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Are Psychoanalytic Paradigms for Us or for Use?

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Clinical Note

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I was recently enthralled by a simple but meaningful phrase spoken by an ecological engineer on public radio referencing an approach to environmental conservation. The phrase was: *sustainability by design*. In the radio interview the pragmatic but difficult paradigm to implement was proposed: To ensure a future for the planet countries would have to find a new way of solving the problem of waste and overuse of natural or man-made resources. In this proposal a design or new construction would be established that would solve the problems of global warming, reliance on petroleum and so forth.

What lingered for me was the phrase *sustainability by design*, or a new way of solving a problem by constructing a design which if followed could make a considerable difference in altering a destructive course. The specific political and economic problems in launching a new paradigm to save the planet are beyond the scope of this paper; and though not intentional the paradigm of *sustainability by design* suggests a chilling similarity between countries that exhaust natural resources, and are not immune from corrupt political ideologies and the narrow-mindedness of psychoanalytic training. I want to address the striking resemblance to the zealousness bordering on turf paranoia over a too sharp differentiation and implementation of psychoanalytic paradigms that delays movement into more comprehensively useful training to deal with the varieties and levels of clinical phenomena encountered since the inception of Freud's monumental efforts to understand the human psyche.

Clinically relevant theory is theory for usage in the clinical encounter. Theory-about-practice is experience-distant from the varieties of clinical situations encountered in daily psychoanalytic work. In daily practice therapeutic activity for each case situation presses for more integration between known clinical theory with something more to meet the challenges of specific patient systems, defenses, impasses, and the like. I wonder about the narrow use of available resources, our paradigms. In some institutes we teach the same clinical paradigm as a one-size-fits-all. Paradigms are available that address couples, families and larger groups but rarely taught on a level playing field. The question for teaching institutions is do they emphasize clinical usefulness, and flexibility, adopting new ideas, or self-preserve the institutions that espouse them? Is the institutional approach to teaching and learning the best use of our psychoanalytic resources?

I am differentiating theory-about-practice from theory-in-practice, which is more likely an amalgam. Personalized, conscious and unconsciously held clinical concepts are cognitively and affectively significant to the specific therapist, as a mixture of style and tools, waiting in readiness during important clinical moments. During these moments a mixture of identification with an aspect of the patient's internal need for a deep understanding intermingles with the therapist's empathy and verbal capacity, and the therapist spontaneously offers a portion of his paradigm in the session. Something is said, or held silent, a felt response, expressed in a facial or bodily movement, customized in the moment that reaches the core affective need of the patient. Or, perhaps not!

Learning from experience is humbling. Our most conscientious efforts may not hit the affective-mentalizing mark. The matter of how and in what manner we reach a patient/s involves how we are prepared to be reached by them. Theory in use continues to be a complex issue worthy of re-thinking and adjustment. The problem may be our misuse of our chosen paradigm. Perhaps we need more therapy, or a different analyst, or supervisor. Paradigms intermingle with our fragile selves and we can become super-ego dominated by them. This dilemma is worth exploring because paradigms over-determine what we think we do.

What if one's paradigm is too embedded in institutional rigidity, and limited in addressing patient needs? What about life outside the dyad? How many alternative paradigms are available but ignored that can illuminate the issues of transference and countertransference in a single case or session for example? If therapy is conducted from a dogmatic position the participants are prisoners, and not freed up to explore and expand paradigms that enrich comprehension of mental space, interpersonal life and use of self. I am suggesting the emphasis on the dyad as the modality of choice is shortsighted, and it is institutionalized.

Recently I had two teaching experiences that made me appreciate the issue illustrated by the aforementioned "*sustainability by design*" comment concerning saving the planet's resources through new paradigms.

The first involved a workshop experience with child therapists, all women, who I was told by the institute director were interested in family assessment when working with child cases.

I introduced the topic by asking about the participant's practices, and sharing my experiences in the field as a child and play therapist. I believed learning about their work would establish my credibility and promote a sense of "We-ness" with respect to play therapy. After I talked for a while about family assessment with young children, I presented my child-focused case with art work obtained in the family context to illustrate whole family assessment--the draw, talk and play modality.

What followed in the discussion was a group phenomenon I had not anticipated: A large number of the child therapists could not take in the family or the model, referring most comments to their responses to the index child (two siblings were present in my family sessions). At first I wondered had I neglected discussing their training as child therapists? Perhaps the group perceived me as over-emphasizing this new paradigm and undervaluing their considerable specialized training. Not so, I learned by opening up discussion further. I asked the group to comment on what had happened to the rest of the family in the case.

One risk-taker stated she had an analyst as a supervisor who did not appear open to involving family members in child cases. Others in the group spoke up and the general discussion turned to their "fears" of parents, and not feeling they could have them involved and protect the child at the same time. A group basic assumption emerged of a flight away from parents and the joining or pairing with child cases as the savior/rescuer of the child.

I offered the observation that the pressure must be great to feel responsible to provide all they believed the child needed but could not receive from parents they regarded as neglectful, or abusive. We went into a few of their case examples in which I surmised the parents were essentially feared by the child therapists. Empathic immersion was evident with children, while parents were regarded as the enemy. I then opened up a discussion about empathic overload and the splitting apparently emerging in my awareness that the therapy of children could alienate parents from effective treatment, even if the child was the main focus. There was some agreement of discomfort and tension keeping parents out, and recognition that too little training in working with families might be responsible for the levels of anxiety that placed child therapists between family members.

Thoughts

Was it their paradigm that limited the scope of the group's consideration of my systems-object relations approach? Could the paradigm utilized by supervisors too narrowly emphasize the dyad leading to an alienation of thinking about family dynamics, placing the child therapist in a paranoid/schizoid position with respect to the child's environment? Could the training institute be carrying a paradigm that, by design, exploits available resources--the family environment, by keeping the individual child in an unrealistic idealized transference to the therapist, while denigrating the family?

A Second Example

I was asked by a senior analyst colleague with couple experience to provide a case consultation and a talk to a group of well-trained analysts in a monthly couple therapy seminar, at their nationally esteemed psychoanalytic institute. They asked me to present some material on issues in couple therapy with a narcissistic spouse. After a 15-20 minute presentation of narcissistic choices in marriage, we turned to the case presenter. I had no prior opportunity to meet with and discuss the format or length of time with the case presenter for preparing her case material, knowing only that we would have one hour for group discussion if she adhered to the time line.

As is my usual approach to group case discussions I made two requests: that we hear no more than 15-20 minutes of any part of what she had prepared (I noticed many pages of typed material she had prepared so I realized this would not be easily accomplished) so that we could have time for group participation. My second request was that after she completed the case material the group could not ask any questions of her. Any questions would be the group task to reflect upon as to what the members were internally responding to about the case. The case presenter would also have the final five minutes to share her personal experience

of the case discussion.

The presenter, as feared, sped quickly through many interesting aspects of each spouse's personality, their marriage history, individual backgrounds, symptoms and difficulties. As I listened and observed the group, several ideas emerged. First, the case material focused mostly on the wife, I thought, the more expressive, volatile and also depressive partner. Borderline tendencies filled my mind. The husband appeared eager to please the wife, fearful of abandonment and withdrawn, also depressed I thought. There was little material about the treatment, couple transferences, or the countertransference. When the case presenter reached the 22 minute mark, I noticed my affective reaction was, as was the group's physical comportment, to withdraw from feeling saturated, and overloaded by the data. There was supposed to be session material presented but we never got to hear it.

I intervened as respectfully as possible and said: "We are over the time line I requested to leave time for discussion; can you wrap up in another minute or two what you want to say? Also, if you went on to read all of the prepared material, which I regard as a considerable preparation effort, would there be an opportunity to have a learning experience? Can we also consider the effect on the group of this couple's pressure on you as a continuing enactment?

She stopped, momentarily and decided to talk a bit more about her consultation with the couple seminar leader about his recommendation for anti-depressant medication for the wife, he felt was unraveling. At this point the therapist had not followed through although she had discussed the idea with the wife's individual analyst.

The group had been withdrawing and in a few minutes several members attempted to take on a few aspects of the case, such as the biological basis for psychopharmacology in the case, vs. the dynamics of the case that warranted intervention. I regarded this discussion as a continuation of the split in the couple, as in who the sickest member is, the case's effects on the therapist's countertransference and the group's challenge to think any new thoughts about treatment. The two out of nine analysts who had contained their reactions added some useful ideas to the dilemma, once we moved into some application of splitting and projective identification to the case, the analyst, and the group exposure to regressive affects.

Thoughts

After we wrapped up for the evening, I reflected that the institute's analytic paradigm for treating couples (traditional Freudian) was limited in comprehending a larger unconscious system--a couple and a therapist triad. Freudian ideas could still have been applied yet the group ignored the potential oedipal conflicts within the treatment, although this was a plausible use of their theory! Group analytic concepts would have been more useful, and I knew that Bion's ideas were included in their readings. Was there an unconscious and parallel process occurring in which the topic requested of me, narcissism, was embedded in the case presentation, the couple in the case, and group adherence to antiquated concepts? I did not consider such a parallel process at the time.

I return to the "*sustainability by design*" paradigm quote from the beginning of this effort in application to psychoanalytic theorizing and education. I offered two examples of learning experiences through two institutional paradigms of treatment: psychoanalytic child therapy, and analytic couple therapy. In both instances I utilized group theory to the experience of the users of two different paradigms implicit in the training programs; each group of trained professionals appeared limited in making a necessary clinical transition into larger human systems they were treating; I believe the paradigms in use were insufficient to make the transition to the pragmatic application of psychoanalytic ideas about larger units. In the child therapy group there was the danger that strict adherence to paradigm structure was demonizing the family. I do not believe child therapy theory or practice promotes such a prejudice; perhaps, selectively, institute faculty do, by consciously or unconsciously idealizing strict dependency on a restrictive clinical frame in the face of paradigms that are more environmentally inclusive.

In the example of the analysts learning to practice with couples, the paradigm most useful in my experience is not classical Freudian, as I believe comprehending individual psychic issues requires a multiple transferencial vantage point. Intrapsychic conflict would be viewed in interpsychic terms; hence group process ideas bear upon accessing couple-therapist triadic enactments in a paradigm more suitable for elaborating the tracking of clinical process via multiples of transference and countertransference.

In sum, the choice of a clinical psychoanalytic paradigm and the individual or institution that espouses it can either conserve the limited human resources available to address a variety of situations encountered, or we may reify the paradigm as "the chosen", with consequent rigidity. Unquestioned beliefs may short change the patients and therapists who work with them. Paradigms ought to be subject to change if we are desirous of theory about practice to account for what we do, namely to help us discuss what we are doing? A good faith effort at resource conservation requires a thoughtful and flexible discourse about what we hold so dear--our identities as analysts/therapists. Identity and identification are intertwined. Our role models include

mentors, past and present, those who came before and wrote about the psychoanalytic approach, and of course our analysts and supervisors. I suggest we reflect on both narcissistic and insecurity motives that disguise our fears of change. Are we being like those we idealized and have we been too invested in an *adhesive* identification? Are we lacking in reasonable open mindedness? Psychoanalytic resources are precious and scarce, and by design, we may be on a destructive course. Denying anxiety about losing relevance, while ignoring real world requirements for building clinical systems may reduce utility and expansiveness. Without re-evaluation of our clinical paradigms and by adherence to dogmatic training psychoanalytic treatment for the real world may not be sustainable.