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Addressing Psychoanalysis's Post-Tower of Babel Linguistic Challenge: A Proposal for a Cross-Theoretical, Clinical Nomenclature

Abstract. After noting how psychoanalysis has fragmented into theoretical and methodological clusters lacking a common language, the author proposes a unifying nomenclature for clinical psychoanalysis. Specifically, he suggests psychoanalysts, regardless of theoretical orientation, *frame* psychoanalytic relationships, bring *presence* to their patients, and *engage* them. These methods facilitate transformation most commonly by bringing features of the unconscious into consciousness. They also disrupt patients' *internalization* processes—phenomena synonymous with what Fairbairn (1941) called the "schizoid background" (p. 250), Klein (1946) "schizoid mechanisms" (p. 99), Steiner (1993) "psychic retreats" (p. 1), Kernberg (2007) the "narcissistic spectrum" (p. 510), and Summers (2014) "narcissistic encapsulation" (p. 233). The author provides a clinical vignette demonstrating how framing, presence, and engagement describe psychoanalytic work, and concludes by discussing how such nomenclature could enhance psychoanalysts' capacity to communicate with one another while also making the field more accessible to the general public.

Keywords: psychoanalysis, nomenclature, clinical, theory, models, terms

Although most contemporary professions evolve towards cohesion, psychoanalysis has fallen to pieces. Rangell (1974) decried the splintering of psychoanalysis a half century ago, noting the field shared "the history of the 20th century: expansion, diffuse application, use and

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misuse, explosion, disaster" (p. 3). Stepansky (2009) coins the word "fractionation" (p. xvii) and, along with Aron and Starr (2013), worries psychoanalysis' lack of coherence could threaten its survival as a distinct profession. Cortina (2016), agreeing with Kernberg (2012) who calls for "suicide prevention" (p. 707) by psychoanalytic institutes, addresses fragmentation in training programs. If the profession will survive, even thrive, steps must be taken to bring greater cohesion to the many varied, oft-warring, tribe-like psychoanalytic schools.

After reviewing the cross-theoretical literature, and reflecting on nearly four decades of clinical experience, I conclude that psychoanalysts, regardless of theoretical orientation, share more similarities than dissimilarities in how they work. In confirmation, Borbely (2013) writes, "most analysts of divergent persuasions would agree today that all schools attempt to and, in general, succeed in establishing a psychoanalytic process with their analysands" (p. 82). And yet the field lacks even a basic nomenclature for describing what they actually *do* in their consulting rooms. Psychoanalysts lack a lingua franca for discussing their work with one another, with their patients, or with the lay public. Even fine artists, such as painters, use commonly understood words like brush, canvas, palette, and color in ways lay persons understand; psychoanalysts lack such a nomenclature. Introducing a common language for clinical psychoanalysis would contribute to the efforts of many others such as Schafer (1975), Klein (1976), Gedo (1983, 1997), Gill (1983), Greenberg and Mitchell (1983), Kernberg (2001), Loewald (1980) and Modell (2013), Rangell (1955, 1968, 1974, 1975, 2006), Sandler (1983) who also seek unification in the field. It also comports with Cortina's (2016) call for an "effort toward greater integration of psychoanalysis" (p. 810).

How do psychoanalysts, even of widely varied theoretical orientations, practice in similar ways? They listen carefully to patients; they make various types of comments on their patients' cognitions, emotions, and behaviors; they manage the conversation, and the entire psychoanalytic relationship, in a specific, unusual, even peculiar way. Psychoanalysts create transformational environments for, attend to, and engage with their patients. These basic methods may be condensed into a uniform language—a phenomenologically based nomenclature—which I have introduced previously (Karbelnig, 2014a, 2014b, 2016). First, clinical psychoanalysts *frame* their psychoanalytic interpersonal relationships to maintain professional boundaries and create an environment within

which psychoanalytic processes may develop. Depending on the particular theoretical orientation, they may also view the psychoanalytic relationship itself as repairing interpersonal trauma. Second, they bring their *presence* to patients through empathy, attunement, interest, curiosity, and similar behaviors. Finally, they *engage* their patients in forms of dialogue, consciously and unconsciously, verbally and nonverbally, and in other, more mysterious ways, such as reverie (Bion, 1963, p. 19). Prominent among their many, perhaps infinite effects, these professional behaviors access, disrupt, or alter unconscious or other denied or disavowed features of mental life.

Comparable to the challenge artists face when discussing their differences in style, proposing a language to facilitate communication between psychoanalysts with diverse theoretical orientations proves daunting. The metaphor of the post-linguistic Tower of Babel challenge best represents my effort. Derived from the book of Genesis, the myth suggests humans shared a common language following the Great Flood. They reveled in ambition and pride. They strove together to build a tower tall enough to reach the heavens. God viewed them as disrespectful, disbursing humanity's one language into many and thereby destroying each group's capacity to understand the others. Psychoanalysts' speech became confounded by a less divine means. However, pride and ambition played a part. Perhaps most commonly, different psychoanalytic theorists in the history of the discipline made similar, phenomenological discoveries, e.g., children forming unconsciously negative self-images to accommodate abusive or neglectful parents. These theorists then created their own descriptions of, and terms for, these similar if not synonymous phenomena, e.g., creating a "false self" (Winnicott, 1967, p. 371), developing an "idealized self-object" (Kohut, 1975, p. 333), or making a "pathological accommodation" (Brandchaft, 2001, p. 260).

Psychoanalysis split apart—in theories of mind, in methods of practice, in terminology—suffering the same fate as post-Tower of Babel humanity. As theoretical schools proliferated, they developed their own terms for common psychological phenomena—often redundant with one another—instead of developing a shared way to communicate them. As a result, Modell (2013) laments, "A 'classical' Freudian ego psychologist, a Kohutian self psychologist, a Sullivanian interpersonalist, and a Lacanian cannot communicate with each other as they do not share in common a set of conceptual assumptions" (p. 59). As I explain in detail,

common assumptions are *not* necessary to develop a shared professional language—particularly if psychoanalysis's clinical work is separated from its theory of mind.

Choosing words to name collective clinical behaviors is a relative, even arbitrary affair. Foucault (1970), who studied the evolution of language and nominalism among his many other philosophical endeavors, would agree. He acknowledges a randomness to signifiers and symbols; he finds the search for word specificity elusive. Foucault (1970) concludes:

> … since the disaster at Babel we must no longer seek for it—with rare exceptions—in the words themselves but rather in the very existence of language, in its total relation to the totality of the world, in the intersecting of its space with the loci and forms of the cosmos. (p. 37)

Psychoanalysis qualifies for the rare exception. Anticipating critiques of the three words chosen, I privilege Foucault's (1970) humbling observations. However, I selected these words—framing, presence, and engagement—for specific reasons. First, they encompass Freud's (1912/1991a) initial description of the psychoanalytic method. Second, other psychoanalysts have used similar phrases when describing clinical work. Laplanche (1999), for example, believes psychoanalysts serve three functions that overlap with the ones I propose: "The analyst as the guarantor of constancy; the analyst as the director of the method and the companion of the primary process" (p. 227). Framing guarantees the constancy; presence offers the companionship; engagement directs the method. Elsewhere, Laplanche (1999) specifically refers to psychoanalysts' maintaining "presence" (pp. 226–227). Third, and consistent with my earlier comparisons to psychoanalysis as performance art (Karbelnig, 2014a), the three words are terms of art in theater: *Framing* means creating the transformational space (as in an auditorium); *presence* refers to actors and audiences bringing their attention to performances; *engagement* describes audience involvement (but, in psychoanalysis, describes both parties' participation). Fourth and last, the terms fit well the phenomenology of psychoanalysts' professional behaviors.

A Map for Exploring the Proposed Common Nomenclature

As a first step in this complex journey, I describe how I limit the project to prevent its exploding into a lengthy monograph or book. Freshly circumscribed, I next expand upon how clinical psychoanalysis can be separated from psychoanalytic theories of mind, thereby allowing a

narrow focus on what psychoanalysts actually *do* during their sessions. I provide a clinical vignette to facilitate understanding of these cross-theoretical similarities in psychoanalysts' behaviors. I then introduce *framing, presence*, and *engagement* in detail. Finally, I describe how a unified clinical language would enrich psychoanalysts' capacity to share their work with one another while enhancing the public's understanding of the profession.

I limit this exploration by focusing specifically on praxis—the nonlinear, dynamic, highly individualized process that Harrison (2014) refers to as the "music and dance" (p. 313) of psychoanalysis. So as to avoid the problems of differing theoretical concepts, I restrict myself to language describing the phenomenology of clinical work as it unfolds in the quiet privacy of a psychoanalyst's consulting room. I intentionally utilize language common to the human experience. I reluctantly utilize words like "psychoanalysis" and "psychoanalyst," because they have become terms of art and have a full century of use in the psychoanalytic world as well as in the broader cultural lexicon. I avoid these words when possible because they reflect the scientism and empiricism characteristic of the modern historical period. Unfortunately, the name of the profession itself—*psychoanalysis*— contains within it (especially the word fragment, "analysis") an emphasis on reason, on rationality, which runs counter to working in real time with human subjectivities. It also fails to describe the nonlinear, dynamic way that psychoanalytic processes unfold. I have suggested that the phrase "transformational encounters" (Karbelnig, 2014a, 2014b) replace the word "psychoanalysis" because it more accurately describes what actually occurs in our offices. Also, it emphasizes an interactive meeting between two human subjects. That said, I retain the word psychoanalysis because it identifies a highly specific type of transformational processes, differentiating it from any number of other experiences that can alter human subjectivity. Yet, I avoid other reductionist words such as "psychopathology," "treatment," "cases," or even "therapeutic" because of their medical ideology.

The more than 100-year history of psychoanalysis reveals a sustained, dynamic equilibrium between diversity and homogeneity, which a unified nomenclature will only enhance. On the one hand, the diversity allows theoretical concepts as varied as internal objects and archetypes to flourish. It invites psychoanalysts with widely differing personal styles to develop their own unique, artistic visions of clinical work. On the other hand, homogeneity provides some degree of consistency found, for example, in concepts like the unconscious or transference.

A well-formulated nomenclature such as the one I propose possesses syntactic functions that facilitate, rather than constrict, the open-ended semantics of psychoanalysis. It facilitates open communication between practitioners without imposing any greater limitation than words like brushstroke, tint, or hue place on painters.

No reason exists for psychoanalysts of divergent theoretical viewpoints to lack a common language. Some may fear that the uniqueness and individuality of psychoanalysis could be damaged by a commonly utilized nomenclature, that a false uniformity might emerge. I disagree. Even if the proposed clinical nomenclature finds wide acceptance, theoretical and clinical diversity will persist. Each psychoanalyst–patient dyad will remain a unique singularity. Alterity will continue to be part and parcel of psychoanalytic processes, as it emerges between psychoanalysts and their colleagues, psychoanalysts and their patients, and even between persons and their unconscious minds. Psychoanalysts will still differ in how they deliver their professional behaviors; they will still differ, as Modell (2013) noted, in how they conceptualize transformation. But they will benefit from having a shared nomenclature for discussing their work.

Why do Patients Consult Psychoanalysts?

Despite their field's lack of cohesive models of mind or practice, and its other limitations, practitioners of psychoanalysis continue to attract patients. Defining precisely what these patients seek is as difficult as finding a unifying theory of mind, and for similar reasons: Patients consult psychoanalysts with essentially infinite potential motivations. I nonetheless proceed, with trembling hand, to offer one organizing theme:

Patients Consult Psychoanalysts in Search of Personal Transformation

The medical model proves inadequate for describing psychoanalysis. It is too constrictive. Not all patients consult psychoanalysts for symptom relief. Some seek reduction in complex, diffuse pain resulting from early childhood trauma. Some experience nightmares, intrusive recollections, hyper-startle responses, and similar reactions to traumatic experiences. Some want to deepen their relationships or, in general, to improve their capacity for intimacy. Some wish to learn about their minds, conscious and unconscious alike, in greater depth. Some seek help with existential

concerns, e.g., finding meaning or facing aloneness, death, and responsibility. Some consult psychoanalysts because their spouses, parents, children, employers, or judges insist they do so. Some know not why they come for help. Even these diverse, if incomplete, reasons for seeking psychoanalysis share a wish for change of some type.

As poetically captured by the title of Zizek's (1992) book, *Enjoy Your Symptom*, Lacan (1991, 1998, 2002) believes, as have many others, that patients universally resist transformation. They present with the conscious wish *for* change but unconsciously do not want *to* change. Whether they struggle against change or not, patients want *something* to be different—less physical or emotional pain, an alteration in their relationships, getting their spouse, parent, employer, or judge to stop insisting they get help. Thus, their resistance does not diminish what motivates them to *seek* assistance from psychoanalysts. A few additional generalizations are worthy of mention.

Psychoanalytic practitioners have typically oriented themselves towards interpreting unconscious processes. Freud, who first used the word psychoanalysis in 1896 (Gay, 1988), defined the field—incorporating the clinical and the theoretical—as "a procedure for the investigation of the mental processes which are almost inaccessible in any other way" (Freud, 1922/1991b, p. 235). As the relational turn (Aron, 1996) invited psychoanalysts to use interpersonal features of the psychoanalytic process, the basic procedure remained the same. Differences over methods emerged; divergences in ways of viewing unconscious structure emerged. But psychoanalysts continued to share the common goal of enlightening patients. Some emphasized increasing self-knowledge through interpretation; others stressed the lived experience of the analytic work. But all agreed that psychoanalysis raises consciousness, enhancing patients' understanding of the elements of their subjectivities lying outside their conscious awareness. Stolorow, Brandchaft, and Atwood (1991) suggest psychoanalysis offers "the unfolding, illumination, and transformation of the patient's subjective world" (p. 363). Fosshage (1997) considers this formulation as "sufficiently broad to include all of the patient's experience, as well as psychoanalysts of all persuasions" (p. 422). In other words, however unconscious structure may be conceptualized, e.g., "ego, id and superego," (Freud, 1923/1991c), "unconscious phantasies" (Klein, 1946, p. 107), "dynamic structures" (Fairbairn, 1952, p. 377), or some other manner, psychoanalysts agree that unconscious structure exists. It is difficult to

imagine how any psychoanalyst, even one exclusively devoted to Klein, Lacan, or Kohut, could disagree with this basic assumption.

Another generalization, broader than the unconscious, may be subsumed under the word "internalization." Persons share various degrees of turning inward, of consciously and unconsciously conversing with themselves. The social philosopher George Herbert Mead (1934) observed how humans relate to themselves much as they relate to others, writing, "one is talking to one's self as one would talk to another person" (p. 141). In other words, consciously or unconsciously, persons are constantly engaged in internal conversations. Psychoanalysts may be considered professionals who have expertise in accessing and altering these inner dialogues.

Internalization exists along a continuum. On the conscious end, persons are cognizant of thoughts, feelings, and behaviors they keep to themselves—negative feelings about a friend, envy for a colleague, etc. These often provide fodder for exploration in psychoanalytic relationships. Moving towards the unconscious, they may harbor dissociated mental content, such as disavowed conflicts or deficits, that psychoanalysts strive to bring into discussion or—at least—into awareness. On the far end of the continuum lie concretized unconscious structures, e.g., the superego (Karbelnig, 2014a, 2014b, 2016). Many prior psychoanalysts have explored the idea of internalization, albeit using different terms in the redundant manner noted previously. For example, Fairbairn's (1941) phrase "schizoid background" (p. 250), Klein's (1946) "schizoid mechanisms" (p. 99), Steiner's (1993) "psychic retreats" (p. 1), Kernberg's (2007) "narcissistic spectrum" (p. 510), and Summers's (2014) "narcissistic encapsulation" (p. 233) name essentially synonymous phenomena. Symington (2002) proposes, as I do, that all humans share such a propensity towards internalization. Psychoanalysts invite patients to bring their intrapsychic conversations into an interpersonal realm, creating transformational experiences that, in turn, expand patients' understanding of how these outside-of-conscious-experience themes affect their thoughts, emotions, and behaviors. These transformational experiences are created by psychoanalysts framing, presence, and engaging with patients.

Clinical Vignette

As a vehicle for demonstrating the application of a universal nomenclature for clinical psychoanalysis, I invented an entirely fictional

patient named Mr. Brexit. I describe the case in the first person singular, but the psychoanalyst, as well as the patient, are imaginary. I constructed the vignette from an amalgamation of my own clinical experiences and those of psychoanalysts I have supervised. A 51-year-old Caucasian male employed as a banker, Mr. Brexit sought a course of psychoanalysis at his wife's request. He considered himself well-adjusted, but she viewed him as depressed and urged him to seek treatment. He initially showed little insight into his situation but, after a few sessions, realized he had lost interest in his life and often felt sad. It was surprising that he took well to a formal psychoanalytic process. We met four times per week for three years. We discovered, together, how he had been essentially abandoned by his parents in accordance with the mores of the upper class of the United Kingdom of his era. Some of his earliest memories consisted of his being paraded, with his one older brother, in front of his parents during teatime. Most of his early life was spent in the company of nannies. He was sent to boarding school when he turned eight. By the second year of the analysis, he had become aware of underlying feelings of hurt and anger related to ways he felt abandoned by his parents.

When the analysis entered its third year, my usual habit of starting sessions punctually became erratic due to a potentially serious medical condition. The disease was ultimately resolved, but it elicited immense anxiety in me for several months. My schedule was disrupted by my need to consult a variety of different medical professionals. I shared nothing about the condition with Mr. Brexit. The disease had no obvious, external manifestations (e.g., a rash, fatigue, difficulties in ambulation or the like), but he likely sensed something was awry. His intuition peaked during one particularly difficult stretch of our work—a period when Mr. Brexit shared painful dreams, dredged up deeply buried memories, and frequently wept. I cancelled several sessions with short notice and was often three to five minutes late for other sessions.

One day when I opened the waiting room door to greet him, perhaps one or two minutes late, Mr. Brexit exploded in anger. He began speaking while we were still walking down the short hallway to the consulting room.

"You are clearly having a problem," he said.

I waited a few minutes to see if he would elaborate. I then asked him as we settled into our seats in the consulting room,

> "Could you tell me a bit more about what you mean?"
>
> "You are a cold motherfucker," he said, his voice raising in anger. "I have counted on you for months, years now. I counted on your regularity. You're backing away! I'm seeing you as a rejecting shit."

Mr. Brexit and I ultimately worked through this episode, but his anger increased before it receded. He threatened to quit the analysis, accusing me of deceiving him, of feigning interest and involvement. He worried I was hiding something from him.

I will return to this fragment later to illustrate framing, presence, and engagement.

Introducing a Cohesive Nomenclature for Clinical Psychoanalysis

The art historian Kubler (1962) suggests that the effort to create a common language for the arts encountered obstacles related to the ever-changing narrative of history. These forces likewise affect the process of categorization in psychoanalysis. Kubler (1962) writes that studying art requires the establishment of "a support, or a vehicle, or a holder" (p. ix), adding:

> These are the bearers of meaning, and without them no meaning would cross from me to you, or from you to me, or indeed from any part of nature to any other part. … In linguistics the forms are speech sounds (phonemes) and grammatical units (morphemes); in music they are notes and intervals; in architecture and sculpture they are solids and voids; in paintings they are tones and areas. (p. ix)

In psychoanalysis, the three words noted, namely framing, presence, and engagement, concisely describe the nature of psychoanalysts' work.

Framing

Defining the boundaries around psychoanalytic relationships has always been difficult, particularly because psychoanalysts lack any technology, formal procedures, or algorithmic methods that naturally create them. Physicians typically don white coats with stethoscopes draped over their shoulders when encountering their patients, naked but for an

examining gown. People seeking legal services typically meet their attorneys dressed in business attire, seated across a desk in offices wall-to-wall with legal journals, books, and stacks of case files. Psychoanalysts, in contrast, meet with patients in more of a den-like setting, deliberately inviting them into a structured interpersonal relationship fomenting personal transformation. This feature of the psychoanalytic relationship, in and of itself, presents challenges for psychoanalysts in terms of boundary maintenance.

During psychoanalysis's early years, psychoanalysts maintained boundaries in ways similar to how physicians framed their relationships with their patients. They assumed the authority granted them as a result of their social role as physician (or psychoanalyst). During that formative era, analysands enjoyed a fairly unequivocal sense of their status as patients. The essentially universal use of the couch by early psychoanalysts provided an external, overt manifestation of the different roles held by the two parties to the process. With the gradual expansion of psychoanalysis as a profession, such easily definable social roles became blurred. Concepts such as Alexander's "corrective emotional experience" (1950, p. 484), Kohut's (1975) "transmuting internalization" (p. 329), and Lindon's (1994) "optimal provision" (p. 553) made framing psychoanalytic relationships more complicated, particularly for those psychoanalysts influenced by the characteristics of the relational turn.

Framing consists of essentially two distinct behaviors by psychoanalysts. First, psychoanalysts are responsible for maintaining the various types of boundaries that establish the professional working relationship. In order to provide a literal space and time for the psychoanalytic process to unfold, psychoanalysts maintain a professional environment and hold regular appointment times. They furnish their offices in a manner that provides patients enough warmth to facilitate an intimate conversation but not one that excessively invites informality. Psychoanalysts and patients who prefer the use of the couch would, of course, have furniture that accommodates patients' reclining.

Framing varies according to the style of each psychoanalyst and his or her devotion to one or more theories. Some of these constraints are obvious. For example, most psychoanalysts would agree that engaging in dual relationships with patients violates the psychoanalytic frame. Even novice psychoanalysts understand that having coffee with patients, employing them as their personal assistants, or otherwise involving them in social roles that parallel their patient role causes confusion that

hampers, if not destroys, psychoanalytic processes. Many psychoanalysts, with Gabbard (1995) among the most notable, have written extensively about boundary maintenance. Gabbard and Lester (1995) helpfully distinguish between *boundary crossings*—defined as departures from the typical professional frame that are harmless, nonexploitative, and possibly even helpful—and *boundary violations* that actually harm patients.

Second, psychoanalysts may utilize framing behaviors in the service of repairing previous interpersonal trauma by not repeating injurious interpersonal patterns that patients unconsciously and habitually replicate. Even conservative psychoanalysts devoted to the "Gemini twins of abstinence and neutrality" (Davies, 1994, p. 156) interrupt transference enactments and interpret them. In other words, those psychoanalysts who disagree with the relational turn still behave a certain way, within the confines of the psychoanalytic relationship, to effect change. Since the relational turn, controversy lingers as to what extent psychoanalysts use their subjectivities as part of the mutative process. Psychoanalysts may attempt to help patients through self-disclosures or by directly expressing caring, concern, or even love. These debates, complicated further by theorists such as Boesky (1990), who proposed that countertransference enactments of some type actually signal the start of a true psychoanalytic process, suggest that boundary crossings are inevitable. How psychoanalysts manage these become part and parcel of their framing work.

Framing behaviors also vary with the personal preferences of psychoanalysts. For example, practitioners who prefer a more formal approach, and who value abstinence and neutrality, will typically structure their psychoanalytic relationships and engage their patients differently than those who prefer the more relational, interpersonal methods. They might decorate their offices in a more formal fashion. They might be more precise about session starting and ending times. Those more influenced by relational methods may create a greater sense of safety and comfort in the way they furnish their offices. Differences also exist outside of this one continuum. For example, Jungian psychoanalysts might display paintings, statues, or other objects intended to elicit mythic, archetypal themes from patients.

Along these lines, some practitioners of Lacanian analysis utilize scansion, or variable length sessions, in working with patients. Fink (2014), a scholar of Lacan, notes how, rather than arbitrarily stopping psychoanalytic processes at an arbitrary ending point at 45 or 50 minutes, "we stop or 'scand' the session immediately after the

significant formulation" (p. 31). Such a methodology allows patients to exit after a meaningful interpretation, or emotionally transformative experience, occurs. He adds, "instead of continuing while the patient says something highly significant, or allow them to bury a meaningful phrase under things of lesser importance, the psychoanalyst stops the session" (Fink, 2014, p. 31). The variable-length session emphasizes the nature of the work accomplished during a session rather than its duration.

Finally, each psychoanalyst, facilitating his or her own unique version of psychoanalysis due to personality, style, cultural, and other factors, offers transformational encounters within clear boundaries, externally (as in office setting and regular appointment times), and internally (as in degree of warmth or self-disclosure). Framing professional relationships occurs regardless of psychoanalytic models of mind or practice and requires the same kind of creativity inherent in all aspects of psychoanalytic work.

My work with Mr. Brexit demonstrates how patient behaviors, including features of the patient's unconscious, can be stimulated by deviations in the psychoanalyst's framing behaviors. I strived for punctuality in beginning and ending sessions throughout my work with Mr. Brexit. However, the frame was disrupted because I was undergoing evaluation for a possible disease process. In terms of the cross-theoretical goal of the proposed nomenclature, the frame may have been likewise disrupted by psychoanalysts of all persuasions. However, each psychoanalyst behaves in a unique way in the same circumstances. Others may have disrupted the frame differently, or perhaps not at all. For example, some psychoanalysts would have cancelled sessions rather than arrive late for them. Framing identifies a commonality across psychoanalysts of different theoretical preferences; it also allows for significant differences in psychoanalytic theory and the personal styles of psychoanalysts.

Presence

Presence informs many professionals' behavior, particularly in the initial phases of delivering services. Physicians, lawyers, and accountants listen to their clients. Because psychoanalysts lack algorithmic procedures like these other professionals, presence proves more foundational to their profession. Freud (1912/1991a) introduced the idea of presence as a basic feature of his clinical psychoanalytic model and, although subsequent practitioners may differ in how presence is utilized, they uniformly apply

it. All clinical models unite in emphasizing attending closely to patients' words, behaviors, feelings, cognitions, and the psychoanalytic relationship itself.

Freud (1912/1991a) identified many of the key elements of presence, describing psychoanalytic technique as consisting of "maintaining the same 'evenly-suspended attention' (as I have called it) in the face of all that one hears" (pp. 111–112). He cautions against taking notes to avoid distraction, suggests listening with an "open mind, free from any presuppositions" (Freud, 1912/1991a, p. 114), and recommends setting aside all emotional reactions, even "human sympathy" (p. 115). In other words, Freud suggests that a nonjudgmental, open, receptive attitude comprises part of the transformational process—regardless of the types of engagement (e.g., interpretations, confrontations) ultimately offered. After famously comparing psychoanalysts to surgeons, Freud (1912/1991a) quotes the French physician Ambroise Pare: "Je le pansai, Dieu le Guerit" (I dressed his wounds, God cured him; p. 115). Here, Freud infers that presence includes *absence*, that is, letting other, arguably mysterious, even divine forces, contribute to the process. Furthermore, Freud (1912/1991a, p. 111) emphasized artistry and individuality in delivering presence and considered his technique as "the only one suited to my individuality" (p. 111), acknowledging individual differences between practitioners or methodologies. Again, subsequent psychoanalytic theorists introduced their own specific ideas about presence using different, but often synonymous, words or phrases. Winnicott's (1960) "holding environment" (p. 591), Bion's (1963) "container" (p. 3) and Greenberg's (2015) "humaneness, endurance, and unconscious attitude" (p. 15) offer examples. In addition, Lacanian psychoanalysts pay close attention to language, self-psychologists to affect, and so on.

Although appearing outside the traditional psychoanalytic opus, Rogers (1951, 1959, 1961) stressed the centrality of empathy to any depth psychotherapy process that, by inference, applies to psychoanalytic ones as well. He introduced phrases such as "unconditional positive regard," referring to the provision of respect, affection, and caring by psychotherapists for their patients. He believed "congruence" develops because the provision of empathy, over time, draws patients' actual self-images and ideal self-image closer. Mirroring my view of presence as one of the three foundational behaviors of psychoanalysts, Rogers considered unconditional positive regard as a necessary but insufficient part of the psychotherapy process.

Sullivan (1953, 1954), credited with bringing interpersonal elements into the mainstream of psychiatry, considered empathy as having its origins in the communion between mothers and infants. He thought self-image was shaped by the degree of empathy provided by significant caretakers during infancy, and, therefore, also played a central role in how depth psychotherapists received their patients. Kohut (1968, 1972, 1973, 1975, 1977) privileged the role of empathy. He developed his own unique nomenclature for elaborating how empathy facilitated psychoanalysis. For example, he introduced the phrase, the "approving-mirroring functions of an admiring self-object" (Kohut, 1972, p. 386). He defined the self-object function as providing a "replacement for lacking narcissistic cathexis of the self" (Kohut, 1981, p. 100).

Mirroring Freud, Rogers, Kohut, and others, many psychoanalysts consider presence a necessary but insufficient feature of the psychoanalytic process. For example, Poland (2007) writes: "Empathy can only approach knowing; it can never lead to full knowledge. For empathy to be valid, respect for the difference between self and otherness is essential" (p. 93). In the same vein, Busch (2007) notes: "Creation of a feeling of safety via the analyst's empathic attunement may alleviate fears, but the specific working-through process of primitive fears available only in psychoanalysis requires more than just empathy" (p. 430). These psychoanalysts clearly agree that presence, although important, does not suffice to foment transformation. These and other pioneers, in privileging empathy, attunement, and similar concepts in creating effective transformational encounters, exemplify the theoretical pluralism characteristic of the profession of psychoanalysis. However, their different words, terms, and signifiers represent essentially synonymous concepts.

Although still endorsing his version of presence, Lacan (1991,1998) argues for a more language-focused, distant one. He recommends psychoanalysts avoid ego-to-ego encounters because they inevitably lead to resistance, submission, premature termination, or other forms of avoidance. He suggests psychoanalysts show indifference, even distain, when patients try to please their psychoanalysts. Further, Lacan (1991) recommends liberal use of inaction so as to make "death present" in the consulting room, "cadaverizing his position" (pp. 228–229). He recommends that the psychoanalyst "introduces *presence* as such, and by the same token, hollows out absence as such" (Lacan, 1991, pp. 228–229; emphasis added). Here, Lacan considers psychoanalysts as vehicles: tools onto which patient's project.

Such ideas comport with Lacan's (1991, 1998) striving to elucidate the desire of the subject rather than the ego. He believes the ego utters "empty speech" (Lacan, 1998, p. 46), and emphasizes psychoanalysts' need to listen carefully to speech *patterns* rather than verbal content. However, just like his colleagues in other psychoanalytic schools, Lacan still brought his interest, curiosity, and attention to psychoanalytic encounters. Practitioners from all schools likewise attend to hints of subjectivity—whether tracking speech or silence, motion or stillness. Presence *encompasses* absence. A similar idea of presence appears in Laplanche's (1989, 1999) concept of the hollowed-out transference. He explains:

> We offer the analysand a "hollow," our own interior benevolent neutrality, a benevolent neutrality concerning our own enigma. The analysand can place there something "filled-in" or "hollowed out." If it's something filled-in, he empties his pouch into it; if hollowed-out, *another hollow*, the enigma of his own imaginary situation, is placed there. (Laplanche, 1999, p. 229)

Laplanche (1989, 1999) believes psychoanalysts actually provoke, rather than elicit, the transference and, once provoked, two types of transference inevitably coexist. Filled-in transference consists in "the positive reproduction of forms of behavior, relationships and childhood imagos" (Laplanche, 1989, p. 161). It represents transference as commonly described, i.e., as the repetition of archaic situations. Hollowed-out transference creates "a reproduction, but this time it is the childhood relationship that is repeated; it regains its enigmatic character" (Laplanche, 1989, p. 161). If nothing but filled-in transference occurred—that is, mere repetition——resolution would prove impossible. In other words, patients confront the enigma of the other who the analyst comes to embody, conferring, as was the case for the child, the hollow, open space where new translations of the enigma may be issued. Fascinating, if obscure, Laplanche's concept of the transference still emerges from psychoanalysts' presence in the psychoanalytic relationship.

How did presence manifest in my work with Mr. Brexit? I provided interest, curiosity, and attention for many months before the disruption occurred. For those theorists privileging neutrality, absence, or even cadaverization, his anger ("you are a cold motherfucker") might have been met with silence. Those more relationally oriented might respond with

nonverbal empathy, like a warm glance, or with a phrase like, "I can see how angry you've become." These variations in how presence manifests lie within the common range of clinical psychoanalytic practice, and allows for uniqueness, individuality, and artistry in how psychoanalytic practitioners manifest presence. Referring to how anthropologists receive the cultures they observe, Geertz (2000) writes:

> Understanding the form and pressure of, to use the dangerous word one more time, natives' inner lives, is more like grasping a proverb, catching an allusion, seeing a joke—or, as I have suggested, reading a poem—that it is like achieving communion. (p. 79)

Cleansed of any remnants of empiricism, Geertz's use of the word "communion" offers yet another way to conceptualize presence. I imagine presence as a metaphorical spreading out of one's arms, an opening up of one's heart, to receive patients. It proves foundational to facilitating psychoanalytic processes.

Engagement

Engagements occur in the context of an extremely dynamic, interactive, interpersonal process. Neither psychoanalysts nor patients know in advance how their sessions will unfold. The start of psychoanalytic sessions may be compared to white water rafting: the psychoanalyst and the patient approach the river with blindfolds on, jump into the raft, and ready themselves for whatever comes next. Perhaps they immediately enter a dangerously roiling stretch of the waterway; perhaps they enter an area of calm. Perhaps a session begins with one patient gesticulating wildly, speaking rapidly while expressing intense affect; perhaps the next patient, well into the process of mourning his or her deceased parent, enters the consulting room quietly and weeps in silence for half an hour.

Most common, patients seem willing, even eager, to explore the thoughts and feelings they share with no others, to reflect on their behavioral patterns, and to delve into their unconscious minds. In these situations, the full range of psychoanalysts' engagement processes come into play. The varieties of engagement depend on a variety of different and dynamic factors, rendering exploration of them necessarily nonlinear. Engagement encompasses a broad range of psychoanalysts'

interpersonal behaviors shared even by psychoanalysts adhering to different, even opposing, theoretical points of view.

Most clinical psychoanalysts believe effective transformation occurs best if engagement occurs within an affectively tinged interpersonal environment. Klein (1952), working within a one-person model, advised psychoanalysts to pursue themes that elicited the greatest anxiety in patients. However, like all elements of the engagement process, even this generality regarding the import of emotional intensity cannot be applied as a default standard of practice. For example, when working with patients on the autistic spectrum, or simply those with highly cognitive personal styles, achieving a high level of affective contact may be difficult, rare, or even impossible. Worse, it might cause such patients to feel ashamed.

Some types of engagement unfold within the spontaneous intersubjective dialogue that occurs between psychoanalysts and their patients. These typically emerge whenever the actual process between the coparticipants to the psychoanalytic enterprise becomes the topic of dialogue. Readers are well-aware of how the dialogue surrounding transference interpretations typically occurs. Less discussed are myriad other ways that psychoanalysts and their patients engage in intersubjective dialogue, including patients expressing love, lust, irritation, anger, or disappointment with their psychoanalysts. These types of interchanges require much greater exploration, but I simply delineate them at this point in order to identify them as forms of psychoanalytic engagement.

Some delicate features of engagement occur *within the subtleties of interpersonal reactions in the moment*, and, therefore, cannot be recorded or digitized. Of course, delineating these more mysterious elements of psychoanalysts' engagement with patients would be by definition difficult, if not impossible. When psychoanalysts study samples of psychoanalyst–patient interactions, many elements of the live, real-time encounters will vanish. Some interpersonal experiences, particularly more elusive ones, are neither observable nor translatable. I propose that terms like "intuition," "resonance," "déjà vu," and "reverie" (Bion, 1963, p. 19) describe these subtle forms of engagement. If psychoanalytic behaviors were limited to the verbal, then types of possible engagement would comprise a fairly limited number of rhetorical devices—clarification of feelings, confrontation, humor, and interpretation. With the exception of the last one, these ways of engaging patients are self-evident.

Whether dynamically unfolding, eagerly pursued, affectively tinged, intersubjective or subtle, all forms of engagement share one universal: *Engagement invites patients into an interpersonal dialogue, moving some of their intrapsychic world into the interpersonal or even intersubjective realm*.

The patient simply seeking recognition, for example, will usually say *something* after psychoanalysts engage with statements like, "It seems you struggle with feelings of sadness since your father died" or "I understand how angry you feel towards your husband." I once had a patient—another mental health professional, ironically—who repeatedly stated he only wanted me to listen to him. When I offered anything further than clarifying feelings, he would abruptly stop and say, "Dr. Karbelnig, you're not hearing me. I'm not interested in what you're selling. I just want you to hear me." I struggled to accede to this patient's desires, remaining conflicted about limiting my engagements until he terminated psychoanalytic psychotherapy a few months later. As Ringstrom (2010, 2012, 2014) helpfully noted, psychoanalysts require great skill in improvisation to engage effectively with the wide variety of persons, styles, problems, behaviors, etc., presented to them by patients.

Most patients venture further than my ill-fated, professional colleague, but still resist exploring their unconscious minds in general, or the transference in particular. I recently provided a year of psychoanalytic psychotherapy for a man struggling in his marriage because of his "extremely limited range of emotion." He could only identify one feeling state: "frustration." He presented a variety of life situations over the course of the approximately 50 sessions we had. I helped him to identify his reactions to these varied encounters, using variations of empathy, confrontation, and clarification of feelings. For example, on occasion I told him I suspected certain other emotional reactions were present: anger for one, envy for another. I waited to see how he responded to my observations. I confronted him when he reported feeling frustrated and I sensed other emotional reactions lying beneath the surface. At other times, when he expressed emotions other than frustration, I assisted him in clarifying the nature of, in naming, and in articulating the emotional experience. By the end of the treatment, the range of emotions he could identify and express grew considerably. Note how, even in these two limited psychoanalytic processes, the patients engaged in some form of an interpersonal dialogue with me. All forms of engagement share a few other basic,

arguably universal, features that I address now while acknowledging the necessarily incomplete nature of the list.

Engagement through Empathy

Empathy may be used as a form of engagement, but in a distinctly different way than presence. Presence, as discussed in the last section, serves as a background, a reception, a sanctuary. Empathy may be more specifically delivered as a form of engagement. As such, it serves an interventional function rather than a foundational one. Some psychoanalysts will distinctly and deliberately deliver empathy, taking the form of a verbal reflection of an emotional experience or perhaps even express emotions, e.g., tearing up when a patient weeps. Self-psychologists utilize empathy as a primary means of engagement; Lacanians steadfastly avoid it. These variations in psychoanalytic schools further demonstrate the differences between presence as a background and empathy as a form of engagement: Considerable controversy exists regarding using empathy as a tool; little controversy exists in its overarching importance in the form of presence. Again, however, presence does not include direct expressions of empathy. Instead, it takes a subtle form as interest, curiosity, focus, witnessing, receiving, and the like. No psychoanalyst, however radical in theory, would support texting, taking phone calls, reading, or otherwise becoming distracted—or not emotionally present—during sessions.

Engagement through Confrontation

Confrontation consists of challenging or questioning patients' presumptions regarding their thoughts, feelings, or behaviors. Existing as an analogue to the immune system's protection of the body, a variety of defense mechanisms keep unresolved conflict, deep deficits, intense emotional pain, and other features of subjectivity outside of conscious awareness. These strategies were identified within psychoanalysis from theorists as diverse as Anna Freud (1992) and Wilhelm Reich (1972). Psychoanalysts commonly confront patients' use of denial, avoidance, suppression, acting out, and other ways of retreating or avoiding. More primitive patients, of course, tend to utilize splitting and projective identification. These prove more challenging for a psychoanalyst to confront. Nonetheless, the confrontation of defenses, and the exploration of what lies beneath them, remains a common form of psychoanalytic engagement.

Engagement through Interpretation

Interpretation remains one of the cornerstones of the psychoanalytic process as opposed to, for example, the cognitive-behavioral therapies (CBT), which focus more upon behavior change than self-understanding. Practitioners of CBT offer presence just like most professionals. But psychoanalysts interpret the unconscious wherever it may appear—in dreams, symptoms, lifestyles, relationship themes, the transference, or virtually any element of patients' lives. Interpretation serves as but one means of bringing features of the unconscious into the light of day, into the psychoanalytic dialogue.

Psychoanalysts typically strive to offer real-time interpretations that capture unconscious dynamics as they present in the psychoanalytic relationship itself. However, as is the case with any means of engagement, the actual process depends on many dynamic factors. I am confident that readers have had the same experience as have I in this regard: some patients easily join their psychoanalysts in exploring themes as they relate directly to the actual psychoanalytic relationship, e.g., transference manifestations; others spend months or years either uninterested in or unable to comprehend how certain tropes become mapped (even obviously) onto the psychoanalytic relationship itself. As suggested earlier, the metaphors that psychoanalysts use to interpret unconscious phenomena differ. Psychoanalysts immersed in Kleinian theory, for example, will likely utilize concepts such as "unconscious phantasy" (Klein, 1946, p. 107), whereas those more influenced by Jungian models may rely more upon archetypes when discussing the unconscious. These differences in theoretical model will affect patients differently. Nonetheless, they share the quality of representing one psychoanalytic way of engaging, namely through interpretation.

The clinical vignette arguably stimulates the most thought when considered in terms of psychoanalysts' engagement behaviors. Would offering empathy, clarifying feelings, or confronting the patient suffice as ways to engage Mr. Brexit? Or would the psychoanalyst choose to offer varieties of interpretation? If the latter, the variations are endless. The psychoanalyst would spontaneously improvise and choose. What part of Mr. Brexit's history might prove most significant: the parents' neglect, the boarding school experience, or the dominant presence of nannies? Would the brief periods of attention when the children were paraded around the parents during teatime deserve elaboration? Would the

patient's anger be interpreted as triggered by the psychoanalyst's actual tardiness alone or by a combination of eliciting factors? Some psychoanalysts reviewing the vignette might interpret the passive-aggressiveness implied by the patient's use of the phrase, "You are clearly having a problem." Others might not. The case of Mr. Brexit offers literally limitless possibilities of psychoanalytic engagement, validating how the term engagement, like framing and presence, paradoxically allows for both homogeneity and diversity.

Regardless of their theoretical orientation, psychoanalysts engage their patients. They do so according to the unique qualities of each psychoanalyst–patient dyad. It changes as the two parties, as well as the field (Baranger, 2013) existing between them, evolves over time. It is also influenced by external factors, such as sociocultural events. For example, the terrorist attacks of September 11, 2001 affected psychoanalytic consulting rooms, creating a different type of reactivity to stimuli, e.g., sudden loud noises. Whereas for two decades the sound of an explosion would not have elicited images of a nuclear catastrophe, such a sound now might cause my patients or me to look south towards downtown, perhaps expecting a mushroom-shaped cloud. Prior to that historical event, such a sound may have been interpreted as benign.

Conclusion

Although clinical psychoanalysis has wobbled in our contemporary world, other professions have become more consolidated. Professions such as medicine, law, and accounting offer packaged services with an identifiable, if not an actual, empirical basis to them. These professions accommodate the audit culture (Strathern, 2010) with its emphasis on empiricism. Psychoanalysis, in contrast, lacks a unified model of clinical practice, and, surprisingly, even a shared nomenclature that can be easily explained and understood. Therefore, it rather easily falls prey to societal critiques. It finds itself increasingly isolated in this posthumanist world (Wolfe, 2010). A cohesive nomenclature for clinical psychoanalysis would allow contemporary psychoanalytic practitioners to better communicate with one another and, by extension, with the lay public.

Several obstacles thwart the development of such a common clinical language. The highly artistic nature of the psychoanalytic enterprise prevents it from being reduced to sets of algorithms or procedures. Psychoanalysts offer their individualized sets of transformational encounters one person at a time, rendering the creation of universals,

even in nomenclature, extremely difficult. Each psychotherapist–patient dyad—intensely informed by the two persons as they encounter one another, multiple contextual factors, and their interest in or devotion to any particular psychoanalytic theory—has its own unique "signature" (Ingram, 1994, p. 175). By analogy, instead of developing a relatively cohesive identity as painters, psychoanalysts splintered into schools like impressionism, abstract expressionism, or cubism. Thus, it is no surprise that no common language has emerged.

The existence of multiple dialectical processes inherent in psychoanalytic work creates another barrier to creating a common nomenclature. Categorizing some of these opposing concepts, Aron and Star (2013) suggest that psychoanalysts enjoy a certain structure offered by their shared pursuit of the unconscious, but their exploration of it through dreams, symptoms, and more, unfolds in a highly unstructured, nonlinear fashion; they facilitate intimate, if asymmetrical, relationships, but lack precise ways for limiting or bounding such intimacy; they offer services intended to help persons with serious, diagnosable mental disorders, but their work differs little with their patients who seek only personal growth; they use a variety of interpersonal influences in facilitating transformation, but have no clearly defined, linear techniques because such would counter the psychoanalytic project that privileges individual differences and "subjectification" (Fink, 1995, p. 70).

Neither the artistic nature of their work nor these opposing concepts necessarily prevents psychoanalytic practitioners from agreeing on a shared nomenclature to describe their clinical work. Such a common language will not and cannot create a uniform, manualized type of psychoanalysis encouraged by the contemporary zeitgeist, e.g., the audit culture and the posthumanist era. As I have argued previously, personal and stylistic features, as well as artistic elements, (Karbelnig, 2014a, 2014b, 2016) will forever maintain the unique singularity of psychoanalyst–patient dyads. These couplings will remain as unique as the individuals who comprise them. Although not conforming to societal demands for accountability and predictability, the application of a universal nomenclature for organizing what clinical psychoanalysts actually *do* in their consulting rooms can enhance the profession in at least two distinct ways.

First, a common language would allow institutions, journals, and conferences to sponsor discussions of clinical work in a manner that enhances cross-theoretical communication. A common language would facilitate the scholarly comparing and contrasting of different

approaches; it could facilitate scientific study of elements of psychoanalysis, such as outcome studies; it would also offer a consistent support, to use Kubler's (1962) term, for teaching students of psychoanalysis in residencies, graduate schools, or psychoanalytic institutions.

Second, the nomenclature would provide a vehicle for enhancing the public's understanding of this oft-misunderstood profession. When they hear the word "psychoanalysis," most Americans think *New Yorker* cartoons. The three words, "framing," "presence," and "engagement," could be used to explain psychoanalysis to the lay public. They provide psychoanalysts with a fairly easy-to-understand way to organize the specific, psychoanalytic transformational process. Even though each term allows for infinite complexity, the setting of the stage for psychoanalytic processes to occur (framing), the psychoanalyst's close attention to the patient (presence), and the various verbal and nonverbal means used to stimulate dialogue, self-exploration, and self-understanding (engagement) can be presented to potential consumers of psychoanalysis in a way they can easily understand.

Such unifying nomenclature would address the "fractionation" (Stepansky, 2009, p. xvii) and the "diffuse application" (Rangell, 1974, p. 3) of psychoanalysis. By identifying clinical psychoanalysts' work as facilitative in nature, their knowledge base as consisting of one theory or multiple theories of mind, and their skills being framing, presence, and engagement, psychoanalysts could build better bridges between the varied approaches. They could utilize a terminology that would allow for a common means of communicating what they do. Although psychoanalysts interested in theory could continue to pursue universals of human subjectivity, clinical psychoanalysts could enjoy an increased sense of community. The phenomenological nomenclature I propose would provide a common language with little constriction: psychoanalysts would remain free to practice their transformational art in varied ways, using divergent models or metaphors.

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