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WITH A NEW INTRODUCTION BY
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CHAPTER 5

The Symptom as Meaning: Intrapsychic vs. Interpersonal Perspectives

When the devil seals a contract, he takes,
as a token of the soul, something
insignificant, perhaps a tiny, almost
invisible piece of the nose . . .
—A folk tale

AS KARL MENNINGER has pointed out, Freud never devoted a book to technique, although "It may be this—the creation of an instrument of investigation—that will ultimately rank as his most important single contribution."[1] As I have indicated, for reasons of cultural and personal import Freud focused his attention on the development of a metapsychology, biologically and energically based. The traditional metapsychological perspectives—dynamic, genetic, topographic, structural, adaptive, and economic—essentially are simply different metaphors for the same energic mechanical paradigm. Some later theoretical developments, as Schafer put it, "may be subsumed under one or more of the traditional metapsychological points of view, while others, though couched in metapsychological language, may be shown to require the development of alternative theoretical language."[2] It is presumed that defenses contain, modify, and distort instinctual forces. Infantile sexuality is central to this thesis. The child must deal with powerful, uncivilized impulses. It is the function of his own defenses, his family, and society to contain and modulate them. Thus, it is understood that the little girl sitting on her daddy's lap is having anxiety because of her sexual feelings. If Daddy tickles her, this is a stimulating real event that may imbalance her controls but is not central to the theory.

From the interpersonal perspective, the sexual impulses of the child are not denied, but they are not the source of the problem. The child will become anxious if the father is anxious. Anxiety for Sullivan is an interpersonal event, a disruption in empathy. The father will become anxious if he is frightened by the child's feeling or his own seductiveness. Some obfuscation of this exchange will then occur. For example, the little girl wiggles on Daddy's lap. He suddenly becomes irritated and says, "Get off my lap if you can't sit still! Why must you jump around so!" The child is hurt but also mystified.

This is to some extent an oversimplification of both positions. Freudian psychoanalysts could claim with justice that they have gone far beyond this early formulation. But, I would claim that this very basic bifurcation in perception and purpose still lurks under the later, more sophisticated and ecumenical developments of psychoanalysis.

It might be argued, what difference does this difference make? Both sides of this alleged schism agree to the basic psychoanalytic algorithm. Both sides agree that family and society work to mold and contain the emergent child. Perhaps it is a chicken-and-egg question: does the child's fantasy lead to a

distortion of the real event or does the real event lead to a distortion of the child's experience and, hence, a fantasy. Does it matter?

For the intrapsychic position, the enemy is within. For the interpersonalist, the enemy is without. From this latter perspective, the patient learns that his perceptions are shaped *in* interaction with others—not, you will note, *by* the reactions of others. The patient is not a passive victim. But he is being indoctrinated into a world where people act to maintain their own social stability. To this end, *semiotics*, not merely language, is the requisite skill, and to develop that skill a great deal of unambiguous experience is necessary. The child who lives in Sullivan's *parataxic* mode does not yet understand the relationship of events. He can grasp the issue of causality in the world only as it is told to him. To develop the *syntaxic* mode, he must order the world, put events in proper perspective. (Patrick Mullahy has the clearest definition of Sullivan's "horrendous" Greek trilogy of prototaxic, parataxic, and syntaxic. As the root suggests, the child learns reality as it is organized and ordered in language.)[3] This is a learned skill and a social one. Our patients are disabled not by their drives or inadequate defenses but, rather, by an inability to read and interpret the world, to grasp nuance, and to operate with sufficient skill to affect the people around them.

Perhaps a clinical vignette will help illustrate the difference. The patient is a twenty-eight-year-old man, a physician. He is a very attractive, cultivated man with impeccable academic credentials and flawless "Ivy League" manners. Neither his name nor his chiseled features would suggest that he is from a middle-class Jewish background. Both the name and the features have been altered: the former legally by his parents, and the latter surgically by him. It is of note that the rhinoplasty took place at age thirteen with the encouragement and cooperation of his parents, particularly his mother.

He is perfectly willing to be identified as Jewish, but his rhinoplasty is the most shameful secret of his life. He has never been able to reveal it to a lover or friend. His anguish approaches a state of idée fixe although he seems otherwise a reasonable and successful man. He is not disabled in social or professional functioning, although, of course, his secret acts as a barrier (or excuse for avoidance) of intimacy. The piece of his nose has been, for him, indeed a contract for his soul.

It's a silly enough problem. Is it simply false pride, arrogance, narcissism? If so, we know something about his character structure. Perhaps he is a "Portnoy," a narcissistic character, his self-esteem unable to tolerate this small flaw. Or, perhaps it is a small symptom with deep and malignant roots. It might signify his lack of authenticity, his tragic flaw revealed. Or, perhaps it signifies castration anxiety, either literally conceived or in the more abstract guise of a displaced doubt about his sexual attractiveness and penile competence. He does clearly feel mutilated and reduced.

Clinical case conferences have a field day with this kind of neat, extruded symptom. One will hear from colleagues a wide variety of what, if you will forgive a pun, one might call nosological assessments. In another, less professional milieu they would sound suspiciously like value judgments. On such occasions the depth of the analyst's religious convictions and the length of *his* nose often take precedence over metapsychological considerations. Or, more blatantly put, metapsychological and diagnostic considerations lend themselves rather facilely to personal prejudices.

At any rate, in therapy all efforts to engage the fantasy that underlay this man's inordinate distress were unavailing. On one occasion, he was again obsessing about whether he could bring himself to tell his fiancée his secret. The usual circular inquiry resulted. He then quite casually mentioned that he would need

to change an appointment later in the week. He did not volunteer the reason, although it was not uncommon for him to rearrange hours to meet his hospital schedule. Nevertheless, the therapist inquired and was informed, again casually, that he was entering a hospital overnight to have some minor surgery done—a correction for a deviated septum in his nose. Why hadn't he mentioned it? It hadn't seemed important.

The therapist suddenly remembered a childhood occurrence the patient had reported a few sessions back. He had been accosted on his way home from school by a boy who threatened him with a knife. He had talked his way out of trouble, rather cleverly, but on his return home did not mention the incident to either parent. Why? He was not sure; they could be counted upon to respond reasonably and appropriately. His mother, particularly, had always been concerned and solicitous in a way that he somehow could never appreciate, although he did not understand why.

When the patient now revealed that he was to undergo surgery, the therapist made some vague sympathetic gesture, although post hoc he wondered why, since he was rather irritated with the patient's withholding information about the much-celebrated nose. On the other hand, the operation was really a very simple procedure. Why should the therapist feel offended at the exclusion?

At this point it occurred to the therapist that he had never thought to wonder why the patient felt obliged to tell his terrible secret, whatever its origins. Granted that it *was* an absurd concern; wasn't it his business whether or not to talk about it with others? Does intimacy depend on total revelation? Clearly, the patient felt that his relationship with another person would be irrevocably contaminated by withholding. Surely, though, it would have been a far more parsimonious solution for him simply to decide that, crazy or not, those were his feelings and he would keep them to himself. The patient was initially shocked and then intrigued when presented with this novel possibility.

One notes that the field of inquiry has shifted here from the meaning of the symptom to him as a solipsistic experience to the meaning of the symptom as a social event. Privacy, it developed, was not considered a manifest virtue in his family. Honesty and openness were encouraged. Secrecy or secretiveness were frowned upon and when he was "open" and revealed his feelings to his mother, she would respond empathetically and with concern. This was as true of his angry feelings as of any others. She always knew just how he felt and shared his distress. When he was upset about his appearance, she rushed him to the plastic surgeon. So, as in fairy tales, where the reward given by the magic helper is always much more than the recipient bargained for, the patient, like King Midas, got his wish. He was one of those unfortunate children of liberated and insightful parents who was doomed never to be misunderstood.

How could a child resent a parent who wanted to know everything and was sympathetic, concerned, and helpful? How could a child distinguish a symbiotic cannibalizing of his feelings from legitimate concern? To do so requires a very high degree of interpersonal skill and perceptiveness. Alice Miller has described this childhood dilemma with great sensitivity in her book *Prisoners of Childhood*. Coming from an object-relationship viewpoint, following the work of Donald Winnicott, Mahler, and Kohut, she says:

> The child has a primary need to be regarded and respected as the person he really is at any given time, and as the center—the central actor—in his own activity.[4]

It has been said that masturbation is the child's first autonomous activity, the first self-gratification possible without the parent's participation. It may be that later, in preadolescence, lying and withholding are necessary developmental skills, protecting a precariously balanced sense of self until the adolescent (and postadolescent) develops semiotic skills that permit him to distinguish between authentic response and spurious concern. I suspect that trust in others (not that elusive infantile benediction, "basic trust," which is supposed to make the child forever-after trusting) *is* lost in preadolescence and recaptured as the child learns the extremely subtle variations in nuance of play: teasing, hurting, sarcasm, affectionate "ragging," irony. These are the exercises for the development of semiotic competence, as will be elaborated later.

Much of what has been described as "narcissism," a psychoanalytic rubric, can be equally subsumed under a semantic heading of sentimentality. Sentimentality can be defined as an investment in emotion as an experience, rather than as a transaction. The sentimentalist wishes to *feel* loving, to experience himself as a loving person, rather than to love someone. It is love in the intransitive state. The sentimental person appears warm, concerned, loving. How does the child distinguish between being a recipient of the other's caring and a bystander? It is very difficult. One can grow up in a family where the parents are sustainedly concerned, friendly, democratic; where the adolescent turmoils and dissensions never take place; and yet, the child is left with a vague gnawing dissatisfaction, a feeling, could he put it into words, of having been unengaged, neglected. A parent may avoid the child's anger, not out of fear of aggression—a dynamic explanation—but because he does not wish his "feeling good" disrupted. As Oscar Wilde put it, a sentimentalist is simply one who desires to have the luxury of an emotion without paying for it.

It is the thesis of this book that people do not run into difficulty because terrible things were done to them, or because they distort ordinary experience into terror, but because they are tangled in an elusive semiotic web of omissions, simulacrums, and misrepresentations. The problem with narcissism is not so much that it is depriving, which it certainly is, but that it is confusing. A deprived child can, often does, turn elsewhere—to a sibling, to the other parent, to a friend's parent. But the confused child stays put, wondering why the love does not satisfy.

Thus, a patient begins a session by describing a play he saw in which a woman was untouched by life until an angry lover slashed her face. It was her first marking by experience. He then goes on to report a dream of two parts. In the first he is going skiing and an attendant is helping him into a device, a chairlift. But it requires assuming a rather contorted position. In the second part, there is a small household idol, a demon of some sort. It is being repaired by a blacksmith. As it is put in the flames, it gets larger and larger, breaks loose, and consumes the countryside, eating everything in its way. This is truly an ecumenical dream; it will delight the souls of analysts from Freudian to Jungian to interpersonalist. One need only add that the therapist is an avid skier. We would all agree that the dream is "transferential"—that it refers, on one hand, to the therapist's overcontrolling and binding the patient like Schreber's father in Freud's famous case; and, in the second part, to the patient's getting out of hand and destroying everything in sight. Is it fear of his oral aggression? What of its mythic imagery? There is Vulcan and his forge; Zipa, the mythical Tibetan monster who consumes everything in the world and finally himself; there is the bed of Procrustes. There is also a more humanistic explanation: namely, that the patient is being pressured into conformity; that the parents are afraid

of his daemon, in Greek mythology a deified hero, or attendant spirit. Perhaps these are only different metaphors for the polarity of excessive constraint and excessive release.

But one may note, in both instances the patient goes trustingly to a helpful and presumably expert authority; both helpers, lift attendant and blacksmith, are impersonal experts. Each time, the results are less than desirable, but not from hostile intent. How does this "idolized" child come into touch with himself? How does one focus his consuming needs? Is it through interpretation, through transferential analysis? What of the countertransference? Can one label it countertransference if the therapist has never disliked this man who is unfailingly attractive, intelligent, and decent? Is it worth noting that he never makes the therapist feel stupid, unpleasant, or unlikable? Is it countertransference if one doesn't have a countertransference?* Perhaps the key to therapy is for the therapist to experience the patient in some real way, even if with contempt, disdain, or total boredom. The consuming demon may be considered his drives, his emergent power, or his interpersonal experience of never being impinged upon by others. In this last sense, endless expansion takes place in a vacuum. Does he need to contain his drives or to develop relationships with people who will engage him, impinge on him, contain him?

From this perspective, consuming aggression or hunger is not a consequence of untrammeled drive but of interpersonal experience that fails to feed or fails to establish limits to the patient's demands. In ordinary living, as in politics, power perverts. Safety and decency lie in the interpersonal matrix, not in an internalized superego. Surely the last forty years of world atrocities should have taught us that. One

*See Laurence Epstein for discussion of hate in the countertransference.[5]

must learn to distinguish between authentic engagement and sentimental bonhomie.

One could say that if the patient surrenders his last (and only) secret, he belongs totally to the other person. In principle he has no objection to that: he believes that state of oceanic "good boy" feeling to be coterminous with love. It is the demystification of his experience of trust, intimacy, and the authenticity of other people's response to him that makes it possible to drop the symptom. Interestingly, it is not lost; it simply stops being important. He learns that whatever its meaning and cause, it is no one's business but his. Besides, the woman's response is no validating indication of her care or concern. She could be amused, caring, or think him a jackass in this particular department. She might, or might not, reveal or even know her feelings in this matter. None of this really bears on her capacity for loving him, or for deceiving him.

Like all clinical vignettes, this one is both overly simplified and yet full of implicit possibilities. Nevertheless, if one sees the symptom as an expression of an interpersonal mystification rather than an intrapsychic fantasy imposed on reality, it emerges that the patient is upset because he cannot sort out the implications of his behavior. The focus of treatment becomes the elucidation of his experience with his mother in the historical past, his experience with women in the present, and with the therapist in the final common pathway, the therapist-patient relationship, loosely referred to as the transference. The therapist's contributions to this exchange are vital data that he must monitor, if not necessarily report to the patient.

The therapist, following the patient's flow of presentation and monitoring his own participation, hears the metaphor as *privacy and intimacy.* One notes I did not say that the metaphor *is* privacy. Metaphor is a carrying-over (etymologically) and is, by definition, perspectivistically infinite. The therapist

did not hear this metaphor until it emerged in his relationship with the patient via the latter's "acting-out" of not telling about his new, reenacted nose surgery. The therapist interprets; that is, he points out the correlation, connects it with the incident with the mother (the therapist's association, but the patient's report). As will be elaborated later, he plays out, or in Ludwig Eidelberg's phrase, "acts-in" a dimension of his interpretation.[6] He says, in essence, "One doesn't have to see things that way. Secrets are possible. I am indicating clearly that I approve of that." Surely, this is directing the patient, or, at best, claiming to provide a corrective emotional experience. Yet it is done deliberately, because it commits the therapist to a confrontation with the problem the patient is having. It is all very well for the patient to know that he has difficulties with self-determination, but it is paradoxical to tell him that the problem shouldn't exist in therapy and *here* he must feel free to tell all and to trust the therapist who, presumably, can be counted upon to monitor and control his participation. Even if the therapist is trustworthy (therapists can be ethical and well-intended; that does not make them trustworthy), can the patient count on this benevolence from the rest of the world?

There is a much-quoted case of Sullivan's wherein he sees in consultation a young man who has been rapidly sinking into a schizophrenic decompensation.[7] On inquiry, Sullivan notes that the patient's parents are described as being quite perfect, beyond reproach, although they have obviously stifled every move towards independence the young man has attempted. Sullivan says to himself, "Oh yeah, it doesn't sound so good to me. It doesn't make sense. Maybe you've overlooked something." Does he say that to the patient? No way! What he does say is, "I have a vague feeling that some people might doubt the utility to you of the care with which your parents, and particularly your mother, saw to it that you didn't learn to dance." Then Sullivan reports, "I was delighted to see the schizophrenic young man give me a sharp look." This exchange, which I think is in language and style worthy of a Baker Street Regular, has been described as technique. Leston Havens, for instance, has written a book about Sullivanian technique and describes this as a conscious decision on Sullivan's part to approach the young man obliquely so not to elicit excess anxiety.[8] In other words, it is a strategy of technique that is appropriate to Sullivan's concept of the schizophrenic dilemma.

But why such a strange, crusty, Edwardian indirection, so different than his first comment to himself? There are other ways of being oblique. Essentially Sullivan is making an interpretation of content. He is saying to the patient something of what he thinks the parents have done. But he is also makig another interactional communication. He is saying to the patient: I am aware that you are aware that what you are saying about your parents' beneficence is sheer boloney. You do not believe it but you expect me to believe it because you think we are all hypocrites aligned against you. I'm not stupid enough to try to be friendly toward you because you would think I'm trying to butter you up, but I thought I would let you know that I'm in on the game. Now, that sounds rather more like R.D. Laing and of course it may not be what Sullivan had in mind at all. But it seems to me it is equally as probable as the idea that he was simply trying to spare the patient anxiety by a studied indirection. In essence it is a very complex communication to the patient about the layering-upon-layer of awareness in his life, in Laingian paradox, about what he doesn't know he knows about what he doesn't know he knows.

What then if the patient withholds information from the therapist? This seems at first glance a bizarre way of doing therapy. The "basic rule" of psychoanalysis is that the patient say

what comes to mind. If he won't, we say we don't have a "working alliance." Yet, almost all patients withhold; events are "forgotten," and remembered only after a focusing interpretation of the analyst. We rather take these lapses for granted, appreciate that the patient is anxious; but we rarely consider that withholding is a perfectly normative social skill and that the patient is exercising it. Perfect patients don't seem to do much better in therapy than perfect children do in life.

When a therapist enforces the "basic rule," he usually gets a flurry of thinking the unthinkable: the patient, especially if on the couch, comes up with every unacceptable hostile and sexual fantasy he can contrive. Most analysts sensibly dismiss this material. In this case, the patient feels he must give up his symptom to the analyst who, in essence, tells him to keep it. After all, he is only distressed about the revelation of it to others. What family therapists would call a "paradoxical injunction" works. The therapist "joins" the symptom. The patient doesn't lose it; he loses interest in it. Why should this work? Possibly because the therapist is focusing not on the meaning of a symptom to the patient but on the meaning of the symptom as it exists in interaction with the therapist.

This defines a very important distinction in the direction of therapeutic movement. From the intrapsychic perspective, behavior with the therapist is carried over, transferred, from the outside world. As Menninger and Philip Holzman put it:

> . . . the patient successively goes from the contemporary situation to the analytic situation, thence to related aspects of the childhood situation, thence to the reality situation and on around the circle in the same *counter-clockwise direction* [emphasis added]. This is the typical, proper, and correct sequence. . . . But if successive material tends to move from the depths directly to the present movement, i.e., in what on our diagram is a clockwise direction, something is wrong.[9]

In other words, the direction of flow determines the definition of reality. The patient creates a distortion in the transference, goes from there to his history, sees the connection, and then can *discard* the transferential distortion as unreal. In contrast, if one treats each event with the therapist as a *de novo* and legitimate exchange, then it becomes simply a place to examine in exquisite detail how the patient deals with experience. It is no more or less real than his historical experience and not very different, not because the patient is projecting, but because in his discourse with his world he shapes and perpetuates it. It is through symbols that one not merely knows but constitutes the world. The patient may proceed from past to present or reverse the flow. For the interpersonalist the direction is circular or helical, not linear and unidirectional. To use a simple example: traditionally the patient sees the therapist as a critical father, then goes back to his childhood experience, which he perceived as similarly critical. He then sees that as a distortion in the service of his inner machinery, or, if true, a stimulus to his internal machinery. He returns to the present, aware that his touchiness about his present life and the transference is a distortion carried over from the past.

In contrast, if one concedes that the patient's perception of the therapist as critical has some grain of truth, then one might wonder how he perceives and deals with criticism—both in the here-and-now and in the past. There is no issue of distortion or of helping the patient distinguish what part of his upset is appropriate and what part not. It will develop that he has great difficulty with that aspect of interpersonal behavior dealing with judgment, criticism, helpfulness, advice giving, the entire set of interactions dealing with one person impinging knowledgeably upon the behavior of another; and, most importantly, that this difficulty lies in his inability to delineate and order his experience in language. Sullivan's concept of the ther-

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

6. Balmary, *Psychoanalyzing Psychoanalysis,* p. 80.
7. Max Schur, *Freud: Living and Dying.*
8. Sigmund Freud, *The Interpretation of Dreams. The Standard Edition of the Complete Psychological Works of Sigmund Freud,* vol. 4, ed. and trans. James Strachey (London: Hogarth Press), pp. 106–21.
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11. Morton Schatzman, *Soul Murder: Persecution in the Family* (New York: Random House, 1973).
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14. Louise Kaplan, "The Development and Genetic Perspectives of a Life History," Presentation to the W. A. White Psychoanalytic Society, New York, October 19, 1979.

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2. Gregory Bateson, *Mind and Nature: A Necessary Unity* (New York, E. P. Dutton, 1979), p. 87.
3. Schur, *Freud: Living and Dying;* Greenberg and Perlman, "If Freud Only Knew"; and Balmary, *Psychoanalyzing Psychoanalysis.*
4. Jones, *The Life and Work of Sigmund Freud: Vol. 1,* p. 19.
5. Adam Kuper and Alan Stone, "The Dream of Irma's Injection: A Structural Analysis," *American Journal of Psychiatry* 139 (10): 1225 ff.
6. Kuper and Stone, "The Dream of Irma's Injection," p. 1229.
7. Tania and James Stern, trans., *The Letters of Sigmund Freud* (New York: Basic Books, 1960), letter no. 61, p. 141.
8. Ernest Jones, *The Life and Work of Sigmund Freud: Vol. 2, 1901–1919.* (New York: Basic Books, 1955).
9. Jorge Luis Borges, *The Book of Imaginary Beings* (New York: Avon, 1969), p. 211.
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3. Jerome Bruner, "Communication and Self," Presentation to the W.A. White Psychoanalytic Society, November 19, 1982.
4. Ibid.

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2. Roy Schafer, *Language and Insight* (New Haven: Yale University Press, 1978), p. 179.
3. Patrick Mullahy, *Oedipus Myth and Complex* (New York: Hermitage Press, 1948), pp. 286–91.
4. Alice Miller, *Prisoners of Childhood* (New York: Basic Books, 1981), p. 7.
5. Laurence Epstein in Arthur Feiner, "The Therapeutic Function of Hate in the Countertransference," in *Countertransference* (New York: Aronson, 1979).
6. Ludwig Eidelberg, quoted by Heinz Kohut, "Clinical and Theoretical Aspects of Resistance," *Journal of the American Psychoanalytic Association* 5 (1979):551.
7. Harry Stack Sullivan, *The Psychiatric Interview* ed. Helen S. Perry and Mary L. Gawel, (New York: W.W. Norton, 1954), pp. 21–22.
8. Leston L. Havens, *Approaches to the Mind* (Boston: Little, Brown, 1973).
9. Menninger and Holzman, *Psychoanalytic Technique,* p. 155.

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5. Bateson, *Steps,* p. 186.
6. Ibid., p. 191.

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2. Ibid., p. 363.
3. Ibid., p. 364.