Interpretation of Psychic Conflict and Adversarial Relationships: A Self-Psychological Perspective

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The differing perspectives of conflict theory and self-psychology are illustrated through clinical material. Transference as described in conflict theory and selfobject transference as considered within self-psychology are discussed as in a changing figure and ground relationship. An emphasis on conflict and resistance analysis may structure analytic treatment along an adversarial dimension with implications for selfobject and object-related transferences. Reference to recent research on infants offers an expanded model for the accretion of psychic structure that can encompass interventions growing out of both theories. The analytic approach to psychic conflict is to interpret what the patient defensively needs to ward off. The approach to self-pathology is to interpret the selfobject functions that the patient needs for self-consolidation and self-maintenance. Accurate assessment of instances in treatment where psychic conflict is the predominant configuration against a background of a silent selfobject transference requires a clinical theory that embraces multiple perspectives.

The impact of self-psychology on clinical practice can be felt whenever symptoms, fears, traits, and behaviors are understood as developmental and self-restorative necessities rather than solely as compromise formations borne out of psychic conflict. The therapeutic advances gained from this perspective have been most gratifying for both patients and analysts. From the standpoint of the treating self-psychologist, however, a specific danger must be averted. In an effort not to repeat the mistakes of the past, there is the danger that the conflicted baby is thrown out with the drive-theory-saturated bath water. Whereas one group of analysts has ignored the contribution of self-psychology,

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endopsychic perception of an aspect of the patient's psychic life. Such a report, such a complaint, is a symptom, a compromise formation ... Adequate analysis will reveal it to be a consequence of the patient's psychopathology rather than a description of it, a consequence that can be properly understood and evaluated only after such an analysis has been done. (pp. 67-68).

Brenner argues that clinical evidence should rule the day, but who would argue otherwise? And who is to be the arbiter of that clinical evidence? Who is to decide when the mind is better understood in conflict, in fragments, or in harmony? However, whether or not conflict is understood as a primary or secondary phenomenon, when a patient is beset by unconscious wishes and

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defends against them because they are associated with painful affects, such unconsciously motivated struggles must be addressed by the analyst.

Advocates of the centrality of conflict in mental life usually hold that frustration of instinctual drive derivatives and defense analysis leads to the capacity to delay gratification and is the royal road to internalization and to structural change. Viewing psychic conflict within a self-psychological perspective retains a role for frustration, but it is only a role, not the central role. How else can internalization and structuralization be promoted if not solely through the analysis of compromise formations, drive or wish, and defense? The research literature on infants points to additional possibilities for the development of psychic structure.

Fine-grained analyses of films and video tapes of mothers and infants in social interactions have revealed that both partners are continuously engaged in a “dance” (Stern, 1977) in which each responds to and influences the other on a moment-to-moment basis. When these mutual regulations become predictable and expectable, they provide one basis for the emerging organization of psychic structure (Beebe & Lachmann, in press; see also Broucek, 1977; M. Lewis & Brooks, 1975; M. Lewis & Goldberg, 1969; Stern, 1977). The infant's organization evolves in a mutually regulated interactional matrix through phases of attuned engagement and attuned disengagement. This increasingly complex interactional matrix is transformed into what we have generally considered to be psychic structure with the onset of representational and symbolic capacity, which begins at the end of the first year of life (Piaget, 1937/1954). Beebe and I (in press) proposed that the infant's self-regulation and the dyadic organization between mother and infant are simultaneous processes, both of which contribute to the emerging organization of the self.

There may be several processes through which psychological organization comes about. One major model for the origins of psychic structure is that psychic structure is formed through external (optimal) frustration leading to internal structure formation. The data Beebe and I examined do not address this issue. However, frustration of drive derivatives leading to internalization, a formulation which is contained in the metapsychology of conflict theory, cannot be the only way. Our study of the data supports an argument against that hypothesis as the sole model for the development of psychic structure. A primary role of an interactive matrix characterized by phases of attuned engagement and attuned disengagement as a base from which psychological organization proceeds has been proposed by Sander (1977), Stern (1983), and others. Because the neonate is capable of a wide range of positive and negative affective states and is capable of complex interactive regulation, the regulation of attuned engagement and attuned disengagement begins at birth (Demos, 1984; Field, 1985). In her critique of Freud's theory in the light of psychological research, H. B. Lewis (1983) has also noted the emphasis on

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“negative” emotions such as frustration and the neglect of “positive” emotions such as attachment in the organization of the psychical apparatus. Beebe and I (in press) have suggested that structure is formed through both the predictable mutual regulation of interactions as well as optimal ruptures and frustrations and efforts at their repair.

Extrapolations from one domain to another are usually risky, and the implications of the research findings on a theory of structuralization require additional study. Furthermore, their applicability to adults and to analytic interventions requires careful investigation. However, a psychoanalytic approach restricted to the analysis of psychic conflict and compromise formations appears too limited in scope in light of the additional pathways for the accretion of psychic structure that have been suggested.

Some critics of self-psychology (e.g., Wallerstein, 1983) have attempted to join self-psychology and conflict theory by proposing that clinical materia is not either/or but rather that it is best understood from a both/and position. Those friendly critics of self-psychology who support the both/and position have not yet presented cases to illustrate its clinical efficacy. In the self-psychology literature, Kohut (1984) has acknowledged the developmental importance of conflict, and the clinical utility of this position has received some attention (Lachmann & Stolorow, 1980; Stolorow & Lachmann, 1980, 1984-1985).
An either/or position is held by numerous analysts (e.g., Goldberg, 1981; Greenberg & Mitchell, 1983). The critics of self-psychology who maintain this either/or stance argue that classical theory already encompasses all that self-psychology has to offer. This position is exemplified in a case study by Richards (1981) in which self-theory and conflict theory are contrasted with respect to the problem of hypochondriasis. Contrary to Richards's thesis, I believe that self-psychology can add a broader perspective to an understanding of the patient and treatment and can illuminate some specific transference opportunities that were not considered.

Richards described the treatment of a hypochondriacal 27-year-old married man to illustrate the superior explanatory power of the conflict model over self-psychology theory. The patient's mother was described as “worried about each new step in [her son's] development: that he would fall when learning to walk, would choke when learning to feed himself…” (p. 323). His father was described as “not too bright but that he remained benignly enough in the background” (p. 322). A sister was born when the patient was 5, and she became his father's favorite. After her birth, the patient stopped eating until a doctor advised the parents to pay more attention to their son.

The patient's presenting complaints were a conviction that he was sexually deteriorating and a fear that he would have a heart attack especially after intercourse. He was convinced that there was something wrong with the condition and configuration of his penis, a worry that could only be resolved by testing it through masturbation in front of a mirror. These symptoms appeared when the patient was making plans to get married and to study abroad, 4 years before he sought analysis.

There are several points in Richards's discussion to which a self-psychologically informed view would suggest contrasting or variant explanations and additional analytic opportunities. These alternatives are offered not as substitutes but as reflecting a both/and perspective on the clinical material. Furthermore, conflict-theory-informed treatment as exemplified in this case introduced a specific unexplored transference dimension into the treatment, an adversarial relationship between analyst and patient.

The patient began his analysis by insisting that his symptoms were “physical” and not “psychological.” The description of these early months of the treatment suggests that, as is not uncommon under such circumstances, an adversarial relationship was established. The analyst was described by the patient as a dangerous, omnivorous person who was robbing him of his time, his money, his independence, and who was placing him in great physical danger by treating his symptoms as though they were psychological rather than physical. When the patient viewed the analyst as strong, he felt himself to be weak, fragile, and in need of care. He ruminated about the analyst's penis and imagined himself sucking it as though it were a nipple.

Although Richards did not label the patient's initial stance as such, implicit in his formulation was the theoretical assumption that the patient's insistence on the physical basis for his symptoms rather than acceptance of their psychological origin was defensive and constituted a transference resistance. Based on this assumption, Richards (1981) interpreted the initial transference as “a replication of an unconscious childhood image of his mother whom the patient had experienced as robbing him of his autonomy, his physical competence, and his independence by her overprotectiveness and anxious overconcern” (p. 324). The initial transference configuration was thus understood as a displacement of a past maternal imago onto the ostensibly blankscreen analyst who was maintaining analytic neutrality with respect to the patient's transference insistence.

Drawing on these data and the clinical theory of self-psychology, what questions can we raise? What inferences can we draw?

The patient-analyst interaction as described lends itself to alternative formulations. The patient's insistence that his problems were physical, not psychological, can be understood as his insistence that his fragile body be attended to first and foremost. The patient's ability to use his mother as an admiring and calming selfobject may have been curtailed by her anxiety, which would have conveyed her view of him as feeble and infirm rather than as strong and intact. The chronic rupture in his reliance on his mother as a mirroring selfobject would account for his sense of vulnerability and would have led to reparative attempts, seeking reassurance from others in general and his father in particular. The disappointment in his father as an idealizable selfobject, specifically with respect to phallic qualities, would then have resulted in further self-disintegration. Thus, in addition to an “unconscious image of his mother” (p. 324), the transference that evolved may have been organized around his thwarted early need for merger with a powerful, idealizable maternal imago.

With respect to the transference resistance described, self-psychology might take a stand different from classical conflict theory.
The patient's bid for attention to his physical condition would not be heard as a defense against unconscious wishes or drive derivatives but as an expression of a developmental need, a meaningful communication in and of itself. This alternate understanding of the initial "resistance" would have altered the transference configuration in that the initial and persisting negative transference may have been averted. But if not, the activation of the "negative transference" might then have been understood in terms of the selfobject functions served and as an indication of the patient's need for a powerful, paternal imago whose strength and phallic qualities he could share.

Given the historical material provided by the patient, the need for an idealizable, powerful father is readily understandable. The patient-analyst interactions as described by Richards embodied this dimension. Their interactions can be seen as providing the patient with an experience with a benign antagonist (i.e., an adversarial relationship). I want to underscore that the description of the interaction between the analyst and the patient as adversarial does not define how the patient experienced the analyst. An adversarial experience can serve defensive purposes as well as such selfobject functions as providing a source of strength or as a contrast to the patient's enfeebled self. I am suggesting that when the patient experiences the analyst as an adversary, that experience can be assimilated into selfobject functions. An adversarial relationship may make the analyst available to the patient as an idealizable selfobject.

Had the analyst viewed the emerging transference from a multiple perspective (i.e., a revival of both the unresolved issues with the autonomy-robbing mother and the search for an idealizable father, with attention to the subtle selfobject transference implications of each), how would the story of the treatment have differed? Had the patient's crucial developmental need for an idealizable, powerful father been recognized and his correlated need to see the analyst as the embodiment of phallic power been similarly understood and accepted, one difference might have been noted during the termination phase.

In the final weeks of the analysis, the patient again presented the analyst with renewed hypochondriacal concerns. It is not uncommon for symptoms to reappear during the termination phase. Classical conflict theory in general, and Richards in this case, understood this reappearance as a final resistance.

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to termination and independence. However, this final resistance bore a striking similarity to the initial resistance encountered in the treatment. That resistance, as was suggested, was a product of the analyst's theoretical convictions clashing with the patient's understandable exhibitionistic needs. Seen in this light, the return of the symptoms may again have indicated that an aspect of self-pathology remained and that archaic selfobject needs were still operative. That is, if the analyst served as an idealized selfobject throughout the analysis, the patient may well have gained in strength and confidence. However, this selfobject function may not have undergone developmental transformations to become internalized, an aspect of the patient's self-regulating structure. The reappearance of the hypochondriacal symptoms then expresses the patient's need for the analyst to function as an archaic selfobject, a needed substitute for vulnerable psychic functions.

Whereas attention to drive derivatives guided the treatment, acknowledgment of the patient's developmental strivings toward capability and strength may not have been addressed sufficiently. A milieu in which such developmental strivings are acknowledged, a milieu of attuned engagement/attuned disengagement, is the necessary complement for the analysis of conflict and optimal frustration to promote the accretion of psychic structure. When a self-psychological perspective is added to the clinical material of this case, additional exploratory opportunities with respect to object-related and selfobject transferences offer themselves. In summary form, the issues that emerge from a multiple perspective and from the adversarial aspect of the therapeutic relationship could be formulated for analytic exploration with the patient. Some ways in which the analyst may explore these issues can be encapsulated as follows: (a) you want to be sure that I will not neglect you, and so you must draw my attention to yourself (recall the family doctor who advised the parents to pay attention to their son); (b) you want to test out if I am going to be as worried about your body's survival as was your mother; (c) maintaining my attention on your bodily symptoms while I am trying to explore your psychological problems reassures you that I am not as worried about your survival as was your mother but may also make you feel unacknowledged. Finally, it may even be possible to describe to the patient that focusing on bodily symptoms might serve to set up an adversarial relationship that might even be welcomed.

The ramifications and developmental origins of these and other configurations would require further analytic understanding and explanation. These issues, derived from the patient's preoccupation with his bodily symptoms, need to be explored from a multiple perspective.

Two vignettes from the treatment are described to illustrate the patient's oedipally based conflict about surpassing his father. Based on self-psychological assumptions, these vignettes would also be expected to express the patient's need to maintain an idealization of his father.

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Richards (1981) writes that “when the patient had occasion to criticize a man considerably older than himself, he was immediately consumed with anxiety ... that the attack would cause him to lose the man's love and friendship. About his superiors in his firm, he brooded, 'If they don't step down, how will I get ahead? But if they die, who will take care of me?’” (p. 325). Richards then comments, “As the aggression implicit in these questions gradually became conscious, he was able to be more critical of his superiors” (p. 325). That the major issue underlying these associations was the patient's aggression is hardly self-evident but is inferred by the analyst from his conceptual framework. Thus, it was part of Richards's therapeutic approach to surface the aggression implicit here to him. On the face of it, this material could be characterized as the patient saying, “I am a frightened, dependent, and lonely person, afraid to offend lest I diminish even further much needed sources of love and care.” And by focusing on the aggression implicit to him, Richards's response can be paraphrased as an acknowledgment by the analyst to the patient. “You are more powerful than you think” or “You are powerful like me.” Analysis of the defenses against aggression may therefore simultaneously provide the patient with a powerful, idealizable paternal image whose acknowledgment of the patient serves selfobject functions which shore up his fragile sense of self.

In a second vignette, Richards (1981) writes, “The patient's “conflicted feelings about surpassing his father were elucidated in the transference when he was aware of feeling anxious because he had the thought that he was intellectually superior to the analyst. This revelation was followed by ruminations that the patient believed he had cerebral arteriosclerosis” (p. 325). Richards (1981) interpreted these associations as indicating that “the somatic concern disavowed his intense competitive wishes ... the patient then recalled ... how he had acquired considerable skill in playing ping-pong when he was an adolescent but would deliberately lose when he played with his father because he did not want to embarrass him” (p. 325).

For Richards, the ping-pong memory reflected the patient's disavowal of his intense competitive strivings. This vignette can also be understood as illustrating the patient's need to maintain his father and the analyst in an idealized position. Both lines of interpretation are plausible—defenses against aggressive competitive designs and maintaining an idealizable father image—from the standpoint of the clinical material. However, that the patient could envision himself as not only a competitor but also as superior needs to be acknowledged by the analyst. Such recognition and acknowledgment may be necessary ingredients for the subsequent internalization of the analyst's selfobject functions. Nevertheless, further exploration with the patient, rather than commitment to a theory, should be used to guide the treatment. Clinical theory should enlarge our clinical opportunities and point toward illuminating explorations rather than close off options by eliminating possible or plausible ways of organizing the material.

Ironically, the analyst's firm stand with respect to the psychological nature rather than the physical basis of the patient's problems, the analyst's mental health ethic, his tilt in the direction of “ambitions” over “illness” and on “autonomy” over “infantility” may have made him appear as the embodiment of the firm, powerful, even adversarial, idealizable father image the patient needed. The idealizing selfobject transference may then have been promoted through the analyst's stance and provided an ever present background for the analysis. Because this stance was intrinsic to the analyst's theoretical commitment and clinical approach, the multiple transference possibilities remained unexplored. I would not ask the question which was the more effective therapeutic agent—the silent selfobject transference or the interpretation of conflict and working through of resistances—but rather ask how the specific role and interrelationship of these two transference currents can be explicated. On the level of clinical theory, Stolorow and R(1984-1985) discussed the selfobject and object-related transferences to be in a figure and ground relationship with the selfobject transference often providing the background.

Presumably, the patient felt sufficiently safe to experience the analyst as antagonistic (within the transference) and to feel antagonistically toward him. This antagonism does not point toward a ruptured alliance or an irreparable empathic failure passively accepted by the patient but rather underscores the complex, multileveled nature of the analytic experience. The adversarial dimension of the therapeutic relationship can contribute to the patient's capacity to experience himself as stronger, more assertive, more intact, and perhaps even as a richer, more complex person. Does the persistence of this dimension also impose a limitation on the treatment? The continual thwarting of the patient's needs for acknowledgment and for mirroring affirmation and for other uses of the analyst as a selfobject could eventuate in both continued structural vulnerabilities and in the renunciation or disavowal of aspects of self-experience. The consequences of such thwarting will need to be studied with respect to the patient's capacity for empathy and the patient's capacity to accept the selfobject functions needed of him by others. Furthermore, the return of the hypochondriacal symptoms at the end of the treatment may have served as a signal that a developmental transformation of archeal selfobject functions was not achieved. Finally, a limitation is imposed on the treatment in that the transferential implications of the adversarial dimension of the therapeutic relationship were not explored.
There is no inherent contradiction in placing adversarial experiences in a self-psychological framework. Wolf (1980) has spelled out a developmental line for selfobjects from their archaic base to their mature forms. Within that line, he has placed the need for ambivalence via ally-antagonist selfobjects.

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To refer to a developmental line for selfobjects is essentially to use a shorthand formulation for a more complex process. It is the selfobject function for which others are needed that undergoes developmental transformations. Feeling understood, affirmed, responded to, as well as opposed to or contrasted with, all describe different relationships that may feel satisfying or frustrating and may serve defensive purposes as well as selfobject needs.

When adversarial experiences serve selfobject functions, such functions can be placed on a continuum of increasing complexity from archaic needs for self-consolidation to self-demarcation and self-enhancement. Adversarial experiences may range from a mildly contrasting or contrapuntal quality to a more antagonistically tinged opposition. Those patients whose childhood experiences precluded the availability of such phase-appropriate adversaries may express a wish for the analyst to serve as an adversary. In turn, rather than enact an adversarial relationship with the patient, the analyst may then recognize and explore the patient's wish for such an interaction. The inadvertent or unanalyzed enactment of an adversarial relationship may obscure or thwart some selfobject functions that have been activated (e.g., needs to be mirrored), and other selfobject functions (e.g., idealizations) may simultaneously and covertly enable such patients to derive a sense of vitality and capability.

Under average expectable circumstances, an adversarial dimension is present to some degree in all interpersonal interactions and contributes to a person's sense of agency, self-complexity, and a sense of being a center of initiative. Indeed, whenever the analyst addresses a warded off aspect of the patient as occurs in interpretations of psychic conflict, the potential for this adversarial dimension is activated.

Stolorow and I (1980) discussed the developmental necessity for acknowledging patients' readiness to experience the analyst in opposition to them. We described instances in the treatment of patients who had for long periods of time required that their selfobject transferences remain undisturbed. At specific points in their treatment, these patients then signaled that they were now ready for the analyst to serve as a target for object-related wishes. One patient described her envy of a friend who, in her treatment, fought with her analyst. Another patient described her interest in group therapy so that she might be subjected to harsher criticism than she received from her analyst. Other patients wanted the analyst to describe his views on some sociological, political, or psychoanalytic issue. All these communications were understood as indicative of patients' increased tolerance for differences and a readiness to experience opposition. That is, these patients expressed a need and a wish to engage with the analyst as an adversary. Such experiences can be understood to serve both defensive purposes and selfobject functions simultaneously. In the cases just described, the patients needed the analyst for self-demarcation and wished that he would differentiate himself rather than that they would have to differentiate themselves from him. Such wishes could also be understood as defensively motivated.

An adversarial dimension may be noted in the treatment relationship in two ways. First, as in the case described by Richards, an adversarial relationship may be activated through the consistent application of a theoretical model in which conflict is central and there is a continuous emphasis on the interpretation of resistance and defense. Some limitations and benefits of this approach have been suggested, but clearly, the effect of the analyst's theory and technical stance on the transference in general and on the selfobject dimension of the transference in particular requires continuous study. Second, adversarial relationships may be sought by a patient as an expression of a psychic conflict. Here the analyst may explain to the patient that he or she wishes that the analyst initiate an opposition and then explore its meaning, function, and developmental origin. A patient may initiate an adversarial relationship or experience the analytic relationship as adversarial in spite of the analyst's attempt to maintain a benign, neutral, and accepting atmosphere. Such attempts on the part of the patient, viewed from a both/and perspective, may be both defensive and in the service of renewed developmental strivings. Which is predominant at any given moment in the treatment is an issue for analytic inquiry.

On the level of clinical interpretation, it is probably quite usual for analysts to work within a multiple perspective. When theoretical advocates present case material, usually only those interventions consistent with the theory advocated are described. I believe it would be useful both for the construction of an integrated theory and for the communication of our clinical work to present case material that illustrates the multiple perspectives at work.

The interweaving of psychic conflict, conflicted object-related wishes, and the need for the analyst as a selfobject are illustrated in

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this vignette from the treatment of a young woman (also discussed briefly in Silverman, Lachmann, & Milich, 1982). She sought treatment because she felt empty, “uninterested in [her] academic work and was increasingly cutting [herself] off from friends” (p. 185) while becoming involved with her boss at work, a married man. She felt that there was nothing she wanted to do. After having already encountered difficulties in her high school work, the patient found the college courses at a university some distance from her home most troublesome. College had been her first “real” separation from her mother whose presence had been providing her with a sense of vitality and capability. Upon arriving at college, she attempted to find substitutes for the functions performed by her mother in that she surrounded herself with the school “celebrities.” Their “failures” in terms of providing her with the interest and attention that she needed were experienced by her as her failure. Rather than derive a sense of vitality from them as she did from her mother’s attention, she felt more isolated, depleted, uninterested in her schoolwork, and depressed.

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When the patient was 6 years old, her parents divorced and her father quickly remarried. The patient remained with her mother and worked hard at establishing and maintaining contact with her father. A close relationship between mother and daughter held until, when the patient was 10 years old, her mother began a love affair with a considerably younger man. The patient was deeply disappointed in her mother but, to maintain her as a much needed source of self-esteem regulation, defended against the disappointment by assuming a protective stance in relation to her. Early in the treatment, she described that she felt angry and envious toward her mother’s lover, whom she called “an intruder.” To some extent through her protective stance, her mother remained a source of comfort whose presence bolstered her self-esteem. Nevertheless, her mother had become increasingly unavailable, and this eventuated in the patient replacing the lost communion between her mother and herself by turning to mysticism in which she sought the missing sense of “oneness on a cosmic level” that she needed to feel restored and capable. Important in her mystical interests was the possibility of communication outside of conventional channels.

Since childhood, the patient had suffered from occasional, severe stomachaches. During the first 2 years of treatment, she brought her symptom to the sessions, and it frequently diminished. The connection between the material explored and the diminution of the stomach pains was not always clear. I speculated to myself that a selfobject transference was gradually being established in which I served certain soothing and self-consolidating functions with respect to some highly charged eroticly tinged memories. The sessions were frequently organized around dreams of an explicit sexual nature in which she was either working out a relationship with her father (or a father figure) or dealing with the intrusions of her mother’s lover into her relationship with her mother. As these issues were clarified, her enactment of aspects of traumatically overstimulating childhood experiences decreased, and she developed more interests, felt less “empty” and depressed, and dated young single men.

During a series of sessions in the third year of the analysis, the patient developed headaches as she lay on the couch. In prior times, symptomatic states would erupt in response to some empathic rupture that we could sometimes identify. This did not seem to be the case here, and in exploring the meaning of the symptom, I asked her what she imagined would soothe her pain. She responded that just hearing the sound of my voice had that calming effect on her.

During prior sessions, r Luences in the self-object dimension of the transference had occasioned various mild symptomatic states, but using the sound of my voice to restore herself had not occurred. Now, I wondered why and listened further. She recalled the time before her parents separation when she also suffered from headaches. Then, her father would sit with her at night and soothingly rub her head until her headache went away and she fell asleep.

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The headaches ushered in a new dimension in the transference—an attempt to restore her family intact with unspoken yearnings for her father.

Earlier in the treatment, the patient’s mystical interests were understood as the (re)establishment of a tie that had been ruptured by her mother’s affair. The mystical interest now recurred with a new dimension. She reported a dream, “I came to your office and all your patients were witches.” The reference to the witches related to their supernatural powers and to an aura of mysticism that made her feel at home in my office. But the witches also referred to my other patients who had now become frightening rivals whose power she feared. However, in referring to my other patients as witches, she also conveyed that she thought she was better looking than they. While retaining my function as a selfobject, the patient began to experience me as an oedipal object whose women were both potentially dangerous but with whom she could now compete.

As oedipal issues became more articulated, a new wrinkle appeared with respect to the selfobject functions for which I was needed. The patient described a particular sense of pleasure during intercourse with her boyfriend from the gentle pressure of his body.
upon hers. She then spoke of feelings that she had recently experienced in her analytic sessions, which she could now articulate more fully. She wished that I would put more pressure on her by introducing new ideas and even contradicting her rather than appearing to be in unison with her. A major developmental shift was noted and acknowledged to her. Subsequently, her defenses against “contradicting” me could be addressed. She gradually became freer with respect to self-assertive strivings and her ambitions, in relation to men, and with respect to her work. She began to consider herself more capable of engaging in and competing in the world.

Self-restoration and structural development had proceeded so that she did not feel so vulnerable and empty. She could function now in contrast to her depleted state during her year at college and at the start of her analysis. At issue now were her conflicted wishes, to be ambitious without fear of retaliation, and how these could be resolved, reconciled, or tolerated.

Assessment of instances in treatment in which psychic conflict is the predominant configuration against the background of a silent selfobject transference requires a clinical theory that embraces multiple perspectives. From a self-psychological perspective, interpretations of psychic conflict can be understood as promoting and crystallizing an organization of the self as wishing and defending and as the center of initiative of these psychological activities.

Summary And Conclusions

The analytic approach to psychopathology in which psychic conflict is dominant is to interpret what the patient defensively needs to ward off. The approach

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to self-patholog is to focus on the selfobject functions that the patient needs for self-consolidation, self-demarcation, and self-maintenance. In these instances, selfobject transferences will become figure rather than ground. The working through process entails developmental transformations through which psychological structures are consolidated. In turn, this permits shifts in the figure and ground of the transference. This description may give the impression of linear transformations, that attention to self-pathology precedes the analysis of psychic conflict. This is not the case. There is frequently a continual shifting between figure and ground even within sessions.

In the discussion of Richards’s case, it was suggested that the analyst adhered to one set of theoretical convictions which may have produced an adversarial relationship and which may have limited analytic exploratory options. Adversarial relationships within treatment were discussed with respect to their assimilation into the patient’s defense system and their effect on the selfobject dimension of the transference. Accurate assessment of instances in treatment in which psychic conflict is the predominant configuration against the background of a silent selfobject transference requires a clinical theory that embraces multiple perspectives.

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