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Thoughts on Psychoanalytic Cure

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In an excellent historical survey, Lawrence Friedman (1978) traced the vicissitudes of the psychoanalytic theory of cure from Freud's writings on the subject to the views of contemporary thinkers. Emerging from Friedman's review were three factors that Freud believed to be important in achieving therapeutic benefits: (1) the provision of cognitive insight, (2) the affective bond to the analyst, and (3) the integration of formerly dissociated experiential contents. Friedman detected throughout Freud's work on the process of treatment a "running battle" between the respective claims of the first two of these factors, although, Friedman noted, "when one looks more closely one sees that it is not equal combat, but a struggle for survival on the part of understanding [that is, cognitive insight]" (p. 526). For example, Freud (1938) pointed to the positive transference as the most important curative agent.

Friedman's study demonstrates that subsequent discourse on the therapeutic action of psychoanalysis has been characterized by a continuation of this "running battle" between the respective claims of intellectual insight and affective attachment. Participants in the Marienbad Symposium on the Theory of Therapeutic Results in Psychoanalysis in 1936, for example, readily accepted Strachey's (1937) ideas about the introjection of the analyst's benign attitudes into the patient's superego functioning, a formulation that clearly placed the accent on the affective bond with the analyst and its internalization by the patient. On the other hand, participants in the Edinburgh Symposium on the Curative Factors in Psychoanalysis 25 years later reacted uneasily to Gitelson's (1962) implied claim that the affective relationship with the analyst can in itself produce structural changes. The other panelists at this conference forcefully reaffirmed the central therapeutic importance of cognitive insight as conveyed by interpretation.

Thus, the struggle initiated by Freud continues, with such writers as Loewald (1960), Stone (1961), Modell (1976), and Kohut (1977, 1984) emphasizing affective attachment, and others, such as Stein (1966), Kernberg (1975), and Curtis (1986), sounding the battle cry of insight through interpretation.

It is our belief that this long-standing debate over the role of insight versus attachment in psychoanalytic cure is symptomatic of a chronic malady that has pervaded not only psychoanalytic theory but Western psychology in general. We refer to the fragmentation of psychic reality that artificially sections human subjectivity into cognitive and affective domains. This false dichotomy has persisted in psychoanalytic self psychology as well. Kohut (1984), for example, divided the interpretive process into two phases, the first emphasizing empathic understanding based on affective attunement and the second emphasizing interpretive explanations based on cognitive inferences.

We contend that the significant psychological transformations that occur in psychoanalytic treatment always involve unitary configurations of experience in which cognitive and affective components are virtually indivisible. *Meaning*—the supreme category of psychoanalytic inquiry—is, after all, an indissociable amalgam of cognition and affect. Furthermore, the conceptualizations of selfobject transference and of the psychoanalytic situation as an intersubjective system provide a framework for recognizing that insight through interpretation, affective bonding through empathic attunement, and the facilitation of psychological integration are indissoluble facets of a unitary developmental process that we call psychoanalysis. For example, from the standpoint of the selfobject dimension of the transference, the therapeutic impact of the analyst's accurate interpretations lies not only in the insights they convey, but also in the extent to which they demonstrate the analyst's attunement to the patient's emotional states and developmental needs. The analyst's interpretations are not disembodied transmissions of insight *about* the analytic relationship. They are an inherent, inseparable component *of* that very bond, and their therapeutic action derives from the intersubjective matrix in which they crystallize.

Emerging from the formulations of selfobject functions, conflict, and resistance discussed in chapters 4, 5, and 6 is, in very broad brushstrokes, a *bipolar conception of transference* (see also A. Ornstein, 1974). At one pole of the transference is the patient's longing to experi-

ence the analyst as a source of requisite selfobject functions that were missing or insufficient during the formative years. In this dimension of the transference, the patient hopes and searches for a new selfobject experience that will enable him to resume and complete an arrested developmental process. At the other pole are the patient's expectations and fears of a transference repetition of the original experiences of selfobject failure. It is this second dimension of the transference that becomes the source of conflict and resistance.

We believe that a well-conducted psychoanalysis is characterized by inevitable, continual shifts in the figure-ground relationships between these two poles of the transference, as they oscillate between the experiential foreground and background of the treatment. These oscillations correspond to shifts in the patient's psychological organization and motivational priorities that occur in response to alterations in the tie to the analyst—shifts and alterations that are profoundly influenced by whether or not the analyst's interpretive activity is experienced by the patient as being attuned to his affective states and needs. For example, when the analyst is experienced as unattuned, foreshadowing a traumatic repetition of early selfobject failure, the conflictual and resistive dimension of the transference is frequently brought into the foreground, while the patient's selfobject yearnings are, of necessity, driven into hiding. On the other hand, when the analyst is able to analyze accurately the patient's experience of selfobject failure, demonstrating his attunement to the patient's reactive affect states and thereby mending the ruptured tie, the selfobject pole of the transference becomes restored and strengthened and the conflictual/resistive/repetitive dimension tends to recede into the background.[1]

It is our contention that the mode of therapeutic action of psychoanalysis differs depending on whether it is the selfobject or the conflictual dimension of the transference that occupies the position of foreground at any particular juncture of the treatment.

When the conflictual dimension is preeminent in the transference, an essential ingredient of the working through process concerns the interpretive illumination of the patient's unconscious organizing activity as discerned within the intersubjective dialogue between patient and analyst. We refer here to the ways in which the patient's experience of the analyst and his activities—especially his interpretive activity—is unconsciously and recurrently patterned by the patient according to developmentally preformed meanings and invariant themes, usually taking the form of expectations and fears of retraumatization. In *Structures of Subjectivity*, we conceptualized the therapeutic action of analyzing this unconscious structuring activity in the transference as a process of structural transformation. Like Friedman (1978), we found it useful to apply Piaget's (1954) principles of structural assimilation and accommodation:

> The repeated interpretive clarification of the nature, origins, and purposes of the configurations of self and object into which the analyst is assimilated, together with the repeated juxtaposition of these patterns with experiences of the analyst as a new object to which they must accommodate, both establish reflective knowledge of how the patient's perception of the analytic relationship is being shaped by his psychological structures, and at the same time invite the synthesis of alternative modes of experiencing the self and object world. As the ossified . . . forms that have heretofore structured the patient's experiences are progressively . . . reorganized, a new and enriched personal reality opens up before him, made possible by the newly expanded and reflectively conscious structures of his subjective world.
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> Analysis thus introduces a new object into the patient's experience, an object unique in the capacity to invoke past images and yet also to demonstrate an essential difference from these early points of reference. . . . Every transference interpretation that successfully illuminates for the patient his unconscious past simultaneously crystallizes an illusive present—the novelty of the therapist as an understanding presence. Perceptions of self and other are perforce transformed and reshaped to allow for the new experience. Assimilation contributes the affective power inherent in the transference, while accommodation makes for change [Atwood and Stolorow, 1984, p. 60].

[1] At certain other times, the patient's experience of the analyst's attunement may *heighten* the conflictual and resistive aspect of the transference because it stirs the patient's walled off selfobject longings and archaic hopes, along with his dread of the retraumatization that he fears will follow from the exposure of these longings and hopes to the analyst (see the case of Martin, chapter 4).

It should be clear from the foregoing passage that any attempt to separate the cognitive from the affective components of such structural transformations would be entirely artificial. The patient's insights into the nature of his unconscious organizing activity go hand in hand with new modes of affective bonding with the analyst, and both contribute to the patient's growing capacity to integrate conflictual, formerly dissociated experiential contents. As we have stressed throughout this book, sustained empathic inquiry into the patient's affective experiences of the analyst, and into the invariant principles that organize them, establish the therapeutic bond as an intersubjective context in which defensively sequestered and shackled regions of the patient's subjective life can be opened up and liberated.

When the selfobject dimension occupies the foreground of the transference, therapeutic action must be conceptualized not as a process of structural reorganization but of psychological structure *formation*. In our earlier (chapter 2) critique of Kohut's theory of optimal frustration leading to transmuting internalization, we suggested that structure formation occurs primarily when the selfobject dimension of the transference is intact or in the process of becoming restored. Innumerable selfobject experiences with the analyst provide a context that supports the development of the patient's capacity to assume a reflective, understanding, accepting, comforting attitude toward his own affective states and needs. (See Atwood and Stolorow, 1984, pp. 61–62, for an earlier discussion of this process.) Furthermore, the analyst's consistent acceptance and understanding of the patient's affective life come to be experienced by the patient as a facilitating medium reinstating arrested developmental processes of self-articulation and self-differentiation. Thus, the structuralization of self-experience is directly promoted by the stance of empathic inquiry. From this standpoint, as we have stated, the therapeutic benefit of analyzing ruptures in selfobject transference bonds lies in the integration of the disruptive affect states that such ruptures produce and in the concomitant mending and expanding of the broken selfobject tie. The selfobject dimension of the transference is seen as an archaic intersubjective matrix that, when intact or becoming mended, permits the patient's derailed psychological growth to resume. Once again we see that the cognitive and affective components of the therapeutic process cannot be separated, since it is the analyst's accurate interpretive activity that demonstrates his attunement to the patient's affective states and needs and

that thereby makes it possible for the patient to establish the analytic bond as a source of requisite selfobject experiences.

CONCLUSION

Transference is conceptualized as a bipolar organization of experience, with continual oscillations in the figure-ground relationships between its selfobject and conflictual dimensions. These shifts occur in response to specific alterations in the intersubjective dialogue between analyst and patient. While the mode of therapeutic action of analysis depends on whether the selfobject or the conflictual dimension occupies the experiential foreground of the transference, in either case insight through interpretation, affective bonding through empathic attunement, and the facilitation of psychological integration are indissoluble facets of a unitary therapeutic process. Every interpretation derives its mutative power from the intersubjective system in which it takes form.