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Curative Factors in Dynamic Psychotherapy

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Psychoanalysis has, ever since Anna O. so felicitously named it, been known as the "talking cure." Leo Stone (1973) called speech "the veritable stuff of psychoanalysis" (p. 58), and, more recently, Paul Ricoeur (1971) has said that "there enters into the field of investigation only that part of experience which is capable of being said" (p. 838). 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. This mastery of the commonplace seems a sorry virtuosity. Talk seems too ordinary an instrument for so difficult an enterprise as psychoanalysis. Yet, as I shall elaborate, from a structural linguistic perspective on psychoanalytic process, there are extremely subtle and intricate ramifications to this most ordinary and unself-conscious function.

To begin with, it seems most likely that what these authors really imply is that psychoanalysis is the *nonacting* cure: that is, what is acted out—rather than talked about—cannot be encompassed in the treatment. This would certainly be consistent with Freud's (1914) 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" (p. 154).

But the distinction between speech and action is often very obscure. Some acting out seems clearly more like a vivid nonverbal 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 who then kicks over the therapist's cocktail table; or the therapist who is unaware of being angry with the patient and is horrified to find 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 to behavior that reflects an extremely subtle resonance between the subject material, the "talk" of therapy, and the patterning of the transference.

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 a rather simple shrimp dish. She now knows what to order. When asked what she makes of this dream (she does not volunteer an explanation), 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 even some of the countertransference implications. Does she not *play out* the content of the dream between us? 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" (in Eidelberg's phase [Kohut, 1957]), 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" on the part of the therapist is permissible? The distinctions so clear to Fenichel and Menninger become, for many of us, increasingly obscure. If transference is the "playground" Freud (1914) considered it to be, what happens in the playground? 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.[2] 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 can be said and what must be shown—is, I suspect, more apparent than real and depends on 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. De Saussure, the Swiss linguist, clearly delineates *parole* and *langue* (1970, pp. 43ff). *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 semantics of the spoken communication as it emerges from this matrix.[3]

Further, one must distinguish language from semiotics, first defined and named by the American philosopher C. S. Peirce (1955). Semiotics refers to "the transmission of signals, signs, signifiers and symbols in any communication system whatever" (Wilden, 1972, p. 111). At the bottom of the communication system hierachy is speech; then comes the intricate machinery for processing speech (language); and finally, there is a more

extensive system of coded communication (semiotics), which involves speech, nonverbal cuings, and most important, the cultural and social context of communication—what Peirce called the "pragmatics" of communication.[4] Psychoanalysts have traditionally been concerned with pragmatics. Jacques 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 the applicability of his position (Lacan, 1977). It is all very well (and correct from the structuralist viewpoint) to claim that the unconscious is structured like a language. But how does one talk with it?

It must be understood, then, that speech is only a small part of an extensive semiotic communication that takes place between the two participants in the analytic process. I am not suggesting that one merely pay attention to how the patient sits or looks. I am suggesting something considerably more elaborate—that there are other extensively coded communications, as informational as speech, that take place in the intersubjective realm.

To begin with, language is also a form of behavior. As Wittgenstein put it, "Words are also deeds." This concept is familiar as Bateson's (1951)

"metacommunication"; that is, every communication has a message about the message. There is an extensive literature on this subject, but it is generally agreed that the metamessage acts on the environment as a "command" or set of instructions (Bateson, 1951). Thus, language not only communicates, it also acts on 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 "harmonic variations" on the same theme. The resultant behavior of the dyad will emerge out of this semiotic discourse.

In other words, the therapist's interpretation is not exclusively an intellectual appraisal of what he has been hearing from the patient, it is also a piece of behavior which resonates to the patient. This interpretation qua behavior will be an extension of the problem under immediate examination, and the therapist's participation will be a transform of the problem. The therapist will become an extension of the patient's problem in order to become part of the solution (Levenson, 1972). The therapy proceeds, not out of the correctness of the interpretation, but out of the dialectical interaction of what is said and what is done in the patient-therapist dyad. How this interaction occurs may be the core issue of therapy.

The patient is a man in his early fifties who has just entered therapy for

an incapacitating depression. He has a history of severe mood swings either caused by, or resulting in, vicissitudes in career and life status. He has had extreme ups and downs in his circumstances. He has also had a great deal of traditional therapy so that he is totally conversant with his dynamics. With great facility, he supplies explanations and interpretations, but all without visible effectiveness. He is also a person of considerable talent and verve. The therapist spends the first few sessions giving a virtuoso demonstration of what H. S. Sullivan called "expertness." He inquires, makes correlations, finds fresh perspectives. The patient's condition continues to decline.

After several sessions, the therapist begins to realize that the patient is making no effort at all. There are no dreams; the patient does not follow up or expand on any area of inquiry. He is like a drowning man who will not reach for a life belt. Proffering this interpretation would be quite useless, since the accompanying covert therapist behavior would be anger at the patient for failing to applaud his performance; i.e., "I give you my best and it is not enough for you!" Thus the therapist, instead of pointing out the patient's passivity and nonparticipation, contributes his own experience, saying that he feels obliged to dazzle the patient with his virtuosity, and moreover, he thinks that this is the way the patient has performed in his life; lots of flash but no solid work.

Two dreams follow. One has to do with work, stupendous tasks, one of

which was getting two immense trees which are side by side to bend apart. This leads, as one might have expected, to the patient's first admission of his inability to arouse his wife's sexual interest.

The second dream I shall present in more detail. The patient arrives at a dock prepared to leave with his wife and children on an ocean cruise. A man intercepts him and indicates that he must first return home for some documents. He is offered a ride in a motorcycle sidecar, but is afraid of the wind and exposure. Suddenly he finds himself riding an old school bus, going very slowly. (The patient never rides public transportation, a point he makes each time he arrives by cab.) He is struck by the fact that as they proceed every small detail of the landscape is vividly etched; every crack, every building, every turn in the road.

The patient doesn't know what to make of this dream. He offers a few Freudian homilies from his kit bag; e.g., the cracks are vaginas, water means birth. These may well be correct, but behaviorally he is demonstrating his immense fatuousness. The therapist, delighted with the dream, which he perceives as a transference dream signaling the first real hope for change, rushes to interpret: arriving at the "Doc," intercepted by the therapist, told that he must first document himself before cruising off into the sunset, in some way afraid of or perhaps addicted to exhilaration and risk-taking, then the insight that the therapy consists of going slowly, reviewing his life,

capturing the details; for once, not his offhand slipshod brilliance but *real* work. The patient is delighted with this effort; the therapist is equally delighted until it occurs to him that he has given another performance with a dream that should have been obvious to the patient with a little real effort. Again, the content of the interpretation is accurate, but the participation is a transform of the patient's facile virtuosity. The therapist finds that he feels manic in the sessions and delighted with his performance (which is usually a prodrome of disaster).

If the therapist had resisted the temptation to interpret the dream, surely an opportunity would have been lost. Or, would the patient have interpreted it himself? I think not. So, to interpret is to act out the content under discussion; to fail to interpret is to act out another aspect of the content under discussion, namely, the patient's impotence and sense of insufficiency in the face of life tasks. This is, I suspect, the dilemma inherent in the speech-action transform. Certainly it can be resolved. The patient emerged entirely from his depression after this session, settling comfortably into a detailed inquiry into his life.

Perhaps resolution lies in what is essentially an expansion of awareness of this bind. The patient brings in material, the therapist interprets, the interpretation has a spoken component that brackets or defines the issue under inquiry. It has also a behavioral component that reenacts the issue.

Change may occur because the therapist is able, through his awareness of participation, to shift the homeostasis of the system; or, as I rather suspect, the simple repetitive restatement/reenactment of the critical issue in the patient's life may be what gradually makes for change. In this sense, the "working through" *is* the therapy; it is not a mere preliminary to interpretive insight.

Therapy is a process of entrapment and either extrication or explication, as I suggested above. The therapist cannot be therapeutic by endeavoring to be correct. The therapist cannot do therapy by maintaining the vaunted mythic neutrality or by "participating" in some wonderful way. His participation must be authentic rather than sincere (Levenson, 1974). (It is an irresistible digression to remind the reader that *sincere* derives etymologically from "to be without fault" and *authentic* from "to be one's own author"; or, alternately and oddly, "to be a murderer" [*Webster's New World Dictionary*, College edition]. To take responsibility for one's own actions, to act without the sanction of the gods, was anathema to the classical Greeks.) If interpretation is behavior, then with each interpretation the therapist risks himself authentically, discovers his meaning in transaction with the patient, and mobilizes his cure by participatory observation.

This has always been implicit in H. S. Sullivan's (1955) concept of participant observation. In its original discrete use it meant, I believe, to

behave with the patient so as to maximize communication. Later it came to mean to use one's participation as a more extensive communication to and from the patient. But, ultimately, from both the operational viewpoint and the semiological, it means that every communication is a participation, which enlarges the communication, which in turn enlarges the participation. Every line of inquiry, including silence, is a choice of alternative participations. Every therapeutic situation—regardless of the therapist's restraint—involves interaction with the patient.

So, 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 Strawson's (1963) division of a statement into what you are saying and what you are saying about it. In some cases this is obvious. For example, 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 underlying meaning of the communication in the therapist's behavior. But, as I have suggested, there are subtler implications.

The patient, a young adult, 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 both the content of the interpretation and the simultaneous transformation of his participation into the sadistic accuser. Surely the patient's tearfulness is both confirmation and resistance, and surely any reasonably competent therapist can handle such an impasse without semiotics. But willy-nilly the therapist is practicing a semiotic skill. I must agree with Edelson's (1975) 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 [p. 63],

I would emphasize that this view of linguistics lies within the purview of structuralism and reflects its particular perspectives.[5] Structuralism claims that all human endeavor, not just speech, is coded like a language and that this pervasive coding may reflect the basic structuring of human thought. From this perspective there is no thought without language. What about dreams, which are largely visual? I suspect the answer would be that we do not see the dream, we have only the report of the patient. Moreover, one can easily make a case for a pictographic language, what Fromm (1951) called

"the forgotten language." If one sees all human endeavor as systematically patterned, as a code, then speech, cultural manifestations such as myths or ceremonials, aspects of developmental psychology, artistic productions, psychoanalysis all become different transformations of the same holistic theme: every aspect of culture reflects and participates in every other aspect. Every piece is complete in itself and yet a part of the larger order (Levenson, 1976).

This particular world view is inherent in structuralism, and in a biological variant of structuralism, general systems theory, which has recently been popularized in Arthur Koestler's (1978) *Janus*. Although it may not be the last word, structuralism is both heuristically appealing and a prerequisite for understanding the relevance of, say, Levi-Strauss, Barthes, Lacan, and even Piaget. Lacan's (1977) statement that the unconscious is structured like a language and Barthes's (1970, p. 136) statement that all human discourse is one giant sentence reflect this viewpoint. We need only add that human behavior is an aspect of human discourse.

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, i.e., behavior is simultaneously language. Taken singly, these postulates are not terribly radical, but combined, several

conclusions become inescapable. First, there is no real discontinuity between speech and action. They are simply harmonic variations on the same theme. Second, "acting in" the transference is not something that occurs intermittently at times of distress; it is a semiotic dimension that goes on continually. 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, past and present. All the dimensions of the therapy—the patient's history, contemporary issues in the patient's life (and the therapist's), dreams, memories, acting out, acting in, transference, countertransference—are of a piece. The ability to range across these transformational variations of the patient's theme is, as Edelson's statement affirms, the therapist's true métier.

From this perspective, countertransference cannot be considered a response only to the patient's infantile experience, or, obversely, only to the patient's real and present self. It must be an authentic response across *all* dimensions. Nor can it be only feeling about the patient; it must be also 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 which makes the treatment

go.

Let us suppose that a patient is reporting 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 and therefore 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 patient's anger, but it may also 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 sangfroid, but it does cue the therapist to some aspect of the patient's behavior that the father was unable to deal with rationally.

All these approaches 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 waits it out. But silence is a participation. It might qualify as a universal nostrum if the patient always got around to further explication, but that does not always happen; sometimes resolution requires the therapist's participation, 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 a sneaking feeling that if things had proceeded properly, nothing would have resulted. Did H. S. Sullivan have this in mind when he reputedly 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 my earlier examples I focused on how the patient replays in the dyad the material that is being talked about. What does the therapist do? Interpretation is not enough, since an interpretation, though 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, or at least expanded, participation with the patient around the material. In some way the therapist must operate with the patient so 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. Sadomasochistic 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 therapist and patient. The therapist who feels benign is not only remote, he is being sadistic. The therapist who feels kindly is repressing his 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 keep such feelings 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 feel sadistic, but without mystification or double-binding of the patient. This would establish a harmonic integrity between the transference and the rest of the patient's life. The message might then be heard, and the discourse, in the structuralist sense, enriched. 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 and experienced and responded to. If behavior is a language, then it must be heard. The therapist who is detached from an angry patient

may hear him on the speech level but does not hear him on the action level.

I do not mean to imply that all the patient's communications are characterological fly traps. One also hears 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 says, "Oh. Where?" Whether the therapist says nothing, asks for fantasies, or casually (perhaps even enthusiastically) answers the patient's question 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 (e.g., the patient *always* feels deserted) seem to me sincere but not authentic. Perhaps one should first listen and then respond.

There is another genre of exchange often touted in the literature as proper technique. This example is from Greenson (1976, pp. 272-273). A patient points out that when he expresses political opinions that match the therapist's he get 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! He plays out exactly that kind of authoritarian inquiry that the patient complained about. The discourse doubles back on itself and stops. The

therapist says, in effect, "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 in itself does not explain why the therapist coerced him. Or, if we suppose the therapist has the tendency to coerce others, that still does not explain why he coerced this patient, or why he was so astonished at being caught out. Would it be unscientific to suggest that therapist and patient talk about their mutual experience rather than "analyze" it?

To summarize: Psychoanalysis originally postulated a serious antinomy between word and deed. It was the "talking cure," and what was acted upon could not be spoken about—that is, could not be analyzed. Classical psychoanalysis had no real lexicon for behavior, and it fell to H. S. Sullivan to introduce the operational concept of participant observation, a concept that others have broadened considerably since its introduction.[6] It now encompasses a rather wide range of behaviors and perceptions on the part of the therapist. Kohut (1971), Kernberg (1975), Muslin and Gill (1978), and Schafer (1978) have recently championed similar but more orthodox revisionisms of traditional psychoanalytic theory.

The concept of transference makes very little sense if one

conceptualizes the patient as only talking or fantasying in the field of an inactive, blank-screen analyst. Such a view denies the operational reality that communication (if not speech) is always going on and that the transference arena is subtle ongoing discourse between the two participants even when the therapist is totally silent.

Linguistic concepts make it possible to view language as more than speech but much less than the total field of semiotic communication. From this viewpoint action, or behavior, *is* a language that is a precise transform of the speech. In the therapeutic context, whatever the dyad talks about will simultaneously be shown or played out between them. *The power of psychoanalysis may well depend on what is said about what is done* as a continuous, integral part of the therapy. Wittgenstein somewhere said, "What can be shown cannot be said," by which I suspect he meant that action and speech are really different modalities, parallel but not interchangeable. Therefore, I am not suggesting that the therapist match his behavior to what the patient says, for example, by being the good father. The interaction must be as authentic and perplexing an aspect of the total discourse as is speech. I don't think it is yet possible to know why therapeutic change occurs, since the neuropsychological mechanisms involved in language are still a "black box" for us; i.e., we do not know the brain mechanisms which mediate communication. There is some suggestive evidence from Pribram's work that there are a number of simultaneous languages of the brain. Insight, change,

reprogramming of perception may require some synchronous fit or lining up of these different languages. Pribram (1971) postulates a holographic component to thinking which is too elaborate to discuss in detail here. But, according to his view, thought is "a search through the distributed holographic memory for resolution of uncertainty, i.e., for the acquisition of relevant information … the term relevant information includes appropriate *configurations* … when problems generate thought, contextual and configurational matchings are sought, not just specific items of information" (p. 370). I feel reasonably sure change is not as a consequence of the communication of meaning alone, although that may be a large part of it. The linguistically alert therapist, by paying attention to the concordance of spoken and acted language, facilitates the process even if he cannot say exactly what it is he is doing.

The psychoanalyst—he-who-talks-with-his-patients—then, is trying to understand and clarify an ordinary process, really most naturally performed without much thought about it. Cloaked in structuralist trappings, the inquiry has tones of grandeur. As Barthes (1970) put it, "Once again the exploration of language, conducted by linguistics, psychoanalysis, and literature, corresponds to the exploration of the cosmos" (p. 144). But, in a humbler simile, we are perhaps more like the centipede, trying to figure out how we manage to put one foot in front of the other without falling on our faces in the process.

REFERENCES

Bateson, G. (1951), *Communication: The Social Matrix of Psychiatry*. New York: Norton.

Barthes, R. (1970), To write: An intransitive verb? In: *The Structuralist Controversy*, ed. R. Macksey and E. Donato. Baltimore: Johns Hopkins Press.

Chrzanowski, G. (1977), *Interpersonal Approach to Psychoanalysis: Contemporary View of Harry Stack Sullivan*. New York: Gardner Press.

De Saussure, F. (1970), On the nature of language. In: *Introduction to Structuralism*, ed. M. Lane. New York: Basic Books.

Edelson, M. (1975), *Language and Interpretation in Psychoanalysis*. New Haven: Yale University Press.

Freud, S. (1914), Remembering, repeating, and working through. *Standard Edition*, 12:147-156. London: Hogarth Press, 1958.

Fromm, E. (1951), *The Forgotten Language*. New York: Rinehart.

Greenson, R. (1976), *The Technique and Practice of Psychoanalysis*. New York: International Universities Press.

Hahn, E. (1978), A reporter at large (Animal communications: Part II). *The New Yorker*, April 24, pp. 42ff.

Kernberg, O. (1975), *Borderline Conditions and Pathological Narcissism*. New York: Jason Aronson.

Koestler, A. (1978), *Janus*. New York: Randon House.

Kohut, H. (Rep.) (1957), panel report: Clinical and theoretical aspects of resistance. *J. Amer. Psychoanal. Assn*., 5:551.

____ (1971), *The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders*. New York: International Universities Press.

Lacan, J. (1977), *Ecrits*. New York: Norton.

Levenson, E. (1972), *The Fallacy of Understanding*. New York: Basic Books.

____ (1974), Changing concepts of intimacy in psychoanalytic practice. *Contemp. Psychoanal*., 10(3):359—369.

____ (1976), A holographic model of psychoanalytic change. *Contemp. Psychoanal*. 12(1): 1-20.

Muslin, H., & Gill, M. (1978), Transference in the Dora case. *J. Amer. Psychoanal. Assn*., 26(2):31 1-328.

Peirce, C. S. (1955), *Philosophical Writings*. New York: Dover.

Percy, W. (1954), *The Message in the Bottle*. New York: Farrar, Straus & Giroux.

Pribram, K. (1971), *Languages of the Brain*. Englewood Cliffs, N.J.: Prentice-Hall.

Ricoeur, P. (1971), The question of proof in Freud's writing. *J. Amer. Psychoanal. Assn*., 25(4).

Schafer, R. (1978), *Language and Insight*. New Haven: Yale University Press.

Stone, L. (1973), On resistance to the psychoanalytic process. In: *Psychoanalysis and Contemporary Science*, Vol. 2, ed. B. Rubinstein. New York: Macmillan.

Strawson, P. F. (1963), On referring. In: *Philosophy and Ordinary Language*, ed. C. Caton. Urbana: University of Illinois Press.

Sullivan, H. S. (1955), *The Interpersonal Theory of Psychiatry*, ed. H. S. Perry & M. L. Gawel. New York: Norton.

Wilden, A. (1972), *System and structure: Essays in communication and exchange*. London: Tavistock.

Notes

1 An earlier version of this chapter was presented at the Annual Meeting of the American Academy of Psychoanalysis, Atlanta, Georgia, May 1978, and appeared in the *Journal of the American Academy of Psychoanalysis*, 7:271-282, New York: Wiley, 1979.

2 Particularly in object-relation theory and its application to borderline syndromes, where much emphasis is put on appropriate and useful responses.

3 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. See Emily Hahn (1978) for an instructive review of animal communication.

4 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 Percy (1954) for extended discussion of this issue.

5 Chomskian linguistics is another matter and presents a different paradigm for a linguistic psychoanalysis (see Edelson, 1975).

6 See Chrzanowski (1977) for a review of contributions to the participant-observation paradigm.