The 2013 Section V Invited Panel at the Annual Spring Meeting of the Division Of Psychoanalysis was designed as a roundtable discussion in which Ghislaine Boulanger, Mary Joan Gerson, Marilyn Jacobson, Robert Prince, and Larry Rosenberg described their work in applied clinical psychoanalysis. David Lichtenstein moderated.

Introduction

By David Lichtenstein

Since the Ambulatoriums started by Freud and the Sex-Pol clinics of 1920's Vienna [German Society of Proletarian Sexual Politics] of Wilhem Reich; Ernst Simmel's war clinic near Berlin during the first world war; the Malting House School run by Susan Sutherland Isaacs in 1920's Cambridge, Anna Freud and the Hampstead War Clinic, the entire career of Marie Langer first in Vienna, then in Argentina, and finally Mexico, Wilfred Bion at the Northfield Hospital and then Tavistock, the work of Joyce McDougall at the Maudsley hospital in London, before going to Paris. The application of psychoanalytic principles to clinical problems outside of the usual two person consulting room has been the younger sibling of the psychoanalytic method since its inception.

Section Five is now devoted to the study and dissemination of this aspect of our field and this panel which follows a similar panel we conducted last April, inaugurates this mission. Applied Clinical Psychoanalysis is perhaps an awkward name as it may bring to mind the idea of applying psychoanalysis to other fields like literature and history, but the emphasis on clinical in our name should set that right: we are interested in the broader clinical use of psychoanalytic thought, broader than the classical frame of the consulting room.

These psychoanalysts discuss various application of psychoanalysis to their work.

Applying Psychoanalytic Principles to a Community Recovering from a Disaster[1]

By Ghislaine Boulanger,Ph.D.

For months after Hurricane Katrina, mental health volunteers streamed into New Orleans offering psychological first aid, workshops on trauma, and short term interventions designed to bring immediate symptom relief. But three years later, the volunteers had moved on and many clinicians in New Orleans found themselves bearing the brunt of posttraumatic uncertainty alone. They were ashamed that they themselves continued to be preoccupied with Katrina, full of doubts about their clinical work, and overwhelmed by an increasing number of new patients who were just beginning to talk about the storm. In response to these concerns, I was invited to become the consultant on a research project initiated by the New Orleans Birmingham Psychoanalytic Center that was intended, and I quote to "make meaning out of the chaos we are experiencing."

David Lichtenstein has asked each of us in this forum to point out how we used our psychoanalytic skills in these applied settings. From a psychoanalytic perspective, it was serendipitous that this invitation came three years after the storm, once the physical recovery was underway and there was room, once again, for reflection rather than a call for immediate symptom relief. In a series of individual and group sessions, town hall meetings, and workshops, a diverse group of clinicians (by no means all analysts and psychodynamic therapists but others who practiced CBT, DBT, EMDR, some forms somatosensory therapy, and pastoral and family counseling) described their early struggles to maintain a sense of continuity in the face of overwhelming personal losses and destruction.

In this applied community psychoanalytic endeavor, it was particularly important that I was an outsider, someone who had not gone through the hurricane and its aftermath but was rather a witness to the psychological and physical terrors that the clinicians and their patients had survived. As an outsider who understood the long reach of adult onset trauma, I could validate the clinicians' experiences, not normalize them as they had been trying to do. My job was to be an other whose recognition and responsiveness to the group's experience helped create a new and shared understanding of the dilemma they had all faced. Over a series of weekend visits to New Orleans, I watched the clinicians becoming increasingly comfortable in describing their personal experiences and increasingly confident in their reported clinical work.

In the course of time, however, I became concerned that my role in the community had become too central. I was in danger of being seen as the omnipotent savior, a countertransferential trap into which many clinicians fall -- or are seduced -- when working with the survivors of massive psychic trauma. I wanted to find a way for community members to take back the role of witnessing for themselves. At a

conference marking the fifth anniversary of the storm, I invited four local clinicians to speak about their own experiences with shared trauma; to describe the moment when they came face to face with the fact that their personal and professional lives had collided in an unanticipated but inevitable fashion. This was a very moving start, but I wanted to involve everyone I had spoken with in this attempt to hand back the responsibility to the community of therapists. With a research assistant and a web designer, I put together a website that described our project. Using quotes from everyone I had interviewed, we compiled a list of best practices for psychotherapists in communities struck by disaster. This website is our legacy to therapists in communities in the future who find themselves sharing a disaster with their patients. Please visit: http://therapistspostdisaster.com/

Caring for Caregivers: Consultation in Non-Profit Agencies

By Mary Joan Gerson,Ph.D.

I am currently working as a consultant to supervisors of case workers in a foster care prevention program, whose mission is to keep children with their biological parents by managing the psychological and addiction challenges that these parents often face. What is particularly challenging about this work? It is my frequent concern about the relevance and usefulness of my psychoanalytic perspective to this abysmally underfunded, at immensely frustrating mission. Over time my clinical knowledge--both psychoanalytic and family systemic--has been of mild interest to the group of supervisors I work with. They are consumed with the Sisyphean burden of completing bureaucratic paperwork and similarly holding their inadequately trained workers to the same deadlines. What I have discovered, however, is that what is seemingly useful and sustaining to the group is my providing a forum, a holding group, for their deep despair and paradoxical amalgam of cynicism and dedication. The ability to hold discrepant emotions, and to tolerate darkness grows out of my psychoanalytic practice, but it is only one aspect of my clinical work. For this group, it is singularly what they find useful, and thus I am determined to provide it.

The Psychoanalyst as a Member of the Medical Treatment Team: Impasse, Recognition and Reward

by Marilyn S. Jacobs, Ph.D., ABPP

Freud created psychoanalysis from his experiences with medically ill patients and within the perspective of neurology. Following these developments, during the first half of the 20th century psychoanalytic psychosomatic medicine was a valued aspect of clinical medicine. However, medicine in the postmodern Western world has little regard for psychoanalysis. Psychological factors related to illness are now generally conceptualized in behavioral terms. Illness is understood as a genetically based and biological phenomenon with little attention paid to meaning. The therapeutic interventions of "behavioral medicine" are stress management, voluntary control of symptoms and cognitive restructuring. Evidence based practice is the basis for treatment validation which limits the value of contextual, narrative, humanistic and phenomenological approaches. This paper discussed the experience of one psychoanalyst who forged a role in a highly scientific subspecialty of medicine with the hope of re-establishing the importance of the narrative in patient's stories of illness. Issues considered were the deficiencies in knowledge related to psychodynamic processes as a means to understand self and other among medical practitioners, the privileging of invasive treatments established by technology, the time limitations of medical practice and how this forecloses an analytic attitude and the distorted belief that a psychodynamic treatment need always be interminable. The presentation included illustrative case material.

1. Bronheim, H. (1996). Psychotherapy of the medically ill: The role of object relations in body image and grief. *J. Amer. Acad. Psychoanal*., 24: 55-525.

2. Brown, T. M. (2000). *The Rise and Fall of American Psychosomatic Medicine*. http://human-nature.com/free-associations/riseandfall.html

3. Gendrault, K. P. (2001). On physical pain: A review. *Psychoanal. Contemp. Thought*., 24: 31-66.

4. Grzesiak R, Ciccone D, Eds. (1994). *Psychological Vulnerability to Chronic Pain*. New York: Springer-Verlag.

Psychoanalysis and Social Context

By Robert Prince, Ph.D.

Rather than a radical step, the turn to applied clinical psychoanalysis represents a conservative return to an earlier concern with the interpretation of culture and society and at times a aspiration to apply the insights of psychoanalysis to the human condition and its institutions. The historical vicissitudes of psychoanalysis have always been the context of the demands of its social surround ranging from the utopian vision of liberating humankind from the destructive consequences of sexual repression to utilizing psychoanalysis to return soldiers to the battlefield. Psychoanalysis in its second century is evolving its aims applications and aims to reflect the needs of a changing culture. Even as interest in psychoanalysis as a preferred treatment modality for neurosis has waned, it has "won in many areas providing a dominant framework for understanding, even when it does so under an alias, eg. implicit processes is a word given to all forms of consulting and intervention, advertising easily, business consultations, group processes, diplomacy, and substituted for the psychoanalytic word unconscious. The need for psychoanalysis is paradoxically reflected in for example, George Bush's famous antagonism to self reflection the destructive consequences of which has turned out to be an advertising point for psychoanalysis. Indeed, Jonathan Lear makes the point that psychoanalysis just may be crucial for the survival of democracy. Finally the relentless technological advances of our culture and the challenges to the definition of human by scientific advances unmediated by humanism creates a hunger for soulfulness and reflection.

Psychoanalysis in the Courtroom and in the Service of the Child Victim

By Larry Rosenberg, Ph.D

Psychoanalytic training does not purposely prepare one for the role of expert witness. Still, it can be argued that there are elements of this role and more specifically the responsibility of providing expert testimony or consultation in child sexual abuse cases that are indeed consistent with a psychoanalytic mindset. Central to psychoanalysis is the goal of making meaning of behavior; to provide insight into behavior and the effects of behavior that is not easily comprehended, and too easily misunderstood. For example, answers to questions about delayed disclosure or the child's on-going relationship with the abuser may address both conscious and unconscious motivation, and do so based upon clinical experience as well as theoretical perspectives supported by empirical findings. Secondly, psychoanalysts, by way of their experience with patients, have a well developed capacity to translate complex dynamic formulations into plain English; something that is essential to communicating effectively with jurors, and attorneys. Additionally, what keeps most of us from wanting to provide expert testimony is the anticipation of cross examination. Here, in particular, ones psychoanalytic training becomes useful. In addition to honesty, to the greatest extent possible, a jury desires neutrality on the part of the "expert". In the face of hostile questioning by an attorney doing his/her best to discredit the witness, one has to put ones narcissism aside, understand the context in which the assault is occurring, manage ones affect internally, and continue to maintain an analytic posture. This is, I believe, entirely consistent with what we do with patients whenever negative transference and powerful counter-transference is alive in the room, with neutrality being historically unique characteristic of psychoanalytic work. It is further suggested that this, combined with the benefits of our own analyses and supervisions, makes us uniquely prepared to contend with the rigors of the courtroom.

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