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The Nature and Function of the Analyst's Communication to the Patient [1]

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Susanne Langer in her study of symbolism, Philosophy in a New Key, observes that 'the great contribution of Freud to the philosophy of mind has been the realization that human behaviour is not only a food-getting strategy, but is also a language; that every move is at the same time a gesture'. By this I understand her to mean two things. First, that psycho-analysis has shown that human behaviour is actuated not only by the need to satisfy instinctual impulses by using appropriate objects but also by a need to maintain a meaningful contact with these objects; and secondly, that human activity is intrinsically symbolic, and comprises an attempt to communicate something. An essential part of her thesis is that the various 'impractical', apparently unbiological activities of man, such as religion, magic, art, dreaming, and symptom-formation—i.e. just those aspects of human life which have become the peculiar domain of psycho-analytical research—arise from a basic human need to symbolize and communicate, and are really languages.

Although I think that Langer is right in this view of psycho-analysis, and would indeed be inclined to add that Freud initiated a revolution in our capacity to communicate by making us aware of previously unrecognized attempts at communication, it is, I believe, also true that theoretical formulations of psycho- analysis have a tendency not to do full justice to the communicative aspects of human behaviour. The reason for this lies in the nature and history of metapsychology. Metapsychology is based on the assumption of a psychic apparatus which is conceived of as a model analogous to a single, isolated central nervous system. Within this apparatus certain structures are assumed to exist, to have certain relations one with another, and to be invested with libido and aggression derived from instinctual sources. Some of these structures, such as the ego and object-representations, are conceived of as being related to objects in the external world and to be the result of the impingement of external reality on a primitive undifferentiated apparatus, but, strictly speaking, metapsychology is concerned with these psychical representations and precipitates of the external world, not with the external world itself or with the interaction between the subject and his external objects. For instance, the term 'object-cathexis' refers to the libidinal investment of an object-imago, not to any transmission of libido to the object itself. For this reason the knowledge and theories that we have about the inter-relationships between individuals, and, in particular, about the relationship between patient and analyst, have never been satisfactorily incorporated into metapsychological theory. Rapaport pointed out in 1953 that a metapsychological theory of technique and therapy does not exist, and suggested that an essential prerequisite of such a theory would be clarification of the metapsychological status of affects. Now although Schilder, Brierley, and others have pointed out that affects play an essential part in communication between individuals and in the interplay between internal and external reality, and although the clinical importance of affects in the analytical situation is clearly recognized, none of the various analytical theories of affects reviewed by Rapaport attaches central importance to what is to my mind the most obvious and important fact about an affect—the fact that it is perceptible by others and has an intrinsic tendency to evoke either an identical or complementary affective response in the perceiving object. It seems to me unlikely that a satisfactory metapsychology of technique will be formulated until this fact is taken into account, that is, until we can formulate ideas about the relationships between

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individuals with the same precision as we can ideas about relations to objects. Until such time our theoretical formulations are bound to give preference to the structural and economic aspects of psychical life at the expense of the communicative.

It will, I hope, be clear that I am not questioning the validity or legitimacy of classical metapsychology or suggesting that it should be replaced by a metapsychology of interpersonal relations. Not only would to do so be a denial of the value of the psychopathology we use daily in our interpretative work with patients; it would also be methodologically incorrect. Even though man is a social animal whose psychical life is primarily concerned with his relations with his objects, each individual is also a separate psychobiological entity with a continuous and independent existence and awareness of self. As a result a conceptual framework within which to formulate hypotheses about the intrapsychic processes and genetic development of single individuals is a scientific necessity. However, there is, I believe, also a need for a related frame of reference arising from the study of the interrelationships between individuals and the means of communication between them. Such a metapsychology of interpersonal relations would prove particularly valuable in clarifying our theories of symbolism, affects, and technique.

At the risk of appearing to digress from the main theme of this paper, I should like to give an example which will, I hope, help to clarify the point I am trying to make. When a baby cries, the cry can be viewed psychologically in two different ways. We can consider it as an event occurring in a field which includes not only the baby but also its mother, or as an experience in the baby's individual psychology. In the former case, the cry is objectively a communication, since it acts as a sign-stimulus to the mother who has an instinctive tendency to respond to it. In the latter case, the cry is certainly a discharge-phenomenon, but we can only view it as subjectively a communication, if and when we are entitled to assume that the mother is psychically represented in the infant's mind. In other words, from the point of view of a psychology of interpersonal relations the infant's affects have a communicative function from the beginning, while from the point of view of individual psychology they do so only after the infant's objects have become psychically represented in the infant's mind.

In The Ego and the Id (1923), Freud himself provided the linking idea between the psychology of the individual and the psychology of inter-personal relations. This is the idea that the development of the ego is intimately related to the establishment of object-relations, that the 'ego is that part of the id which has been modified by the direct influence of the external world'. That this external world primarily comprises objects with which the individual has had communication is suggested by his further statement that the essential difference between an unconscious idea and a preconscious idea is that the latter has been 'brought into connexion with verbal images'. Now since words are all learned from objects and their primary function is to communicate with objects, this statement implies that the essential quality of preconscious, and therefore conscious, ideas is that they are communicable and that the ego is that part of the id which is concerned with communication with objects. The importance of communication arises from the fact that the capacity for interpersonal relations is not simply a matter of being able to use objects to satisfy libidinal impulses—a food-getting strategy in Susanne Langer's phrase—but is the ability to maintain a reciprocal relation between self and object before, during, and after the consummatory acts appropriate to the particular relationship. It also involves the ability to maintain a living internal psychical relationship with the object during its physical absence. In other words it is the ability to keep in contact and communication with objects that are realistically conceived and are recognized as separate from the self.

Now the purpose of psycho-analytical treatment is to establish, restore, or increase the patient's capacity for object-relationships and to correct various distortions thereof. The analyst's various technical procedures are designed to establish a (special form of) relationship between himself and the patient. The first thing he does is to provide a setting within which this relationship can develop. This comprises, among other things, a quiet room with a couch and a chair behind it, a closed door, regular and frequent appointments—and himself. This setting is itself a communication to the patient, since its details are all signs that the analyst intends taking up a certain attitude towards the patient, that he intends to listen to him, to concern himself with him without requiring the patient to be concerned with him,

and to protect the contact between them from external interruption or distraction. In other words, he tells the patient that he intends to provide one component part of an object-relationship, a person who will maintain a steady and sustained interest in his object, the patient. He does this, then, in the first instance by means of signs —I am here using the word 'sign' as a technical, semantic term— which indicate the existence of a particular psychological situation. The position of the analyst's chair in relation to the patient's couch signifies the analyst's preparedness to listen to the patient, his arrangements about times of sessions, his preparedness to continue to do so, etc. These details are all primarily signs of the analyst's contribution to the establishment of a relationship between himself and the patient, this notwithstanding the fact that the patient may also use any particular detail as a symbol with which to represent specific ideas within his own mind.

I have here made use of the distinction drawn by logicians between signs and symbols. Signs indicate the existence or presence of some process, object, or condition, while symbols refer to or represent conceptions of processes, objects, or conditions. Psychological signs are also signals, since their function is to communicate to a responding object. A baby's cry is not only a sign that there is a baby in distress; it is also a signal of distress, which tends to evoke an appropriate response in its mother. Signs seem to play a fundamental part in communication of affects, since most forms of emotional expression are innate and are immediately comprehensible without recourse to symbolic interpretation. Dreams and symptoms, on the other hand, are symbols, since they refer to, and are only comprehensible in relation to, conceptions existing in the patient's mind. The words used in analysis are also symbols, since they refer to ideas in the patient's and analyst's mind, but the inflections and tones of speech are signs, since they indicate the speaker's affective state.

After the analyst has introduced the patient into the analytical situation, explicit, symbolic communication begins. The analyst invites the patient to talk to him, listens and, from time to time, he himself talks. When he talks, he talks not to himself nor about himself qua himself but to the patient about the patient. His purpose in talking is to extend the patient's awareness of himself by pointing out that certain ideas and feelings, which the patient has not communicated, are part of, and relevant to, his present psychological state. The patient has previously been unaware of these ideas, or, if he has been aware of them, he has been unaware of their relevance. In other words, the analyst tries to widen the patient's endopsychic perceptual field by informing him of details and relations within the total configuration of his present mental activity, which for defensive reasons he has been unable to notice or communicate himself.

The analyst is able to do this, largely, though not entirely, because he assumes that although the patient may be consciously only talking to and about himself, he is also unconsciously trying to satisfy his need for an object-relationship by making contact with the analyst. As a result the patient's communications tend to be concerned with the analyst, in the same way as the analyst's are concerned with the patient. The difference between the two is that the patient's conception of the analyst is profoundly influenced by projection on to him of various internal imagos, dating from his past, to which he is attached at the expense of external objects, whereas the analyst's conception of the patient is relatively undisturbed by projections. As a result the analyst's communications to the patient tend to be concerned precisely with his feelings and ideas about the analyst, and with the discrepancy between them and the actual reality of the relationship between patient and analyst. These transferred, discrepant feelings, which consist of unadmitted, inadmissible wishes and phantastic fears, are what prevent the patient from making realistic contact with the analyst and establishing an anxiety-free relationship with him. They are, of course, the same wishes and fears which disturb his capacity for interpersonal relations in everyday life. The analyst's successive interpretations help the patient increasingly to discriminate between his phantastic and infantile preconceptions of the analyst and the reality of his present relationship with him, and, therefore, make it progressively easier for him to become aware of his thoughts and to communicate them to the analyst. His drive to do this is his wish, which has previously been frustrated in so far as he has been ill and therefore isolated, to have a relationship within which he can share experience. The analytical situation enables the patient to communicate, share, and bring into relation with an object, feelings, memories, and thoughts which have previously been repressed or which, even if they

have been in a sense conscious, have been experienced in neurotic isolation. Since these communications are predominantly verbal, the analytical process brings previously unconscious and unformulated ideas 'into connexion with verbal images'. The fact that the analyst is more tolerant and realistic than the internal imagos which comprise the patient's super-ego permits ideas, which had previously been repressed, to be verbalized and communicated. One aspect of the communicative function of words is the permissive; comprehension of an idea by an object allows the subject to entertain it. In addition the analyst's understanding of the language of dreams, symptoms, phantasies and defences enables him to translate into words unconscious attempts at communication which had previously been incomprehensible, while his knowledge of infantile sexuality and relations enables him to interpret and put at the patient's disposal derivatives of pregenital drives which would never be tolerable or comprehensible in their original unsublimated form.

The patient's increasing capacity to be aware of, communicate, and share his mental life cannot however be attributed solely to the intellectual content of the analyst's verbal communications to him. It is also the result of the fact that every 'correct' interpretation, even when it is, as it should be, entirely free of suggestion or reassurance, contains within it a whole number of additional implicit communications. In addition to an explicit statement about, say, the patient's phantasies or defences, it contains a statement about the analyst himself and his attitude towards the patient. It says, in effect, 'I am still here. I have been listening to you. I understand what you are talking about. I remember what you said yesterday, last week, last month, last year. I have been sufficiently interested to listen, and remember, and understand.' Also 'You are not the only person to have felt this way. You are not incomprehensible. I am not shocked. I am not admonishing you or trying to get you to conform to any ideas of my own as to how you should feel or behave.' The first group comprises a statement of the analyst's interest in the patient as another human being and of his ability to understand him. The second gives the patient permission to be himself and tells him that it is possible to have a relationship with another person without violation of his personality and intrinsic capacity for growth.

Now this implicit statement is a sign of the analyst's interest in and concern for the patient, of his capacity to maintain an object-relationship, at least within the confines of the consulting-room. It tells the patient the one thing that he needs to know about the analyst, and it is the analyst's major contribution to making the relationship between himself and the patient a real and not an illusory relationship. It is an affective communication and, as is characteristic of affective communications, it is made by signs and not by symbols. Although explicit, symbolic communication would be possible, it would also be useless, since it would be an attempt to convey something that the patient can only credit in so far as he has already acquired a capacity for object-relationships. Indeed, many patients would assume that the only possible motive the analyst could have for verbalizing his interest in the patient would be that it was insincere.

In addition therefore to their symbolic function of communicating ideas, interpretations also have the sign-function of conveying to the patient the analyst's emotional attitude towards him. They combine with the material setting provided by the analyst to form the analyst's affective contribution to the formation of a trial relationship, within which the patient can recapture the ability to make contact and communication with external objects. This trial relationship is accompanied by introjection of an unidealized 'good' object and widening and strengthening of the patient's ego.

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