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16 Optimal Responsiveness and the Therapeutic Process  
Howard A. Bacal, M.D.

Although tacitly accepted as an important element in the therapeutic practice of psychoanalysis, the concept of optimal frustration has received little theoretical clarification. The publication of Heinz Kohut's (1977a) landmark work *The Restoration of the Self* established optimal frustration as a central aspect of the curative process viewed from the perspective of self psychology. With one of his critics, Kohut (1977b) recognized the problematic nature of the question "What is optimal?," yet he never arrived at a satisfactory answer.

I intend to reexamine this question in light of the related issue of "optimal gratification." My purpose is, in part, to demonstrate the significance of the latter, which has until recently been regarded with some suspicion as a form of countertransference acting-in, evoked perhaps by the patient's acting-in in the transference; as a manipulation of the transference itself by the analyst deliberately adopting a role (the so-called "corrective emotional experience" of Alexander, 1956); or, at most, as a useful but temporary parameter to be discarded at the first possible opportunity.

I will suggest that any discussion of the concepts of optimal frustration and optimal gratification becomes inevitably entangled in insurmountable theoretical difficulties and endless debate when separated from the more useful and encompassing idea of optimal responsiveness, defined as the responsivity of the analyst that is therapeutically most relevant at any particular moment in the context of a particular patient and his illness. Empathy or vicarious introspection is the process by which the therapist comes to understand the patient by tuning in to his inner world. Optimal responsiveness, on the other hand, refers to the therapist's acts of communicating his understanding to his patient.

#### Optimal Frustration

The origin of the term "optimal frustration" is not clear. Although he credits Bernfeld (1928) with its first mention, Kohut (1972) appears to have

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first applied it to the psychoanalytic process. The idea of optimal frustration, however, has always been a cornerstone of psychoanalytic treatment. As early as 1946, Anna Freud wrote:

[As analysts,] we have to play a double game with the patient's instinctual impulses, on the one hand encouraging them to express themselves and, on the other, steadily

refusing them gratification—a procedure which incidentally gives rise to one of the numerous difficulties in the handling of analytic technique, (p. 13)

... the ego [of the patient] is victorious when its defensive measures effect their purpose ... and so transform the instincts that, even in difficult circumstances, some measures of gratification is secured.... (p. 193)

However, the “measure of gratification” to which Miss Freud referred was not regarded as an aspect of the analytic process, but as one of its results.

While still working within the classical psychoanalytic perspective, Kohut and Seitz (1963) defined optimal frustration as an experience that is intrinsically related to that of gratification in the therapeutic process:

optimal frustrations involve sufficient delay in satisfaction to induce tension-increase and disappointment in the attempt to obtain wish-fulfillment through fantasies; the real satisfaction occurs quickly enough, however, to prevent a despairing and disillusioned turning away from reality. (p. 356)

Kohut indicates that the infantile impulses that have encountered optimal frustration are transformed into neutralizing psychological structure by the internalization of innumerable experiences of optimal frustration, but that “[t]he barrier of defences, on the other hand, which walls off an unmodified residue of infantile strivings, is the result of the internalization of frustrating experiences and prohibitions of traumatic intensity” (Kohut, 1963, p. 369).

In other words, optimal frustration of instinctual impulses promotes the development of internal structure comprised of transformed, or sublimated, instinctual drives; whereas traumatic frustration causes a protective barrier to be built up around these impulses, which are left unchanged. Gratification, or “real satisfaction” must be an inherent element of the therapeutic process at some point and in some measure, or else “optimal” frustration will be anything but optimal. Yet, Kohut and Seitz do not satisfactorily define what optimal frustration and its associated optimal gratification amount to in the psychoanalytic process. Nor, to my knowledge, has this theoretical lacuna been redressed elsewhere.

In *The Analysis of the Self*, Kohut (1971) reiterates his position, still within a classical framework, but focuses now upon the importance of optimal frustration for narcissistic equilibrium rather than for drive modulation:

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as continues to hold true for the analogous later milieu of the child, the most important aspect of the earliest mother-infant relationship is the principal of optimal frustration. Tolerable disappointments in the pre-existing (and externally sustained) primary narcissistic equilibrium lead to the establishment of internal structures which provide the ability for self-soothing and the acquisition of basic tension tolerance in the narcissistic realm. (p. 64)

... The skillful analyst will assist the patient in keeping the patient's discomfort [vis-à-vis the necessary, i.e., therapeutic, frustration of the narcissistic transferences] within tolerable limits; i.e., he will conduct the analysis according to the principle of optimal frustration. (p. 199)<sup>1</sup>

Further, Kohut (1972) stated that omnipotent objects “become internalized every time the child discovers a flaw in them, providing the discovery is not of traumatic degree but optimally frustrating” (p. 869).

Kohut thus saw optimal frustration as central to the process of transmuting internalization, which he regarded as the essence of the process of analytic cure. As he wrote 5 years later,

Little by little as a result of innumerable processes of microinternalization, the anxiety-assuaging, delay-tolerating, and other realistic aspects of the analyst's image become part of the analysand's psychological equipment, pari-passu with the micro-frustration [my italics] of the analysand's need for the analyst's permanent presence and perfect functioning in this respect. In brief, through the process of transmuting internalization [via optimal frustration] new psychological structure is built. (Kohut, 1977, p. 32)

Kohut (1977), however, also questions the validity of the view that some individuals with severe psychopathology have had caring mothers who, in attempting to gratify their children's wishes, have deprived them of the optimal frustration that would have enabled them to develop a mature ego. While acknowledging the possibility that these individuals might not have been sufficiently frustrated as children, he suggests that the determinants of their illness appeared to be more complex when viewed from the perspective of an analysis conducted on the basis of self psychology. By way of illustration, he cites his account of Mr. U whose mother and grandmother had ... apparently acted out an unconscious fantasy of their own [in] gratifying the child's drive wishes for their own purposes. Fully in tune with his every drive demand, they simultaneously disregarded the boy's maturing changing self, which cried out for a maternal (and later also paternal) confirming-admiring responses and approval [of his own capacities. The boy's fixation on a fetish] was therefore essentially not the result of overgratification but of a specific traumatic absence of maternal empathy for

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1 In a letter dated a year later Kohut (1972, September 23) also makes the point that “the drive-curbing behaviour of the selfobject is in essence experienced by the child as a narcissistic injury [and therefore] ... structure formation is always due to a loss of the prestructural selfobject, not of the drive-curbing true object....”

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the healthy grandiosity and the healthy exhibitionism of his forming independent self. (p. 79)

Although Kohut recognizes that insufficient frustration or “excessive gratification” may contribute to psychopathology, he suggests that the pathogenic factor is not the “overgratification” of some instinct, but the accompanying traumatic insufficiency of recognition and “gratification” of a selfobject need. In this context, it is instructive to recall an aphorism that Kohut (1977) introduced in a now-famous passage in *The Restoration of the Self*:

Man can no more survive psychologically in a psychological milieu that does not respond empathically to him than he can survive physically in an atmosphere that

contains no oxygen ... the analyst's behaviour vis-à-vis his patient should be the expected average one—i.e., the behaviour of a psychologically perceptive person vis-à-vis someone who is suffering and has entrusted himself to him for help. (p. 253)

There is an apparent contradiction between this view and the recognition of the therapeutically beneficial effects of frustration. In order to explore this contradiction intelligibly, it is necessary to consider the difference between “optimal” frustration and “traumatic” frustration, and their relationship to so-called “empathic failure.”

#### Optimal Frustration and Traumatic Frustration

Let me say at once that the notion of empathic failure by parental selfobjects cannot by itself answer the question of what is traumatic, since it is likely that not all empathic failures lead to long-range deleterious effects on the psyche of the child. Indeed, since optimal frustration by selfobjects is regarded as essential to the growth and development of the self, empathic failure by selfobjects in childhood, as well as by the analyst as selfobject at a later stage, should according to this theory be welcomed. The central issue, both developmentally and in analysis, is what will lead to structural deficit or defect and what will be “optimal,” in the sense of curative, leading to transmuted internalization of experience that is structure-building or fault-reparative?

The question still remains, however, what is “traumatic”? The earliest conception of trauma focused on isolated events, in particular on sexual seductions. The idea of trauma as the product of ongoing processes and relationships was not recognized before the contributions of such object-relations theorists as Balint, Winnicott, and Masud Khan (1963) with his notion of cumulative trauma. All would agree, however, that trauma involves a degree of intensity that is too great for the ego to master and has far-reaching effects on psychic organization. For example, Kris (1956)

distinguished between “shock trauma,” the effect of a single powerful experience

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impinging on the child, and “strain trauma,” the accumulation of frustrating tensions. Kris, however, did not emphasize the quality of the relationship, but conceived these events as occurring within a drive—tension—discharge model (Kligman, 1983). Kohut and Seitz (1963) also regarded the quantitative factor as a distinguishing element of trauma, but they also suggested that the qualitative factor was significant:

The differences between experience of traumatic and optimal frustration are differences in degree. It is the difference between one mother's harsh “N-o!” and another mother's kindly “No.” It is the difference between a frightening kind of prohibition on the one hand, and an educational experience, on the other. It is the difference between one father's handling a child's temper tantrum by an equally hostile counter-tantrum and another father's picking up the child and calming him—firm but non-aggressive, and loving but not seductive. It is the difference between an uncompromising prohibition, which stresses only what the child must not have or cannot do, and the offering of acceptable substitutes for the forbidden object or activity. (pp. 369-370)

According to Balint (1969), there are three conditions or phases associated with the occurrence of trauma. In the first stage of the traumatic process, the relationship between the child and the potentially traumatogenic object must be characterized by a certain intensity and be a mainly trusting and loving one. Trauma occurs, in this situation, when the adult does something highly exciting, frightening, or painful, either once and quite suddenly, or repeatedly. This action may involve an excess of tenderness or cruelty, whether or not sexuality is involved, and may result in severe overstimulation of the child or, if the child's approaches are ignored, in rejection and deep disappointment. The first two phases outlined by Balint are necessary but not sufficient to produce trauma. In order for trauma to occur the adult must act with indifference toward the child's experience, whether excitement or rejection. Balint's thesis goes beyond merely quantitative considerations pertaining to the degree or intensity of traumatic experience (i.e., the field of one-person psychology) to the study of the quality of object-relationship (i.e., the field of two-person or multiperson psychology). In this way, Balint extends the work of Ferenczi (1933) who suggested that the real shock to the psychic organization of the child who is interfered with sexually is the adult's betrayal of the child's trust. The trauma derives from the fact that the child's tender or playful love is mistaken for passion and either responded to or rejected and is not primarily due to the stimulation or frustration of the child's innate sexual drives.

Classical analysis, however, fails to make a meaningful distinction between the pathogenic and the pathogenic that is also traumatic—a distinction, I would suggest, that is of great clinical importance. This failure on the part of classical analysts and current object-relations theorists stems from their attempt to understand the effects of the environment in the context

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of a theoretical position that is essentially a one-person psychology, where excessive or pathological drives are regarded as the determinants of the psychopathology. From the self-psychological perspective, this is not an issue, as the theory presupposes that psychopathology results from a failure of environmental response to the needs of the child's developing self. Although Winnicott adopted this position quite early, he did not systematically explore its clinical significance. Self psychologists, on the other hand, have only recently adopted the insight of early object-relations theorists such as Balint regarding the specific quality of the relationship between a particular child and a particular parent as the context of pathogenesis, and that between a particular therapist and a particular patient as the context in which pathology is potentially resolvable. In both cases, the relationship is a product of the interaction of two vulnerabilities and two capacities, those of the parent and those of the child and, later, those of the analyst and those of his patient (Stolorow, Brandchaft, & Atwood, 1983).

It has never been our intention, as analysts, to either traumatize or frustrate our patients, however optimally, but to understand them. Consequently the notion of optimal frustration is not tenable as a working clinical concept; however, the idea of optimal gratification conceivably could be. For to be understood can be deeply gratifying and is, perhaps the most important function performed for us by our

selfobjects. It is possible that the gratification of being understood by one's selfobject is of central importance in the curative process. If internal structure could not be built and defect repaired through the experience of being understood, the analyst would be wasting much of his time doing good work instead of making calculated errors thought to lead to manageable disruptions between himself and the patient and, thus, to transmuting internalization through the associated optimal frustration and its understanding. This is obviously unsatisfactory, and brings to mind the so-called "corrective emotional experience" of Alexander (1956) in which the analyst adopted the role that he considered to be the opposite of that of the pathogenic nuclear object. This confusion can be resolved if we reflect that no one comes for understanding unless they feel they have not been understood. As analysts, we are constantly confronted with a complex spectrum of varying degrees and kinds of frustrated need for understanding, sometimes of a traumatic order. Our responses must satisfy (a better word, perhaps, than gratify) the frustrated need for understanding of a particular patient or they will not be helpful. We will, as therapists, make mistakes, if only as a result of the analytic inertia that is inherent in our technique and, thus, inadvertently trigger or intensify the patient's frustration. The patient, moreover, will inevitably reenact his frustration with us in an attempt to right the original wrong. In many, perhaps in the majority of instances, if we understand, as and when our patients need us to, frustration will not be a factor in the therapeutic process. We are not analytic machines, however, and upon the not infrequent occasions

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when we fail, when we are in a state of empathic lapse, or when our responsive understanding is not accurate, we will encounter a patient who is frustrated with us. The term "optimal" means "a condition, degree or compromise that produces the best possible result" (Collins English Dictionary, 1979, p. 1032). Since our approach to psychoanalytic therapy is to do the best we can and we do not, indeed we cannot, set out optimally to frustrate our patients, I suggest that the idea of optimal frustration is really an after-the-fact metapsychological explanation of what happens when the analytic relationship breaks down, retrievably. From the patient's point of view, it breaks down when his selfobject needs are greater than the analyst's capacity to understand and respond at a particular moment.<sup>2</sup> Furthermore, the patient's apparent stubborn resistance, and "negative therapeutic reaction" may not represent an intention to defeat the analyst, but are caused, at that moment, by the breakdown of the analyst's empathy and the patient's incapacity for reciprocal empathic resonance (Bacal, 1979; Brandchaft, 1983; Wolf, 1981). When, however, the "intersubjective disjunction" cannot be resolved, even by an honest scrutiny of countertransference, and a "decentered" (Stolorow, Brandchaft, & Atwood, 1983) perspective on the part of the analyst, it may be useful to consider whether the patient's feeling that he is not optimally responded to, may be attributable to a traumatic injury or frustration that has caused a defect or deficit in the self, that is, whether he has been seriously hurt in a state of extreme vulnerability (Balint, 1968, 1969). I propose that an experience is traumatic to the psyche of the child if it has apparently caused a degree of defect or significant

enfeeblement of the self, in our patients, that is not responsive to ordinary interpretative work. This operational definition of traumatic experience can be crucially important as a guide in our treatment of those patients for whom the resumption of selfobject relatedness, after disruption, is especially difficult to achieve, and sometimes impossible to restore by ordinary analytic work—even in instances where both patient and analyst agree they are grappling with the relevant issues.

Freud, “in the social matrix of his time ... felt constrained to publicly overemphasize restraint and austerity in analytic practice in order to mute criticism engendered by having placed sexuality, and particularly infantile sexuality, at the center of his scientific investigations” (Wolf, 1976, p. 104). While this was an understandable concern in Freud's day, I would agree with Wolf's (1976) assertion that “contemporary psychoanalysts need rather less constraint and more freedom to engage the analysand in the analytic process” (p. 104), because of the increasing numbers of patients whose pathology is the result of serious disorders of the self. The real

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2 Stolorow, Brandchaft, and Atwood (1983) have discussed this issue in terms of dissonant intersubjective states between patient and analyst.

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“danger” inherent in the analytic situation is not the possibility that the analyst might respond sexually to his patient, as such behavior is governed by moral and ethical principles and cannot seriously be regarded as a valid part of the therapeutic process. The danger is rather that the analyst, by assiduously or rigidly avoiding any interaction with his patient except that of verbal exchange, may mistake a regressively repetitive transference for acting-in and repeat and perpetuate the childhood experience that caused the self defect or developmental arrest in the first place and, in this way, miss the patient's bid for a creative transference relatedness. Freud's counsel to frustrate the patient's wish for libidinal gratification has, unfortunately, often been taken as a directive to block all satisfaction within the analytic situation. As Wolf (1976) noted, “a misreading of this rule of abstinence creates a cold and critical ambience and will result in transference artifacts that are easily mistaken for derivatives of aggressive drives (p. 113).... Ideally the psychoanalytic situation ought to be constructed in such a way as to yield the optimally facilitating ambience for the ongoing psychoanalytic process” (p. 111).

#### Interpretation and Therapeutic Relationship

Balint (1969) argued that we have “two major therapeutic methods, one of which is interpretation and the other the creation of a therapeutic relationship between the patient and ourselves. Compared with the first, the techniques for the second method have been much less well studied and it is important that we should start investigating them” (p. 435).

The self-psychological understanding of the therapeutic process and its associated analytic technique more closely represents a synthesis of these two facets of

therapy, “interpretation and relationship,” than the traditional psychoanalytic model. There are, however, contradictions and inconsistencies still to be resolved. For some time, Kohut was undecided as to whether interpretation or relationship is the fundamental therapeutic component in psychoanalysis. In *The Restoration of the Self*, Kohut (1977, p. 31) held that interpretation and insight are not in themselves what cure the patient, but are the means by which the essential curative factor, the beneficial structural transformation of the self, is effected. For example, Kohut described his work with Mr. M as follows:

[The analyst's] attention is focused predominantly on the analysand's subjective transference experiences and, on the basis of his understanding of their form and content, [he] reconstructs the experiential world of the patient's childhood during the genetically decisive junctures.... In Mr. M's case, the essential psychological fact (the reactivation of the decisive genetic determinant ...) was that he experienced his mother, and in the transference the analyst, as traumatically unempathic vis-à-vis his emotional demands and as unresponsive

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to them. True enough, the analyst might occasionally wish to point out (in order to retain a realistic framework—if, for example, because of the intensity of the frustrations he experiences in the transferences, the patient might seriously consider quitting the analysis) that the patient's expectations and demands belong to his childhood and are unrealistic in the present. And he might at the appropriate moment also wish to explain to the patient that the intensity of his childhood needs may have led to a distortion of his perceptions of the past (in Mr. M's case, to a falsification of his perception of his adoptive mother's personality). The essential structural transformations produced by working through do not take place, however, in consequence of such supportive intellectual insights, but in consequence of the gradual internalizations that are brought about by the fact that the old experiences are repeatedly relived by the more mature psyche. (pp. 29-30). By reliving these early experiences with the analyst the patient transmutes (i.e., converts and assimilates) into his self structure the “anxiety-assuaging, delay-tolerating, and other realistic aspects of the analyst's image” (p. 32)—that is, the function of the analyst as a selfobject. Regardless of whether it is “optimal frustration” or “optimal gratification” that produces this curative process of transmuting internalization, Kohut emphasizes the curative effect of relationship. Although Kohut never explicitly addressed the issue of interpretation and relationship as complementary aspects of therapeutic work, the clinical process in psychoanalytic self psychology illuminates their interacting functions. Let us consider, for example, from the self-psychological perspective, a therapeutic situation in which frustration is not a significant factor in the relationship between the analyst and the patient. In what he judges to be a facilitative ambience (Wolf, 1976), the analyst communicates through interpretation his empathically determined understanding of the patient's inner world. The patient's response, although perhaps a negative one, nevertheless indicates that the intervention has been successful, that is, accurate and useful. If the analyst's intervention takes the form of a transference interpretation, it would also be considered mutative



(Strachey, 1934). While some would argue that all interpretation frustrates or irritates in that it causes a degree of narcissistic injury by revealing to the patient something he does not know about himself, at least consciously, I believe that the feeling of being deeply understood is more frequently a rich and gratifying one that relieves frustration and tension.

Since optimal frustration has not occurred here, but understanding and explanation instead, must we conclude that transmuting internalization and related structure building have not taken place and that the apparent therapeutic gain will be shown during the termination phase to be illusory? As I have already indicated, the patient brings to the analyst his frustration at not being understood so that any additional frustration caused by the analyst's lack of understanding cannot be regarded as optimal. In this situation, the

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interaction between the analyst and patient did not generate frustration; rather, the analyst recognized the frustration that the patient brought to him and the patient felt understood by this response. In Wolf's (1981) terms, harmonious or reciprocal empathic resonance took place between analyst and patient: "At the moment that I really understand what is going on in the analysand, I also know that he really understands what I am doing" (p. 7). The accuracy of the analyst's empathic insights is confirmed by the patient's expression of his own empathic grasp of the analyst's psychological activity at that moment. A process of transmutation of the analyst's functions into the patient has begun. The interaction has been optimal from both the analyst's and the patient's point of view and neither need question the appropriateness of the gratification he receives in this way.

As this suggests that frustration is not a necessary condition for transmuting internalization and real structure building to occur, what, if any, is the therapeutic element in the working through of "optimal" frustration? According to the clinical model emphasizing optimal frustration, the patient's reaction to the therapist's supposedly empathically derived communication (or silence) tells the analyst that he has not been attuned to his patient's psychological state. The patient's frustration is manifested in resistance<sup>3</sup> until, under favorable circumstances, the analyst is able to overcome his empathic lag (Bacal, 1979) and perhaps, in addition, achieve an increased awareness of some aspects of his countertransference. Finally, the process of mutative interpretation is completed by a careful analysis of the events that precipitated the disruption and, concomitantly, of the analogous childhood experiences.

In this situation, the analyst believes that his interpretation is empathically correct until the patient's response makes him reconsider its accuracy. Simultaneous with the correction and clarification of the transference disruption, the analyst is able to restore the previous harmonious selfobject relationship with the patient and, in the process, a transmuting internalization occurs.

If both the foregoing processes are therapeutic, what is the common curative element? It is, I believe, the patient's experience of the analyst's optimal responsiveness; and the quality of the therapeutic relationship at that moment confirms, for the analyst, that his response is usable by the patient. In the second

example, the resumption of the harmonious selfobject relationship is therapeutic, not because the understanding of disruption is therapeutic, but because understanding is therapeutic.

Although interpretation is the principal means through which the analyst conveys optimal responsiveness to his patients, it may not be a sufficient

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3 I understand resistance here as a variety of blockages of communication that are defenses not against drives, but against the anxiety of retraumatization (Wolf, 1981).

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or appropriate expression of responsiveness in every case. The continuing controversy among psychoanalysts as to what constitutes a valid addition or alternative to interpretation is due to our failure to evolve a framework for the systematic consideration of the psychoanalytic nature of the therapeutic relationship and how it relates to the interpretive process.<sup>4</sup> Acceptance of the importance of relationship for the analytic process has until recently been limited to the recognition of the part it plays in the so-called working or therapeutic alliance. Although Wolf's (1976) recognition of an analytic ambience that is therapeutic represents an important advance, most analysts consider the therapeutic aspects of relationship in treatment as a necessary evil, or at best, as a temporary parameter making possible the resumption of the "real" analysis. As analysts, we evade this issue because it raises the spectre of transference and countertransference acting-in. Those of us who have extended the scope of psychoanalytic treatment to include the more serious disorders of severely traumatized people, however, have found an in-depth understanding of the analytically legitimate therapeutic aspects of our relationship with our patients increasingly important.

Optimal Responsiveness and the Developmental Line of Empathy

In his final address to the fourth annual self psychology conference, Kohut (1981) stated that the most important insight contained in *How Does Analysis Cure?* is that "analysis [ultimately] cures by giving explanations, i.e., interpretations...." He maintained that the analyst must proceed from understanding to explanation, from showing that he is attuned to his patient's inner life, his feelings, thoughts, and fantasies, to the next step, interpretation. Kohut (1981) defined the advance from understanding to interpretation as a progression "from a lower form of empathy to a higher form of empathy," and described the analogous development within the individual with the following example:

a child and the mother are in the park. The child was a young child who clung to the mother. The sun was shining, pigeons were walking around there. All of a sudden, the child felt a new buoyancy and daring and it moved away from the mother toward the pigeons. He goes three or four steps and then he looks back. The general interpretation of that is that he is anxious, he wants to be sure he can come back, to be encased in her arms, cradled, et cetera. That is true, but something more important is true. He wants to see the mother's proud smile; he wants to see her pride [looking] at him walking out now, on his

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4 There are, in fact, two authors who more or less explicitly address this issue (Gill, 1982; Lichtenberg, 1982a, 1982b).

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own—isn't that wonderful—and at this moment, something extremely important had happened: a low form of empathy, a body-close form of empathy expressed in holding and touching ... is now expressed only in facial expression and perhaps later in words: I am proud of you, my boy.

Kohut (1981) believed that interpretation in psychoanalysis performs a parallel function for the patient as these events in the development of the child. In this process, the “bodily holding” or “merger” phase is superseded by a much higher form of empathy, verbal interpretation, which is a psychological message on a more evolved level of understanding. In the case of the severely damaged patient, this process may be a very prolonged one.

As we have already noted, Kohut was for some time undecided as to whether interpretation or relationship is the therapeutic component in psychoanalysis. Although he maintained at different times that it was not interpretation but the relationship that essentially cured, he still firmly believed in the healing capacity of insight. Kohut's (1981) recent view that progress in the therapeutic process from understanding to interpretation represents a parallel advance on the part of the patient from a lower to a higher level of what he called the developmental line of empathy, integrates the two major methods of psychoanalysis and confirms the intuitive conviction of many analysts that interpretation and relationship are both curative. This is not merely an academic or semantic issue, but has practical implications for the way we respond as psychoanalysts and as psychoanalytic psychotherapists to our patients. Kohut (1981) felt that future research in self psychology should concentrate upon the continuum of empathic stages, “the developmental line of empathy,<sup>5</sup> from its early archaic beginnings to such high levels as barely touching, as barely still having any trace of the original holding that communicates the empathic understanding.”

This issue, I believe, can be addressed most effectively in terms of the concept of optimal responsiveness. The analytic attitude that is here termed “optimal responsiveness” is described by Wolf (1976) as follows:

The decision about a proper response to a patient's demand, be it experienced ever so subtly or directly, must depend upon a proper dynamic understanding of the current analytic situation, its transference implications, and the genetic background. It is thus no different from any other analytic understanding or intervention.

Whether to comply enthusiastically or reluctantly, whether to refuse firmly or hesitatingly, or not to respond at all, these decisions belong to the armamentarium of alternative action to be used in accordance with one's total understanding of the analytic process. (p. 107)

Earlier, Winnicott (1967) expressed a similar concern when he stated that the analyst's true function is not to provide the correct interpretation,

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5 After preparing this chapter, I had the opportunity to read an interesting clinical paper by Charles Coverdale (1983), which deals specifically with this topic.

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but to be available to respond with understanding that is appropriate and useful to his patient. In self-psychological terms, the analyst's response must be commensurate with the patient's level of self—selfobject organization or the degree of intactness, defect or deficit within the self.

In the majority of cases this response is communicated largely through verbal interpretation. Changes in the patient population, however, require corresponding changes in the analyst's vocabulary of response. Kohut (1981) recognized the need on the part of analysts for greater freedom to respond to their understanding of their patients in a passage that, because of its controversial nature, has had insufficient attention from self psychologists who are understandably reluctant to adopt a position that might expose them, however unjustifiably, to accusations of engaging in the “corrective emotional experience” advocated by Alexander (1956): the more one knows, the less one needs to stick to some ritual anxiously, because one knows [my italics] what is appropriate and inappropriate. The question [relates] to treating patients with very severe self disorders who cannot possibly benefit from interpretations for [a very long time, perhaps even] many years. They do need an empathic understanding on the closest level we can muster. It does not mean we cannot naturally move slowly and gradually into higher forms of empathy<sup>6</sup> [the form of optimal responsiveness that we call explaining or interpreting to the patient] much later on.

Kohut (1981) supports this controversial view with a clinical example drawn from the lengthy analysis of an extremely vulnerable woman patient:

She lay down on the couch the first time she came, having interrupted a previous analysis abruptly and she said she felt like she was lying in a coffin and that now the top of the coffin would be closed with a sharp click ... she was deeply depressed and at times I thought I would lose her, and that she would finally find a way out of the suffering and kill herself.... [A]t one time at the very worst moment of her analysis during ... perhaps a year and a half, she was so badly off I suddenly had the feeling—you know, how would you feel if I

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6 I am indebted to Dr. Bonnie Wolfe, who responded to my initial presentation of this material with the following comments: “It seems to me that the important issue is whether and how the analyst's empathy can be conveyed to the patient in a way that the patient can experience as being responsive to him [my italics]. Sometimes, the patient can discern the analyst's responsiveness only through gestures, tone of voice, or facial expression ... [and] ... attempts at verbal communication are experienced as unempathic and non-responsive to the patient's state ... I am [here] also reminded of Dr. Basch's nice example of the parent lifting the baby and saying, “U-u-up we go.” At a more developed state or stage, the patient may be able to utilize (and tolerate) responses that are more predominantly verbal; although this verbal

responsiveness may need to be at a primitive level (“you feel that,” “it hurts”). At a more advanced level, you may find responsivity in the reciprocal communication [of Wolf’s (1981) notion of reciprocal empathic resonance] of abstract ideas about psychological functioning” (Wolfe, 1983).

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let you hold my fingers for awhile now while you are talking, maybe that would help. A doubtful maneuver. I am not recommending it but I was desperate. I was deeply worried. So I ... moved up a little bit in my chair and gave her two fingers. And now I'll tell you what is so nice about that story. Because an analyst always remains an analyst. I gave her my two fingers, she took hold of them and I immediately made a genetic interpretation—to myself. It was the toothless gums of a very young child clamping down on an empty nipple. That is the way it felt. I didn't say anything ... but I reacted to it even there as an analyst to myself. It was never necessary anymore. I wouldn't say that it turned the tide, but it overcame a very, very difficult impasse at a given dangerous moment and, gaining time that way, we went on for many years with a reasonably substantial success.

Kohut is not alone in responding to his patient in this way. Although few analysts have admitted to similar experiences,<sup>7</sup> Winnicott (1947) recognized the appropriateness in certain situations of this kind of intervention:

There is a vast difference between those patients who have had satisfactory early experiences which can be discovered in the transference, and those whose very early experiences have been so deficient or distorted that the analyst has to be the first in the patient's life to supply certain environmental essentials. In the treatment of a patient of the latter kind all sorts of things in analytic technique become vitally important, things that can be taken for granted in the treatment of patients of the former type. (p. 198)

The important clinical issue raised by Winnicott concerns what response on the part of the analyst can be considered optimal in relation to the patient's level of organization of his self—selfobject relationships. This level, as one would expect, corresponds to the position the patient has achieved on the developmental line of empathy.<sup>8</sup>

The empty nipple for Kohut's patient was the antithesis of a selfobject that would satisfy her selfobject need (not only drive need) to suck. Other selfobject needs may require a responsiveness for which verbal interpretation will not do and we need to study the significance of these optimal responses for the patient, for example, the warmth provided by the analyst's blanket, or the thirst or faintness that elicits a drink,<sup>9</sup> as well as other needs that may be related to the “psychological survival of the self.”

In my opinion, there is no such thing as a “parameter,” an extraanalytic, or unanalytic, measure we adopt for a time in order ultimately to return to doing proper analysis in the traditional way. We must respond in ways that enable us to communicate understanding to the particular patient with whom we are working. That is analysis.

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7 Freud apparently did the same for Marie Bonaparte (Bertin, 1982).

8 Compare Wolf's (1980) notion of the "developmental line of selfobject relations."

9 Eva Rosenfeld (1966) reported that Melanie Klein gave her a glass of sherry under similar circumstances during an analytic session.

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### Optimal Responsiveness and the Repetitive and Creative Aspects of Transference

The concept of transference can be usefully reexamined in light of the idea of optimal responsiveness. As no one simply repeats pathological patterns and distortions, selfobject transferences are better understood as creative aspects of transference, since their aim is to forge a link with a selfobject that will be a better version of the old one. This is true of virtually every patient, but particularly significant with respect to severely traumatized individuals in whom the development of the self has been seriously impeded. These patients sometimes create what I have called a fantasy selfobject (Bacal, 1981) around a nuclear figure whose archaic idealization or mirroring function has virtually no counterpart in the patient's antecedent experiences.

The creative aspect of transference has to do with the area of illusion, the area of play, and what Winnicott (1951) called "the transitional object" and "transitional phenomena." The experience of this kind of illusion is necessary in order for disillusion to not become disillusionment and traumatic frustration in analysis. Then and only then will the inevitable disillusion with a new version of the old selfobject, now recognizable as "good-enough" in Winnicott's terms, become associated with the ability to tolerate the fact that one's fantasy may or may not always elicit the response for which one hoped. This, in my opinion, is the only frustration that can be considered "optimal," nontraumatic frustration that alternates and is interwoven with the building of developmentally essential illusion associated with experience of a new responsive selfobject. In this way, confidence in the possibility of a "good-enough" selfobject can begin to develop. In this way, an optimal experience with the analyst can occur in which self defect or faulty self structure is repaired and new self structure can be built. Both analyst and patient should feel that progress is resulting from this process. The patient should feel stronger and be able to deal more effectively with the stresses specific to his particular vulnerability. Similarly, disruptions of such an inordinately painful degree that the patient recurrently feels that he cannot go on with the analysis, should not occur.

These ideas assume that there is a basic tendency toward growth and development in every individual that requires the optimal responsiveness of the selfobject in order to be realized. This is, I believe, the implicit assumption that underlies all psychotherapeutic efforts, whether psychoanalytic or not. The concept of "optimal frustration" mainly serves to give analysis respectability. It "proves" we don't think of ourselves as gratifying our patients when we treat them. Related to this image of the hard path that the patient must travel toward cure is that of fixation points of the libido and the idea that patients will adhere to these positions to which they have

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regressed unless confronted with reality or with the deleterious effects of their continuing to function in their archaic ways with objects. According to this perspective, unless patients are optimally frustrated and exhorted to progress they will simply be gratified by the understanding, demand more and more, and remain where they are. An even less fortunate outcome of "gratification" is said to be the so-called "malignant regression" (Balint, 1968) in which the analyst's accession to the patient's demands is thought to produce a spiral of negative, resistive, clinging, and increasingly demanding attitudes. In a previous paper (Bacal, 1981), I attempted to distinguish therapeutic regression from malignant regression on the basis of their genesis: therapeutic regression occurs as a result of accurate empathic responsiveness; while malignant regression occurs as a result of catastrophic selfobject failure in patients with particularly vulnerable selves. The latter tend to be those whose selfobjects have been predominantly fantasy selfobjects and who, as children, have been pervasively related to by their significant nuclear figures as selfobjects.

An optimal synthesis between the experience of the creative selfobject transference, and the working through of the repetitive transference is necessary. Before he can usefully allow himself to experience the old unempathic selfobject in the new selfobject constituted by the analyst, the patient's self must become stronger as a result of a good deal of positive interaction with this new version of the old selfobject. Sometimes, even where the good selfobject is not of the order of a fantasy selfobject, the analyst may have to be experienced by the patient as a good selfobject separately from the old selfobject and it is countertherapeutic to interpret this self-reparative move as "pathological splitting." Rather, it must be accepted as creative transference relatedness.<sup>10</sup> perhaps for some time. However, the split-off good selfobject in these cases is often the good fantasy selfobject; and, in this situation, when the experience of the split-off bad selfobject occurs in the transference, the patient may fragment dangerously. At these moments, the analyst virtually becomes for the patient the original traumatically unempathic or unavailable archaic selfobject (Bacal, 1981); and situations of this sort may be just barely retrievable. I believe that Kohut (1977) may have had something like this in mind when he suggested that defensive structures may sometimes usefully be left intact and that analytic working through in these cases will be carried out predominantly in the area of compensatory structures. The criticism that this would be merely supportive psychotherapy is undermined by the recognition that working through in the area of compensatory structures is related to the creative aspect of transference.

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<sup>10</sup> Contrast this to the Kleinian notion of splitting as a way of protecting the good primordial part-object from one's inclination to attack and destroy it.

### Resistance and Countertransference

A reexamination of resistance and countertransference will throw further light on the relevance of the clinical usefulness of the concept of optimal responsiveness. Resistance in classical analysis refers to the patient's inability or reluctance to

participate in the analytic process cooperatively, that is, to free associate. The patient's silence, controlling, acting-in, or acting-out is attributed to his fear of the consequences of expressing his instinctual drives in relation to the analyst. From the perspective of self psychology, resistance to the analytic process is seen as reflecting a fear of retraumatization through repetition in the analytic relationship of traumatic childhood experiences. This fear is sometimes justified by the analyst's countertransference, of which the patient is usually aware, and which the analyst should not only analyze in himself but judiciously acknowledge to the patient. In some instances, in order for the inevitable frustrations of the patient by the analyst to be nontraumatic and even potentially useful by enhancing the patient's trust in the analyst and contributing to the working through process, the analyst will not only acknowledge this countertransference, but respond to the distress it occasioned with an explanation that his patient can manage and assimilate. Of course, the analyst must not burden the patient with his own problems. The analyst works within the inevitable limits of his understanding and his countertransference. His personality will determine, to some extent, his capacity to provide an optimal therapeutic experience for his patient. An analyst who is committed to providing an ambience of replenishing deficits will not provide a patient who needs to engage in recurrent disruptions with his analyst (in order to repeat his pathological nuclear situations for the purpose of healing his self defects) with the analysis he requires. On the other hand, an analyst who is committed to the working through of optimal frustration (that is, transference disruptions) will provide the patient who needs developmental experience with a new selfobject and an understanding of this experience with an analysis that may be worse than useless. Often, of course, both are necessary for analytic progress. It is important for us to consider what I would regard as the clinical counterpart of Winnicott's (1952) assertion that "there is no such thing as a baby, ... [there is rather] a nursing couple" (p. 99), the idea that "there is no such thing as a patient, there is only an analytic couple." A good match between the analyst and the patient does not have to be present at the outset. It may evolve as a result of the analyst's willingness to scrutinize the intersubjective context in which his interactions with his patient occur (Stolorow, Brandchaft, & Atwood, 1983), and from his capacity to respond in a relevant way.

The following clinical example may help to illustrate and integrate the central concepts and issues we have been discussing.

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In her first analytic session, Dr. M, a psychologist in her late 20s, reported a dream that she had not long after her initial interview with her analyst, which took place a few weeks prior to the beginning of the analysis. She prefaced her account of the dream by what was, in effect, an association to it: she said how much she appreciated the generous gesture of the analyst friend who called the prospective analyst to prepare the way for her referral. In the dream the friend appeared as a taxi driver and drove her to a bridge where he said that he had forgotten the analyst's phone number and address. As she searched in her purse for the directions, the contents, her money, and things she had on her mind, fell out. Her



son called "Mommy" to her and, as at home, everything was once again pulling at her.

Although the analyst recognized even then that the dream would have significance for the whole analysis its meaning was only partially apparent at that time. The interpretation reached, although tentative and incomplete, was that, despite her hope that her relationship with the analyst (whom she associated with her analyst friend) would enable her to enter a world in which she might receive the generosity of which she felt deprived by her parents, she feared she would again be caught up in a relationship in which she would be traumatized by being exposed to and emptied by another's limitless needs and demands.

A few months after the analysis started, she began to convey to her analyst her increasing anxiety about her financial situation. Although she earned a very good salary compared to a number of her colleagues, she was having serious trouble maintaining her standard of living largely because of the meanness and vindictiveness of her estranged husband with regard to child support for her three children.

Proud of her ability to manage independently, it was with great difficulty, embarrassment and hesitation that she asked the analyst for a small decrease in her fee. He agreed, and there soon followed a second request for a substantial decrease, a request that was associated with continuing anxiety about her ability to cope financially. The analyst was initially reluctant to comply with this second request and the situation was discussed over a number of weeks. Dr. M reacted to her analyst's reluctance with a complex mixture of desperate insistence, anger, increasing tension and anxiety, as well as with a continuing sense of shame at having to make the request. Attempts to analyze the issue led only to a heightening of the tension and the analysis showed signs of breaking down. Finally, the analyst acquiesced, and told his patient that he was acceding to her implied request to pay nothing more than the amount that the national health insurance would reimburse her, until such time as she felt she could pay. He also explained that, while he knew that she was aware only of the economic determinants of her need and he was not denying the importance of these factors, he felt the psychological one to be paramount, although at the moment he was not completely cognizant of its significance.

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After this, the impasse disappeared, and analytic work resumed. The unfolding of the significant issues and events of her childhood revealed that when she was 3 years old, her father, with whom she apparently had a close, idealized relationship, left the family and moved to a distant city. Her parents were divorced and she was left with her mother, whom she experienced as deceiving and exploiting her throughout her childhood and young adulthood by repeatedly failing to fulfill implicit and explicit promises to meet her emotional and financial needs. Following the departure of her father, she saw him on only two occasions until her late teens, as he did not visit and would not send her a ticket to come to him. Their total contact was restricted to letters, which they exchanged about every 2 months. She maintained her idealization of him, however, and throughout her childhood, never

stopped longing for him to come to her. He remained extremely important to her as a sustaining figure. Except for his answers to her letters, she alone sustained this sense of relatedness to him through her capacity to create for herself, where only the barest basis for such a creation ever existed, what I have called a fantasy selfobject (Bacal, 1981).

Within a few weeks of the analyst's accession to the patient's request, the analysis of its meaning also began. This analysis had not been previously possible while the analyst was committed to a method (which might be described as optimal frustration) of not complying but trying just to understand and interpret. It is not possible to fully elaborate here the analysis of this incident of the fees, which extended over months and continued from time to time over years—as, indeed, one may have guessed from the account of the initial preanalytic dream. The most significant meanings, which were focused in the transference, were her need to create a new selfobject relationship with her analyst as both the mother and the father who would respond with demonstrable generosity; her need to have tangible proof of being protected from becoming entangled in a trusting relationship with someone who would only take from her and drain her of all her resources; her need for the analyst to respond by demonstrating to her beyond a doubt that he would share her burden and that she could in this sense exercise some control over him (money had always been a symbol of control in her family). Deeper than her need to know that she would not have to bear all of the burden herself lay the need of the child within her not to have to feel she had anyone to care for, specifically, the analyst-mother-child. As the analysis proceeded, a lifelong, sometimes suicidal, depression lifted. Her shaky self-esteem and self-assertiveness strengthened impressively, her career moved forward, and she was able to show her talented and very creative work to others, including the analyst, for the first time in her life. Ultimately, the analysis of the patient's request and of the analyst's eventual responsiveness to that request revealed what were perhaps their deepest meanings. The analyst, by responding to her request, provided her with the first incontestable experience in her life of someone considering

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her interests before their own. More than anything else, it meant that someone believed in her, that she was worthwhile investing in.

In this connection, let us consider Wolf's (1981) recommendations for treatment. Ideally, the analyst by virtue of his empathy and his theoretical orientation, can recognize the legitimate selfobject needs underlying the archaic and distorted manifestations, manifestations that he experiences often with some discomfort also. This then leads to the next substep in achieving empathic resonance. The analyst explains and interprets the sequence of events to the patient. He corrects his own previous misunderstanding of the patient. Again, it is important to point out, that the disruption, like the preceding harmonious selfobject transference, are not new experiences with a new object for the patient. What is new is that the analyst does not respond in a manner of an ordinary social situation but responds by explaining and interpreting on the basis of an empathically informed understanding. Nor is such an explanation a gratification of a need—neither of a selfobject need, nor of an

instinctual wish or need—except for the need to be understood. By again feeling understood, the empathic flow between analyst and analysand is restored. (p. 6) I am in essential agreement with Wolf except, perhaps, on two counts. The first is that, while the disruption was not a new experience for this patient, the means of its restoration in the regressed selfobject transference was essentially new. Dr. M needed to effect a shift or change in her analyst in order to create a selfobject response that was significantly different from anything that she had previously experienced. Secondly, while there was what could be called a gratification of a selfobject need, I would suggest that it was the responsiveness that was optimal for the patient at the level of organization of her self—selfobject relationships, in other words, at the level of development of her inner experience of empathic responsiveness in relation to nuclear selfobjects.

Implicit in this understanding of analytic work is the recognition of the therapeutic significance of what I have called the creative aspect of transference and its associated archaic selfobject, which can, I believe, legitimately be regarded as a “fantasy selfobject” or as a “transitional selfobject.”<sup>11</sup> The transitional selfobject can be viewed as a prestage of the transitional object, in effect, a selfobject created by the patient, partly out of himself (in fantasy) and partly out of a sense of pliable surroundings. It constitutes a necessary intrapsychic stage as a precondition for the apprehending of the concrete transitional object, such as a blanket or a teddy bear. (In a sense, it represents, “I know that I can create that inside me.”) The fantasy selfobject is created by the patient when the environment provides almost nothing around which he can elaborate a need for the responsiveness

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<sup>11</sup> Winnicott described the transitional object as the “first not-me possession” (Winnicott, 1951), that is, something that is experienced as part of the world and yet as belonging to me, something about which it is not to be asked, who created it, me or mother?

he requires. Dr. M's demand for a response to a fantasy selfobject need was responded to optimally, which meant, at this level, that it was “gratified.” Far from producing a malignant regression, this enabled the analysis to resume and to deepen.

Although the analyst did not subsequently raise the question of the fees, Dr. M herself brought it up from time to time. She wanted to pay a fee but continued to struggle with her anxiety about paying anything. At the same time, it was evident that she was testing the analyst to see whether he would require her to do so. One day, three years after the analysis began, she reported a “new fantasy” that she felt completed the dream that she had shortly before entering analysis. The fantasy concerned the part of the dream where all her money fell out of her purse and her analyst friend picked it up and returned it to her. She reflected at this moment that she had never paid the cab fare. Apparently, no one paid for the cab ride, which she thought symbolized her need for it not to cost her any more than it had already. She felt that no one took care of her, and remarked, “you can't fall apart when there is no

one to take care of you.” At that moment, the analyst learned that her disintegration anxiety, with which she was struggling when she needed him to reduce the fees, could not have occurred unless she felt there was a potential selfobject who might respond. She was afraid at that time that she would cease to exist personally, professionally, or in some other sense. She reminded the analyst of the enormous difficulty that she experienced in asking to see him during the recent summer break as she was convinced that he would tell her that he had given her enough, that she was selfish, and that she shouldn't ask for such a thing. On another occasion she referred once again to the part of the dream where all her money spilled out of her purse and her subsequent anxiety about the fee arrangement. The original fantasy underlying the dream seemed to be that if she paid her analyst, he would get all her money and she would starve, and if she didn't pay him, she would survive and he would have nothing. The new fantasy was that she could pay him something at some point and the amount would vary according to what she could afford. She experienced this fantasy as hopeful and accepted the analyst's interpretation that it expressed her feeling that the amount that he would have and that she would have could be regulated. Less than 3 months later, she offered, without anxiety and with a quiet pride, to pay a fee commensurate with her economic situation at that moment. Kohut has indicated that some patients require a gesture of what he called “preliminary enactment” without which no further analysis can take place. While I would essentially agree that certain patients may need this in a preliminary phase (in this sense, the notion of a “transitional selfobject relatedness” is useful), I suggest that it should not be thought of as a stage to be overcome so that the real analytic work can begin. Rather, it should

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be regarded as central to analytic work with these patients at the level of the development of their experience of empathy.

Sometimes, for some patients, this need arises as a result of progress, as, to some extent, in the case of Dr. M. She told the analyst that the experience of having both her requests granted, particularly having her wish for an extra session during the holiday break gratified, enabled her to think about his limitations. The knowledge that she was in an atmosphere in which she could make requests combined with the fact that she had grown stronger, enabled her to consider not only what she might ask for but also what she might or might not receive. She felt it was important for her to deal with the analyst's limitations and believed that his tolerance helped her to do so. She estimated his tolerance as falling somewhere between saying yes to one extra session, and refusing altogether. Her initial fantasy was to ask for all of them since the analyst was in town for the holiday, but she decided that he would probably refuse this.

I do not believe that the analyst's accession to his patient's request should be regarded as an “enactment” or a parameter. Although many would claim that it is indeed the latter, this seems to me an unnecessary apology on the part of analysts who struggle within the limits of their countertransference and their hard-won theories toward an intelligible flexibility in analytic work. Rather, I would suggest that we reexamine the so-called “parameter” as a necessary aspect of the analyst's

optimal responsiveness for his patient.<sup>12</sup> In order to answer the question of what is optimal responsiveness for a particular patient at a particular time, I believe that we need to consider carefully the creative aspect of the selfobject transference. We need to remind ourselves that the selfobject transference is not predominantly a repetition, but rather is mainly an attempt at the creation of a new kind of relatedness with the frustrating nuclear object. Fantasy selfobjects, fantasy selfobject relatedness, and the specific examples of this that I think deserve to be called transitional selfobjects and transitional selfobject relatedness, are instances of the transformation of traumatic (often

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<sup>12</sup> I am grateful to Dr. Michael Basch (1983) for a number of helpful comments on reading the draft of this chapter. He suggests that a differentiation should be made between “transference of need” and the “transference of solution.” “When there is a transference of need, a deficit, then the transitional selfobject relationship is called for; when, however, the patient demonstrates that he is bringing now inappropriate attempts of problem solving into the analysis, then these, I think, must be interpreted genetically, contrasting the analytic to the past situation, rather than taking it for axiomatic that the analyst has made a mistake in his relation to the patient. To use your terms, optimal responsiveness on the part of the analyst is not limited to one or another position. Optimal responsiveness can involve the analyst's functioning as a transitional selfobject at one time, as an interpreter of the patient's past reality at another, and as an interpreter of the analytic or external situation at still another time. This, I think, is in complete agreement with your statement ... to the effect that there is no such thing as a ‘parameter.’”

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quite early) selfobject failures into creative aspects of selfobject transference by seriously injured patients. While the analyst need not intentionally enact a part different than the significant parent (“corrective emotional significance”), he does have to consider what response will be optimal in relation to the current level of his patient's specific developmental capacity to utilize empathic understanding of his selfobject needs for human relatedness. This will be therapeutic. If, however, the analyst does not wish to or feels he cannot respond to the archaic selfobject demand, no shame should attach to his refusal. Indeed, he may feel that to refuse will constitute an optimal response for that patient's growth. I would suggest, however, that there is less danger in responding to a regressed patient's suggestion as to how he needs to be treated than in refusing on the basis of the unproven thesis that the patient will develop if he is frustrated to the optimal degree.

While frustration is an inevitable part of life, I question whether the analyst can usefully regard it as “optimal” when he is working with his patients. This applies to gratification as well. Neither, per se, are appropriate considerations as part of a therapeutic process. They are legacies of a psychoanalytic morality, an intrusion into the clinical situation of a psychoanalytic ethic that regards the patient's “real” unconscious and conscious intent to be the discharge and satisfaction of instinctual

drives. Responsiveness, rarely perfect, almost always flawed in some way, can be optimal and comprises the legitimate efforts of our analytic work. What does the analyst do with those patients for whom his kind of responsiveness does not work? As I have suggested, it is important to recognize that some forms of responsiveness that are crucially therapeutic may entail responses that an analyst cannot or will not, for ideological reasons, provide. For example, the necessary response to patient X may be withheld by analyst Y either because he simply does not respond to “acting-in” or because the patient's need gives him countertransference difficulties. From this perspective, what is designated as optimal frustration may sometimes be a rationalization of countertransference inflexibility on the part of the analyst. While the therapist must be himself, he also needs to be flexible to a degree or he will be correspondingly limited in treating certain patients. Kohut understood his concept of an average expectable environment as the “normal human responsiveness” promoting the patient's analysis and growth.<sup>13</sup> I would like to stress that this will be different for each person.

#### Conclusion and Summary

My thesis is that if our analytic responsiveness is optimal (and I would define optimal as relative and specific to the particular patient, not simply

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<sup>13</sup> Kohut conveyed this notion in a conversation with me in 1978.

a matter of degree as Kohut and Seitz viewed it) then our efforts will be growth producing. Selfobject relationships will mature and the self will become stronger and more free, flexible, and more resilient. An “optimal” frustration can only be optimal when it is optimal for something to be frustrated. It would be interesting to know what this might be. The view that optimal frustration alone produces internal structures is a hypothesis that needs to be challenged. As I believe I have shown, we cannot assume that all internalizing processes occur through frustration. In a good-enough situation, for example, identification and assimilation occur. Similarly the prior internalization of the parent/analyst as a responsive selfobject allows the child/patient to tolerate the former's inevitable unempathic responsiveness when it occurs, and to accept with less disturbance the limitations of the selfobject. This is particularly true in the case of patients whose relations with selfobjects in childhood have been traumatic.

It may well be that transmuting internalizations that occur without engaging transference frustrations are those where deficit (versus defect) is predominantly present, both self deficit and defect being ordinarily encountered together. This would be interesting to research in the psychoanalytic situation.

It is my belief that the notions of optimal frustration and optimal gratification can usefully be replaced by the concept of optimal responsiveness. Optimal responsiveness is an analytic concept that is distinct from the concept of the “parameter” and the “corrective emotional experience,” which are devices that are essentially nonanalytic, but deliberately planned and actively initiated by the

therapist. The optimal responsiveness of the analyst is determined by the position of the patient on the developmental line of his self—selfobject relations, and on his position on the developmental line of internalization of, and capacity for, empathy. It is not simply part of the ambience (Wolf, 1976) or the “frame” (Pines, 1981). Nor is it just an expression of the therapeutic or working alliance. Rather, it is the analyst's job. Interpretation and relationship are only the component aspects of optimal responsiveness in psychoanalytic treatment.

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