INTEGRATION AND ALTERNATIVES: SOME CURRENT ISSUES IN PSYCHOANALYTIC THEORY

David G. Phillips, DSW, BCD

ABSTRACT: The first great bridge between psychoanalysis and social work came with the concepts of ego psychology which provided a synthesis between the worlds of the social order and the psychological depths. Current psychoanalytic theorists now question whether any one psychological theory is sufficient to describe the complexity of human experience, and suggest that each theory has a piece of the truth because it states something that is correct about the patient at a particular time in the treatment. Adherence to multiple theories makes a complex problem for the clinical practitioner, who must decide from which perspective to respond to the clinical material of the moment. Psychoanalytic theorists are also questioning the degree to which it is actually the content of the therapist's interpretations which brings about change in the patient. This article suggests that these developments in psychoanalysis, with their emphasis on therapeutic flexibility and the importance of the relationship will renew and reinvigorate the bridge between psychoanalysis and clinical social work.

It is well known that the practice of clinical social work has been heavily influenced by psychoanalytic theory. A number of authors have, in particular, noted how the development of the concepts of ego psychology in the 1930's not only gave social caseworkers a treatment method that made sense to them, but also helped to integrate the long standing split between the clinical and the societal emphasis in social work. In the words of Briar and Miller (1971, p. 19):

It was not the id and infantile conflicts that were important but the adaptive apparatus of the client... One did not puncture defenses, one worked with them. Ego strength, defense mechanisms, adapta-
tion, resistance, were the watchwords . . . Here at last was that happy synthesis between the social order and the psychological depths—the ego, which bridged these two worlds.

The psychoanalytic theory referred to here, the ego psychology that had such an impact on social casework was the product of Freud and his followers. This fact was also emphasized by Hollis (1970) in her summary of the psychosocial approach to casework when she stated that Freudian personality theory with the emphasis on the adaptive capacities of the ego serves as the most useful frame of reference for the psychosocial approach, and that a second emphasis of the psychosocial approach is that of differentiation of treatment according to the needs of the client (p. 36).

The implication of Hollis’ remarks, that the framework of ego psychology can provide an adequate frame of reference for the differentiation of treatment according to the needs of the client is, however, just the point that is now open to question. Many psychoanalytic theorists have started to deal with the impact of alternative conceptual models, such as those of objects relations theory and self psychology, and clinical social work must ultimately do the same. One of the key questions to be asked as a consequence of this theoretical pluralism is whether any one psychological theory can provide an adequate framework to understand anything as complex as a human being.

The reader might respond that in actual clinical work he or she is not only not influenced by psychoanalytic theory, but is uninfluenced by any theory. This type of argument might, for example, stress therapy as a process of empathic atunement and hold that a preoccupation with theory takes away from a true understanding of the patient’s experience and feelings. I would suggest, however, that in the process of actually doing treatment it is possible to escape being affected by psychoanalytic theory, but it is not possible to escape being affected by some theory; there is always a cognitive aspect to the internal process of the therapist. As Schafer (1983) has pointed out the process of empathizing itself has a number of cognitive aspects including those of constructing a mental model of the patient; being alert to one’s own affects and fantasies in response to the patient’s expression; and being prepared to use these responses reflectively as cues to significant expressions by the patient (p. 36). The point here, as Schafer has developed it, is that since empathizing requires the therapist to construct a mental model of the patient, then the patient can only exist and can only be empathized with as he or she exists within that model. We do not know the patient as he or she actually is, only as he or she exists within the mental model we have, and it is our theories that guide us in the construction of that model. We can’t, in other words, escape the impact of theory as an as-