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Features

Clinical Wisdom in Psychoanalysis and Psychodynamic Psychotherapy: A Philosophical and Qualitative Analysis

Cynthia Baum-Baicker and Dominic A. Sisti

ABSTRACT

To precisely define wisdom has been an ongoing task of philosophers for millennia. Investigations into the psychological dimensions of wisdom have revealed several features that make exemplary persons "wise." Contemporary bioethicists took up this concept as they retrieved and adapted Aristotle's intellectual virtue of *phronesis* for applications in medical contexts. In this article, we build on scholarship in both psychology and medical ethics by providing an account of clinical wisdom *qua* phronesis in the context of the practice of psychoanalysis and psychodynamic psychotherapy. With the support of qualitative data, we argue that the concept of clinical wisdom in mental healthcare shares several of the key ethical dimensions offered by standard models of phronesis in medical ethics and serves as a useful, albeit overlooked, reference point for a broader development of virtue-based medical ethics. We propose that the features of clinical wisdom are pragmatic skills that include, but are not limited to, an awareness of balance, the acceptance of paradox, and a particular clinical manner that maintains a deep regard for the other. We offer several suggestions for refining training programs and redoubling efforts to provide long-term mentorship opportunities for trainees in clinical mental healthcare in order to cultivate clinical wisdom.

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INTRODUCTION

Elusive and difficult to operationalize, the concept of wisdom has existed as a highly valued, multidimensional abstraction across cultures and time. But what exactly is "wisdom"? And how is "clinical wisdom"—its manifestation within medicine, psychotherapy, and psychoanalysis—exemplified? How can we begin to define it, to understand its components, to mine the complexity of a virtue that seems self-evident yet remains resistant to a precise meaning?

These questions sit at the interface of clinical psychoanalysis, psychotherapy, philosophy, ethics, cognitive science, social psychology, and gerontology and are the foci of this article. In addition to describing the conceptual contours of clinical wisdom, we present qualitative data

gathered by one of us (CB-B) as part of the Wisdom Project—an ongoing initiative aimed at understanding clinical wisdom through the voices of practicing senior psychoanalysts. These data are then placed in the broader context of the philosophy of medicine and the applied ethics of behavioral healthcare.

Our goal is not to define what it means to be a wise person, but to examine specifically how clinical wisdom has been characterized by individuals who are, themselves, considered wise by their peers and what they have learned from the many decades they sat with patients. What do they now know about clinical work and the human condition that they did not know when they first began, and how have they operationalized this knowledge? In gathering responses to such questions, we identify core qualities of the virtue of clinical wisdom in psychodynamic psychotherapy.

To frame our analysis, let us first draw upon salient discussions in the philosophy of medicine and biomedical ethics concerning the nature and acquisition of clinical wisdom. We will highlight particular theoretical parallels between the bioethical concept of clinical wisdom *qua* phronesis and the concept as it has been described in the actual narratives provided by seasoned analysts. Thereafter we provide further detail of the concept of clinical wisdom in psychoanalytic/psychodynamic practice by drawing on recent empirical findings. We conclude with a brief proposal of how clinical wisdom might be inculcated among young trainees and cultivated throughout one's career.

PHILOSOPHICAL PERSPECTIVES ON CLINICAL WISDOM

The meaning of the word "philosophy" is literally "love of wisdom." Therefore, it makes sense to begin our analysis of clinical wisdom by first touching on insights handed down by wisdom's greatest admirers. The question of what exactly constitutes the object of their affection has preoccupied philosophers since before Socrates interrogated the Oracle at Delphi's assertion that there was no man wiser than he.[1] For Socrates, it seems, wisdom is a multidimensional form of epistemic competence that includes the possession of knowledge and experience, both of which are steeped in humility. Socrates points to wisdom as being both necessary and sufficient for happiness—that is, the wise person could live without worldly goods and be perfectly happy.

Wisdom *qua* practical virtue appears in Plato's *Republic* as a governing force of the rational part of the soul and the ruling virtue for moral decision making.[2] The critical role of wisdom as a practical skill is most explicitly described in Aristole's *Nicomachean Ethics*. It is here that we find an explication of the intellectual virtue phronesis—roughly translated as situational prudence or practical wisdom—that serves as a governor of all the other virtues in aiming one toward the goal of living the good life.[3] The concept of phronesis, and virtue ethics more generally, have enjoyed a modest revival in contemporary biomedical ethics. And with the "rediscovery" of virtue, there has been a marked shift away from formulaic approaches to clinical-ethical decision making that rely on principles or rules meant to be applied to cases. Bioethical approaches that emphasize the primary importance of virtues eschew what Caplan dubbed the "engineering models of ethics" in favor of contextual, pragmatic, and situational ways of thinking.[4] We will see this as a most obvious parallel between the concepts of *phronesis* and clinical wisdom in psychodynamic psychotherapy; descriptions of what constitutes clinical wisdom in behavioral healthcare place an implicit (and often explicit) emphasis on the value of nonformulaic modes of treating and healing patients.

Within biomedical ethics, the integrative role of phronesis has been described most eloquently by Pellegrino, who states, "*phronesis* fuses the intellectual virtues, which have truth as their end—e.g. science, art, intuitive wisdom—with the moral virtues, which have the good as their end."[5] Pellegrino argues that the typical construction of medical expertise in which technical knowledge (*episteme*) and the art of healing (*techne*) is better characterized by phronesis, which provides the conceptual resources to explain the complex form of wisdom required by physicians.[6] Likewise, Kaldjian, reflecting both Aristotle and Aquinas, has pro-

posed that the core elements of practical wisdom include:

1. Pursuit of worthwhile ends (goals) derived from a concept of human flourishing
2. Accurate perception of concrete circumstances detailing the specific practical situation at hand
3. Commitment to moral principles and virtues that provide a general normative framework
4. Deliberation that integrates ends (goals), concrete circumstances, and moral principles and virtues
5. Motivation to act in order to achieve the conclusions reached by such deliberation.[7]

Again we will see below how aspects of both Pellegrino's concept and Kaldjian's pentavalent model of practical wisdom have been similarly articulated by Wisdom Project participants.

We should note that a distinction is often drawn between clinical judgment on the one hand and practical wisdom on the other. In the case of the former, the clinician is able to make sound decisions about a medical problem using the technical tools of medical and scientific decision making. The integrated nature of clinical wisdom, however, encompasses both clinical judgment and practical wisdom that is gained through decades of practice. Both concepts have as their aim an idea of what is best for the patient. Indeed, as Pellegrino contends, a key element of clinical judgment includes answering the normative question, "What should be done?"[8] This question requires practical wisdom—thus the virtue of clinical wisdom is a fully integrated form of clinical judgment combined with practical wisdom.

In a similar way, Jonsen and Toulmin argue that medicine requires a unique blend of theory and practice, in which phronesis serves as the linchpin between these domains of knowledge. Excellent (or even acceptable) medical practice, they contend, is not reducible to a deductive form of logical analysis or "medical geometry," whereby the laws and corollaries of biology are objectively and formulaically applied to particular cases. Rather, medical cases present with such ambiguity that they would bedevil the strict technician.[9] Analogously, as we will see in the narratives, clinical wisdom in psychotherapy requires the ability to integrate both theoretical and practical forms of knowledge.

We agree with Radden and Sadler, who characterize phronesis as a metavirtue that allows clinicians to adeptly grasp the particulars of a case and cleverly navigate toward a good resolution: "*Phronesis* is the virtue to deal with matters that are uncodifiably particular and not reducible to orderly principles."[10] And while phronesis is an important virtue for correctly handling quotidian conflicts in everyday life, it is a particularly well-suited virtue for behavioral healthcare, where technical knowledge will not suffice in the face of an individual patient's unique experience of psychic pain.

This point is reiterated by Brendel who, in describing the role of practical wisdom, points out that psychiatric practice involves a dialectical relationship between scientific theory and artful practice. He contends,

> When working on the scientific side of the science/humanism divide, the psychiatrist aims to practice evidence-based medicine and employ a well-demarcated set of explanatory concepts to achieve unified, empirically supported accounts of human behavior. But exclusion of alternative explanatory concepts may be detrimental. . . . Narrowly focused, scientific explanatory models in psychiatry may be flawed and inadequate insofar as they restrict the clinician's flexibility in making diagnoses and implementing treatments.[11]

Indeed, technical and formulaic methods of psychotherapy seem to be antithetical to practitioners' ability to draw upon clinical wisdom and experience, precisely because they rely heavily on an ostensibly "objective" scientific process or method. Similarly, both the conceptualization of patients ("clients") as consumers and the demands placed on clinicians ("providers") by insurers for quick, standardized, and marginally effective treatment has perpetuated the rise of formulaic methods. On the other hand, a lack of a positivistic scientific evidence base is anathema to eclectic psychotherapeutic approaches that require truly wise application.

With this philosophical background now sketched, let us survey the way in which clini-

cal wisdom has been conceptualized and empirically examined in the field of psychology.

PSYCHOLOGICAL PERSPECTIVES ON WISDOM

Psychoanalyst Leon Wurmser has said that with wisdom we get more by giving. Wisdom is not like a cake that gets smaller when it is shared; but rather wisdom is like a candle—the more that it is shared, the more light it provides.[12] And while the illuminating force of wisdom should have therapeutic benefits, much of the work on the psychology of wisdom has been conceptual and not applied clinically. Although there is a paucity of clinical research on wisdom, there are examinations of how wisdom relates to patients and clients with regard to their ability to achieve treatment goals, to overcome depressive episodes, or to be relieved of existential frustration.[13] Therapies designed to increase mindfulness, humility, contextualism, and other core competencies typically associated with wisdom indicate that the cultivation of wisdom can help patients who suffer from various emotional problems.[14] Additionally, according to Baltes and Staudinger, theories of wisdom may be categorized according to the use of wisdom as a folk concept. These so-called implicit theories frame wisdom in terms of its shared meaning of exemplary, well-intended, individual functioning. In contrast, explicit theories point to the behaviors that exemplify wise decisions and behavioral expressions of wisdom.[15]

Nevertheless and in stark contrast to the canon of biomedical ethics, there is no readily apparent definition for "clinical wisdom" in the psychology literature. Bromberg had written about "clinical judgment," which he described as a relationally negotiated clinical decision-making moment, co-created by patient/client and therapist.[16] But this is not "clinical wisdom" in the longitudinal or developmental sense—that is, what the talented senior clinician gained through decades of careful listening and practice. Empirical studies, such as the Berlin Wisdom Paradigm, have included substudies on the cognitive mechanisms that facilitate or help to operationalize wisdom as "expertise in the fundamental pragmatics of life."[17] To that end, the Berlin Wisdom Paradigm reports where a small sample of clinical psychologists fell on the wisdom scale.[18] Similarly, Piazza-Bonin and Levitt have begun to examine the concept of wisdom within the practice of psychotherapy.[19]

Notwithstanding these findings, little has been done to tap into the insights of senior practitioners about their understanding of wisdom. Because most—but not all—understandings of wisdom include the desideratum of experience, learning from senior psychoanalysts seems crucial.[20] Therefore, the Wisdom Project aimed to tap into insights of wise elders to bring their perspective to the nascent conversation about what it means to be a "wise" psychotherapist, what clinical wisdom means for the practice of analysis and psychotherapy, and how wisdom might be cultivated in young practitioners.

Key features of clinical wisdom include openness, curiosity, and critical reflection, which are all requisites for competency in practicing psychoanalysts and psychodynamic psychotherapists. In fact, Kramer reviewed the empirical research and concluded that openness to experience is the most common personality predictor of wisdom.[21] As Sternberg opined, the "wise person" endorses a judicial thinking style, trying to understand why, rather than judge.[22] There can be no clearer way of describing the psychoanalyst's mission. Wisdom is "an expertise in uncertainty," a reflection of the nonformulaic, analytic mode of treatment.[23] Those who are deemed wise have flexibility and can embrace change.[24] Thus, there is some consensus that the trademark of wisdom is in knowing how, where, and when to (1) take risks and (2) deal with uncertainty.[25]

Baltes and Smith also note that observable indicators of wisdom include verbal behaviors such as insightful commentary on difficult and uncertain matters of life and nonverbal behaviors associated with affect regulation and empathy in interpersonal contexts. In addition, they noted that this kind of observable wisdom in action can be seen in the doctor-patient relationship.[26] There is support for this in current research, which reports that unconscious affect regulation plays a critical psychobiological role within the therapist-patient dyad.[27]

NARRATIVES OF CLINICAL WISDOM

Participants in the Wisdom Project were nominated as therapists who were judged as having "clinical wisdom" by their peers. The 18 participants, whose ages ranged from 73 to 100, were psychoanalysts from the fields of clinical psychology and psychiatry. The interviews lasted anywhere from one and a half hours to three hours. The interview began with open-ended questions that led into in-depth discussions. Following this, interviewees were handed a potential topics list and asked to talk about any topic on which they might feel they had something worthwhile to say. Approximately 50 hours of interviews have been transcribed and examined. A review and qualitative coding of the interview transcripts showed the responses clustered into several categories, with overlap between the categories. Responses coalesced around the following themes:

1. Creative technique and pushing treatment limits
2. Wise listening
3. Humility, kindness, and humor
4. Pearls of wisdom
5. An appeal to paradigm cases
6. Mentors and mentoring.

Creative Technique and Pushing Treatment Limits

Interviewees pointed to the need for clinicians to employ techniques that are creative and exploratory. They talked about the importance of playfulness and of working creatively: "Play has to do with not knowing where you're going. Work is more like knowing where you're going. And if somebody knows where it's going in the therapeutic dyad, something's wrong."

This perspective was reinforced by others who made the point that if clinicians are more creative in their work, patients will also be. Moreover, creativity seemed to be the great antidote to loss and mourning. This point was made in several instances by interviewees who related personal experiences of loss that were transformed by their own creative enterprises; experiences they bring to the clinical work. Over and over, interviewees stressed that clinicians not be blinded by the prevailing wisdom of our day. Their advice was to question the assumptions and standards of rules of practice that might serve as obstacles in their relationship with patients. One participant said there's one fundamental rule: "The patient is more important than the rule." Another said, "We need to shed the authorities, the super-egos—the Institute training analysts, the teachers, everybody, your colleagues, people who start referring to you. Everybody is crowding into that connection with the patients. . . . I always say it's like a young mother who has a mother-in-law and her mother, and everybody tells her what to do with the baby, and uh, just tell them to go away and listen to the baby."

Another clinician conveyed this attitude: "The rules are valuable, but they're there to be broken. Don't be doctrinaire: go where you feel it is going to be a healing way of being with this particular patient. But be careful about the boundaries—keep them where they belong and don't let them be fuzzy." This clinician related a case in which a woman patient hungered for touch. The therapist and the patient created a "hands game" in which they exchanged hand touches: one would place her hand on top of the other's, and then vice versa. In this way, the therapist kept a boundary she felt was necessary, while bending the no-touch rule.

One interviewee provided examples of how her work stretched the standards of analytic application, not only regarding the kind of patients with whom she worked, but also in how she worked with those patients. She related the now well-known case of Rosie, a small child she helped lure out of her autistic shell. Rosie was musical, and the piano was her exclusive love object—she explored the insides of a piano as other children might explore the body of a mother. This therapist knew how important it was to allow these explorations, and yet she also knew she needed to preserve the piano from Rosie's aggressions. Her solution? She had a second piano put into the playroom that Rosie was allowed to destroy.[28]

Creativity requires an independent spirit and confidence. One clinician said matter-of-factly, "I don't mind going against the current or against the grain." Another, in referring to a conversation with an authority who questioned

whether her technique would marginalize her, said, "[It] is not my job to be accepted here, there, or everywhere."

Wise Listening

The importance of active listening in psychotherapy has been described extensively in both the scholarly literature and introductory textbooks. Again, often what these texts offer are top-down models for listening. That is to say, the specific counseling methodology determines the mode and manner of listening. For example, cognitive behavioral therapy emphasizes a form of listening in which therapists focus on the client's thoughts, logical constructs, and reflections on schema that might be causing cognitive distortions. Such filtered and distanced listening might miss important dimensions of the patient's narrative. Participants in the Wisdom Project conveyed their perspective on listening as holistic, flexible, and generally atheoretical. One respondent said,

> I don't think you listen the same way to each patient. Each patient creates a situation in which you're willy-nilly embedded and if you extract yourself from that situation too much, so that you retain the same identity with each patient, then you're not really working with the patient. So if you allow yourself to flow into their embeddedness, whatever it is, then they're coercing you into listening in a particular way, and that's part of the treatment.

The notion that listening requires fully embedding oneself in a patient's narrative is reflected by a clinician who, channeling his former supervisor, Erich Fromm, uses the metaphor of observing waves while sitting on the beach:

> I would say, let it wash over you. Fromm used to say that listening has got to be like being at the beach. He said if you're at the beach and you watch a wave break, the wave goes into the sand as it breaks and then it goes back out again. As it goes back out again, the plankton, the little microorganisms are deposited on the sand. You see the little sandpipers running around. That's food. It deposits sand; it deposits all kinds of things. Then it goes out again. And his idea was that listening had to do with letting what you hear wash over you and go through you continuously.

This was reflected by an interviewee who emphasized the art of listening by comparing his/her interview style to that of listening to symphony: "With a kind of unfocused listening. I wouldn't say it's a reverie, but I try to hear, like musical instruments, the overtones, the *obbligato*." The importance of metaphor in wise listening is reflected in the following: "I use a lot of metaphors. I also try to listen very carefully to the patient's metaphors, because I really try to frame the treatment in their metaphoric world. And you have to learn a lot of languages. I can speak as a professional engineer or as a musician, as an artist, as a businessman. . . . I enter into their metaphoric world."

An additional aspect of wise listening was described as knowing when to "listen" to silence. These moments present in many forms, but all seem important to the wise clinician. "There are all kinds of silences. And some are very comforting. Ah, to be comfortable, and to make the other person in the room feel comfortable . . . just being . . . and waiting, rather than trying to fill space."

Throughout the interviews, respondents described features of wise listening in terms that were radically different than methods outlined in structured interview techniques. They mentioned standard dialogic moves such as reflection or clarification, but these were in the context of an organic conversation that shared features of any normal conversation.

Humility, Kindness, and Humor

Resonating classical understandings of wisdom, almost all interviewees suggested the wise therapist approaches her or his work with an attitude of "profound humility," of "not knowing and wanting to understand," and admitting that "if you come from the position of knowing less . . . you're more open." One therapist put it thusly: "I often said [to the client], 'You know I want to understand this better. Would you mind going over it again?' In other words my own vulnerability . . . the fact that stupid ass that I am,

I didn't understand it." Similarly: "If there's a balance, the balance is, I know my place. One of my places is, I'm not so important."

The importance of humility in speaking with clients was reflected in the way one participant talked about his experience talking with Anna Freud, whose wisdom was conveyed in her ability to speak eloquently but plainly: "She did not use one technical term at all, and explained the most complex identification processes and family dynamic in plain English. And I think that's a sign of wisdom, because people who use jargon are retreating behind something." Similarly, participants described their attitude of humility as being steeped in kindness—the unconditional respect and deep regard for the client—that seems a natural adjunct to approaching clients humbly:

> It takes, finally, over many, many decades, developing a kind of caring of compassion for this person . . . and what he's been through . . . and to respect the stuck points, to respect what he can't do, and not to shame him in terms of your goals. It's a humility and a caring for this particular soul and this particular circumstance and to see what will yield. What the circumstance can give you, what this particular person can give him or her self, and you can't rush it.

Another ranked the need for kindness alongside that of clinicians' authenticity: "Kindness is certainly one very important factor. Very great honesty—inwardly and outwardly. An analyst who manipulates and deceives in life cannot be a good analyst. Kindness, honesty, obviously perseverance, very much a sense for what is hidden and a curiosity about what is hidden."

A capacity for kindness is a prerequisite for being a therapist: "it's the kindness, that attitude of kindness. By the way I've decided what comes first is being decent for a therapist. If a person is basically decent then they'll use anything they know to help the patient. And if they don't have a basic decency, it doesn't matter what they know. Nobody's going to get help."

One clinician, quoting Ian Maclaren, reminded us, "Be kind, for everyone is carrying a heavy burden."[29] This includes the therapist, as one participant pointed out the need for self-care and kindness to oneself: "I think that's another important thing that people have to learn, to forgive themselves for the errors they made or the things that they didn't do or did do. I mean, I've watched people too often really torment themselves. And I don't think you can give it to people, I think they have to give it to themselves. That's what the work is about. Of letting people be kind to themselves too."

Participants described the need for humor and a capacity to find respectful amusement in the clinical encounter, which they often associated with humility and kindness. One said, "There has to be room for play and playfulness. Humor is very important. Life isn't all plodding like Schermberg; you can have levity even though you're dealing with very serious stuff. I think it lightens up the seriousness of the business." Another clinician describes humor as a job requirement if working with adolescents:

> If you work with teenagers, they are different in one way. You can't work with a teenager unless you find teenage hostility funny. You can't laugh at them but you can enjoy it. Because it's not like hostility at a younger age or an older age. They come in and they're going to work you over . . . they'll tell you you're stupid, you don't understand anything, you're square, you never give advice that's worth anything, and they will work you, they'll tell you this for the whole hour and then you remember that they can't understand why they talk to you, that it was snowing and this guy walked half a mile in the snow to get here, but there was no reason for his being here. And teenagers do this, they work you over the same way they work their parents over. And unless you think it's funny, you can't work with them.

Pearls of Wisdom

Participants identified favorite phrases and witticisms that they employ to encourage or assure their clients of therapeutic potential, to describe the nature of mental illness or to clarify treatment goals. More than simple platitudes, these pearls of wisdom often convey years of experience in just a few words. Crystallized descriptions of the causes of mental suffering and

illness included, "You're not sick because you're confused, you're sick because you're sure of things that aren't true." Another says, "We're all too much for ourselves. We're just too much for ourselves." And still another, "We're all two years old before we get to be 20."

Treatment is enhanced by a clinician who routinely encourages clients to think with radical freedom ("It is okay to think or feel anything."), acknowledging that such freedom is unconventional in a society that uses guilt to limit thought ("Our culture doesn't teach that. They teach you you're supposed to be guilty about your thoughts."). Again, metaphor is employed ("From deep in the hole it is hard to see anything.")

When encountering a pregnant pause, another clinician reports occasionally saying, "I think there's something which should be said at this point, I don't know what to say though . . . as soon as I find something worthwhile of saying you'll be the second to know." These simple dialogical moves have proven productive, have enhanced therapeutic relationships, and have been discovered through trial and error over the course of wise elders' careers. In a sense, such well-delivered and thoughtful one-liners hit particular pressure points that, when engaged, allow the conversation to begin to flow.

An Appeal to Paradigm Cases

Participants in the Wisdom Project emphasized the critical importance of paradigmatic cases that stand out over the course of their careers. When asked about the source of their wisdom, they described these cases in vivid color, often remembering details about their patients from decades past.

Each clinician articulated how very difficult cases served as important touchstones in their development as caregivers, providing needed lessons that could only have been learned through experience. We present here a few of the many cases presented by interviewees that reflect their importance in inculcating wisdom.

> There was one man, at the time when he came he was very, very troubled. He was very bright. He had gone to [an elite liberal arts college] and he was in the honors program in philosophy. And the article that he did for his honors thesis was Philosophy something and Psychoanalysis. And one day, he said to me, "Do you want me to tell you what's helped me, what's worked?" And I said of course, I always want to know. And I thought I'd get something very brilliant and erudite from him because he was a brilliant guy. He said, "I would come in here, and I would be very anxious. And when I would leave, you weren't. It didn't rub off on you." And that ultimately, we worked together for a very long time and he did very well.
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> And then this patient called me—this was a number of years ago—and she said, "You hear this sound?"—and it was like a machine—she said, "I'm standing up in a full bathtub and this is the hair dryer." She said, "If I drop it, it's the end." There was something in the press about an unfortunate accident, a woman was taking a bath, and she was gonna wash her hair, and she had the hair dryer right on the edge of the tub and it slipped in and she was electrocuted. . . . So I was in my office; there was nothing I could do. I said, "Don't do it. I'll see you Tuesday morning." And I hung up . . . I felt that she was challenging me in this way and there was no way that I could deal with it. She comes in very sheepishly on Tuesday morning, I said, "I'm sorry to tell you but our outpatient work is over . . . you need [hospitalization] . . . because these kinds of threats are too dangerous and it's simply unethical for me to work with you on this basis."
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> This case I will never forget: The wife was here, the husband was there, and he said, she doesn't love me. And her jaw dropped. She said, looking at him, how can you say I don't love you? And he looked to me and said, she says that, but she means only when I'm good. But, the badness is the real me. If she doesn't love me when I'm bad, she can't be loving me.

Recent cases continued to inform and refine the wise elders' approaches and methods:

> There have been many cases, and to me, that's a wonderful thing about being in this field. That there are new things coming all the time. I could go back to different eras in my career—I would say that a very profound one has been in the last seven years when I've worked with a patient who's in a chapter that I'm about to submit for a book, that uh, was extremely regressed, blocked, angry, depressed, very anxious. And a picture of sexual abuse by her father gradually unfolded as well as narcissistic abuse by her mother who didn't give the patient any attention and demanded the attention. . . . She had a vague sense that something had happened with the father. . . . And then, by chance, her niece was hospitalized for an eating disorder and the niece confessed to the therapist that she, the niece, had been incested by her grandfather, who was the patient's father.

Paradigmatic cases also served to redirect career foci and research:

> The very first patient before I had any training, when I just started out as a psychiatrist and threw myself into psychotherapeutic work . . . was a young student, don't recall what she was studying at the time, who had been hospitalized for years, diagnosed as psychotic, and practically hopeless, brilliant intellectually, super student before, hallucinations, severe eating disorder, suicidal. . . . I think it was during the treatment that she made a severe suicide attempt with 200 pills. And she was not found right away so it was really a very, very serious one. And I worked with her day and night, many hours a week. And I brought her that far that she started studying medicine and was doing quite well and I don't know what became of her. But I learned a tremendous amount from her. . . . Shame. The centrality of shame. I learned it from her. And then I saw that there is a considerable group of patients who are misdiagnosed as psychotic. All these symptoms that are described but are truly just severe neurosis. And I called them the archaic shame psychosis, or shame syndrome, and wrote about it in the shame book. And that really paved my way for the grasping of the immense importance of shame. When this girl was just brimful with shame. So in that case she was my Anna O.

A Need for Mentors

The crucial role of a mentor in developing wisdom is part and parcel of classical theories of wisdom and pedagogy. Similar to any oral history, knowledge gained by Wisdom Project participants through one-on-one supervision by now-deceased elders Bruno Bettleheim, Anna Freud, Erich Fromm, Jenny Waelder-Hall, Paul Gray, Edward Glover, Margaret Mahler, Franz Alexander, Thomas French, Donald Winnicott, Jacob Arlow, Sylvan Tomkins, Richard Sterba, and Heinz Kohut was maintained and passed down to be used and built upon by the next generation. Interviewees identified the need for lifelong education and mentoring to cultivate their own wisdom. ("I wouldn't say that they're models, but I, but they've been like rich mines to dig into and to draw from.") The need for continual guidance was particularly important for managing common flash points that occur during therapy sessions. For example, participants identified the need for continued support and training to deftly manage a client's anger:

> I guess I learned from my analyst: When somebody's in a rage with you and you let the rage run, they're doing to you what they couldn't, they're saying to you what they couldn't say to their parents. And I got this, a guy said to me, a long time ago, came back one time after he was in a rage the day before, he said, "You know what I like about you? I can call you a son of a bitch and you come and smile at me the next day."

In speaking about his cases, one senior analyst said:

> It's very invigorating. Certainly there are particular cases that put you up against the wall and make you re-evaluate everything that you held dear up to that moment. But in general this is a wonderful field for personal development. Not only if you let yourself go and actually allow yourself to be influ-

> enced by things, you know, you're inevitably gonna grow. . . . I have a peer group that's been meeting for, . . . since 1960s I guess it's 45 years or so. We meet once a month. . . . Our little peer group—we're 88, 90, . . . we present our papers, our ideas to one another.

Many interviewees highlighted the need for ongoing peer supervision throughout their careers. In fact, one participant, at 92, attended two different peer groups, one of which was a group that she had supervised when they started.

Some participants articulated the role of the "anti-mentor":

> I didn't have training with people that influenced what I ended up doing, it gave me a feeling of what I didn't want to do. I would say the supervision I received was uniformly terrible and it instilled in me a picture of what a supervisor should be like, based on them with a "minus" sign, . . . they were dogmatic, . . . the experience is that strong, that they really were not interested in the patient but rather in the deliverance of a certain theoretical model.

This reveals an insight already possessed by the trainee who recognized that mentors should not be blindly followed.

ELEMENTS OF CLINICAL WISDOM IN PSYCHOTHERAPY

The reflections of the 18 wise elders who were part of the Wisdom Project resonated with central concepts in the philosophy of wisdom. Based on the insights provided by project participants and in the context of philosophical work on the concept of phronesis in clinical bioethics, we propose the following working definition of clinical wisdom in psychotherapy:

> Rooted in pragmatism, *clinical wisdom* is the capacity to carefully balance an interplay of paradoxes in an open and nonjudgmental way; it is built upon kindness, humility, and a deep regard for the other. Four elements of clinical wisdom in psychotherapy emerge:

1. Clinical wisdom is pragmatic
2. Clinical wisdom is balanced
3. Clinical wisdom is paradoxical
4. Clinical wisdom is a manner of being.

Clinical Wisdom Is Pragmatic

Our claim that clinical wisdom is pragmatic is almost tautological, because the foundational concept, phronesis, as we described above, is itself practical wisdom. However, it should be emphasized that a key dimension to our notion of clinical wisdom is that it serves as the capacity for clinicians to work toward tangible outcomes using both conventional and unconventional or nonformulaic methods. By replacing "pragmatist" with "psychotherapist" and "professional philosophers" with "mainstream mental healthcare provider," an expression of how clinical wisdom in psychotherapy is characteristically pragmatic can be no better articulated than by William James himself:

> A pragmatist turns his back resolutely and once for all upon a lot of inveterate habits dear to professional philosophers. He turns away from abstraction and insufficiency, from verbal solutions from bad a priori reasons, from fixed principles, closed systems, and pretended absolutes and origins. He turns toward concreteness and adequacy, toward facts, toward action and toward power. That means the empiricist temper regnant and the rationalist temper sincerely given up. It means the open air and possibilities of nature, as against dogma, artificiality, and the pretence of finality in truth.[30]

Indeed, the impulse to appeal to rules, methods, and dogmatic practice principles was clearly eschewed by Wisdom Project participants. They instead described their eclectic approaches to patient care by recognizing the potential fallibility in their approach—fallibilism is another hallmark of pragmatism—as well their "teleological attitude," that is, that their work should be done not for the sake of employing this or that method for its own sake, but to reach the goal of healing patients above all else. As one interviewee noted, "Freud did not call his technique a 'rule' but rather a 'rec-

ommendation.' " It was perhaps those less wise who codified it rigidly into rules of technique.

In psychological investigations, the pragmatic dimension of wisdom remains front and center. Baltes and Staudinger's Berlin Wisdom Paradigm study found that wisdom includes an expertise in understanding and navigating the fundamental pragmatics of life, which are defined as "knowledge and judgment about the essence of the human condition and the ways and means of planning, managing, and understanding a good life."[31] By operationalizing these pragmatics in the clinical setting, the wise therapist is able to move outside her- or himself toward whatever steps are needed to affect a positive change in her or his client's life. As participants implicitly conveyed, ostensibly hard-and-fast rules pertaining to boundaries, transference, or self-disclosure may be prudently bent; the ability to know when such rule-bending is acceptable requires practical wisdom.

Clinical Wisdom Is Balanced

Sternberg said wisdom is based in balance; between knowledge and doubts, intense emotion and detachment, an ability to critically reflect while maintaining attentional flexibility.[32] The notion that wise interactions between clinician and client require a balancing of competing values or dialectal relationships was recognized and highlighted by Wisdom Project participants. For example, one participant crystallized the importance of balance, stating:

> I think balance is a very important consideration, ongoing, because the patient is very conflicted and so you want to have a balance between interpreting the defense, and interpreting what's underneath the defense. You need a balance between empathizing and reflecting. And sort of interpreting what's there, as opposed to emphasizing your understanding of how the patient feels. And I think wisdom is very importantly achieving a useful balance for that person. It's almost like you have certain ingredients and you have to cook up a special diet for this person. And you have to get in all the right nutrients but they have different allergies and this and that, so you have to be creative in how you uh, dish it up.

Wise balancing allows clinicians to ably negotiate the dialectic between observation and embeddedness, empathy and involvement. One participant put this balancing act thus: "For me, I like Sullivan's idea of participant observation. We're never outside of the field, we're always in the field. But the question is, who's participating more? Who's observing? You know, observing more and too much observation, and you're detached. Too much participation and you're embedded. So it's the right balance." Another reiterated this theme:

> Well I think it is just that quality when you use the phrase "going deep in ourselves." If you go deep in yourself you do recognize the person as a separate person and it has to do that he or she has a mind of her own. And at the same time, it's a mind of her own that needs to connect. I'm a pretty good analyst because I do give the patient an awful lot of myself, but the balance is one between connecting and separateness.

Finally, consider this quote from a centenarian participant of the Wisdom Project, who, in a recent article, said, "I have many thoughts about the future, and I remember the past with both joy and sadness but without nostalgia. I am grateful for being able to live in the present with what feels like an appropriate mixture of awe and despair, of hope and dread."[33] Notice her affective blends and the expression of "balance."

Clinical Wisdom Is Paradoxical

Winnicott placed paradox in the transitional space—that area between illusion and reality—and he believed it was where psychoanalytic dialogue took place. It was there that analyst/therapist and analysand/patient live in the past and present simultaneously.[34] Accepting the paradox, as Winnicott implores, requires the wisdom to first recognize it and then transcend it creatively. Creativity, as a hallmark of clinical wisdom, integrates what is contradictory, by lifting conflict to a level where it becomes complementary.[35] Interviewees expressed their recognition and acceptance of paradoxes that exist in the therapeutic relationship, in concepts of mind and psyche upon which they base their

practices, and in confidence about their own abilities (see table 1).

Clinical Wisdom Is a Manner of Being

The definition of "clinical wisdom" proposed here notes that the wise clinician is one who is "open, nonjudgmental, kind, and has a deep regard for the other." Wisdom, as a manner of being, is consistent with theories of affect regulation such as Labouvie-Vief's Dynamic Integration Theory, which describes two independent emotion regulation strategies: (1) affect optimization (gravitation toward positive emotions) and (2) cognitive-affect complexity (search for differentiation and objectivity).[36] As such, there is a dynamic balance between positive affect (optimization) and differentiation. Likewise, this parallels Erikson's definition of wisdom, which posed a dialectical struggle in old age between a search for integrity and a sense of despair and disgust/disdain, and noted that these contraries, in dynamic balance in integrity's favor, are essential to wisdom, which he considered the ultimate human strength.[37]

Interestingly, as people age, they often gravitate more toward positive than negative emotions.[38] But they often do so by reducing cognitive complexity: the world looks brighter when you are duller around the edges (that is, denying the negative by reducing a felt sense of differentiation). This is not so for people who achieve wisdom in old age; they are able to integrate negative experiences into an overall positive whole, even as the self becomes increasingly tolerant of diversity and difference.[39] Wise older people display more complex thinking about emotions in terms of emotional blends and transformations across time and context.[40]

In a similar way, Kohut emphasized the acceptance of transience and humor as he differentiated someone who is wise from someone who is just smart.[41] The stereotypic arrogant, cold psychoanalyst is a senior clinician who has maintained a sense of cognitive-affective com-

TABLE 1. A sample of statements by Wisdom Project participants that convey the paradoxical dimensions of clinical wisdom

In good treatment we maintain the boundary and push the boundary.
We push the boundary and accept the limits.
We let the clinical material wash over us as we pay attention to the details.
The psyche is blocked and it moves.
We idealize our analysts and de-idealize them [disillusionment].
We know and we don't know; we listen with a knowing confusion, keeping and throwing out all that we've learned during our training.
We start life in an essential aloneness, while at the same time this aloneness can only take place under conditions of dependence.
We're attached and we're separate.
We're separating, individuating, and oedipal.
Analysis is an emotional connection created within a profound loneliness.
Psychotherapy requires acceptance of the patient while simultaneously working towards change.
In therapy you are, and are not, on safe ground.
The very fact of the safety in the therapeutic relationship is what allows for the transferential repetition to unfold with the degree of risk that it necessarily entails.
We help people feel safe and want to stay with us so that they can leave us.
Relationships have permanence and impermanence.
When the analytic relationship ends [termination] it continues.
We are very much a part of, and very much outside of, our patients' lives.
As one becomes more intimate with oneself, one becomes more of a vast unknown.
We are wanted and abandoned; helpless and powerful.
Psychoanalytic theory is something you have to learn and then learn to forget.

plexity, but has not achieved an orientation toward positive affect. We would expect participants of the Wisdom Project to recognize such analysts as being quite smart—perhaps even brilliant—but their manner of being is wanting, in that they are neither humble nor kind.

As we can now conclude, Wisdom Project participants articulated aspects of clinical wisdom that reflected and reinforced the concept of phronesis as it has been described over the past several decades by biomedical ethicists. Thus, the concept of clinical wisdom in psychoanalysis provides a helpful paradigm for understanding and cultivating clinical wisdom in other areas of medicine. Because psychoanalysis requires a specialized form of clinical wisdom, and such clinical wisdom overlaps so nicely with phronesis, we can begin to extrapolate important lessons about how phronesis in clinical medicine might be recognized, characterized, and cultivated by studying the wise elders of the fields of psychoanalysis and psychodynamic psychotherapy.

IMPLICATIONS FOR EDUCATION

The responses from the wise elders in the Wisdom Project have prompted reflection on not only what constitutes wisdom, but how and if wisdom can be taught to trainees in clinical social work, psychology, psychiatry, or any particular specialty of clinical medicine. It is certainly unlikely that a wise clinician can be created *de novo* with didactics or mentoring. Rather, it should come as no surprise that clinical wisdom is a way of practice that must be cultivated and nurtured through decades of experience, self-reflection, critical appraisal by teachers and mentors, and trial and error.

Regrettably, teaching strategies employed in clinical psychology and psychiatry often are antithetical to cultivating wisdom in young practitioners. Any pedagogical technique emphasizing the rote application of a prefabricated interview, for example, seems alien to our view of how wisdom is learned and employed. Similarly, teaching primarily to the *DSM* (*Diagnostic and Statistical Manual of Mental Disorders*) is not a fruitful way to train a cadre of young therapists. As one interviewee put it, "with the diagnostic inflation ravaging our field, with such exaggerations of pathology, one blocks human empathy and the understanding of the other's genuine distress." Other risks to wisdom-based education are products of the ongoing push for super-specialization or specific certifications that can be achieved without much time with patients. The proliferation of compact programs that emphasize content absorption and regurgitation in the interest of speed is hardly a seeding ground for wisdom.

Nonetheless, there are a few possible starting points to encourage the cultivation of wisdom in trainees in the context of behavioral healthcare. We first suggest course work in clinical wisdom. Over the past few decades, training programs have added a course in ethics—but these courses deal purely with the ethical and legal parameters of practice such as conflicts of interest, boundaries, and regulations concerning HIPAA (the U.S. Health Insurance Portability and Accountability Act). Instead, we would encourage the development of an ethics track for medical students, residents, and psychology trainees—such as the one recently launched at our institution—designed around the conceptual examination and clarification of foundational concepts in psychiatry. We also suggest that senior, seasoned clinicians routinely come into the classroom and present cases utilizing clinical wisdom as a scaffold for case analysis. In this way, we would hope that young clinicians would internalize a model by which to approach case material. Additionally, we hope these appearances would eventually develop into more formal mentoring relationships between junior and senior clinicians.

Finally, we propose training young clinicians in self-reflection. If, as one clinician paraphrasing Hillel noted, ethics is a tension between self and other, young clinicians must be trained to better know themselves, not just observe the other. Training should include the ability to observe their internal world and reactions, not just external observable phenomena. This might be achieved through teaching mindfulness. In addition, "emotional agility," one interviewee's term for a sense of ease and comfort with the full spectrum of one's emotional life, might be cultivated via support for train-

ees to examine internal experiences. They ought to be helped to develop a language to convey this, for such language is essential if they are to develop the manner of being we are suggesting.

Another continuing challenge will be to shine a light on the so-called "wisdom gap"—that clinicians believe they are more wise than they truly are—identified within psychology. This gap is characterized by senior clinicians' self-perception that they are more adept than their trainees in navigating complex ethical and moral issues in practice, when, in actuality, they are not. Sulmasy, Dwyer, and Marx identified this dissonance within various levels of medical staff and proposed such self-misperception is a key obstacle in adequate role modeling and mentoring.[42] Therefore, it is crucial that senior practitioners themselves engage in an honest assessment of their own wisdom through critical self-reflection, peer evaluation, and solicitation of candid feedback provided by trainees and clients.

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NOTES

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