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Clinical Research in Child Psychoanalysis

Michael Rustin

Research in psychoanalysis, or the alleged lack of it, has become a burning topic in the field of British psychoanalysis and psychotherapy. The widespread insistence by government policy-makers and health service managers on 'evidence-based medicine', as an aspect of public service 'modernisation', has understandably extended to demands that mental health services should be better justified by the evidence of empirical research. This faces psychoanalytic psychotherapists and other exponents of 'talking cures' with the challenge of how to justify their public existence. This is not an entirely new problem, of course, since in Anglo-Saxon cultures psychoanalytic ideas have long been criticised as 'unscientific' or 'pseudo-scientific' through the influence of Karl Popper's philosophy of science, and through the predominantly 'empiricist' training of most academic and clinical psychologists.

But while psychoanalysis has been placed under this rather hostile pressure, other cultural changes have been working in its favour. Historians and sociologists of science such as T.S. Kuhn (1962, 2000) and Bruno Latour (1983, 1987) have demonstrated in their studies that the sciences do not conform to unitary prescriptions, but are in reality quite diverse. (Galison and Stump 1996). Different 'objects of study' give rise to different 'methods of study' - to different ontologies correspond different epistemologies. Thus evolutionary biology, which makes much of descriptions, classifications and differences, does not have the same methodological form as theoretical physics, with its more theoretically and mathematically based universalism. The human sciences, whose 'objects of study' (people and societies) are often transformed by the ways in which they are described and theorised are

different from these natural sciences in yet other ways. In Britain a widespread movement to include psychoanalytic programmes, both clinical and academic, in university curricula in the last two decades, has also made a positive difference, since postgraduate and especially doctoral level courses require more sophisticated reflection on methodological issues than was the case when trainings were confined within professional institutions.

Two developments within the psychoanalytic and psychotherapeutic field have followed in this situation. The first is a significant attempt to bridge the divide between 'mainstream' social science research methods, and psychoanalysis, for example in the work of Peter Fonagy (2003) by finding ways of 'operationalising' psychoanalytic ideas, giving more replicable and predictable form to therapeutic interventions, and developing reliable measures of treatment outcome. [1] The strategy here is to bring psychoanalysis closer to mainstream social science approaches, and enhance its legitimacy by this means. Critics of this approach perceive in it a risk of dilution of psychoanalytic methods and principles, in the search for scientific acceptability and policy-relevance. The second development is attempts to clarify and justify the methods of knowledge-generation which have been followed throughout the history of psychoanalysis itself, and to understand their necessary relationship to the primary object of study of psychoanalysis, namely unconscious mental processes. This approach follows the precepts and example of recent historians and sociologists of science in holding that it will be more enlightening to describe how practising scientists make sense of what they actually do, than to prescribe what they should or should not be doing. Thus clarifying the ways in which knowledge has in fact been generated within the psychoanalytic tradition is deemed to be the best starting point for improving its methodological sophistication. A number of writers have taken this approach, for example in the 75th anniversary special issue of the *International Journal of Psychoanalysis* on

[1] The programme of clinical and research practice based on the concept of 'mentalisation' is the strongest example of this approach (Bateman and Fonagy 2004).

Clinical Facts (1994) edited by David Tuckett, and in Rustin (2002, 2007) , and Hughes (2004) . Debates between these different perspectives can be found in Fonagy (2003), Rustin (2003), Midgley (2004, 2006), and Mace, Moorey and Roberts (2001)
The primary site of psychoanalytic discovery has from the beginning been the clinical consulting room. This is because the main object of psychoanalytic investigation, the unconscious mind, can be most easily studied in the 'laboratory-like' conditions of the consulting room, with (especially given modern 'technique') its stable and reliable setting, its fixed duration and frequency of sessions, and with its reliance on the phenomena of the transference and counter-transference as its main 'evidence'. The impact of unconscious mental phenomena in everyday life is ubiquitous and profound, but it is much more difficult to trace its effects in 'outdoor' conditions than it is in the constructed situation of the transference relationship. James Strachey's description (Strachey 1934) of how the role of fantasy can be made evident to analysands by demonstrating, little by little, differences between their (mis) perceptions of their analyst and the reality, was a crucial one. Thus the ontology of psychoanalysis - its particular conception of what exists - is linked to its epistemology - its means of perceiving its object. The means of investigation of many if not all sciences are equivalently connected to their chosen object of interest, through the design of specific instruments of measurement, for example.

In the humanities, parallel connections are to be seen, though these are usually formulated as the necessary relations between content and form, rather than ontology and epistemology, being and perceiving. Thus lyric poetry, tragic drama, and realist novels, develop different forms which can grasp the particular areas of experience which they are exploring. Psychoanalysis shares attributes with both the sciences and the humanities, sharing attributes of each of these respectively generalising and particularising kinds of inquiry.

Methods of study thus differ in relation to their objects. But there is another important source of variance between fields of investigation, and this is the

relation between methods of inquiry and the intended audiences for, or users of, new knowledge that emerges from it. In the case of psychoanalysis, the primary community for whom its findings have been intended has been that of practising psychoanalysts themselves, and the purpose of its concepts, theories and classifications has been to guide analysts in their consulting room practice. Of course, psychoanalytic ideas have been widely taken up in western culture, and are now part of the understandings of everyday life. Nevertheless, the primary source of its knowledge has been clinical work with patients, and it is for this reason that one of its primary 'inscription devices' , or means of communicating its findings, (Latour 1987) has been the clinical case study.

One can think of the body of psychoanalytic theories as the evolving outcome of a Kuhnian 'scientific revolution' initially accomplished by Freud. This brought into existence a new paradigm of knowledge, whose fundamental ideas at the beginning were the unconscious, fantasy, repression, the transference, the oedipus complex etc.. From these early moments of 'revolutionary science' the practice of a 'normal science' then developed, in which psychoanalysts set out to solve 'puzzles' posed within the foundational theory. 'Puzzle-solving' within psychoanalysis concerned itself with stages of development (the issues of narcissism, paranoid-schizoid and depressive positions, the mid-life crisis); pathological states (autism, the neuroses, psychotic states, borderline states, and more local dysfunctions such as eating disorders, sexual disorders etc.): and with questions of technique (Klein's 'play-therapy', the treatment of severely disturbed children, Joseph's 'total transference situation', etc.) One should view the development of psychoanalytic theory and technique as primarily the outcome of a clinical research programme conducted by psychoanalytic practitioners over a period of more than a hundred years.

The 'normal science' of the psychoanalyst or psychoanalytic psychotherapist includes the problems of understanding individual patients, in their particularity. This is part of its distinctive 'ethical' and 'aesthetic' commitment, in which it seeks to aid persons in their own self-understanding,

as individuals with unique histories and relationships, rather than merely as members of diagnostic categories. Psychoanalysis sets out to enable individuals to be themselves, in some way which they themselves can feel is good enough. It is not <u>only</u> about solving symptomatic problems, or achieving a measure of acceptable normality.

The interest of psychoanalysis in the diversity of its subjects, and a mode of practice (summarised as 'free association') which ensures a high degree of unpredictability in how they will display themselves, has implications for the kind of knowledge which is found most useful to practitioners. (Polanyi 1958) Psychoanalysts make use of psychoanalytic concepts and theories as symbolic resources available to guide them in the understanding of clinical phenomena as they present themselves, not as 'textbook knowledge' to be applied to phenomena which have already been classified prior to their appearance. Though clients can be assessed prior to analysis, and judgements can be made about their states of mind and psychic history, such assessment rarely does more than establish some broad expectations. Indeed some have persuasively argued that the most important thing to establish in a psychoanalytic assessment is a patient's capacity to respond to a psychoanalytic setting. (Rustin 1982, Rustin and Quagliata 1999).

T.S. Kuhn, in <u>The Road Since Structure</u> (2004) suggested that the development of science has parallels to biological evolution, in that what takes in both is a process of speciation or differentiation. Kuhn describes 'the speciation-like process through which new disciplines emerge, each with own lexicon, and each with its own area of knowledge.' (Chapter 4 p 100). This not only fits the development of psychoanalysis as a field, but also the increasing differentiation of knowledge <u>within</u> psychoanalysis, as its lexicon of classifications of psychological conditions, developmental patterns, techniques, etc., expands in response to clinical experiences.

Most of the time in psychoanalytic practice, practitioners seek to understand their patients using the lexicon of concepts etc. available to them in the literature, and learned during their training and supervision. It is difficult

enough to find fit between experience and some already-existing ideas, good enough to help the therapeutic process. But sometimes clinicians find themselves looking not only at the patient, from the perspective of the available psychoanalytic ideas, but also at the adequacy of the ideas themselves to give meaning to the clinical situation. Sometimes when the 'container' seems inadequate to 'contain' its object, it is found necessary to modify the container itself. One can see the development of many crucial concepts in psychoanalytic history as the outcome of a revision to existing thinking, brought about by the need to account for an intractable clinical phenomenon. Paula Heimann's (1950) discovery of the 'counter-transference' as a valid source of understanding, and Herbert Rosenfeld's (1971) bifurcation of the concept of narcissism into its libidinal and destructive variants, are two examples.

It is has often been particularly gifted psychoanalysts who have brought about such major innovations. (The theoretical developments initiated by Klein, Bion, Winnicott, Joseph, and Meltzer are some examples). But in the field of child psychotherapy in recent years, one can see a more collegial style of innovation in operation, as 'clinical workshops' (Rustin 1991) have sustained groups of colleagues in developing new areas of work, even though there are usually outstanding psychoanalytic practitioners among them.

As doctoral programmes in child psychotherapy in Britain have developed, more practitioners find themselves explicitly engaged in 'clinical research', since as a condition of doctoral study they are expected to identify a psychoanalytic topic in which they hope to make an original contribution to knowledge. Such practitioners have to reflect more rigorously on research methods than has been traditionally the case in psychoanalytic study. This has led to a number of studies (e.g. Hindle 2000, Anderson 2003, Reid 2003) in which psychotherapists have continued to undertake their normal form of psychoanalytically-based practice with patients, but have taken greater care to select patients with presenting similarities, to facilitate comparison, and even more important have developed methods of analysing clinical data (often using 'grounded theory' methods derived from Glaser and Strauss 1967,

Tuckett 1994) which are more systematic and accountable than in conventional case-write-ups In this way further 'sub-fields' of classification and explanation are being developed, providing new resources for clinicians to refer to in their practice.

It is interesting to reflect from this point of view on Margaret Rustin's paper in this symposium 'Finding an Authentic Voice: Observation, Intuition and the use of Counter-Transference in work with children and adolescents'. In the main, her paper shows how approaches already established in the psychoanalytic literature can be used by an experienced clinician to understand and work with difficult patients. The paper shows how an informed understanding of current developments in psychoanalysis can extend therapeutic possibilities. The discussion of observational methods refers to a great deal of work which has been going on in recent years in Britain and France, to develop Infant Observation (as originated by Esther Bick) not only as a valuable form of pre-clinical training, but also as a source of psychoanalytic understanding in its own right. (Rustin 2006, Waddell 2006). There is a description of an episode from one infant observation, describing unconscious communications made to the observer, and putting to a successful test her capacity to contain the intense anxieties of the parents of a baby who had been accidentally injured. The discussion of the 'counter-transference' and the 'total transference situation' which are important to understand this observational experience, also shows how attention to the patients' unconscious communications to the therapist of their states of mind, through projective identification, can provide resources for understanding patients who seem on the face of it to be communicating very little, but who may mainly be conveying their distrust of emotional contact of any kind.

Margaret Rustin's paper is primarily intended as an example of how a child psychotherapist can make use of selected new ideas and techniques to do difficult clinical work. It does not explicitly propose innovations in theory or technique, or present itself as a contribution to psychoanalytic research. Nevertheless, I think one can discern in the paper at least one implicit topic for research, within the context of the 'speciation' and 'puzzle-solving' of

'normal science.' The topic might be identified as that of 'silent patients', of which two clinical examples are given. The 'research questions' might be these. How can we do psychoanalysis, which normally depends on talk, with patients who refuse to talk? And, what meanings can be located in patients' refusal to talk to their therapists? How might therapists understand these silent episodes, in particular by reference to their own counter-transference experiences, and through the idea that patients push states of mind into their therapists in the implicit hope that they might then be understood? Failure to attend sessions, even over a lengthy period, may sometimes be regarded in the same light, in so far as it leaves the therapist bearing the anxiety of feeling rejected and 'out of mind', perhaps with a surmise that the therapist may understand and later do something with this feeling. [2]

There are no assurances that a 'presenting phenomenon' like that of patients' persistent silence, which may be of considerable clinical concern, should become a topic for clinical research. Theoretically, it might be that the 'symptom' expresses too many different states of mind to be a useful focal point for investigation. Methodologically, there is the problem that it would not be possible to pre-select a sample of patients for treatment for this condition, (unlike severe depression or anorexia for example) since it manifests itself <u>within</u> the therapeutic setting, after treatment has been commenced for other reasons. (Although patients might be referred to psychotherapeutic treatment because of a wider inability or refusal to communicate, which might or might not then be re-enacted in the clinical situation.).

But one could imagine that cases of this kind undertaken by different practitioners could be gathered together for reflection and for systematic analysis, perhaps within a clinical workshop setting. If good sessional records are maintained, subsequent analysis of them can be undertaken, comparing cases undertaken by different clinicians. One can certainly imagine that some exploration of this specific clinical phenomenon in the literature, setting out

[2] Margaret Rustin has discussed one experience of this kind in Rustin M.E. (2001).

how it can be understood and managed, might be valuable to clinicians, providing another 'classification' or 'kind' in their lexicon of clinical phenomena, to guide them should they meet it in their practice. In this case it forms a particular instance in broader current genre of clinical study, namely that of the technical issues involved in treating deprived or otherwise difficult child patients. This guidance is, in an informal way, what Margaret Rustin's paper already offers. It is not a very big step to imagine this as a topic for more systematic investigation.

This is not to say this should be done. Topics for clinical research are best identified by practitioners themselves, arising from their own clinical experience and their interests in current developments of theory and technique in the field. In any case, there is never going to be time or money to research every topic that is of interest to clinicians, and traditional forms of clinical writing will remain indispensable. Furthermore, some conceptual starting points will be more fruitful than others. Probably the best work takes place where a sub-field has already been defined, and the 'puzzles' within it have some coherent relation to one another. Clinical research in child psychotherapy on autistic spectrum disorders (Alvarez and Reid 1999) and psychotherapy with severely deprived children (Boston and Szur 1983) are examples of productive sub-fields. But as this brief paper on psychoanalytic research was originally presented as a response to Margaret's, it seems worthwhile to suggest on an indicative basis how one can think about her presentation in the context of child psychotherapy's clinical research programme.

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Biographical Note

Michael Rustin is Professor of Sociology at the University of East London, and a Visiting Professor at the Tavistock Clinic, London.