Reflections on Cure, or “I/Thou/It”

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Cure is a topic much on our minds but rarely in focus. This paper probes what systematizes this protean thing called cure, hoping to open it to new meaning. It reveals cure as a moving target; illustrates several ways of putting a working definition together; and, while reflecting on three treatments, considers cure as both state and process. Cure’s vernacular definition is not unknown to analysts: recovery from illness, a state of well-being restored. But psychoanalysis also deems the mind’s heart a rupture that does not heal: if we are our scars, then there is no return to a state of continuous well-being, because none never existed. In both daily clinical life and the long run, as some clinical examples illustrate, we cannot choose between these two meanings, but must rather operate in the difficult tension, the irony, between them.

Being a psychoanalyst troubles the very idea of cure, which, much on our minds, is rarely in focus. This curious lacuna is the symptom of an unavoidable problem: we work in the tension of two irreconcilable meanings of cure,¹ one commonsensical, the other ironic. Although often invoked, cure is rarely defined. Instead it must be deduced from case reports, technical advice, or meta-psychology. Still, there is one quick and dirty route: just flip to the end of what you are reading, and you will probably find a door knob idea or two about the good life, almost as if the author dares avow when no longer bound to decipher what is in effect a palimpsest.

Cure, as idea and standard, floats as much in cultural as clinical ether. It has a context and a history, and therefore its meaning changes. Both a vernacular and a professional concept, it practically screams for deconstruction. Here I probe what “systematizes” (Foucault, 1963/1975, p. viii) this protean thing called cure, hoping to open it to new meaning. In limning this complexity, I mean to reveal cure as a moving target; to illustrate different ways of putting a working definition together; and, while reflecting on my work with three patients, to consider it as both state and process.

CURE IN CONTEXT AND CONTEXT

When listening to or narrating case reports, do we not ask, even if silently, “Did it work?” Signs of healing inspire pride, joy, satisfaction, while their retreat or absence stirs anxiety and despair.

¹This project began in 1981, when Sue Shapiro, Ph.D., and I gave a well-attended workshop at the annual retreat of the New York University Postdoctoral Program in Psychotherapy. Its title: “What Do We Really and Secretly Believe Is Mentally Healthy?” Note the “really” and the “secretly.” Even then, we were puzzled about the doublespeak in which we were working.

This essay has benefitted from many critiques, including especially Stephen Seigman’s astute editing.

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(Mitchell, 1993, p. 213). That psychoanalysis is as much personal as clinical labor makes such emotional responses unsurprising. But emotions also carry ideas and values. Notions of cure hinge on those of health and illness, which in turn hinge on views of mind, how one lives, with whom one lives. If ideas, social values, and emotions saturate one another (Geertz, 1973; Jaggar, 1989), then of this mélangé is made cure’s discursive infrastructure.

Cure is construct, political football, opinion. It means one thing to a patient, another to the analyst, and a third to the patient’s family (who say, “I don’t think you’re getting any better”). Mental health institutions offer competing versions: consider the rival claims of, for example, managed care, psychopharmacology, cognitive behavioral therapy, and psychoanalysis. Furthermore, cure not only means but is one thing in one era, something else in another. In other words, cure is relative, which means it situates complexity, debate, struggle.

The classical psychoanalytic relation among sexuality, illness, and cure had a lot to do with a set of ideas and practices about desire, authority, and gender. On the omniscient analyst’s blankness were screened the patient’s conscious and repressed wishes and fantasies, spurred by the excitement and danger of sexuality. Transferring from the unrequited past onto the unrequitable present, the patient purchased a requitile future. The patient came to desire the analyst as lost lover and rival, and, through the ensuing illness, emerged healed, reconciled to renunciation and open to love, in the form of appropriate marriage, and to work. Dissolving the Oedipal crisis forever, the patient traded hysterical misery for ordinary unhappiness.

Postclassically, not sex but personal meaning-making organizes clinical work (Chodorow, 2000); cure is particular, variable, emergent. At the same time, a one-person psychology has ceded to a two-person model of mind and treatment. With the analyst as real person, an exploration is initiated in a relationship both mutual and asymmetrical (Aron, 1996) so as to discover and create the subjective significations emergent in intersubjective space. These meanings may be old or new, sexual or narcissistic, related to difficulties in attachment or in living. As crises testing the hardness of the analyst–patient bond transform both parties, it is less the analyst’s certain knowledge than the analyst’s ongoing effort to understand that makes the difference (Loewald, 1980).

At the same time, older meanings stain through: cure is a palimpsest of dissent and options. On one hand, in a zeitgeist that rejected the doctor’s omniscience and unreachable authority, most of us ditched the medical model in which cure is a final, everlasting state. Theories of relativism and relativism, democracy in of the consulting room, feminism’s critique of analyst and patient gender, postmodern cool—these militate against the earnestness of “cure.” Yet a seemingly outmoded idea clings to up-to-date theoretical and clinical practices, our feelings, and our social institutions. We bow to our lack of monopoly on truth, certainty, authority. But hidden in plain sight is the medical vocabulary of health, illness, and cure harking back to a satisfying, authoritative narrative, and it still contextualizes our work. I want to consider whether we might somehow reclaim it.

**BUT FIRST, A FEW DECONSTRUCTIONS**

**The Meanings of Cure and Health, Then and Now**

Cure’s meaning is elusive even if we turn to our conventional lexical authority. In the *Oxford English Dictionary* (*OED*, 1971), its most common definition is “Successful medical treatment…” (p. 626), that is to say, “restoration to health.” This apparent clarity fogs up, however, when we try
to define “health,” for which are given “soundness of body” and “well-being” (p. 626). That corporeal sturdiness means one thing to, say, the Wolf-Man and another to Lance Armstrong; that well-being varies depending on whether you are a desperate housewife or a desperate single (mother)—this range reveals just how malleable and unclear that definition of cure actually is.

As for mental illness and healing, which do not merit separate entries in the OED, the problem redoubles. For example, I have a friend whom colleagues deem mad but who sees himself suffering as one suffers in life; he feels no need of psychotherapeutic curing. Might he have been less stigmatized in the Renaissance, when, in Foucault’s (1965) probably romantic view, madness was mundane and therefore not subject to cure? In the 17th century, Foucault (1965) argued, insanity, now an illness to be treated, became confined if not hidden: the mad, behind open bars, were publicly visible at a distance, “no longer a monster inside oneself, but an animal with strange mechanisms” (p. 67). By 19th century’s end, however, mental aberration was deemed illness, hence subject to treatment and cure, themselves construed as at once private and professional matters, held in the family and medically handled.

Today, it is perhaps not surprising that notions of cure are up for grabs, given that understandings of mental illness are increasingly jumbled. Like sex, madness is both flaunted and stigmatized: We use our 15 minutes to spread-eagle our private craziness for talk-show or memoirist view, while the insanity of Wall Street and warmongers is touted as reason. Exceptions that treat psychic suffering with dignity exist: serious, celebrated memoirs (Jameson, 1995; Solomon, 2001; Styron, 1990); fictionalized, respectful accounts of treatment (Greenberg, 1964); and profound assessments of craziness as cure (Kovel, 1981; Laing, 1970), in which madness is read as contention with a sick society.

Cure as End-State

With this brief sketch of cure’s shifting significance in mind, I would like now to focus less on what cure is than on how it is. Compare two different psychoanalytic theories that anticipate outcome as end-state. In Groddeck’s (1923/1961) view, first, cure is a state of voluntary disinhibition. Based on his extreme notion of health—cousin to Reich’s (1936/1969) sexual determinism—it reduces to the question, “Why don’t we do it in the road?” Curing by command, he wrote,

If I say to people, and I do say it, “You must so change that in broad daylight you could crouch down in the middle of the street without embarrassment, undo your trousers, and evacuate,” then the emphasis is on the word “could.” (pp. 134–135)

Unimpeded, conscious access to your fundamental psychic process, for example, your affective relation to your fundament, permits a relaxed, stress-free life. That Groddeck’s claim now seems naive does not mean it is wrong. For example, to Mr. IM’s repeated doubt about his sexual identity, I finally suggested he give his fundament a chance: “But you’ve never even dated a man!” My affect (was it really just mine?) had a long-term effect: in time, he did pick up a guy and, after some doubt, eventually came out.2

2More than Freud, Groddeck (1923/1961) was sanguine about disciplinary authority. “To keep the patient from ever doing it,” he wrote, “there is the safeguard of the police, of custom, of the anxiety bred in him for centuries" (pp. 134–135). Freud (1908), in contrast, understood the irony, having already indicted these civil safeguards as irremediably key to the illness that psychoanalysis calls upon itself to cure. Civilization requires restraint, disgust, shame, and repression, making sublimation and neurotic necessary partners. That cure is only patently achievable by reason intensifies another irony that would not, however, be recognized for another two generations.

In contrast to cure as an endematically tiredness and cure as a continuing process, the cure of postwar abounds with “alienation, at Fromm’s diagnosis, isolation in a fallible social order, the panhandle to its degeneracy.”

AN

Cure as Process

Let me continue my definition of cure as shift from the psychologism to the psychodynamic as a cure in a new world order. Fromm’s 1928 statement with Cassirer’s 1927-28 profoundness, now twice-winnowed.

The resolution of achievement is to me. He went on, and its cure profound achievement relationship and its cure in the new world order. I am Horney (1937) in a different self, she is Horney can-do ethic or organization. His problem, the problem of assuming.

““What” and “Why”

Classically, Freud (1908) was a talker, in his high-pitched
In contrast to Grodecke’s cure-by-command is the interpersonal and culturalist construal of cure as an end-state at one with the process by which it evolves. These schools of thought systematically take illness, cure, and health as socially constructed. In Sullivan’s (1953) view, illness and cure emerge in relationship. They arrive at many junctures, early and (development continuing past the 5th year of life) late, and in many guises. Congruent with this relational angle on development is Fromm’s (1941/1965, 1970) social critique of psychoanalytic thought: Insofar as classical notions originated in an economy of want, he proposed, an illness of deprivation and insufficiency—the dilemma of desire—was a logical target for cure. In contrast, the postwar abundance of the second half of the 20th century saw the locus of psychic pain shift to “alienation, anxiety, loneliness, the fear of feeling deeply... lack of joy” (Fromm, 1970, p. 29).

Fromm’s diagnosis certainly applies to Mr. IM, who suffered, as I have indicated, not only sexual inhibition presided over by an internal “ogre” but also what he called a “malaise,” a companionable loneliness.

AND SO TO THE WHAT/THE HOW, THE I/THE THOU, AND THE IT

Cure as Process

Let me continue here with IM as a way to review and proceed. As he and I worked, not only his but my definition of cure evolved. In the context of an ongoing supportive relationship with me and a shift from the patriarchal culture of his childhood to the sexually open culture of his adulthood, IM gradually felt safe enough to address the limitations of his treatment. For me, the usual uneasy liveliness accompanying countertransference work was spiced by an unanticipated ingredient: cure in a new guise. Assured that what mattered was the meaning of his work with me, IM experimented with not only sex but other therapeutic relationships: An Esalen marathon on courage persuaded him of the depth of his pain and longing, and allowed him to start using the couch for his now twice-weekly treatment. Soon after that he came out.

The resolution of IM’s sexual preference, however, was not a cure in the sense of the achievement of a final state. As it turned out, there was more curing to be done, but not with me. He went on to consult a male body therapist who, IM found, suited him better, and he ended our work. I would have preferred him to finish with me. That being impossible for him, his cure process took a different turn. As IM later wrote to me, he eventually established an intimate relationship, quit his brutal if highly remunerative job, moved to the country, and took up new work that, by the by, involved him with his community. IM’s cure materialized what Horney (1950/1970) would have forecast: Where Grodecke speaks of the knowledge of the hidden self, she imagines the living of that self. Her mid-century manifesto suits the United States’ can-do ethic: we “want to help the patient... find himself [and]... work... toward... self-realization. His capacity for good human relations... includes his faculty for creative work and that of assuming responsibility for himself” (Horney, 1970, p. 334).

“What” and “How,” “I” and “I/Thou”

Classically, IM’s panic-stricken heterosexuality, which I have not described, and the alienation of his high-paying job, might, analyzed, have constituted an acceptable ordinary unhappiness. In our
work, however, to shift to my subtitle, an “I” came to life through an “I/Thou” as a more fruitful solution to his malaise. If Freud’s was a dystopian vision, the two-person psychology showing up first in interpersonal theory and object-relations theory, then later in self-psychology and relational psychoanalysis, is and was its opposite number: a utopia of self and pleasure and human connection as within reach, and usually illustrated via an enactment (perhaps my exclamatory suggestion that he try out his desire). IM chose to do it, if not in the road, then up in the country, and his released desire not only addressed his alienation but entailed connection to the world he lived in.

My experience with IM challenges the conception of cure as a state of affairs and asks us to consider it as process instead. If we do this, we can discern a sea-change in the relation between the what and the how of cure, or, more formally, between theories of mind and theories of technique. Classically, there was both an interimplication and a tension between the idea of cure and the act of cure. Illness, encapsulated in one person, was transformed into health by another. Treatment done, cure achieved. Metapsychology, the theory of neurosis, and the path to cure were all put in terms of individual development, a narrative with beginning, middle, and end. In this one-person psychology of the “I,” the omnipotent, well doctor fixes the unknowing, ill patient (McLaughlin, 2006, p. 59; Sullivan, 1953).

The two-person psychology of postclassical psychoanalysis (Ghent, 1989; Greenberg & Mitchell, 1983) is putatively more democratic and fostering of freedom. Mind emerges in relationship, of which it is also made. By the same token, doctor and patient meet as two equals in search of Buber’s (1970/1996) I and Thou. In experiencing this new self-in-relation, each has something to say, and, if the patient is to heal, even the analyst must change too (Slavin & Kriegman, 1998). Via joint exploration of meaning, the patient’s self emerges in its various states, whole and multiple. Postclassicism is also noted for its varied use of both the analyst’s self and intersubjectivity in curing. Attention to the analyst’s subjectivity ranges from noticing its presence (Bonasia, 2001); to the private exploration of countertransference (Jacobs, 2001; Joseph, 1983; Ogden, 1994); to—after Ferenczi’s rehabilitation (see Ferenczi, 1933/1988)—its overt clinical use.

Over the last century, cure as state and cure as process came into closer alignment. As “I” made room for “I/Thou” in models of treatment and mind, relativity and provisionality settled in. In a one-person psychology, the medical model and its absolute authority reign; mind is primary, relationship, secondary. Cure is definable, if, at least for Freud, a mixed blessing, an end-state. In this stance, doubt exists, but only on the side. In a two-person psychology, in contrast, both parties to the analytic encounter are equally mortal. Their differences are only relative: together they foster and observe one party’s progress from a state of relative ill-health to the state of relative well-being that characterizes the analyst’s state of mind. Uncertainty is analysts’ (post)modern fate because, to echo the sound-bite often attributed to Jacques Derrida, there is too much truth. Since, as complexity theory claims, each dyad, like each being, contains more possibilities than can be realized, doubt marks outcome as well as technique.

At the same time, one wonders whether the contemporary focus on the analytic relationship is the new certainty, and as such, whether it grounds our view of cure. The “I/Thou” is now being pursued as not only technique but goal all around the psychoanalytic globe. This mode is evident in the frequency of reference to “the couple,” a figure that has been gaining increasing presence in psychoanalysis. Consider two metaphors in common use. In a PEP Web search, “the analytic couple” shows up 560 times, with only 30 of those occurrences taking place before 1980 and 510 occurring 1991 and after. As for “the nursing couple,” this image appears 9 times before 1962 and 110 times afterwards. (2 years.) This sort of p 20th century.

Does the analytic cerebral harmony between (2010) criticizes the promise of human happiness and hence of terminal postclassical iterations says, “attainment of a guide for technique.”

Although, in other words and healthy life, Barish’s (2004) assess. tance: positive, “affirm capacity for enjoyment Thou.” But I wonder version: “a matrix of p jects is psychically i internalizations in the

The “It” and the “I”

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Does relational emphasis, the I/Thou dissociation—Bromb on—helps us contempo 1989), unformulated, surely, enactment the remembering, occurring may, say, the I is the acting analyst and pa verbalize.
more fruitful showing up of sexuality and relationality and human proclamation in the world, he asks us to reflect between times of tech-nocure and tech-nother. Treatment were all mixed in. In this ill patient Berg & Mitteilungs, of Buber’s essay, and, if intuicism is attention to the exploration of rehabilitation as “I” made real in. In a primary, relational state. In this with parties to ethy fostering well-being, fate beareth. Since, as can be real-

110 times afterwards. (And these counts are incomplete, since PEP Web is current only to the last 2 years.) This sort of pattern suits the analytic focus that began shaping up midway through the 20th century.

Does the analytic couple, however, become a model for (a patient’s) life? There is possibly an eerie harmony between this emphasis on couples and underlying beliefs about cure. Cheuvront (2010) criticizes the psychoanalytic bias towards “life-time pair-bonding ... as the likeliest guarantee of human happiness.” He worries that their arrival is often taken as the sign of mental health and hence of termination’s arrival. Wisely, he notes this prejudice in not only classical but also postclassical iterations, demonstrating the field’s attachment to an implicit ideal. Arguably, as he says, “attainment of a coupled relationship has ... acted as a bull’s eye for treatment,” a goal and guide for technique.

Although, in other words, coupling may not be a universally suitable life-goal, our take on a healthy life still privileges it. Certainly it needs be within the range of results, as in Barish’s (2004) assessment of a good psychotherapeutic outcome for kids: insight and self-acceptance; positive, “affirming interactions with adults and peers” (p. 398); confidence, resilience, and capacity for enjoyment. Or, in other words, an “I,” one or more “you”s, and the capacity for “I/ Thou.” But I wonder whether it must be as central as in Schafer’s (1968) contemporary Kleinian version: “a matrix of present experience that includes significant, lasting and realistic external objects is psychically more mature and satisfying than one that involves primarily desperate internalizations in the passive mode.”

The “it” and the “I”

Obscured by this sensible, warm focus on “I/Thou”—the couple—is a less palpable thing that I dub the “It” and about which, curiously, diverse schools of psychoanalysis have something to say. I’m not entirely certain what I mean by It. Many things, probably. The privacy of the self as conceived by Winnicott (1958/1965) and Khan (1974), Groddeck’s It. And Buber’s (1970/1996) “It-world,” which “coheres in space and time,” in contrast to the “I-[Thou]-world,” which coheres in no material or measurable location, but rather “in the center in which the extended lines of relationships intersect: in the eternal [Thou]” (p. 148). I also see It as that which inhabits psychic interiority but can never find a way out, never wants to come out, cannot be said. Here I think of LaBanc’s (1991) Real, which escapes, refuses, is unreachable by mind and knowable only by its effects. I include also how Laplanche (1976) construed the infant’s experience of the mother’s (unconscious) desire: although arising in the maternal I/Thou, the enigma lodges in the infant as a disturbing site of Otherness, an It.

Does relational psychoanalysis neglect a significant privacy? Or is the problem perhaps one of emphasis, the I/Thou overshadowing the It? Indeed, much work on trauma’s wordlessness, and on dissociation—Bromberg (1996), Davies (1998), Davies & Frawley (1992), Stern (1997), and so on—helps us contemplate this internal and intersubjective site—the unthought-known (Bollas, 1989), unformulated experience (Stern, 1997)—where words do not necessarily apply. And surely, enactment theory, now ubiquitous, embodies It ness tout court: living out, or repeating as remembering, occurs in a medium where language, although present, is not central. Here, you might say, the It is that which, resisting certain knowledge, is returning from dissociation. Enacting analyst and patient each do things to and with the other that, only sometimes, they later verbalize.
ONE CURE OR MANY?

Between a Rock and a Hard Place

Willy-nilly and in conflict, psychoanalysis operates, I think, with two general notions of cure, and we cannot choose between them, just as, I propose, we are always being worked at once with I/Thou and It. On one hand is cure’s common-sense signification—getting better, recovering from illness, restoring a state of well-being. This positive definition states what cure is, provides a satisfying narrative of accomplishment: something was wrong, something is fixed. On the other hand is an ironic, negative definition stating what cure is not and indicating why we think of cure as process too: continuous well-being, whose restoration we seek, is an illusion because cure is a contradiction in terms—the mind’s heart is a rupture that does not heal. Loewald (1980) noted the impossibility of the first and, his double negatives registering the troublesome ambiguity of our work, said, “I suspect that there is no psychoanalytic understanding worthy of the name that leaves that which is to be understood altogether untouched and unchanged” (p. 381). You understand it, it changes, there is something new to grasp, and, maybe, to do some more work on.

One seeming solution to this problem of cure/noncure has been to deem cure relative, multiple, a strategy that depends on an I/Thou view that “life is with people” (Zborowski & Herzog, 1952). For analysts from Schafer to Davies, the self becomes known and enriched from the intimate I/Thou of early life to ever widening circles of human and social relations. Hence the convergence between our one-person and our two-person psychologies, each deeming cure relative and multiple. Schafer (1992), for example, narrates how the self’s multipotentiality generates many changing stories:

progressed analysands depart … convinced not only of a better and truer set of storylines with which to give an account of a past life, including a past analytic life, but [of the existence of] better and more truth-making sets of storylines with which to organize and conduct a life among people in the future.

(Davies 2003), rethinking sexual development, proposes many sorts of I/Thou solution: “several pathways lead to an assortment of potential outcomes, focused not only on sexual orientation or object choice but … on the particular qualities of intimacy, eroticism, and deeply resilient mutuality” (p. 7).

But each narrative too contains unavoidable tensions between this multiplicity, the coupled goal, and the lingering, primal psychoanalytic focus on individual mind in individual body—on the I. For Schafer, the self is development’s telos: “mature self-interest and self-interest” make a complex web of self- and object-representations, and of relations with “realistic external objects” (Schafer, 1992, p. 20). In other terms, Davies (2003) anchors her clinical and developmental theory of sexuality as multiply instantiated and experienced by revising the preoedipal, oedipal, and postoedipal developmental storyline of psychic development.

As Harris (2005) quips, we speak postmodern but inhabit the Enlightenment; indeed, such critiques of developmental lines (see also Coates, 1997; Corbett, 2001) may themselves articulate cure’s conflicted duality. Even as contemporary psychoanalytic thought values many roads to Rome, it maintains an evaluative, unitary developmental line from immaturity to a maturity of relatedness that necessarily assesses health, illness, and cure. If we are thinking “maturity,” we must

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REFLECTIONS ON CURE

by implication being thinking *immaturity*, and if so, then *prematurity* as both assessment and critique. (Is it noteworthy that we never think of *postmaturity*)?

Whose Cure Is It, Anyway?

When it comes to cure, we are netted by tensions. Who defines cure, analyst or patient? Of a patient whose treatment afforded a feeling of reality, intellectual creativity and meaningfulness, and successe of harrowing anxiety, Khan (1979) writes that nevertheless he “lives a life which, by ordinary standards, is extremely lacking in human contact… He is just an alienated isolate in human society and lives from that stance” (p. 170). A contradiction obtains between a hint that convention might not be our best guide to a well-lived life (McDougall, 1980), and pity for the poor patient. “Just an alienated isolate” signals the disciplinary drift of Khan’s assessment. The case of lonesome IM had, save its homosexual wrinkle, a traditional happy ending. But perhaps aloneness suits you? Suppose your patient wants to be a monk in a cave?

Dismantling analytic authoritarianism, Renik (2006) now holds that patients define their own cure. Yet might that be an authoritarian statement? Suppose a patient’s idea of cure is that you define it? Even as we try to topple the master’s house, by, for example, imagining multiple story lines, we operate with a single story of curing too, which inevitably means we are participating in surveillance, control, adaptation, and so on. Just as we cannot escape an idea of cure, even as we critique it, so we cannot escape being the ones who define cure. “So those of us who are interested in developing more mutual and egalitarian relationships with our patients should not deny the extent to which we are drawing upon the ritualized asymmetry of the analytic situation to give that mutuality its power” (Hoffman, 1996, p. 121). The mantle of authority finds its way to our shoulders even as we keep shrugging it off, as in my work with KF.

KF’s “cure” did not take place with me. Indeed, I don’t know whether it has taken place yet or not. But if cure is a process, then perhaps her work with me consisted of a moment or series of moments in her cure/curing. One day, KF said that she was going to say something cruel to me. I knew how to push her buttons: I try to make her cry because I want to be in power, and she knows that’s how analysis works. She will talk about something from which I will try to divert her toward something painful. What I say always makes sense and so she follows me. I am manipulative in the interests of my own power. It is cruel to tell me that’s what I do, which is to be cruel to her.

But, she says, of course she is a paranoid and this is how she thinks everyone is and so she is always on her guard in order to retain her power. Only when she cries does this paranoid structure break down. Then there will be an immediated relation between me and her, and she will feel recognized. Yet to be recognized is to be manipulated. That she is paranoid does not mean she is wrong; being the authorized one in the room, I do hold the power. That she recognizes what she feels to be her resistance doesn’t disappear my power. As she got up from the couch, she said, with an ironic smile, that she’d been just about to start crying. “Saved by the bell,” I replied, getting the last word.

With KF, however, irony was not hard to maintain. Two weeks before she stopped treatment—an ending putatively ordained by her upcoming return to her native country—she had been angered by my not being more present as a person. I’d missed the previous Friday for a speaking engagement. She rang my cell phone as I was boarding the plane; we spoke briefly, and then it seemed I couldn’t call her back for over 24 hours. The next week, in what turned out to be the penultimate session, she said she needed my help to do something really hard. She had to tell me that
what she was feeling about my emotional unavailability was not her problem. It was mine. She at the analyst is not always blames herself, but this time she knows I have a problem. At the end of this excoriation, she sat up and said, “Well, that’s it.” An exclamation point best capsules my reaction. “You’re leaving?!” “Well, I said I had to do something really hard.” “So that’s it? You tell me off and you leave?” More of this, and then she said she’d come the next day.

Now, writing this, I see she was right: in subtle ways—for example, getting the last word, not calling back sooner—I hadn’t been open enough. I maintained my hope, however, that this was one of those crises any good treatment has to go through (E. Levenson, personal communication, 1983) and that her cure would arrive in her treatment with me. The next morning, though, she lay down and repeated, “I want to ask you to help me with something really hard. I want to be able to say good-bye without blaming myself or you. I almost called you last night to say I wasn’t coming. But then I thought, ‘No, you have to talk to her. Do it different.’”

Cure, I could see, was going to elude my grasp. But whose cure is it anyway? Accepting with a sinking feeling that her cure was going to occur elsewhere, I replied, “I have thought about your complaint about me. I don’t know whether you are correct or not, but I want to consider it, and I want to say that were we to continue, it would be something we would be talking about.” Weeping, she said, “You know, I think there’s a place in me that has never let you in, never lets anyone else in. Maybe you have been here, and maybe I didn’t take the opportunity.” I like to think that this moment was part of her curing, even if our relationship was about to end.

Was KF more comfortable with cure as processual, even as discontinuous, than I? Or did her apparent comfort salve loss? She went on to view her dilemma in terms of the Third (an It, if there ever was one). “It’s like in Kafka’s The Trial: when we stand before the Law, there is an open door with a guard at it. Do you go in? Maybe that door was always meant for you, but you don’t know that. Between the two, ‘Go in, don’t go in,’ what is the answer? I suppose it is to contemplate the question.” KF’s solution, in keeping with her intellectual predilections and defenses, is to find her cure in probing, perhaps testing, the uncertain limits of life.

Cure, Termination, and Analysts’ Narcissism

My work with KF raises the question of termination and its relation to cure. KF terminated: she stopped the treatment 10 days before she had to leave, because she saw no point in adding, to the anxiety and chores of departure, continued descent into sadness. Of course, as she’d agree, she was not only clearing a space for enjoyment but also finessing the final cut, not to mention getting the last word. I imagine, once home again, she’ll get round to the grieving, find another analyst. And if she doesn’t? Would that mean she is not cured? Does an abrupt ending mean the treatment “failed”?

Here the question of cure opens onto the problem of the analyst’s (narcissistic) vulnerability. I find myself wanting to tell you about a case that terminated properly. And so I will. Yet in setting out to articulate what I mean by “properly,” I find myself confused. Does it mean that analyst and patient agree that the end has arrived? If they do not, does that disagreement bear on what the analyst means by cure? You may stop treatment and get better; you may continue and never be well. Like the medical notion of cure, the idea of termination suggests a conclusive narrative. However, with Lacan, I would say that, along with the enlightenment provided by psychoanalytic reason, we need also sometimes expect, in the end, darkness, confusion, inconclusion, silence, a question. For some, at least, Lacan was right to claim that an analysis is done when the patient, recognizing that Negative Capabi
negative capability, and the Gerund

They are odd, these textbook moments. This one had its Buddhist resonances. It's not that the analyst knows nothing. Rather, as Saffran (2004) puts it, "The point is to have analysts who don't pretend to know the unconscious. They may hear the half-said, but only later; they don't pretend to know in advance." (p. 26). Toni Packer, a Buddhist teacher, asks her students, "What is it?". Like Socrates, she teaches by questioning. Usually the first loan her students work with is Mu, which means "Who?" But, in her view, _Mu_ is an inquiry: "Who am I?" or "What is it?" (as cited in Friedman, 1987, p. 42). Buddhist work begins to sound remarkably like ours; Packer "questions not only all your beliefs and conditioning, but also the usual framework of teacher-and-student. She is not there to give you anything, nor to impart the truth. There is something taking place, but it has nothing to do with a giver and a receiver. Two minds are meeting and, if there is openness, something may move, shift, clarify." (Friedman, 1987, p. 42).

Must we go elsewhere to discover ourselves? Perhaps what I am trying to do here, in these reflections on cure via "I/Thou/It," is to defamiliarize. Buddhism asks about negative capability. Packer again: "Can there be just listening, without wanting, without preferring this to that?". Words are a vehicle, not the truth. "Truth is direct seeing, and it cannot be taught." Contra Packer, I'd reply, "Maybe. I'm not convinced the answer on truth is in." Says Packer, two people, "much more alike than not, raise[e] questions together, look ... at 'the whole thing' together, ... Sometimes clarification happens. Sometimes not." (as cited in Friedman, 1987, p. 55).

If I have so far used "cure" as a noun—an end-state—and as a verb—to cure—I would like, insofar as it is also a process, to end by using it as a gerund: curing. In my value system, cure is the examining of a life by whatever means—a one-person psychology, a two-person psychology, a social psychology, a nonpsychology, a mix, Words, emotion, action, silence. "Examining" does not mean all becomes and stays clear. Sometimes it does, sometimes confusion abides, leaving us unsettled, not comforted in the holding mutual recognition of I/Thou. "What is it?" allows that unset-
tlement to become what it must—an idea, a feeling, a meaning, a relationship, trouble, pleasure, jouissance.

Time is therefore intensely involved. One of my favorite images from Freud (1913, p. 47) is his definition of free association: you are looking out the window of a train on which you are riding backwards, and the landscape you see only just after you have passed it is that region of mind to which we lack immediate access. Cure is like that: ongoing, knowable only in time, after the fact. Over time, its meaning changes, not only in history, but in the course of an analysis. Consider IM who had one idea about cure initially. But his wish for heterosexual normalization shifted into a longing for integrity, and showed up as homoerotic desire lived in a committed relationship. Perhaps it is possible that a wished-for state of cure might be found in different self-states.

I am intentionally describing this in one-person terms, because I want that I and that It as well as that I/Thou. But consider also this two-person scene: Marcelle Clements (personal communication, 1995), a writer with many years of analysis behind her, calls the analyst “a witness to your deal.” The I of the patient and the analyst separately, the I/Thou of patient and analyst together, the It of the ordeal, the calm and impassioned process of witnessing and being witnessed. I long for the It to escape the I/Thou’s claustrophobic romanticism. Sometimes I want to be in the room with you without It having anything to do with you: being alone in the presence of another means, if Winnicott’s (1958/1965) formulation, that although I may exist for you, you—“Thou” as a subject do not exist for me. A complex, nonlinear system, says complexity theory (Coburn, 2002, 2004, 2007), is incompressible and nonrepresentational. I cannot be compressed to I/Thou. And it remains, exceeding what can be represented of my being even as it cannot represent the rest of me; either. Rimbaud famously said, “Je est un autre.” “I is an Other,” an It. I want room for my and your otherness, our unknowability, for the unexpected places we might arrive at, separately and together, in time. My ordeal is mine.

Cure is...
ease, at home, to lack tension. Here the sense conveyed is of self-assurance, somewhat stronger than simple relaxation. "L'aise also has multiple meanings; it can mean 'pleasure' and 'satisfaction' as well as 'joy'" (p. 96, footnote 6). Her both/and stance evokes McDougall's (1995) view of adult entitlement as entailing both narcissistic and sexual gratification. Oddly, we return here to Horney; although we might criticize her (like Fromm's) idealization of alienated labor, we can still value her recognition of a nascent, even elemental pining for fruitfulness and contentment in life.

Sweetness and bitterness, however, define each other. L'aise contains a divide. Being-at-ease straddles a familiar split: well-being is situated equally in material surety and "access to ... subjectivity" (Irigaray, 1993, p. 71). But since neither the two nor their achievement is co-terminous, insufficient, discomfort, and struggle await. Asked recently about his idea of perfect happiness, Hanlin, the Chinese novelist, responded,

"I often tell my wife and son that the best life for me would be to go up in the morning and go to a cafe and have coffee and meet friends and read the newspaper. But you can't do it every day, because if you did, your life would be effortless. And an effortless life is a meaningless life." (D. Solomon, 2005, p. 15)

Influenced by social thought, Irigaray (1993) makes a special point with regard to women, for whom gender must be achieved in relation to subjectivity as well as to material goods and services. "To be in good health, women need to discover for themselves the characteristics of their sexual identity. They also need reciprocity in sexual difference, whether it's a question of love, culture, society, or politics" (p. 105). Since I disagree with her about the hetero-essentialism of women's sexual identity, which she presumes, I would put it that women need a relation to their own bodies—"the examined life"—as well as the conditions that make life worth living.

We are the fault lines that crack and web us, rupture and suture and structure us. They are our tragedy and opportunity—or, if you are a pessimist, opportunity and tragedy. I/Thou/It is an account of the fault lines. Awaiting us, these fault lines emerge (a) in the I divided from itself by repression, dissociation, and foreclosure; (b) in the I-thou, where "the extended lines of relationships intersect: in the eternal You," in relatedness and its troubles, and (c) between the I and the It:

what we do not understand, cannot know or predict, the Real, the Other's desire, the chance to become what we could not expect.

Psychoanalytic process is too unpredictable and its outcomes too indeterminate for a stable definition of cure. Each patient, or analyst, or analyst-patient dyad, resembles a snowflake: no two are alike, as Wolstein noticed. Each curing—or "cure" as "a medical or remedial treatment" (OED, 1971, p. 1262; see also the French locution, la cure)—takes its own time. Each cures something, but not everything, each comes out its own way. Cure is patchy, as every analyst, and grown-up, knows: contentment and suffering alternate as figure to ground, flaws paint self-esteem, shameful acts spoil serenity. What changes is how we relate to our sites of pain: we no longer think it's always raining, because now we can recall, as Schaefer put it, that sometimes the sun shines too. Ferenczi (1928/1955) writes, "It is not within the capacity of psycho-analysis entirely to spare the patient pain; indeed, one of the chief gains from psycho-analysis is the capacity to bear pain" (p. 90).

If this view sounds cruel, perhaps we might also recall the thought attributed to Kafka, that the only suffering one can avoid is the effort to avoid suffering. We learn to "limp well," says Karol Marshall citing Derrida (personal communication, November 6, 2005). Or consider Donald
Moss’s (2005) view: “Working the panic/anxiety interface, for me, protects against a drift toward Foulcault’s (1965) view: ‘The kind of utopian normativity, a standard against which all of us, I’m afraid, will always fail—melancholically, catastrophically, cockily, or deflatedly. For me, less panicked will do as a goal.’ And so, at this doorknob moment, I ask, Could we make something of this patchwork? Can we think of curing as the difficult, always temporary, never homogeneous joining of pleasure and pain? I have used cure as noun, verb, and gerund. I have proposed we think of it as happening in time, therefore never complete, therefore always allowing for suffering and for the changes that inevitably accompany the shifting conditions of personal and cultural life. I have, perhaps, oppositionally, underemphasized the sunny days. So lest you think I am privileging darkness, lack, and lost illusions, banishing health and enjoyment from some politically correct lexicon, let me return to the OED (1971, p. 1273), where we find that, in 16th-century English—in the Renaissance, when, Foucault claims, madness went out in daylight—health is a verb. It might be fun if we could say of our patients, not to mention our loved ones, enemies, even ourselves, that, what ever their sufferings and struggle, ‘They now are healthy, and carressing deep.’

REFERENCES

Drift toward a failure—mental illness as a goal.

Work? Can we define pleasure and suffering in the human world? Can we change the terms of our existence? Can we change our economy? Can we change some of the changes that have, perhaps, been happening in the Western world? Can we change the terms of our existence? Can we change our economy? Can we change the terms of our existence? Can we change our economy?

In the Renaissance, it might be fun if you look. That's what I mean.


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