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# The Boundaries are Shifting: Renegotiating the Therapeutic Frame

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Psychodynamic treatment is under siege. Shifting societal values and increasing economic pressures are shaking the structures of our work. In this chapter, I will examine this crisis by looking at the phenomenology and current treatment of personality disorders. Using this illness as a lens, I shall examine the impact of current pressures on therapists' ability to establish a reliable framework for dynamic treatment. Such a framework has always included the interplay of interpretation and management (Milner, 1957; Baranger, 1966; Langs, 1976). The increasing intrusion of third parties into the treatment setting, however, requires us to reconsider the relationship between these two methods of intervention.

continue to provide us with rich ideas about human psychopathology and development. The challenge that faces us is how to apply these ideas with integrity for patients in treatment settings affected by new forms of resource management.

## PERSONALITY DISORDER

A personality disorder is an adaptation an individual makes to an aberrant interpersonal environment, usually the environment of a family (Shapiro, et. al., 1975). Families create a shared human context to meet the needs of individuals within them. In families whose members have personality disorders, individuals often form rigid defenses against recognizing limitations in themselves, in others, and in the availability of resources (Shapiro, 1982a). These defenses protect them from feelings of helplessness, anxiety, rage, and grief. The price of this protection is the development of rigid or aberrant interpersonal and family boundaries (Shapiro, et. al.,1975; Shapiro, 1982b). Children's adaptation of their personality structures to fit their experience of these boundaries -- no matter how traumatic -- is functional. It helps with their emotional survival and supports parents' engagement in some kind of caretaking roles. Adaptation to a constricted family environment does not, however, help develop the child's long term capacity to grapple flexibly and creatively with ever-changing reality outside the family.

The world does not conform to the individual's needs. In response, the so-called personality-disordered person displays what the DSM-IV calls "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture." This pattern represents an effort by the individual to change the world into a familiar place (Shapiro and Carr, 1991). Limitations in the world -- impassible boundaries marked by insufficient resources or conflicting needs -- can cause the character-disordered individual to become symptomatic. For example, obsessive patients faced with time limitations can become anxious and narcissistic patients confronting the unavailability of significant people can withdraw or become angry. Clearly defined task and role boundaries in therapy -- which help articulate experience so that patients can fully acknowledge it -- may allow for a different outcome. These boundaries slow the interactions so that the obsessive can notice how his efforts

to control contribute to his anxiety. The narcissist can recognize his need for the other's attention. For patients, experiencing and studying transactions across these therapeutic boundaries offers an opportunity for learning (Bion, 1962). Patients begin to recognize their desperate efforts to change the outside world to fit their needs. With this recognition, they have a chance to gain perspective on their childhood and current maladaptive style and notice that situations in the world require negotiation.

Mental health professionals are in a comparable position. We have grown up in a professional "family" to which we have adapted. Generations of thinkers in dynamic psychiatry have taught us to offer our patients a particular therapeutic setting in the hospital or in the therapeutic dyad. This included time for an externalization of aspects of the patient's personality within the transference. Seeing these externalizations provided an opportunity for the patient to gain perspective on what he or she was trying to repeat or reconfigure. Our increasingly focused interpretive efforts and therapeutic zeal allowed us, with our patients, to extend treatments. Although the individual session was determined by the beginning and end of the hour, psychotherapy was without time boundaries. For some, therapy became a way of life, lasting more than a decade. Deep became deeper, with formulations and case reports emerging in the psychoanalytic literature about the recovery and fruitful analysis of infantile, pre-verbal experience. Because our focus was relentlessly inward, we were more likely to overlook the impact of a decade-long intensive therapeutic relationship on our lives and families and those of our patients. For example, to my knowledge, there has been no study of the incidence of therapist or patient divorce following extended psychodynamic work. We have decreased our attention to outer world boundaries -- initially noted with the establishment of the frame -- in exchange for an extended focus on interpretation.

The outer world has now intruded. For most of our patients in psychoanalysis, psychotherapy, and hospital care, we can no longer provide this traditional setting. Like our character disordered patients, we, too, are now facing unanticipated boundaries and limits in the outer world. Psychodynamic therapists had found it difficult to incorporate resource

management functions into their settings because of their involvement in the therapeutic process. Insurance companies and managed care organizations have now taken authority for these functions. As Plaut (1990, p.310) noted, ". . . that part of common reality which we shut out for the sake of the necessary seclusiveness . . . has a way of reasserting itself." It does not look like we can change this world back into a familiar place. Our difficulty in acknowledging and integrating aspects of the altered external context into our treatment framework may even repeat boundary disturbances characteristic of our patients' families. To maintain our integrity and keep our therapeutic enterprise grounded in reality, we must reexamine the basics of our treatment setting in this new context.

## THE FRAMEWORK

Over the years, psychoanalysts have increasingly learned to define and manage a therapeutic framework within which a deepening treatment can take place (Milner, 1957; Baranger and Baranger, 1966; Langs, 1973, 1976; Raney, 1982). Milner (1957) noted that the frame has a crucial boundary function, in that it "marks off an area within which what is perceived has to be taken symbolically, while what is outside the frame is taken literally" ( p. 158). It is our responsibility to manage this framework, which includes: confidentiality and role boundaries, time, place, setting, financial arrangements, and vacations. We structure these arrangements in the outer world of our contractual negotiation with another adult, who agrees to take up the patient role. We do all of this both to take care of ourselves and to support an interpretive treatment task.

The framework thus has footholds in external reality and in the analytic dyad. For example, we set our fees according to pressures in our outer world in response to the market and our patients' resources. Fees, vacations, the management of missed sessions -- all of the

framework issues -- are the context within which our patients make sense of us. These structures, therefore, link the developing transference to external world pressures on both patient and analyst. If the patient's spouse and child require particular vacation times that do not coincide with the analyst's vacation, it raises a framework issue. When the analyst requires the patient to pay for sessions missed during the patient's vacation, it affects the patient's family relations. If the analyst does not charge, the patient's vacation affects the analyst's income and, indirectly, his or her family

life. Every aspect of framework negotiation is deeply imbedded in the inner and outer worlds of both participants.

When patient and analyst negotiate a clearly structured framework, they respectfully address this complexity and provide a safe, predictable, transitional space for therapeutic work. With this security, an individual can take up the patient role and risk a symbolic regression in which an interpretable transference to the analyst can evolve. Though the management structures of the framework quickly enter the patient's inner world of private meaning (Raney, 1982; Rudominer, 1984; Dimen, 1994) and what Ogden calls "the third of the analyst-patient intersubjectivity" (Ogden, 1994), the analyst is responsible for establishing them. The way in which the analyst manages these issues is a reflection of how she manages the boundary between her inner and outer worlds. It, therefore, provides information to her patients about her character (Langs, 1976). The patient's interpretation of the analyst's management is a reflection of the patient's inner world. We meet our patients at this intimate management boundary to engage in the task of interpretive treatment.

The management of the framework and its incorporation into an interpretable transference illuminate the necessary integration in dynamic treatment of management and interpretation. There can be no interpretation without competent management, and no useful management without interpretation. When linked to the shared task of understanding, the two

methods -- understood psychoanalytically -- provide tools for examining the boundary between the patient's inner and outer worlds.

For neurotic patients, the framework is largely a silent aspect of the work. These patients have internalized a stable psychic structure. Patients with severe personality disorders, in contrast, crash against boundaries. Many enter the hospital because of their inability to manage a secure framework for their outside lives. Quite often, it is within and around the framework of treatment that these patients enact their psychopathology. These interactions impinge on therapists at our management boundary, evoking countertransference reactions and framework errors. The study of these mutual enactments has deepened our learning about the fine distinctions between transference and countertransference. In such treatments, our authority for the framework, our ability to manage it, and our commitment to holding the treatment task as primary become crucial.

## MANAGEMENT AND INTERPRETATION

Advanced technology has contributed to an increasingly interdependent world. We are more aware both of our needs for others and our limited resources. Institutions that society has counted on to manage dependency -- the family, religion, education, health care -- have become less dependable. These changes make growing up in this society more difficult and have escalated demands for mental health care. In response, the mental health field has grown enormously. Now that its requirements have threatened to exceed limited resources, its variously trained practitioners have reacted to the pressures with both disarray and rigidity. The therapeutic pair is deeply imbedded in a world where there is less time available for sustained intimacy. An intensive, intimate relationship makes powerful demands on both participants. Pressure builds to meet dependency needs instead of interpreting them. We can see the disarray in the increasing number of therapists who have lost their capacity to manage themselves in role. One reaction is for therapists to surrender their management capacities in exchange for a quasi-delusional intimacy manifest in sexual involvement. Alternatively, for some, time boundaries can become irrelevant with the therapeutic grandiosity of an endless treatment.

Another response to the intensity of the work and the limited resources is to develop a defensive, rigid, hyper-management style. Questioning the dangers of interpretive intimacy, many mental health practitioners are turning to the use of prescribed and highly organized management interventions without interpretation. For many practitioners untrained in dynamic thinking, this mode of intervention serves as an adaptive defense against powerful feelings -- the patients' and their own -- that they can neither tolerate nor understand. However, such prioritization and monitoring of the patient's behavior transforms the semipermeable learning boundaries between therapist and patient into impermeable barriers and risks depleting the treatment of meaning.

In each instance, one aspect of the work is lost: management or interpretation. In each, we move away from the combined interventions that allow for containment and exploration of the patient's inner world. We substitute either the delusion of "oneness" or the safety of arbitrary and rigid management. We fuse with our patients or we direct them. Both responses are defensive substitutes for the risky possibility of learning with them in a transitional space that allows for both empathy and interpretation (Brickman, 1993). Both groups engage in an irrational split where projections and counterprojections flourish. The heartless fiscal manager is no less a projected stereotype than the greedy, self-indulgent clinician.

In the face of this anxiety and splitting, extraordinary changes have taken place. Businesspeople run psychiatric hospitals and have developed new approaches to manage money and institutional survival. Clinical thinking no longer guides institutional life. Even more disturbing is the way that manic defenses have replaced terrified withdrawal. The most sober clinicians are now touting the effectiveness of seven-day treatments for patients with personality disorders. To a certain extent this change represents a course correction from our past avoidance of external reality. However, there is real danger that the power of a genuinely negotiated interpretive understanding of people's lives will be irrevocably lost in the service of managerial efficiency.

At the meetings of the American Psychiatric Association, I discussed several papers on the treatment of personality disorder in the managed care era. The papers inevitably focused on short-term interventions into lifelong disorders and offered a range of approaches in response to the current pressures in the field to manage symptoms without interpretation.

One group of authors represented the managers. They discussed the need to focus behavioral and educative interventions in a brief period. One (Silk, et. al., 1994) described how his staff works effectively with hospitalized borderline patients in seven to fourteen days. The staff advises patients in advance about the time limits and encourages them to have modest goals. Staggered by the rapid turnover and severe patient pathology, staff members benefit from having clearly defined offerings; group and educational sessions help patients by structuring their brief time in the hospital. Patients agree to work on cognitive-behavioral learning, which bolsters their defenses against the feelings of abandonment that lead to their intolerable actions. Silk suggested that a regularly interrupted but essentially long-term relationship with the institution allows patients gradually to recognize and face these feelings. The task of hospitalization is to educate patients about their illness and teach them to manage their symptoms. There is no time for interpretation, and no secure relationship within which one can interpret. Silk does not comment on the possible social implications of setting up a covert managerial system of chronic care. Nor does he consider the possible enactment of a potentially interpretable dynamic of sustained dependency, not unlike that of interminable dynamic treatment.

Another author (Falcon, 1994) assessed this strategy by pooling statistics from Blue Cross/Blue Shield utilization review. Intensive management of mental illness (through constricting hospital stays and duration of treatment) appeared to save a great deal of money. However, when he examined the total expenditures, he found that the costs remained the same, before and after managed care. What had shifted was the accounting of these costs from the psychiatric column to the medical. Patients with mental illness who received no definitive treatment ended up in emergency wards and internists' offices with behavioral and physical

manifestations. Management without interpretation seemed to lead to cost shifting without cost saving.

Dr. Glen Gabbard (1994) from Menninger spoke in defense of the work of the interpreter. He noted that the artificial limits caused by rigid resource management caused damage to patients working in an interpretive frame. In his studies, borderline patients begin to allow the development of a negative transference at approximately the thirtieth session. This is a customary limit of outpatient resources. Arbitrary interruption at this point was particularly traumatic, as patients regularly experienced it as confirmation of their negative transference, which made it impossible to interpret. Gabbard focused on the need for continuity in the therapeutic relationship, suggesting that a primary task of treatment is to help patients develop a sense of self-continuity over time. Speaking to the necessity for extended treatment, he portrayed resource managers as unwittingly attacking and endangering the patients' treatment. He did not comment on the possibility of integrating the external limits into the therapist's framework.

The differences between managers and interpreters are evocative. Interpreters imply that resource management is destructive and argue for long term treatment. Their therapeutic neutrality gives patients room to take charge of their lives. It may not, however, sufficiently attend to the covert gratifications of interminable treatment for both participants. The passionate argument of interpreters -- which gives management little significance -- makes it increasingly unlikely that third party payers will continue to finance this approach.

Managers offer patients coping strategies, frequent short-term admissions, and cognitive schema. Interpretations are irrelevant. Managers use less expensive staff, place patients in groups to study behavior, and prescribe a combination of medication and education. They move people along. Patients treated this way may not take charge of their illness. They may end up receiving nonpsychiatric care that is just as expensive as definitive psychological treatment.

Such management interventions have unexpected side effects for patients with personality disorders. Many of these patients use externalizing defenses, blaming others for

what happens to them. In intensive treatment, these patients reveal that behind the externalization lies punitive unconscious self-criticism (Kris, 1990), a phenomenon that leads to their self-destructive behavior. In a treatment environment where managerial experts judge and correct their behavior, show them their vulnerabilities, and teach them "more adaptive" ways to live, these patients readily mobilize this self-criticism. They can interpret a managerial approach as confirmation of their incompetence. In addition, many of these patients have grown up in families where parents believe they know what is going on in the child's mind. They tell the child the way to live rather than helping her discover her own way. This "pathological certainty" (Shapiro, 1982b) contributes to the despairing sense many of these patients have that their ideas, their motivations, and their efforts to understand are of no interest and no value. Managerial therapists may unwittingly contribute to an unproductive repetition of this experience.

Interpreters also run into problems. Gabbard (1991) noted how patient and therapist can join to idealize interpretation and exclude and stereotype the financial manager. This repeats a different familial pattern in which one parent forms an exclusive dyad with the child, stereotyping and excluding the other parent. The use of the child as an ally interferes with learning and excludes the third party necessary for grappling with reality. Collusive pairing between therapist and patient in an endless treatment is problematic. It can conceal a shared hatred of limitations, a fantasy of endless resources, and a delusional dyadic structure. Bion (1961) described the shared irrationality inherent in any "pairing" disconnected from the larger group's task. The notion of an
isolated dyad, however, is an illusion. The therapeutic pair has always been imbedded in a larger context: the community, the profession, the managed care networks, the mental institution. Though we do not always pay attention to this, there is inevitably a "third" that keeps the pair grounded in reality.

There is increasing interest within the analytic literature in the notion of "the third." Abelin (1971) wrote about early triangulation and the function of the father for both mother and

child in protecting the pair from being overwhelmed with symbiosis. Lacan (1975) developed the idea of the symbolic third ("le nom du pere") as a function that grounds the individual in a larger context. Brickman (1993) described interpretation as a third factor facilitating separation from therapeutic symbiosis, and Ogden (1994) described "the third" factor of the analyst-patient intersubjectivity.

Though the issues differ, these notions are applicable to the external third of the managed care reviewer and insurance company. In the childhood triad, the father shares the same task as the mother-infant dyad: facilitating the child's development. The payer's task, however, is different from that of the therapy pair: financial management, not treatment. But these latter two tasks are linked: both financial management and treatment require attention to the reality of limitations.

Inevitably, the patient brings external parties into the relationship and incorporates them into the interpretive space. This is a familiar phenomenon of psychodynamic work (Schafer, 1985). It is not just the patient, however, who introduces third party resource managers. These agencies bring pressures to bear on both members of the dyad in ways that affect the therapist's capacity to focus on the patient's experience. The therapist must come to terms with them to undertake the work and to clarify what "the work" can be, given the limitations.

Focusing on the dyad, Freud once referred to the patient's family as "an external resistance to treatment" (Freud, 1917). Some have argued (Langs, 1973; Raney, 1982) that managed care providers constitute such a powerful external resistance that interpretive treatment is impossible. Others disagree (Rudominer, 1984; de Nobel, 1989). No matter the source, patients struggle with these external third parties over available resources and interpret that struggle according to their own psychopathology. Therapists can use these struggles as a part of the treatment, if they can find a way to take in the external limitations as an aspect of their treatment frame.

Patients with personality disorders chronically repeat problematic behavior. These repetitions, however, are more than self-destructive enactments. They are also desperate efforts

to learn something new, to gain perspective on an unconscious process. When the patient's experience is not conscious and is enacted through dangerous behavior, a safe space within a secure frame is essential. A secure framework represents a negotiated reality that incorporates the limitation of resources. For many patients, third party managers represent an aspect of that reality. If the therapist can incorporate this external factor into the framework, she can help her patient understand the transference meaning of these limitations and how such meaning has governed his behavior in the past or governs it in the present.

AN INSTITUTIONAL MODEL

The Austen Riggs Center has developed a management structure that brings together financial people and clinicians to address the framework for treatment. Limitation of resources is both reality and metaphor. Patients, staff, family, and insurer share the reality: they must recognize and manage it. The metaphor requires discovery and interpretation. Our effort has been to bring the patient and family into the financial discussions between the hospital and the external third party. This allows them to examine their assumptions regarding the need for treatment and the limitations of resources. The process eventually authorizes the patient to speak and act as the critical agent of change. Inevitably, the patient's reactions to limitations reflect a character driven response to frustration and illuminate repetitive dynamic themes. Excluding patients from this experience or confusing them by discounting or devaluing the financial managers deprives them of an opportunity for speaking as well as learning.

Dr. Eric Plakun (1994) from Riggs has described how a patient's mother continually rescued him -- both emotionally and financially -- from taking charge of his life. She repeatedly bailed him out when he overextended himself. In the hospital, when the insurance coverage was about to end, the patient's behavior worsened. He requested a rate reduction from the hospital to stay longer. The financial officer was inclined to agree. In the clinical-financial discussion, the clinical staff recognized and interpreted to the patient the repetition of his family dynamic, with the hospital in the role of mother. He saw how he was enacting a lifelong pattern of inviting his

mother's overprotective response. He began to see his pattern of blaming his mother for her overprotectiveness while demanding through regression that she continue to meet his needs. The discussion led to a decision by the patient to step down to a less expensive program. He obtained a job to support the program and negotiated a small reduction from the hospital and a contribution from his mother. Through the staff's integration of management and interpretation, the patient could begin to take charge of the conflict.

With the help of this interdisciplinary structure, we invite patients to take responsibility for making moves to less expensive settings in our system. Facing their own financial limitations, they initiate requests for transition rather than allowing others to move them. Stimulated by pressures from insurance companies, managed-care firms, or families, our patients frequently resist assuming authority for these moves. The clinical staff works with them toward articulating their resistance within the developing transference. Feelings of abandonment, neglect, and abuse regularly recur. The therapist, with the help of the institution, attempts to mediate these pressures and feelings with the patient, sustaining the reality limitation and placing the feelings within an interpretive context. Grief often results. With this working link between clinical and financial thinking, patient, family, and staff have an opportunity to learn from their shared irrationality about limits. In this setting, the negotiated management of limitations becomes the framework for interpretation.

It is possible in a short period, even with disturbed patients, to develop collaborative dynamic interpretation of these reactions. The therapist must, however, incorporate the reality of limitations into his framework and interpret within that space. When therapist and patient develop a shared recognition that resources are limited, the patient often directs his rage at the therapist as representative of that reality. Working through this rage leads to grief, mourning, and a genuinely intimate engagement around treatment and its limitations. For example, an adopted patient had lost his biological father at an early age and did not get along with his new father. Throughout his life he had been beaten by his stepfather when he could not perform. Unable to provide help or recognize his stepson's need for him, the older man would strike him.

This patient gradually developed a characterologic adaptation to challenges, oscillating between helpless vulnerability with wishes for idealized rescue and aggressive grandiosity. The vulnerability reflected his need for a loving father, the grandiosity, his angry effort to manage everything himself. When faced with a task, he thus unconsciously evoked his relationship with his stepfather. He needed help in seeing the pattern, tolerating the experience, and putting it in perspective so that he could increase his choices (Semrad, 1969). This patient was overwhelmed by his fear of his wish to rely on a man. Without containment and interpretation, he could not allow himself to recognize and identify with a man's strength, vulnerability, and competence to become his own man. He needed help to separate from his past.

This patient was hospitalized because of a decompensation around losing his job. Enacting his defensive character solution, he did not hire a lawyer to represent him. He grandiosely took up his own defense and ended up feeling battered by the complexities of the case. In the hospital, he wanted the institution to take his side in court. A success would provide the resources for the long-term treatment he needed. As it stood, he had resources only for short-term treatment. The repetition was familiar. The patient wanted the therapist (as the idealized father) magically to help him get the resources he needed for a better developmental solution. Any failure to respond meant abandonment. When the therapist noted that they only had a short time to work together, it provided a reality boundary. With this, the patient could experience and begin to interpret his negative transference. He saw the therapist as a bad father, who was "knocking him down" without helping him develop his "inadequate resources." With the recognition of a familiar rage, he could begin to see his terror of turning himself over to his therapist for what the therapist had realistically available -- treatment, not legal advice. This recognition freed him sufficiently to allow the therapist to define with him an achievable goal. In a brief stay, this patient could learn enough about his terror of relying on a man so that he could dare to hire an effective lawyer to represent him.

## DISCUSSION

A familiar and painful life experience for patients with personality disorders is the lack of resources in their families and their lives to ease their emotional development. They have shaped their characters to deny this fact. Managed care -- as metaphor -- represents this experience. In establishing a treatment setting in which patients can address these issues, therapists must face the changes in our world caused by the limitations of resources. The third party reviewer -- no matter how untrained or clumsy -- is the representative of that reality. We must integrate their perspectives into our own framework to provide a safe transitional space in which the patient can risk an interpretable transference.

provide a safe space for treatment. A defensive response, however, interferes with the possibility of providing either management or interpretation for the patient. Both patient and clinician become incompetent and despairing. This was the experience for one patient, who wrote:

> "I'm confused about everything. Should I stay or should I go? I'm so ambivalent and apathetic, it's making any decision impossible. It was my assumption that I'd come to the hospital, cut to the chase, as it were, and concentrate on intensive therapy. But the insurance company has made that quite impossible. I don't have a clue when they'll say, "You're out of here," so I had a mind set to go home this week because I thought they'd kick me out. Talk about undermining any work to be done. So now that I'm in this mind set, I want to go home. It has become more appealing the more I've thought about it. That's tough though, because the stuff makes me feel so bad and I sure don't want to go to school with all this dredged up shit making me feel bad. ...The insurance company is also making me feel really uprooted here and since I know I'm going home before school anyway, I might feel more settled by moving home. .. I've been living on the edge for more or less eight years, so I personally don't see the difference where I am. Home, school, hospital. Now it's all the same. Because I couldn't get what I wanted out of hospital and that was my last resource. So I'll just have to keep doing what I've been doing."

Even in these cases, however, the therapist can manage a dynamic intervention if she holds to her interpretive task. The recognition that patients with personality disorder regularly use aspects of the frame for enacting a repetitive theme is central. With our help, they can use this experience to discover their metaphor. The patient does not initially experience his or her behavior either as repetition or metaphor. Grasping the metaphor, however, is itself a shift toward recognizing and stopping the repetition. For this patient, her suicidal depression and isolation stemmed from the disruption of her family in early adolescence. During this period, her family was unpredictable and chaotic, intermittently absent, and confusing. She had to take

charge of her life alone, with resulting despair. In the face of the managed care response, this patient could see how she chose a familiar interpretation for a more complex reality. The third party reviewer was, like her parents, confused, uncertain, and not attending to her needs. However, the therapist, who had incorporated this reality, was available to her to make sense of this, both as reality and as transference. Choosing the familiar and devastating chaos as the reason for her despair was this patient's repetition. The overwhelming repetition of childhood confusion did not allow her to discover her adult perspective and resources. With a stable focus on the interpretive task within this framework, she could recognize this and make more complex choices.

The title of this chapter is "The Boundaries Are Shifting:Renegotiating the Therapeutic Frame." I suspect that this apparent shift in framework boundaries and our pressure to redefine and renegotiate them is both reality and illusion. The confusion derives from our anxious uncertainty about the future and our reluctance to see how we have contributed to the development of systems of external management. As John Muller (1994) has noted, "If the contemporary rush toward the dyad in our theories has served to eclipse the place we give [the] third, one possible outcome is to leave the field vacant for an unwelcome intruder. The place of the third . . . has been seized by the managed care [provider, who]. . . structures the dyadic process from first to last, determines its semiotic conditions, influences what is to be said or not said, [and] dictates what shall be taken as meaningful and what shall be desired as an outcome. "

I suggest that if we hold to the essence of our frame, we have a chance to ride out this storm. We can continue to provide our patients with definable structures for interpreting their lives if we can help them manage sufficient resources for even the beginnings of an interpretive space. Then, we may rediscover how competent management and reliably negotiated interpretation are inextricably linked in the provision of dynamic treatment.

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