts) to explore this distinction further. One can listen to and deconstruct music, rendering an explicit understanding of how it is constructed. This takes some training. More often we do not do that. Rather, with repeated listenings, we come to experience it more deeply. It becomes enriched. Different aspects interest, surprise, and delight us at subsequent hearings. One "knows" it better, in the sense that the experience is enriched. When a patient and therapist work together, something similar happens. The distinction between the cognitive understanding of experience and the enriching of experience is vital.

Of course there must be a search for meaning so that a psychodynamic understanding can be constructed, and a life narrative created. For this, a verbal explicit account of the patient's experience is paramount. But there must also be a process of appreciating the experience of the patient more deeply, of feeling his experience and sharing it with him so that there is an enriching of who he is, what it is like to be him, and what it is like to be-with-him. For this enriching of the experience of another to occur, the flow of moving along in the session, the intersubjectively shared present moments, and the implicit knowings are paramount.

The distinctions between implicit/explicit, nonverbal/verbal, appreciating/understanding, and experience/meaning can be summarized in terms of their role in therapeutic change. In talking therapies the work to interpret, to make meaning, and to narrativize can be seen as an almost nonspecific, convenient vehicle by which the patient and therapist "do something together." It is the doing-together that enriches experience and brings about change in ways of being-with-others through the implicit processes discussed. Complementary to this, verbal meaning making and narrativizing as forms of explicating can be viewed as also bringing about therapeutic change. Here the implicit doing-together and altered implicit knowing frames the flow of explicit understanding and locks it home.

Both are needed. But each demands a different descriptive and explanatory model. I have concentrated on the implicit and experiential because it is a less charted territory. To do this has required looking at the therapeutic process through the lens of the present moment.