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apist as "consensual validator," then, can be taken as the therapist helping the patient distinguish between what is real and what is not (which Sullivan certainly did) or as participating with the patient and, simultaneously, examining with him their nuances of interaction.

Regardless of the therapist's ostensible intent, he cannot help but react to the patient. If the patient is a homosexual, the therapist has his own experience of that. He can try to minimize revealing this to the patient in an effort to keep his participation neutral. One might debate the feasibility and even honesty of that effort. If the patient thinks the therapist is critical, and the therapist is aware of his criticality, then they can explore together what happens when they collide. Being not-critical of something infantile and exploitative can be as much a collusive participation with a patient as being critical out of competition or resentment. An arena of almost infinite nuance opens up. The patient's past, the patient's present, and his interaction with the therapist become *transforms* of each other, immensely useful as different parameters of the same experience.

CHAPTER 6

Praxis: The Common Ground of Therapy

Psychoanalysis extends language beyond the logical plane of rational discourse to the alogical regions of life, and in doing so it makes that part of us speak which is not so much dumb as it has been constrained to silence.

—PAUL RICOEUR

EVEN A CLINICIAN who abjures the direction the "nose" vignette took will recognize something hauntingly familiar about it. There are the traditional constraints of the fifty-minute session, fee, the limitation of contact with the patient to sessions. The patient presents his symptom—an obsessional preoccupation not with his appearance but with deception, and withholding. He then, apparently without awareness of connection, mentions first a change of appointment, which on inquiry turns out to be for a minor surgical procedure on the much overinvested nose. In the process of inquiring into why he didn't think to mention it, a childhood incident in which he withheld information from his parents reemerges. The therapist then reexamines and revises his own

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sense of understanding of the transaction and shifts the focus of his inquiry.

The therapy has proceeded in a circular way, from symptom, to acting-out, to childhood memory, to transference, to countertransference. As I said in the previous chapter, this circling through the material is described by Menninger and is familiar to any psychoanalyst, regardless of theoretical or institutional persuasion. In a word, there is a similarity of method that underlies the difference in purpose. This praxis of psychoanalysis could be defined as Freud's core contribution; it is an act that can be held separate from metapsychology. It is possible to break the psychoanalytic praxis into a series of systematic steps that can be followed methodically. Such a procedure is called an algorithm. As I stated earlier, the success of an algorithm does not depend on the correctness of its theoretical underpinnings. It is possible to have an algorithm that works although the theoretical explanation of its efficacy is incorrect or incomplete.

Much empirical wisdom works that way. In the Middle Ages it was known that night air caused the ague. Consequently, windows were sealed, plants removed from rooms, and beds heavily muffled in hangings. It was also known that the night vapors were worse in low lands, so whenever possible people built their houses on high land. They did not, of course, know about the anopheles mosquito carrying the parasite of malaria. They used the paradigm of Aristotle's humors and devised an algorithm for preventing the ague. The paradigm may be wrong or, to our eyes, naive; and yet, the algorithm may work. Freud's paradigm was Newtonian and energetic. But his algorithm is pragmatic and not paradigm-bound. To put it more simply, the theory can be separated from the therapy and may not even have very much connection.

The algorithm can be divided into three steps:

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1. The establishment and definition of the therapeutic frame.
2. The elaboration and enrichment of implicate and explicate order in the patient's life.
3. The elucidation of this order in the therapist-patient relationship.

I shall elaborate these three highly condensed steps, but I would emphasize again that this algorithm is at the core of any psychoanalytic position, from the most conservative to the most radical interpersonal. A rational, detailed inquiry, in which scotomata and inconsistencies are pointed out to the patient and in which the therapist attempts to interpret "distortion"—that is, to point out to the patient where he is distorting reality—falls short of psychoanalysis by anyone's stringent definition. Nor is a therapy that provides the patient an opportunity to get in touch with feelings or to have a healing encounter with a loving and concerned preceptor properly considered psychoanalysis. This is not to deny that these can constitute a rationale for effective psychotherapy, more appropriate for some patients than psychoanalysis. But they do not meet the requirements of the psychoanalytic algorithm.

This is, of course, an extremely arbitrary position, but it approximates Freud's definition of psychoanalysis as any therapy that accepts transference and resistance. As Frederick Crews put it, "Freud wrote (in 'On Narcissism') that 'the whole structure' of psychoanalysis stands apart from metapsychological propositions, which 'can be replaced and discarded without damaging' that structure. Freud knew that high-level theory was an afterthought to the relatively direct inferences of the consulting room."¹ These terms, "transference" and "resistance," are used more rhetorically than rigorously. Psychoanalysts seem to make a word mean whatever they wish; it is only a question, as Humpty-Dumpty put it, of who is to be master. Still, it is a definition of psychoanalytic praxis that few analysts

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would disagree with. How they interpret it and how the outcomes differ is another matter altogether.

The "frame" is a concept first introduced by Bateson and since used extensively in sociology and psychoanalysis.² It is the conceptual delineation of the constraints of patient-therapist interaction. The physical constraints are the obvious ones: limited contact, time, money, frequency, promptness, cancellations, vacations, and so forth. There is the mutual contract, to endure and to examine what happens between them. The patient is held to the contract of honest effort, reporting of dreams, associations, and commitment to coming even when he doesn't want to.

Simultaneously, a much subtler definition of limits takes place; a structuring by the therapist, within the first few sessions, of the patient's motivations for being in therapy, his goals, his expectations of the therapist. Moreover, in the process of inquiring, the therapist defines and frames *his* own limitations and areas of competence. A patient who has just separated from his wife and is depressed is not necessarily a candidate for psychotherapy of any sort or, less so, for psychoanalytic therapy. A therapy in which the patient wanders in, states his complaints vaguely, and extracts a tacit agreement from the therapist to treat him has already violated the rigorous constraints of the algorithm. The patient frequently comes into therapy to perfect his neurosis. It is the function of the therapist to create a field of omission, to warn the patient that he will fail him, in that respect. The frame constrains the therapist as well as the patient.

To repeat, the first step is essentially a definition of limits. That means not simply the physical framing of the therapy but defining the limits of possibilities, the limits of commitment, the limits of interest. This may include such embarrassingly

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mundane issues as how busy the therapist is, who referred the patient, the relative ages of therapist and patient, issues of comparative socioeconomic status. There may be vaguer aesthetic issues: is the patient attractive to the therapist; does he/she remind him/her of someone from his past; is he interested in what the patient does or how he lives? The therapist is *never* without motive. He does not begin the therapy cleansed of purpose, and the patient who must believe in this Parsifal-like purity is already entangled in a paranoid net. The therapist must actualize his variables, not exclude them—the latter, a patent impossibility. In countertransference, as was said of the Minié ball, in the Civil War, "You never hear the one that gets you." What is known of the therapist's participation is grist for the mill, what is out of his awareness is what causes problems. Conscious or preconscious awareness of a therapist's motives can be used effectively as a therapeutic instrument, even when it is indisputably "countertransferential."

Khan has a marvelous vignette in his treatment of a very attractive young demimondaine who had been exposed to an elegant seduction by her uncle.³ Dr. Khan arranged to see her on Sunday, charged her a reduced fee, saw her irregularly, on demand. He, of course, did not define this as a psychoanalytic therapy but as an attenuated "psychotherapy."

After violating the traditional constraints of the frame, making special arrangements for her, for no apparent reason other than her attractiveness, Dr. Khan then proceeded to treat her with circumspection and genuine solicitude. She would appear for sessions (on the couch) in miniskirts and see-through blouses and make seductive overtures. Dr. Khan conceives an extremely elaborate hypothesis about her wish to be a boy, and she responds very well to treatment. Was it because of the accuracy of Dr. Khan's formulations or his paradoxical manipulation of the frame? Although he does not say so, I suspect this

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was a deliberate strategy. She would not have tolerated a traditional psychoanalytic frame. By his first seducing and then not seducing her, she was given an opportunity to play through and resolve issues of trust and reliability. It is psychoanalytic psychotherapy; the transference and countertransference is utilized and manipulated but never made explicit and analyzed. For treatment to be fully realized as psychoanalysis, the relationship of therapist and patient with all its nuances and ambiguities must be made explicit.

There is also a temporal dimension to framing. Besides what is talked about, the therapist establishes a very deliberate pacing—neither too rushed nor too slow. The therapist avoids—either by silences, grunts, detailed inquiry, or interpretations—being flooded by material or a loss of therapeutic impulsion. The eager neophyte, wrestling enthusiastically with the material, may find a year later that he is bogged down with a passive, dulled patient. In a successful treatment, the patient carries the therapy. As I shall describe in the next chapter, the *sine qua non* of therapy, the capacity of the therapist to make connections, to hear the “line” of associations depends on the paced impulsion of the patient’s process. Hermeneutics notwithstanding, this sense of timing and pace may be the single most important factor in establishing a working milieu.

To add a somewhat irreverent proxemic simile, it is a bit like lion taming. The tamer must locate precisely his training distance; if he gets too close, the lion charges him; too far, and the beast loses interest. So it is with patients; one finds the working distance and slowly retreats. Hopefully, the patient comes forth. Perhaps a more dignified comparison would be to Martin Buber’s concept of dialogue that depends on both *relation* and *distance*. One both enters the interhuman relationship and simultaneously puts the other at a distance. This

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is a point Buber made specifically for a psychoanalytic audience in 1957.⁴

There exists a very wide range of framing from the loose boundaries of, say, Sándor Ferenczi to the virtual stockade established by Charles Brenner or Robert Langs. “Framing” lends itself metaphorically to the idea that one is simply putting an arbitrary boundary around a piece of life, just as the frame of a landscape defines the piece of real estate the artist has chosen to portray. Thus, one might think of the psychoanalytic setting as focusing the patient’s life or creating a microcosm of life for the patient to experience, for first-hand corrective experience with reality.

This misses the essential nature of the psychoanalytic setting and misconstrues the purpose of the constraints. As Bateson pointed out, psychoanalysis is a game: it is structured *play*; it is not real life. Freud, too, referred to the transference as a “playground.” Still, this is a point likely to offend anyone who equates play with not being serious or with triviality. No such pejoration is intended. Play is serious business; games can be played to the death. The psychoanalytic frame does not simply focus one’s eye; it establishes a set of rules. As Bateson put it, “The first step in defining a psychological frame might be to say that it is (or delimits) a class or set of messages (or meaningful actions).”⁵

Play, by definition, is not what it purports to be. As Bateson pointed out, a nip is not a bite; that is, the dog playing pretends to bite but does not really threaten his playmate. The dog’s metamessage is in his rear end: the front of the dog growls, lays back its ears, bares its teeth; the rear end is elevated, the tail wags. The metamessage is, “This is play!” Puppies are sometimes killed by adult dogs when they misread the message. Psychoanalysis is feasible as a treatment modal-

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ity only because it is play. Otherwise, the patient would simply be having an experience with another person, certainly an expert, a well-intentioned one, but, judging from analysts' personal lives, no better or worse than the rest of mankind. The analyst is freed by the metamessage of the frame, "This is play," to experience himself in a different fashion—if nothing else, to be less anxious—since it is one thing if one's patient never hears anything one says, quite another thing if it is one's mate.

The frame, then, is not a contract in real life, but a highly delimited piece of play, with hierarchical sets of metamessages, and it is this very layering of message and meaning that psychoanalysts explore. This becomes readily evident when one encounters a patient who cannot make the distinction. The patient does not develop a "positive transference"; he falls madly in love (or hate) with the therapist and expects it to be reciprocated. We call this kind of early erotic transference "ominous" and the patient "concretized," with unstable boundaries. Really, the patient doesn't know how or refuses to play the game. A simpler example is the patient who slyly asks, "If you really care about me, why don't you treat me for nothing?" The therapist either maintains silence or lamely explains that, without the fee, the patient would not be really "committed to change." The truth is that we are not the patient's friend but his analyst. It is not a lesser category or a less concerned one: it is simply different. Again, to quote Bateson:

The resemblance between the process of therapy and the phenomenon of play is, in fact, profound. Both occur within a delimited psychological frame, a spatial and temporal bounding of a set of interactive messages. In both play and therapy, the messages have a special and peculiar relationship to a more concrete and basic reality. Just as the pseudocombat of play is not real combat, so also the pseudolove and pseudohate of therapy are not real love and hate.⁶

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From the Freudian viewpoint, this defines the playground in which regression can take place and the patient can experience his fantasy distortions. From the interpersonal perspective, it is a situation of augmented and clarified semiotic message rendered unique by the framing and permitting patient and therapist an opportunity to examine the layering of semiotic experience first-hand.