

## MENTAL IMAGERY IN THE ORGANIZATION AND TRANSFORMATION OF THE SELF

John Suler

Mental images are sensory-perceptual experiences that occur in the absence of environmental stimulation. Usually the term "imagery" refers to visual memories and imaginings, so called "pictures before the mind's eye"—though auditory, tactile, olfactory, and gustatory sensations are also considered to be imagery submodalities. The scientific study of imagery has a long and extensive history in the academic field, especially cognitive and developmental psychology. Psychoanalysis also has a long history of exploring dreams and visual symbols, but investigations of imagery as a range of sensory-perceptual experiences within the therapeutic hour are relatively new and mostly draw on concepts directly or indirectly derived from the economic and structural models (see Horowitz, 1983; Singer, 1974; Suler, 1988). The revisions of traditional psychoanalytic theory that emphasize the vicissitudes of the self rather than drives—including object-relations theory, self psychology, and psychoanalytic phenomenology—often imply the importance of imagery as a basic feature of psychological functioning by the frequent but usually unclarified use of such terms as "parental imago," "body image," and "self and object images."

The underlying assumption seems to be that imagery plays a fundamental role as a representational system for organizing subjective experience and building self structure. Drawing on concepts from self psychology and psychoanalytic phenomenology (Atwood & Stolorow, 1984; Stolorow, Brandchaft, & Atwood, 1987; Kohut, 1977, 1984), this paper will explore the function of mental imagery in the development, maintenance, and transformation of the self—

as well as the clinical implications for working with mental images during psychoanalytic treatment.

*Imagery and the Network of Representational Systems*

Reviews of empirical and clinical research (e.g., Ahsen, 1982; Horowitz, 1983) have led to the conclusion that there are three systems for processing information and encoding memories. Imagery is one of those systems. A second is the "lexical" system, which involves abstract or conceptual symbolization using language and verbal processes. The third is the "somatic" system, including motor patterns and behavioral enactions related to muscle movements, as well as other physical responses and sensations related to neuromuscular activities. These three systems are alternate mechanisms for the organization of the subjective experience of self and object, for the creation of what Sandler and Rosenblatt (1962) called the "representational world." In normal psychological functioning all three systems operate as an integrated network, providing a cross-coding and confirmation of subjective experience that results in enhanced coherence of self structure.

In the course of development, especially before the maturation of language and verbal processes, the most fundamental aspects of self structure evolve through the interplay of the imagery and somatic systems. Developmental research suggests that self cohesion, continuity, affectivity, and agency are consolidated through the creation of "episodic memories" (Stern, 1985)—patterns of perceptions, sensations, actions, and affect that are associated with real life experiences, stored as whole units, and reactivated (remembered) as whole units via "imaging capacity" (Lichtenberg, 1983). The mnemonic patterns can be modified and added to by a tallying up or averaging of the episodes of lived experience over the course of development—so that rather than being memories of specific events, episodic memories are more generalized memory structures that preverbally represent the subjective experience of the interaction between self and other. It is the affect associated with these structures that gives them their meaning. Because the patterns fulfill the fundamental human need to organize experience, they create expectancies that are eagerly sought, that are a compelling source of a need to repeat.

Lichtenberg's (1983) idea that these memories are revived through "imaging capacity" suggests that the imagery and somatic systems may form an intimate network—and that imagery can reactivate somatic patterns of experience. Empirical research does in fact demonstrate that imagining specific behaviors or stimuli may reactivate the motor and physiological patterns associated with the actual performance of those behaviors or the actual experience of those stimuli (Craig, 1968; Hebb, 1968; Lang, 1979). Because the imagery system extends into bodily activities and regenerates the former sensory, perceptual, and somatovisceral patterns associated with actual experience, it serves an important function in the structuralization of experience and the integration of self.

A widely accepted idea in empirical and clinical research is that imagery is a potentially powerful vehicle for encapsulating, regulating, and reviving emotional states—more so than the verbal/lexical system (see Horowitz, 1983; Suler, 1988). No doubt the close link between images and the physiological responses of the somatic system partly accounts for this potential. Traumatic and highly emotional memories often surface in the form of vivid, intrusive images—"unbidden images" (Horowitz, 1983) that push for the expression and integration of the affect, and once that goal is accomplished, fade away. Images, therefore, may significantly influence the regulation and consolidation of affect within self structure.

In psychoanalytic treatment, stimulating and exploring images may activate the interconnections between the three representational systems. By vitalizing this network, images can arouse a variety of physical, conceptual, and affective patterns related to self experience. Working with an image can open pathways for the integration of previously dissociated or repressed aspects of self structure.

Cindy, a 19-year-old college freshman who came for treatment because of poor grades and a lack of motivation for school work, at first avoided talking about her family and claimed that she could not remember her childhood. While discussing her low grades and feelings of failure, I asked her if any images came to mind in response to the word "failure." Her first reaction was the heightened sensation of her chin. This physical sensation, which indicated an activation of the pathways between the imagistic and somatic patterns of self experience, led to a string of associations. She imagined

how her chin looked since she gained weight, or will look when she gets older "like my mother." She recalled how her mother, who was narcissistically preoccupied with her daughter's weight, took her for acting lessons when she was five in order to boost her self-esteem (her mother had always wanted to tap dance but suffered from stage fright). Another childhood memory centered around her tripping over her sister's legs and cutting her chin, which required stitches. Although the stitching eventually accentuated her double chin, her parents' concern for her welfare, the trip for ice cream after the hospital visit, and their praise that she was "so good" temporarily satisfied her usually neglected self-object need for mirroring and feeling special.

Resistance and defense can be understood in terms of barriers that are established at the boundaries of the somatic, lexical, and imagery systems (Horowitz, 1983), resulting in the dissociation and repression of threatening configurations of experience. Because the purpose of resistance is to safeguard a self structure that is weak or fragmented (Kohut, 1977, 1984), using images to open the pathways between these systems necessitates a holding environment that facilitates the assimilation of potentially overwhelming affects and the titration of the disintegration anxiety that may be triggered when once ward off configurations of experience begin to surface. Rapid access of traumatic memories via imagery may heighten perceptual and physical reactions, resulting in a "reliving" of the experience. Often only fragments of the dissociated or repressed aspects of self can be integrated between the imagery and somatic systems. Internal safeguards that are designed to prevent self fragmentation—and optimize the integration of psychic structure—will dilute, filter, or restrict the intensity of the revived images and the associated physical responses. The clinician can assist or therapeutically bypass these safeguards by either dampening or stimulating the "experiential scope" (Suler, 1988) of the image—i.e., its vividness, completeness, and affective intensity.

A clinical case will illustrate these ideas. In his second year of treatment, Dan, a 23-year-old electronics technician with a schizoid personality structure, struggled to recall his earliest memories of his father, who had died from a brain tumor two years prior to Dan's seeking treatment. At that time Dan learned from his alcoholic mother that his father, on several occasions, had been arrested for



exhibitionism. Recalling only a vague feeling of having been “suppressed” by his father, Dan fell into silence, unable to articulate or even think of anything. To temporarily bypass the barrier blocking the lexical system’s access to this realm of object relations, I suggested that Dan try to see an image that depicted his relationship with his father. Dan’s face turned white and his hands tightened on the armrests of his chair. He jumped up, began pacing the room, and described vivid sensations of choking, defecating, and anxiety. He stated that an image had flashed through his mind, though he could not see it clearly. By the end of the session, after much pacing, long periods of silence, and my sustained empathic acknowledgment of Dan’s fear and of his sense that “there’s something important there”—the sensations faded. In subsequent sessions he discussed his dawning suspicion that his father had sexually abused him.

### *Imagistic Organization of Self*

Similar to the function of dreams, as described by Atwood and Stolorow (1984), imagery fulfills the fundamental need to maintain the organization of experience by “concretizing” experience in the form of sensory/perceptual symbols. When experiences of self and other become expressed through vivid scenes before the mind’s eye they can heighten one’s conviction that these experiences are valid and meaningful. As Atwood and Stolorow state—perceiving is believing. Images, like dreams which are a type of imagery, revive the most basic form of knowing—seeing, hearing, feeling—and therefore become the guardians of psychological structure by affirming and solidifying representations of self and object through concrete depictions.

Images can also be divided into two categories similar to the two types of dreams described by Kohut (1977) and Atwood and Stolorow (1984). In those cases where emotional conflicts narrow or distort self experience but self structure retains its cohesiveness (i.e., structuralized conflict), images often affirm a particular organization of experience in which specific relationships between self and object are dramatized. Because the manifest image is the product of symbolization, condensation, and displacement, free association and interpretation are needed to explore its multiple latent meanings. The power of imagery over lexical systems of representation is

its ability to simultaneously depict multiple facets of self and object relations. Transference and the variety of meanings embedded in it are easily expressed in a single image. As Horowitz (1983) stated, one can "play around" with images: one picture is indeed worth a thousand words.

For example, in a session during the treatment of Dan, while we were exploring his family relationships, he again fell silent, feeling blocked in his ability to express himself verbally. When I asked him if any images came to mind, he described a brief, simple picture that had passed through his thoughts—a picture of a giant hand pinning him to the wall. The multiple meanings of this single image became clear. The hand represented his narcissistically vulnerable, alcoholic mother who stifled Dan's separation and individuation. It represented me, whom he perceived in the transference as holding him captive and intruding into his intrapsychic world. Finally, as revealed by the regressive connotations of the hand being "giant," it represented his father who had sexually abused him. In turn, the aggression implicit in the image depicted his own rage towards these exploiting objects.

In the second type of imagery, concrete symbols do not depict and affirm a particular pattern of self and object relations, but instead sustain and shore up a self structure that is threatened by fragmentation. An example are self-state images, which are analogous to self-state dreams that provide identifiable sensory patterns as a way to give shape and form to the otherwise unverbalizable experience of self disintegration (Atwood & Stolorow, 1984; Kohut, 1977). In these types of images the distinction between latent and manifest content is less germane. The primary function of the image is to depict the vulnerabilities of the self—and by doing so attain some measure of self affirmation and stability.

In the first month of treatment, Mathew, a 25-year-old graduate student and part-time magician, struggled with his inability to reach a decision about his career plans. In each session he appeared anxious, unfocussed, hypomanic. During that month he described a variety of images that captured the various ailments endangering his sense of self: structural disorganization, narcissistic depletion and enslavement to his parental self-objects, internal emptiness, alienation from his nuclear self. He described himself as a painter in front a canvas "who has a thousand different colors but is forced to

paint by the numbers." He described a dried-up sponge, attached to a hose, waiting for someone to turn on the water so it could fill up and expand. He imagined himself hacking at a block of ice, trying to get at someone inside who looked like himself. When discussing his possible career as a magician, he showed me a photograph (an imagistic communication) from his portfolio—a photograph of himself, with a surprised look on his face, pulling nothing out a hat. To provide some measure of order and continuity for the otherwise chaotic therapy sessions, we often returned to the image of his hacking at the block of ice as an organizing theme for his treatment and for his evolving sense of self.

Using images in treatment as a reference point for establishing self and object constancy is consistent with research on the role of imagery in development. The creation of "episodic memories" is the basis for building self continuity and cohesion (Stern, 1985). During their mother's absence, children in the practicing subphase become low-keyed and inner-directed while they attempt to image the mother and hold onto an "ideal state of self" (Mahler, Pine, & Bergman, 1975). Images of the self-object during the absence of the primary caretaker (or therapist) may be the cognitive vehicle for the creation of self structure via transmuting internalizations (Kohut, 1977). Even over the course of many years a single cherished image may provide an important stabilizing self-object function. Kohut (1984) gave the example of a patient with a vivid childhood image of his parents, dressed up in elaborate costumes, giving him a quick kiss and leaving for a party—even though he was sick with a high fever and measles. Rather than being a memory of parental deprivation, the image was a reminder that he was the child of fun-loving, enterprising parents—an idealization that offered some definition and health for an otherwise failing sense of self.

Such examples illustrate the point that "selfobjects" are not the caregivers themselves, but the individual's subjective experience of them as serving certain intrapsychic functions (Stolorow, Brandchaft, & Atwood, 1987). These examples also illustrate how images encapsulate this subjective experience of the self-object and retain its continuity across time.

The meanings embedded in an image, rather than being represented in its content per se, may be concretized in how the image is subjectively experienced or the characteristics of the image produc-

tion. For example, while recalling a dream in which he argued with his excessively punitive father, one patient felt a headache beginning to develop—which he later discovered to be an identification with his kindly grandfather who died from a brain tumor. When he quickly committed himself to wedding plans at a critical junction in our understanding his compulsion to cross-dress (which began after his grandfather died), he imagined a blurry picture in which he was “speeding along, dizzy, fogged in”—a depiction of his blurry sense of self which he attempted to remedy by anchoring himself to his girlfriend, who served self-object functions similar to his grandfather and to cross-dressing in feminine undergarments. Patients may experience a variety of affects and sensations while imaging or trying to image. They may see the image at a distance, framed, through a tunnel, frozen in place, in color or black and white. They may feel blocked, blank, empty, frustrated, blacked-out, tired. In these cases self-experience is represented in the *staging* of the image and the somatic reactions to it.

### *Images, Words, and Empathy*

Traditionally, psychoanalysis as a talking cure has placed great emphasis on the expansion of the patient's ability to verbalize the unconscious, including the ability to verbally analyze dreams, which are a form of imagery. Only recently has there been an interest in the therapeutic qualities of imagery itself and its relative merits as a mode of organizing experience (see Suler, 1988). In radical contrast to tradition, Spence (1982), suggests that only the “original” memory image, which he likens to a photographic snapshot, captures the subtle complexities of experience—whereas verbal attempts to reveal and explore that image tend to distort, contaminate, and fragment it, thereby altering its truth.

Much empirical and clinical research suggests that images, rather than being snapshots of experience, are *constructions* derived from a complex interaction of perceptual, cognitive, and affective processes (Strosahl & Ascough, 1981). Subject to both selective perception and “associative elaboration” (Suler, 1988), they are representations of subjective experience, not of an “objective” reality. They often are synthesized from an averaging or combining of a variety of past experiences, as in episodic memories (Stern, 1985)

and screen memories (Freud, 1899)—and they are always created *through* the subjective structures into which the experiences are assimilated, even when the image does depict a single specific event. While it is true that patients may censor or distort their verbal description of the image they see in their mind, only the verbal exploration of the image by the combined efforts of the patient and clinician can reveal the complex subjective meanings embedded in it. Although there have been claims that working with imagery alone, without verbalizations, can yield therapeutic results (see Suler, 1988), the additional verbal exploration of imagery enhances the cross-coding and confirmation of experience across the imagery and lexical systems of representation, thereby fortifying self structure. In the clinical examples of Dan and Cindy, imagery did succeed at accessing levels of self-experience where verbal expression failed—but the therapeutic effect culminated in their ability to describe and verbally master the subjective meanings of those aspects of self.

Words bind the patient to the therapist. They are a transitional phenomena linking self and object, a realm of shared meaning through which the intersubjective dialogue of psychoanalytic treatment flows. By comparison, the patient's imagery is more private, less accessible to the clinician. However, to think that the communication between the therapist and patient is reducible to words overlooks the more subtle power of the intersubjective field. The patient's communications often create images within the therapist. Through imagistic language, voice modulation, affective expression, well-timed pauses, metaphor, and body posture—what often amounts to good storytelling—patients stimulate images within the therapist that more accurately convey their experience than words *per se*. Shared images between the patient and clinician are a powerful vehicle for empathic contact, an almost literal form of “vicarious introspection,” of “dreaming along” with the patient (Schafer, 1959). Clinicians are familiar with those moments in treatment when the patient's verbalizations become rambling, stale, and almost seem to lose meaning—and when, in the course of listening with evenly hovering attention, the clinician's awareness suddenly rivets to one of the patient's associations—often because it triggered an image that punctured through the therapist's drifting thoughts.

A single, important image can reestablish empathic contact

through the course of treatment, as well as provide a reference point for facilitating the cohesion and continuity of self experience. Jean, a 30-year-old patient with an hysterical personality structure, sought treatment because of her repeated failures to establish longterm relationships with men. Unable to integrate her sexuality and need for nurturance within one relationship, she often found herself caught between two or more men. During the second year of therapy, she became involved in a love relationship in which she showed signs of being able to combine these two aspects of her self experience. In the middle of an intense sexual encounter with this man, a frightening, lifelike image intruded into Jean's thoughts—an image of her charismatic father angrily pulling her away from her lover, drawing her back into his body. Soon after that night, Jean let the relationship crumble. Over the following months of therapy, during her frequent descriptions of her failing relationships with other men, that image occasionally flashed through my mind, at times almost below the level of conscious awareness. The image usually was triggered by Jean's descriptions of being suddenly, unexplicably anxious in sexual situations with these new men, or of being "drawn away" from them. My inquiries into Jean's associations almost always revealed that the same image had flashed through her thoughts. The empathic connection to this subconscious aspect of Jean's experience invariably steered the therapeutic dialogue into deeper issues, including the genetic origins of her problems with men. Oedipal themes about her attachment to her father, his narcissistic attachment to her, and the detrimental consequences for love relationships gradually became important organizing themes in the treatment.

By offering an imagistically worded interpretation—including a vivid description of a scene, what people did, how the patient reacted, the emotions involved—the clinician can also activate imagery within the patient. The interpretation can empathically highlight previously unclarified configurations of self-experience and create a holding environment that facilitates structure building through the integration of that experience. The therapist's empathic sharing of this imagery with the patient is an excellent example of how the intersubjective nature of psychoanalytic treatment involves the "articulation" of the patient's subjective reality via the subjective reality of the therapist (Stolorow, Brandchaft, & Atwood, 1987). The empathic, containing function of imagistic interpretations was implied

in Silverman's (1987) use of long, imagistically vivid, and emotionally charged interpretations that were designed to implode the patient into areas of warded-off affect, thereby facilitating the working through of unconscious conflicts.

In our clinical research group that was devoted to the study of imagery in psychoanalytic treatment, Silverman once played a tape recording that had been sent to him by Joseph Stampfl, a pioneer in the use of implosive imagery (Stampfl & Lewis, 1967). As part of his invited colloquium at a psychiatric hospital, Stampfl was asked to interview a catatonic patient who had not spoken in many years. Apparently, from the background information given to him, Stampfl surmised that patient's critical issues revolved around the primal scene. As the patient remained completely silent, Stampfl proceeded through a long, richly described, and affect-laden story about the patient being a tiny baby, looking through the bars of his crib, seeing his father brutally engage in intercourse with his mother—and then turning on the patient, attacking him sexually, finally forcing him to retreat to the security of his mother's womb. At the end of the interview the patient spoke. Though Stampfl would attribute the therapeutic effect of his intervention to the imploding of affect, the interaction can also be conceptualized in terms of an empathic holding environment and structure building through the intersubjective medium of shared imagery. Stampfl's vivid story provided coherence, context, and symbolic meaning to a realm of the patient's experience that had forced him to retreat to catatonia in order to protect his precarious self organization.

A danger in using one's own imagery as the basis for an intervention is that the image may be more a product of misaligned countertransference than an accurate understanding of the patient. The image may not constitute an empathic overlap of the psychological structures of the patient and therapist—what Atwood and Stolorow (1984) call an “intersubjective conjunction”—but it or components of it may create an “intersubjective dysjunction” between the subjective worlds of the patient and therapist. Kern (1978) described how the global characteristics of his countertransference images helped facilitate his empathic understanding of his patients, but that an examination of the fine details of his imagery—the seemingly innocuous, almost unnoticeable elements in the background “woodwork” of the image—were derived from memories related to re-

pressed aspects of his own self and object representations that did not correspond to the patient's experience. His self-analysis of these hidden elements revealed subtle distortions in his empathic attunement.

Margaret, a 25-year-old student, spent the first few sessions of treatment describing her regrets over the recent breakup with her boyfriend with whom she frequently argued. She also discussed difficulties with her father—a rather controlling man who would not let her grow up. Her therapist experienced a very vivid image of the father as being bald and pale—though Margaret had offered no specific description of him. While supervising the therapist, I asked her if that image reminded her of anyone from her own past. At first no one came to mind, but then she suddenly recalled a memory from high school. A student who was infatuated with her proclaimed that he would cut off his hair if she did not date him. When she declined a romantic interest in him, he appeared one day at her home with his head shaved. On other occasions he slept on the steps of her house and carved her name into his arm with a knife. We were alerted to the possibility that this image might reflect some potential countertransferential distortions to understanding the patient. However, in a later therapy session, Margaret talked about her boyfriend having been involved with other women while dating her. She described an incident when she left a knife out in the open after an argument, intimating that she would use it on herself. Issues about being self-destructive with this man became the focus of therapy and pointed to other genetic issues about her self-punitive relationship to her seductive father and his narcissistic injury in response to her separating from him.

Another potential problem in using imagery in treatment is that the intervention itself may take on a meaning in the intersubjective field that complicates or disrupts the empathic process. Techniques vary greatly in their "level of directiveness"—some are subtle attempts to encourage awareness of images, others are more obvious, directive strategies to stimulate and intensify imagistic experiences (Suler, 1988). The more direct the clinician's approach, the greater the need to explore how patients experience the intervention according to the configuration of subjective meanings that constitute their representations of self and other. For example, in the case described previously, when I encouraged Cindy to find an image in



response to the word “failure,” she experienced a period of going blank, of being unable to see anything. Her anger toward herself about this blocking, and toward me, revealed her ambivalence about my exploring her self-experience. On the one hand, she believed I was saying “teach yourself”—just as her parents had neglected the development of her sense of self and expected her to do it alone. On the other hand, my intervention reminded her of a teacher in an acting course whose imagery exercises helped her “be in touch with my inner feelings”—and thereby served an important mirroring function.

Finally, the clinician must take into consideration the fact that there are wide individual differences in imagery ability—that people may vary in the extent to which they rely on the imagery, lexical, and somatic systems for encoding and communicating experience (Horowitz, 1983; Suler, 1988). Self-experience that is locked into one representational system may be a sign of defense and/or fragmented self structure. However, to initially establish empathy, clinicians may attempt to express themselves in ways that are consistent with the patient’s primary mode of experiencing self and other—i.e., by using language that emphasizes the imagistic, verbal/conceptual, or physical aspects of experience. To establish this empathic concordance, one must also take into consideration the fact that some patients and therapists may experience vivid images within submodalities other than the visual—for example, hearing music or a song “in one’s head.”

### *Issues Underlying the Study of Imagery*

Research on imagery leads to underlying issues about the functions and structure of the self. The patient’s experience of an image and the therapeutic work with that image activates the function of the self to observe itself—to observe the configurations of meaning that constitute self structure. Patients often subjectively encounter the image as “a picture before the mind’s eye.” Often they will see themselves, the representation of themselves, in that picture. In the facilitating form of a sensory-perceptual display, the image affords patients the opportunity to step back to observe and understand the themes and meanings rooted in self structure. Traditionally this function has been called the “observing ego.” Atwood and Stolorow

(1984) used the term “decentered self awareness”—which is the ability to decenter from the organizing principles of one’s own subjective world in order to grasp the meaning and implication of those principles. The same observing function is stimulated by the therapeutic work with dreams, which actually is work with the patient’s *imagistic recollection* of the dream in the waking state.

This observing self may serve as a grounding point for subjective experience, as a precursor of structure building and structure reorganization. It may enhance “agency”—the sense of the self as being a center of volition and an initiator of action. By perceiving and understanding an image, the patient in essence says, “I can look at this experience; I can step into the self that is separate from it; I can take that experience into that larger self.” In a case study described by Atwood and Stolorow (1984), the patient dreams she is consumed by a fire at a train station; only her eyeballs survive the flames, rolling about in their attempt to glance at each other. Atwood and Stolorow point out the theme of self-disintegration and the last desperate attempts, symbolized by the eyeballs, to maintain self-cohesion. But we should also note that if the eyeballs too were totally consumed, leaving nothing of the corporeal body, there would still be an observing self to witness the event—there would still be the dream, and the recollection of the dream, rather than a total experiential void. The observing self captures the experience, begins the shaping of its meaning, and centers the willful impetus for change.

Images serve to build self structure by concretizing experience and encapsulating the subjective meanings of self and object representations. However, to claim that images *are* “structures” may be a theoretical error. Though an image that surfaces in analytic treatment conveys and affirms the structures of the self, the therapeutic exploration of that image may culminate in its dissolving. In Kohut’s (1984) example of the patient with the visual memory of his parents dressed for a costume party, the interpretive work with the image ultimately resulted in its disappearance. Breuer and Freud (1895) similarly noted how the analysis of the multiple meanings of an image—which accompanied the “taming” of the affect in it—led to its dissipation, as if “the picture vanished like a ghost that had been laid to rest” (p. 280).

What would account for this fading of images that had seemed

so crucial to the therapeutic process? Kohut (1984) stated that once a developmental course has reached its completion, the individual links that sustained the overall forward motion can dissolve. "Our mind has no more use for them; they sink into oblivion via processes that are unrelated to repression—just as, at the end of a truly successful analysis, the patient is not burdened by the memories of the numerous interventions and responses from the side of the analyst that assisted him in reaching a state of reliable self-cohesion or in resolving structural conflicts" (p. 159). In the case of transmuting internalization, he claims, the idealized parental imago is ultimately broken up and the separate functions of the object are internalized as smoothly functioning, prereflective, "seamless" aspects of self structure and self regulation. In this case the parental imago is the *precursor* of structure.

So too images of any type are the precursors or ancillary buttresses of structure rather than the fundamental structure itself. This also holds true for the somatic and verbal systems of representation. It is the *integration* of the three representational systems—the verbal exploration of the subjective meanings of imagistic and somatic experience, and especially the identification and assimilation of the affect encompassed in experience—that culminates in the building of a cohesive and harmonious self structure. This higher order, unitary structure is sustained by the three representational systems, yet transcends them. The concept of self structure in this sense can be intuitively useful to the clinician—but as noted by some theorists (e.g., Kohut, 1977; Schafer, 1968), attempting to define "structures" at this level runs us into troublesome tautologies and metapsychological dilemmas. Perhaps these structures, being the very basis of subjective experience, cannot be observed directly and are not accessible through empathic-introspection. They can only be revealed indirectly and "signified." Perhaps, as Kohut (1977) suggested, this level of experience is the final bedrock of the self through which psychoanalysis cannot pass.

## REFERENCES

- AHSEN, A. (1982). Imagery in perceptual learning and clinical application. *J. Mental Imagery*, 6:157-186.
- ATWOOD, G. E., & STOLOROW, R. D. (1984). *Structures of subjectivity: explorations in psychoanalytic phenomenology*. Hillsdale, NJ: Analytic Press.

- BREUER, J., & FREUD, S. (1895). Studies on hysteria. In J. Strachey, ed. *Standard Edition of the Complete Psychological Works of Sigmund Freud*, 24 volumes. London: Hogarth Press, 1953-1974, 2.
- CRAIG, K. D. (1968). Physiological arousal as a function of imagined, vicarious and direct experience. *J. Abnormal Psychol.* 73:513-520.
- FREUD, S. (1899). Screen memories. *Standard Ed.*, 3:301-322.
- HEBB, D. O. (1968). Concerning imagery. *Psychol. Rev.* 75:466-477.
- HOROWITZ, M. J. (1983). *Image formation and Psychotherapy*. New York: Jason Aronson.
- KERN, J. W. (1978). Countertransference and spontaneous screens. *J. Amer. Psychoanal. Assn.* 26:21-47.
- KOHUT, H. (1977). *The restoration of the self*. New York: International Universities Press.
- (1984). *How does analysis cure?* Chicago: University of Chicago Press.
- LANG, P. J. (1979). A bio-informational theory of emotional imagery. *Psychophysiol.* 16:495-512.
- LICHTENBERG, J. (1983). *Psychoanalysis and infant research*. Hillsdale, NJ: Analytic Press.
- MAHLER, M., PINE, F., & BERGMAN, A. (1975). *The psychological birth of the human infant*. New York: Basic Books.
- SANDLER, J., & ROSENBLATT, B. (1962). The concept of the representational world. *Psychoanal. Study Child* 17:128-145.
- SCHAFER, R. (1959). Generative empathy in the treatment situation. *Psychoanal. Q.* 28:342-373.
- (1968). *Aspects of internalization*. New York: International Universities Press.
- SILVERMAN, L. H. (1987). Imagery as an aid in working through unconscious conflicts. *Psychoanal. Psychol.* 4:45-64.
- SINGER, J. E. (1974). *Imagery and daydream methods in psychotherapy and behavior modification*. New York: Random House.
- STAMPFL, T. G., & LEWIS, D. J. (1967). Essentials of implosive therapy. *J. Abnormal. Psychol.* 72:496-503.
- SPENCE, D. P. (1982). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis*. New York: W. W. Norton.
- STOLOROW, R. D., BRANDCHAFT, B., & ATWOOD, G. E. (1987). *Psychoanalytic treatment: An intersubjective approach*. Hillsdale, NJ: Analytic Press.
- STERN, D. N. (1985). *The interpersonal world of the infant*. New York: Basic Books.
- STROSAHL, K. D., & ASCOUGH, J. C. (1981). Clinical uses of mental imagery: Experimental foundation, theoretical misconceptions, and research issues. *Psychol. Bulletin*, 89:422-438.
- SULER, J. R. (1988). Mental imagery in psychoanalytic treatment. *Psychoanal. Psychol.* 5.