then shift that posture into the relationship with the therapist and again try it out.

Will he arrive at the right answer? I doubt if there is one. I suspect that cure emerges from the successive enrichments of perspective as this circling through the data proceeds. The dream of the optimal insight, the "Aha! at last I see that . . . " is an ever-elusive Holy Grail. I don't believe it happens, because life is not that simple. If it were, one would be having bad experiences but not, from my viewpoint, the mystification that makes for neurosis. Unmystified parental abuse makes for angry people, perhaps psychopathic ones, but not for neurosis. The neurotic crimes are either crimes of omission, the failure to provide an experience that cannot be clearly missed because it was never experienced; or crimes of commission that are so obscured that the patient cannot define them.

Children, I have noted, will tolerate and even show compassion for severe parental defects, as long as they are clear what it is that is wrong and clear that it is not their doing.

The significant insights in therapy, and they do occur, are not solutions but *connections*—connections drawn between previously unrelated events. Much of the excitement of the therapeutic play is the sense of seeing first-hand how things hang together. What, after all, was the Sphinx's riddle?—an analogy requiring a novel shift of perspective, seeing a connection that was heretofore unapparent: four legs, two legs, three—*Man!*

CHAPTER 8

Praxis: Uses of the Transference

Words are also deeds.
—LUDWIG WITTGENSTEIN

THE THIRD and most definitive step of the psychoanalytic algorithm is the utilization of the patient-therapist transaction: classically, as a screen on which the patient can project his fantasies; as the object-relationship therapist would have it, as a mirror in which he can see his self (not himself) reflected; or, from an interpersonal reference, as an interactional field that can be observed as it takes place. From the intrapsychic viewpoint, the therapist's participation is unwanted, a warp in the screen, a flaw in the mirror. From the interpersonal view, it is intrinsic to the dialogic participation which is the *vis a tergo* of therapy.

All psychoanalysts would agree that the patterning of the patient-therapist field is redundant; that is, that it repeats the patterning noted in other parameters of the therapy. It is at this point that the parting of the roads occurs and the implications are immense. An entirely different paradigm is implicit;

from giving the patient an arena in which to actualize and contact his fantasies, we have gone to participating with him in what may be called a *language-act*. The focus has become language.

It must be understood that when the therapist talks with the patient, he *behaves* with him. Therefore, every verbal exchange (and those are the only ones officially sanctioned), every interpretation, consists of a piece of behavior with the patient and then a commentary, in speech, on that behavior. The commentary, the content of the interpretation, is, then, our old friend, the metamessage. From this perspective, the classical effort to purge interpretations of all participatory intent seems illusory. The therapist cannot help but be there.

When psychoanalysts of different persuasions settle down to examine clinical data, it is in a virtual field of straw men replete with murmurs of "Of course, we take that into account . . . " It is therefore necessary to examine what therapists commit to print, since we may assume that the written word represents their considered position and bears the imprimatur of their editors. It is unfortunately true that any clinical presentation, particularly a written one, is so adumbrated as to have the vitality of a pinned butterfly. Any effort to "present" clinical material is simultaneously an act of courage and a murder. Even unkinder things may be said of attempting an exegesis of someone else's presentation. But the consequences of underestimating one's interaction with the patient are crucial and must be examined.

I wish to use a brief part of a case presentation by Charles Feigelson as an example of a therapist's attempt to treat his participation as neutral.[1] Dr. Feigelson, a faculty member of the New York Psychoanalytic Institute, defines the psychoanalytic technique in this way: "We interpret defenses, we interpret what is defended against, we interpret the reasons for the

defense."[2] He also quotes Freud's caveat on focused attention that would lead to the therapist's selection, unwittingly, of the data. Thus, neutrality is enforced, if the therapist maintains "evenly suspended attention."[3]

Feigelson tells of a thirty-four-year-old homosexual man. It is important, first, to note that there is no question, in the mind of either the therapist or the patient, that a successful outcome of the treatment will make him heterosexual. Moreover, it is clear that the patient agrees that he has come into therapy in order to relinquish his homosexuality. The patient has apparently, with some persuasion from the therapist, just had his first heterosexual experience with a prostitute. He did not particularly enjoy the experience and felt removed, but not repulsed.

He reports the following dream: "I was in a Spanish-style house; there was a room which had cracked walls, like the canvas had been torn away. It was like a room that I had canvassed for my mother; it was wet and moist." As he described the wet, moist sensations, he began to experience them, and this suddenly reminded him of the sexual feelings with the woman, and he was somewhat surprised that he had previously dissociated this awareness of the feeling of intercourse. In the dream, in the room, there were feces coming out of the cracked walls. Walking around in this Spanish house was the Pope; he was a benevolent Pope, and he felt in his dream that he was being somewhat irreverent. There was also a tiny bull lodged in some concrete or cement, and it had shiny gold horns." The patient talked about the horns as representing penises, and he thought how much damage they could do.

Feigelson's interpretation is that the patient had felt the sexual experience was like being in a bullfight and that "his precious golden horns would be dirtied by the woman's crack." The patient responded to this by wondering who would be the bull and who would be the matador. He felt that the woman

would be the matador and that he would be killed. "It was the experience of wet and moist that came to him as part of his dream experience that helped him to know that his dream had to do with his sexual experience. It lent conviction to the interpretation of the dream."

To begin with, the interpretation made by the analyst utilizes only a small part of the imagery in the dream—that part of the manifest content which supports the therapist's formulation of the significant theme, the "latent content." Any interpretation is not only a perception of meaning in the dream, but it is a participation, a piece of behavior on the therapist's part. The therapist tells him that his sexual experience was "like a bullfight" and that his "precious golden horns would be dirtied by the woman's dirty crack." The use of words like "precious" and "dirty crack" and the attitude of the interpretation imply that the therapist is indicating some scorn and disapproval of the patient's fastidiousness and repulsion by female genitalia. The therapist is taking a rather forceful, macho position, as if to model for the patient an appropriate role. So, one has both the content of the interpretation (which, albeit possibly correct, is limited) and second, the behavior and metacommunication of the therapist *around* the content, which pressures the patient toward a heterosexual adjustment.

In the dream, the room has cracked walls "like the canvas had been torn away. It was like a room that I had canvassed for my mother." The cracks in the wall, the peeling "canvas," and the references to feces coming through the wall could also certainly imply something about his experience in a real sense with his mother. One might suspect that she was either psychotic or in some way very unreliable as a mother figure. This is not in any sense taken up later in the material. Why was it a Spanish-style house? There is one suggestion from the material that the patient is of Latin origin, either Spanish or Italian, although that is never made explicit. Now, why the Pope? No comment is made on the obvious verbal pun of the papal "bull." A papal bull is, of course, an official document, edict, or decree from the Pope. One way of conceptualization is in Jacques Lacan's or Martin Heidegger's sense of the hidden archaeology of words. It is also metonymy; that is, a partial concept that stands for a larger whole. The literal meaning of "bull" is from the Latin *bulla,* meaning a knob or seal, originally a seal affixed to a document, especially to one from the Pope. It would seem that the transference implication of the dream was that the Pope ("Papa" in Italian, or father or analyst) was attaching his paternal seal to the patient's heterosexuality or to something in his relationship with women or his mother. Moreover, it is a tiny bull, it is embedded in cement, and it has shiny golden horns. The contrast between the gold of the horns and the rest of the bull implies something about the patient's ambiguous feelings about the value of the papal injunction. One might suspect from this, in a transferential mode, that he has some marked misgivings or ambiguity about the value of the therapist's help, particularly in pressuring him to be heterosexual.

If one were to postulate that instead of an oedipal castration anxiety, as the therapist formulates it, there is a much deeper terror and distrust of the mothering person, one might have been inclined to pursue more what his experience had been with his mother. However, the patient does become heterosexual in the course of therapy (certainly no small effect), but one might wonder whether it was the validity of the interpretation that brings about his heterosexuality or the model of the therapist as a powerful, somewhat disdainful father who pushes him through his phobic terror of women. Paradoxically, he may very well have become heterosexual as a submission to his therapist. Perhaps his problem is resolved; or perhaps his terror of the

woman is simply pushed much deeper underground. One can become heterosexual as a homosexual submission!

Interestingly enough, in a series of subsequent dreams presented in the clinical material, the issue of the patient's hostility toward the father and fear of the father and fear of killing the father is focused. But hostility is never discussed in relation to the therapist! It is never focused as an issue in the transference clustered around a real issue between the therapist and the patient: the patient's becoming heterosexual because the therapist considers homosexuality "pathological." Supposing the material had gone in another direction—namely, to investigate the patient's feeling that he had to be a good boy and become heterosexual, because that is the way to be, because that is the only way he can win the father's approval and love. This might have released him to be heterosexual; or it might have given him the room to explore what might underlie his homosexuality, some kind of terror and rage towards the woman. This would also open the possibility of exploring what actually went on in his childhood home and to what extent the father colluded in not permitting him to see something about the mother's mothering. Or did the father insist on an obsessional heterosexuality to cover his own homosexual attachment with his son, or *his* horror of women?

The patient would understand not only that he is afraid of his father, afraid of killing his father, and afraid of his father's rage, but also that he is horrified by his mother, frightened of all sorts of dimensions of his experience with mothering, that he perhaps prefers homosexuality and should stay a homosexual, that he has an autonomous decision to make about what really interests him sexually and how he wants to live his life. He might come out of the therapy a satisfied homosexual, or a heterosexual for conventional reasons, or a heterosexual because of a genuine change of erotic object.

Any therapist's "interpretations" do not talk to the patient's unconscious; they are *acts* with the patient that influence his participation in the therapy. In addition, they serve to divert the patient from what the therapist is *doing* with what he is saying. The patient's symptom, his homosexuality, does not disappear, like Rumpelstiltskin, because its name is known, but because of his experience with the therapist. In a more interpersonal mode, the emphasis would be on the observation and reporting of the therapist's participation, as noted by the patient in the dream and as validated by the therapist's awareness of his own investment in the patient's change.

Psychoanalysis is not what Anna O. so felicitously named the "talking cure"; rather, it is the cure that reestablishes the relationship *between* talk and behavior. *Psychoanalysis deals with what is said about what is done.* Leo Stone called speech "the veritable stuff of psychoanalysis." More recently, Paul Ricoeur has said that "there enters into the field of investigation only that part of experience which is capable of being said."[4] I quote these two contemporary sources to affirm that this is by no means a vestigial concept. Yet, we know that all the talk in the world doesn't change patients, that persuasive formulations of psychodynamics can fall flat, and that neophyte analysts more often talk too much than too little. It seems that what these authors really imply is that psychoanalysis is the *nonacting* cure; that is, what is acted out, not talked about, cannot be encompassed in the treatment. This would certainly be consistent with Freud's position in "Remembering, Repeating, and Working Through": "He [the therapist] celebrates it as a triumph for the treatment if he can bring it about that something that the patient wishes to discharge in action is disposed of through the work of remembering."[5]

But the distinction between speech and action is often very obscure. Some acting-out seems clearly more like a vivid non-

verbal language than pure evasion; and it is often precisely at this elusive interface of action and speech that the most impressive psychoanalytic insights take place. Consider the patient who announces that he could not possibly be angry at the therapist and then kicks over the latter's cocktail table; or the therapist who is unaware of his anger with a patient and finds, to his horror, that he has forgotten to appear for a session. These examples might be considered simple parapraxes, yet they are one end of a continuum of behavior that ranges through more precise symbolic reenactments of psychoanalytic content onto a far subtler resonance between the subject material—the "talk" of therapy—and the patterning of the transference, the behavior.

For example, a patient dreams she is sitting in a Japanese restaurant, unable to decipher the menu. At a table next to her sits a man with graying hair who holds the menu up in the air and points out to her a rather simple shrimp dish. She now knows what to order. When asked what she makes of this dream (she does not volunteer), the patient replies, "At first, it didn't make any sense to me, but then I thought to myself, what would *you* say about it?" She then proceeds to present a quite sophisticated explication of the transference aspects of the dream, and, indeed, some of the countertransference implications. Does she not *play out* between us the content of the dream? She must read the therapist's instructions (even if they are "simple" or "tiny"). She does it everywhere: she can only arrive at a decision by first applying the template of someone else's experience. Surely, all this between us is mediated through speech; but is it not also action, speech-as-behavior?

The debate begins to sound sadly familiar. Is it acting-out, acting-in, or parapraxis? Should the term "acting-out" be limited only to behavior that repeats earlier infantile experience?

It seems much the same ambiguity that pervades the discussion of countertransference. What is real, what is not real, what is regression, how much "participation" is permissible on the part of the therapist? The distinctions so clear to Otto Fenichel and Menninger become, for many of us, increasingly obscure. If transference is the "playground" Freud considered it to be, what happens in the playground?[6] If there is regression in the transference, is it only talked about? Can it be only talked about because the therapist will not play? Or, is the transference a variety of that old playground activity, Show and Tell? These dilemmas have been increasingly festooned with metapsychological elaborations designed to bridge the widening gap between orthodox restraint and more radical participant observation. We see this particularly in object-relations theory and its application to borderline syndromes, where much emphasis is put on appropriate and useful responses. It is, to some extent, like bolstering a sinking house by adding another story. Certainly we must agree that speech mediates therapy, but why not look at the nature of the medium, in addition to what is carried?

This apparent dilemma about talk and action—about what is capable of being said and what needs to be shown—is, I suspect, more apparent than real, developing out of a series of misconstruings about the nature of language and its role in psychoanalysis. The confusion begins with the failure to distinguish between speech and language. Ferdinand de Saussure, the Swiss linguist, clearly delineates *parole et langue.*[7] Parole is, of course, "talk," the spoken aspect of language. Language is, in de Saussure's aphorism, "speechless speaking." It is the whole set of linguistic habits that allow an individual to understand and be understood. That is, it encompasses those conventions, rules, or givens that govern the syntax, grammar, and se-

mantics of the spoken communication as it emerges from this matrix.*

Further, as I indicated in chapter 5, one must distinguish between language and semiotics, first defined and named by C.S. Peirce. To repeat Anthony Wilden's definition, semiotics refers to "the transmission of signals, signs, signifiers, and symbols in any communication system whatever." In the hierarchical ordering there is speech, then the intricate machinery for processing speech (language), and finally a more extensive system of coded communication, which involves speech, nonverbal cueings, and, most important, the cultural and social context, the "pragmatics" of communication.† Psychoanalysts have traditionally been concerned with pragmatics. Lacan, the stormy petrel of French psychoanalysis, with his emphasis on "symbolic, real, and imaginary" imagery, seems primarily interested in the semantics of semiotics. His preoccupation with the "word" (with meaning) makes him very difficult for psychoanalysts (or anyone else, for that matter) to read, since there is absolutely no pragmatic base for applicability of his position.[9] It's all very well to claim (from the structuralist viewpoint, correctly) that the unconscious is structured like a language. But how does one talk to it?

It must be understood, then, that speech, spoken language, is only a small part of an extensive semiotic communication that occurs between the two participants in the analytic process. I am suggesting something considerably more elaborate

*This distinction between speech and language is perhaps most vividly illustrated by ethological studies with chimpanzees, which have no speech capacity but considerably more language resources than we had heretofore suspected. Washoe, the first chimpanzee to be cultivated linguistically, had an extensive repertory of sign language symbols and could recognize hundreds more. Lucy, another chimpanzee, was able to construct compound words: "cry-hurt-food" for a hot radish, "dirty cat" for a cat she didn't like. This is certainly semantic creation.

†This can open a can of worms, since the French treat language as more encompassing than semiotics, and the Americans follow the hierarchy I have indicated. See Walker Percy for a discussion of this issue.[8]

than simply the idea that one must also pay attention to how the patient sits or looks. I am suggesting that there are other coded communications, as informational as speech, that take place in the realm of the intersubjective.

To begin with, language is also a form of behavior. This concept is familiar as Bateson's "metacommunication"; that is, every communication is a message and a message about the message.[10] There is quite a bit of literature in this area, but it is generally agreed that the metamessage acts upon the environment, as a "command" or set of instructions. Thus, language does not only communicate but it acts upon the environment. It is a process of making. To put it simply, when we talk with someone, we also act with him. This action or behavior is, in the semiotic sense, coded like a language. *The language of speech and the language of action will be transforms of each other;* that is, they will be, in musical terms, harmonic variations on the same theme. The resultant behavior of the dyad will emerge out of this semiotic discourse.

This has also been implicit in Sullivan's concept of participant observation.[11] In its original, discrete use it meant, I believe, to behave with the patient in a manner that maximized one's communication and minimized distortion. Later it came to mean using one's participation less as an arbiter of reality and more as a source of interactional data. But, ultimately, both from the operational viewpoint and the semiological, it means that every communication is a participation, which changes the communication, which changes the participation. Every line of inquiry, including silence, is a choice of alternative participations. There is no way to be with another person, regardless of the therapist's restraint, without interacting with him.

To understand the effect of an intervention one must consider both the semantics and the pragmatics. The effect depends on the attribution of meaning, plus the behavior of the

dyad around what is being said. This is akin to P.F. Strawson's division of a statement into what you are saying and what you are saying about it.[12] In some cases this division is obvious. A therapist can make a quite accurate interpretation out of anger or a need to distance or seduce a patient. The patient will perceive the meaning of the communication in the behavior. But there are subtler implications.

A young woman dreams of being the princess with the pea under her mattress. The therapist suggests that she may be referring to an excessive touchiness or sensitivity to criticism. The patient feels hurt and begins to cry. This kind of resonance between content and behavior illuminates, I believe, the heart of the therapeutic dilemma. The therapist must deal with the content of his interpretation and the simultaneous transformation of his participation in to the role of sadistic accuser. Surely the tearfulness is both confirmation and resistance, and surely any reasonably competent therapist can handle this impasse. One doesn't need semiotics to know how. But, like the man who fornicated quite expertly without knowing what he was doing, the therapist is willy-nilly practicing a semiotic skill. I must agree with Marshall Edelson's claim that psychoanalysis is a semiotic science and that

> linguistic competence—the internalized knowledge of language that is possessed without conscious awareness of it or even the ability to explicate it—is a significant foundation of the psychoanalyst's clinical skill. . . . Much of the understanding the psychoanalyst attributes to empathy, intuition, or conscious or unconscious extralingual information actually derives from his own internalized linguistic (and semiological) competence, of whose nature and existence he may be altogether unaware.[13]

To recapitulate my four postulates: first, speech and language are not coterminous; second, language is to be subsumed

under the larger rubric of semiotics; third, language is simultaneously behavior; and last, behavior is structured like a language, or behavior is simultaneously language. Singly these postulates are not terribly radical, but combined, several conclusions become inescapable. First, there is no real discontinuity between speech and action. Secondly, "acting-in" the transference is not something that occurs intermittently at times of distress. It is a semiotic dimension. It goes on continually, and the relationship between the patient and the therapist is played out, over time, in a patterned, structured way. This *discourse of action* is isomorphic with whatever the patient and therapist are talking about. It is also isomorphic with whatever the patient has told the therapist about his outside life in the present and historically. Every dimension of the therapy—history, contemporary issues in the patient's life (and the therapist's), dreams, memories, acting-out, acting-in, transference, countertransference—all are of a piece. The therapist's ability to range across these transformational variations of the patient's themes is, as Edelson's quote affirms, the therapist's true metier.

From this perspective, countertransference cannot be considered a response only to the patient's real and present self. It must be a response across *all* these dimensions. Nor can it be only feeling about the patient; it must also be behavior toward him. We are interested in countertransference not only because it distorts the truth of what we tell the patient but because it determines the way we behave with him. And, it is the correspondence of that behavior with other "languages" of the therapy that makes the treatment go.

Let us suppose that the patient is reporting on inexplicable childhood beatings at the hands of his father. The therapist listens in silence. The patient accumulates and expands his sense of fury and finally abreacts in an explosion of heretofore

suppressed rage. But it is quite likely that the patient is identified with his father, is perhaps subtly sadistic toward his own children or the therapist. He cannot hate the father without hating the father-in-himself. Thus his abreaction leads into another morass, namely, his self-loathing. Suppose that the therapist, instead of listening quietly, asks for more details, attempts to establish what the father was so angry about and what the context of the beatings was. Certainly this is a different participation. It may undercut the anger, but it may make the father more comprehensible and release the patient from his self-loathing. Let us suppose, as a third alternative, that the therapist listens to the tearful report and thinks to himself, "I can understand why someone might want to bash this guy." This may not demonstrate the proper psychoanalytic sang-froid, but it does cue the therapist in to some aspect of the patient's behavior that the father found himself impotent to deal with rationally.

All these constitute initially different participations with the patient around the same material. One might argue that all but the inactivity are bad technique. Presumably the patient will progress along his own trajectory if the therapist stays out and waits. But silence *is* a participation. It might qualify as a universal nostrum if the patient always got around to further explication. But that may not be so; sometimes resolution requires a participation on the part of the therapist, often at some risk to his neutrality. Sometimes our best results follow countertransferential acting-out, losing our tempers, making mistakes. We may be left with an uneasy feeling that if things had proceeded properly, nothing would have resulted. Did Sullivan have this in mind? He is reputed to have said "God keep me from a therapy that goes well!" The material may never emerge if action is not taken; sometimes interaction with the patient must precede explanation. This is particularly true with patients we label borderline or schizoid. For these distrustful people, the correspondence of word and deed must be very high.

Therapeutic effectiveness, then, depends on the correspondence of "show" and "tell." In the examples I used earlier I focused on the patient's replaying in the dyad the material that is being talked about. What does the *therapist* do? Interpretation is not enough, since an interpretation, factually accurate, can be contextually wrong. A variety of working-through takes place—not analysis of the patient's resistance to the interpretation but, rather, a changing participation with the patient around the material. The therapist must operate with the patient in some way as to be "heard."

Let us take that classical purveyor of therapists' despair, the masochistic patient. What is a sadist? Someone who is kind to a masochist, goes the old joke. Sado-masochistic impasses are not resolved by recourse to interpretations, which progressively become acts of desperation or rage on the part of the therapist. Something must happen between them. The therapist who feels benign is not only remote, he is being sadistic. The therapist who feels kindly is repressing his own rage and is afraid of his sadism. What is left? There is a zen koan: "What do you do when you are hanging over a cliff, holding on with one hand?" "Open your fist" is the answer. The therapist must recognize that there is no way to "hear" the patient without feeling angry and sadistic. There is no way to get that feeling out of the therapy except by dissembling, and a lie in behavior is no less abusive than a lie in speech, so the therapist is, again, sadistic. Perhaps a true discourse requires that the therapist be permitted to feel angry and perhaps even sadistic, but without mystifying or double-binding the patient. This would establish a harmonic integrity between the transference and the rest of the patient's life. The message might be heard and the discourse enriched. I don't know if this is really inevita-

ble, but it seems to me a logical extension and well worth considering. Corrective emotional experiences largely disappear in the tar pit of the patient's self-equilibrating system. I doubt that the patient grows because he is supplied with a nurturing environment. I suspect the patient must be engaged, encountered. If behavior is a language, then it must be heard and reacted to. To be detached from an angry person may be to hear him on the speech level but not to hear him on the level of action.

This is not to imply that all the patient's communications are characterologically fly traps. One can also hear simple requests, quiet messages. To those, the therapist can answer directly. For example, the therapist informs the patient that he is going on vacation. The patient asks, "Oh. Where?" Whether the therapist says nothing, asks for fantasies, or casually or perhaps even enthusiastically tells the patient depends on his "third ear," his unconscious linguistic skills. He could be wrong, but at least he listened. Doctrinaire positions about how one should handle this kind of exchange (for example, the patient *always* feels deserted) seem to me shouting in the wind. Perhaps one should shut up and listen and respond.

There is another genre of exchange that can be found touted as proper technique in a number of books and articles. This example is from Ralph Greenson: a patient points out that when he expresses opinions that match the therapist's, he gets marginal cues of approval; when he doesn't, he is subjected to masked hostile analysis. He documents this position with examples. The therapist, decently and honestly, is amazed at his blind spot. He validates the patient's perception, admits his fault, and then asks, Why do you feel obliged to satisfy my political views?—just at the time when the patient has struck back.[14] He plays out exactly that kind of authoritarian inquiry of which the patient complains. The discourse doubles back

on itself and stops. What does it say but, "Very well, you caught me and you were right; now, let's get back to working on you." Why not wonder how they got into that subtle coercion? How does it match with other aspects of the patient's life? What was called out in the therapist? Let us suppose the patient was always very submissive to his father's opinions. That does not explain why the therapist coerced him. Or, if the therapist has that tendency, it does not explain why he did it with this patient, or why he is so astonished to be found out. Would it be unscientific to suggest that they talk about their mutual experience rather than "analyze" it?

To summarize: psychoanalysis had originally postulated a serious antinomy between word and deed. It was the "talking cure," and what was acted upon could not be spoken about, or analyzed. Classically, psychoanalysis had no real lexicon for behavior, and it befell Sullivan to introduce the operational concept of participant observation, a concept that has broadened considerably since its introduction. (See Gerald Chrzanowski for review of contributions to the participant-observation paradigm.)[15] It now encompasses a rather wide range of behaviors and perceptions on the part of the therapist. Otto Kernberg, Heinz Kohut, Hyman Muslin and Morton Gill, and Roy Schafer have recently championed more orthodox revisionisms of traditional psychoanalytic theory.[16]

Transference, as a concept, makes very little sense if one conceptualizes the patient as only talking or fantasying in the field of an inactive blank-screen analyst. It is a denial of the operational reality that communication (if not speech) always goes on and that the transference arena is a subtle, ongoing dialogic discourse between the two participants even when the therapist is totally silent.

Linguistic concepts make it possible to view language as more than speech and much less than the total field of semiotic

communication. From this viewpoint action, or behavior, *is* a language that will be a precise transform of the speech. What the patient and the therapist talk about will be simultaneously shown or played out between them. To reiterate: *the power of psychoanalysis may well depend on what is said about what is done.* This is a continuous, integral part of the therapy, not an intermittent artifact of bad therapy. Ludwig Wittgenstein said, "What can be shown cannot be said," by which I suspect he meant that talk and action are really different modalities, parallel but not interchangeable. Therefore, I am not suggesting that the therapist match his behavior to what he hears by being the good father or stern father or whatever. The interaction must be as authentic and perplexing an aspect of the total discourse as is speech. I don't think it is ultimately possible to know why change occurs, but I feel reasonably sure change is not a consequence of the communication of meaning alone. The linguistically alert therapist, by paying attention to the concordance of spoken and acted language, facilitates the process even if he doesn't know exactly what it is he is doing.

The psychoanalyst—he who talks with his patients—is the person who is trying to understand and clarify an ordinary process, really most naturally performed without thinking too much about it. Cloaked in structuralist trappings, the inquiry has tones of grandeur. As Roland Barthes put it, "Once again the exploration of language, conducted by linguistics, psychoanalysis, and literature, corresponds to the exploration of the cosmos."[17] But, put in humbler terms, we are trying to figure out how we manage to put one foot in front of the other without falling on our faces in the process.

CHAPTER 9

Psychoanalysis: Cure or Persuasion

When [psychoanalysis] becomes an institution, when it is applied to so-called "normal subjects," it utterly ceases to be a conception that can be justified or discussed on the basis of cases; it no longer cures, it persuades.
—CLAUDE LÉVI-STRAUSS

THE ACT of psychoanalysis, the praxis of therapy, follows a commonly-held algorithm. This algorithm is not derived from theoretical or metapsychological postures but is arrived at empirically. It works because it taps into an intrinsic deep structure of cognition. It contrives a game, a highly-augmented situation in which semiotic transactions can be observed and influenced. It must be emphasized that its efficacy, no different from that of other forms of propagandizing influence, depends on its resonance to deep structures of thought. It can, therefore, be used to different ends. What is cure and what is persuasion? In psychoanalysis, the danger is that the theory becomes