

INTRODUCTION

Psychoanalytic Paradigms, Clinical Controversy, and Coparticipant Inquiry

Throughout its history, psychoanalysis has been threatened by internal dissension and external rejection. In our own day, the search for psychic truth and personal wisdom in self-exploration finds a cold reception in an increasingly narcissistic, unreflective, and hurried society—impatient, addicted to magical solutions, other-directed to the extreme. Externally beset by these societal demands for an instantaneous, effortless, and painless therapy and internally split by sectarian divisiveness, psychoanalysis is now again, as in its earliest days, characterized by clinical controversy and wide differences of opinion on what constitutes the core of clinical psychoanalysis or best defines the psychoanalytic method.

Contemporary answers to many of the pressing clinical questions and theoretical issues in psychoanalysis are diverse despite recent signs of a growing rapprochement among the various psychoanalytic schools. Frequent calls for a less fractured relationship between competing psychoanalytic methodologies and metapsychologies have not yet led to greater harmony. Today, psychoanalysis, with its various subschools and clinical orientations and almost endless variety of clinical methods, goals, and practices, truly encompasses, in William James's terms, a pluralistic universe of clinical theory and method.

The psychoanalytic search for self-transformation and a healing therapy has not only resulted in a diversity of points of view; all too often it has been accompanied by political strife, rigidity of belief, and fear and contempt for innovative clinical conceptions and treatment approaches. Such narrow partisanship and diversity of therapeutic orientations is perhaps not surprising given the emotional intensity and deeply personal nature of clinical analytic work and the crucial life issues at stake for both analyst and patient. Positions taken on

various clinical issues are not simply an abstract matter. They are matters of vital significance. Different conceptions of the nature of psychoanalytic data, process, method, and therapeutic action and competing metaphors of the analyst's therapeutic role—whether the analyst is seen as interpretive surgeon, objective mirror, mirroring self-object, participant observer, confronting expert, comforting supporter, participant, or coequal explorer—have very real and significant consequences for analysts and patients.

Paradoxically, despite such divisive partisanship in psychoanalysis there has been a significant cross-fertilization of ideas and practices among the different psychoanalytic schools, perhaps more so today than at any previous time in the history of psychoanalysis. Furthermore, there has been a growing heterogeneity within the various analytic schools as well as cognate developments among them. This has led to a blurring of the boundaries between the different schools, sometimes making it difficult to know what exactly distinguishes one from another.

As our psychoanalytic universe has evolved and expanded and become ever more diverse and complex, theorists have tried to impose order on this complexity by formulating comprehensive metamodels of analytic theory and practice. Analysts from different analytic orientations have constructed meta-metapsychological schemata and meta-methodological paradigms. Thus, for example, Thompson (1950), Munroe (1955), and Hall and Lindzey (1957), writing from different psychoanalytic or psychological perspectives, advance classificatory schemas that divide psychoanalytic theory and practice into two incompatible models: the drive (libido) and the relational, cultural-interpersonal, or social-psychological (nonlibido) schools or paradigms. More recently, Greenberg and Mitchell (1983), representing a relational perspective, similarly divide psychoanalytic theory and practice into two metamodels: the relational and the drive paradigms.

Writing from a more clinical perspective, the seminal interpersonalist Wolstein (1977) states that psychoanalytic inquiry has moved from a biological (id) model to an ego-interpersonal or sociological (ego) model and that we are now moving into a third, psychological, model of psychoanalysis and to a coparticipant model of clinical inquiry. From another interpersonal point of view, Levenson (1972, 1991), employing a different clinical typology, asserts that we have moved from the machine age of Freudian analysis through the information paradigm of Sullivanian analysis into the “organismic” global time and sensibility of contemporary psychoanalytic inquiry. Similarly, Kohut (1977), writing from his unique vantage point of psychology of the self, asserts that we live in the age of tragic, rather than guilty man, and that our work is to restore developmentally

arrested selves rather than to solely interpret psychic conflict. Again, there is a bifurcation of libido versus nonlibido paradigms of psychoanalytic praxis. Gedo and Goldberg (1973) call for a more complex typology or paradigmatic schema, asserting that analysts must use five different clinical models in order to understand all of their different patients.

Contemporary psychoanalysts draw primarily from three clinical models: (1) the nonparticipant mirror; (2) participant observation; and (3) coparticipant inquiry. In this book, I focus primarily on an exploration of coparticipant inquiry. Whatever classificatory schemas we use in our efforts to order the diversity of psychoanalytic praxis, and however complex our theorizing and metatheorizing becomes, the basic facts of the clinical psychoanalytic situation remain invariant. All theories of psychoanalytic therapy represent differing conceptual perspectives on the inevitably coparticipatory nature of the analytic process. The psychoanalytic encounter, like all human relatedness, inherently defines or involves an intersubjective or coparticipant experience. This fundamental property of the analytic inquiry encompasses two intertwined clinical dimensions: (1) dyadic interactivity and reactivity, and (2) psychic subjectivity, in both (a) immediate experience and (b) reflective structuring of meaning.

The psychoanalytic process is, in other words, essentially three-dimensional in nature—at once relational, narrational, and experiential. Invariably and irreducibly, each and every analytic inquiry, though individually and uniquely patterned, is built out of these interpenetrating elements: a human relationship between two people; an effort to form (discover, uncover, construct, or deconstruct) a personally meaningful narrative or interpretation of one's life; and a lived experience of that process and relationship. These dimensions define the analytic process in both microscopic and macroscopic ways. Any concrete moment, specific analytic process or dynamic (psychic action, interaction, fantasy, etc.) or part of a session is complexly woven from interpersonal, interpretive, and experiential analytic strands.

Similarly, on a macroscopic level, these dimensions may be seen as phases of the overall process of any particular psychoanalysis. In a sense, all technical controversies in clinical psychoanalysis derive fundamentally from differing perspectives on these analytic dimensions and ultimately from one's concept of analytic participation or coparticipation.

Contemporary psychoanalytic praxis, as noted earlier, seems to draw from three broad clinical perspectives or models of inquiry: the impersonal *nonparticipant mirror*, the interpersonal *participant-observer*, and the personal *coparticipant inquiry*.

These clinical models or paradigms differ fundamentally in their understanding of the three essential analytic dimensions, and they represent significantly different conceptions of psychoanalytic data, technique, and process; in other words, they are positioned quite differently on the dual clinical axes of dyadic interactivity and psychic subjectivity. And, of course, they represent different perspectives on the nature of analytic participation. The various traditionally defined analytic schools have borrowed from all three models, though some schools lean more heavily on one or another model to guide their understanding of analytic inquiry.

The impersonally oriented *nonparticipant mirror* paradigm encompasses the orthodox analytic theory of inquiry whose guiding metaphor of the analysis is that of the nonparticipant mirror or psychic surgeon who reflects and interpretively operates on the transference biopsychic fantasies of the individual patient. This is the model of inquiry prescribed by Freud and practiced most purely by the American neoclassicists of the 1950s. Even today, it remains the most widely held view of what is proper psychoanalysis.

The interpersonally focused *participant-observer* paradigm, in contrast, focuses on the social mind, the intersyche, as it arises from the social field; the interpretive and experiential interplay of self and other within the interpersonal analytic matrix forms both analytic data and therapeutic action. This model of inquiry informs the clinical approach of a wide range of analysts who practice some variant of participant-observation, however widely they may differ from one another in other respects. This paradigm covers the heterogeneous span of British object-relations theory, the American school of interpersonal psychoanalysis, and Kohutian self-psychology, as well as some contemporary Freudians.

The deeply personal clinical model of *coparticipant inquiry*, historically rooted in the clinical ideas and experiments of Sandor Ferenczi, is based on the interpersonally oriented participant-observer paradigm but has a more personal and intersubjective focus. In this model of praxis, analyst and patient are seen as forming a coparticipatory and coordinate inquiry into both their interpersonal relatedness and their uniquely individual experience. The coparticipant model emphasizes the importance of real factors in transference and countertransference experience as well as the curative role of the personal relationship. This model of inquiry, which also bears an existential influence, significantly informs (often unconsciously) the work of a number of contemporary analysts and is becoming increasingly influential in its effect on analytic practice.

Each of the three paradigms I posit here has or has had some influence on the traditionally defined psychoanalytic schools, even if only minimally in some instances. Each school has found the logic of one or another

paradigm, its particular premises and emphases, more compelling or compatible than those of the other paradigms. The emergence of these major paradigms represents focal attempts to comprehend the fundamental nature of the analytic encounter and an effort to find the approach that is clinically most fruitful for the psychoanalytic situation. Each of these paradigms also arose in response to other factors—intellectual and philosophical trends, social currents, previous paradigmatic beliefs, emerging clinical problems (tied to previous paradigmatic limitations), new trends in psychopathology and in its diagnosis, clinical discoveries, trends in psychoanalytic sensibility, and the general spirit of the times.

The different paradigms have generally followed a historical path, from the classical conception of the analyst as nonparticipant blank screen to the interpersonal participant-observer to the coparticipant inquirer. All the paradigms have been influential since the early days of psychoanalytic therapy, but each one came to dominate psychoanalytic praxis in certain historical periods.

My classificatory schema of clinical paradigms or models, like all such efforts at classification, is inevitably Procrustean, despite its heuristic merit. It simplifies and clarifies the complex, bewildering plethora of analytic problems and practices, but it misses the individuality and particularity of each coparticipant psychoanalytic situation.

A fundamental feature of the psychoanalytic encounter is its coparticipant nature, expressed clinically in interactivity and experienced subjectivity. The three psychoanalytic paradigms I posit offer different ways of seeing the nature of the coparticipatory analytic encounter and its constituent psychic subjectivity and dyadic interactivity. The different paradigms guide analysts' conceptions of the nature and sanctioned or proper use of their analytic coparticipation, shaping their understanding of their integration with their patients. All questions, issues, and personal rules of analytic conduct spring ultimately from one's concept of his or her participation in inquiry—from one's ideas about the meaning, value, and impact of his or her analytic coparticipation.

Coparticipation refers to both the intrapsychic and the interpsychic, to the inner psychological world and the outer material world, and to their dynamic and often reciprocal relationship. Analytic coparticipation does not mean only what is visible in behavior, but it refers also to what is felt and thought, to the processes of the mind, as in listening, thinking, judging, evaluating, feeling, wanting, remembering, etc.

The psychoanalytic relationship is, without exception, a special instance of human coparticipation. All questions of technique and process derive

fundamentally from one's concept of his or her coparticipant engagement with his or her patient. The three paradigms of analytic participation cut across traditional theoretical lines. Most analysts who practice some form of coparticipant inquiry identify themselves in terms of their metapsychological affiliations or schools, such as interpersonal, self-psychological, Freudian, Jungian, Kleinian, etc., rather than in terms of the model of praxis that guides or informs their way of working.

My aim here is not to give the definitive word on coparticipant inquiry; rather, I want to draw attention to emerging coparticipant trends in psychoanalytic praxis that push us to the farther edges of accepted analytic investigation. This book is an exploration of an emerging unique psychoanalytic paradigm that promises an innovative approach to the analytic task. In my exploration of the coparticipant themes and concepts that arise in the study of such psychoanalytic phenomena as the therapeutic dialectics of the multidimensional self, the dynamics and therapeutics of narcissistic processes, the "living through" process, the "analytic working space," and the therapeutic implications of "openness to singularity," I will touch upon the central controversies in clinical psychoanalysis. This includes a discussion of questions such as: What defines the most effective approach to transference analysis? What is the role of extratransference inquiry? What are the promises and perils of countertransference analysis? What is the analytic role of regression? How do analysts listen? What is the role of dream analysis? What is the nature of therapeutic action in psychoanalysis?

These questions represent some of the major questions and controversies that divide contemporary analysts who draw from different paradigms or models of inquiry. In sum, the clinical controversies that characterize contemporary psychoanalytic praxis derive from different conceptions of the coparticipant psychoanalytic situation and its constituent processes of dyadic interactivity and psychic subjectivity. An analyst's position on these clinical axes determines his or her theoretical understanding of psychoanalysis and the analyst's role in it as well as the details of his or her praxis and its therapeutic potential.