

## **Paraprofessionals' Workshop – Sep 19, 2008.**

My experience in Mexico, with what we call “acompañante terapeutico” which means “therapeutic companion”, is not an issue of paraprofessionals against professionals, even though I will talk about this point later. The issue for us has been the difference between the medical model and the psychoanalytical model.

You may work with professionals or paraprofessionals, depending on the specific conditions of each clinical case. The difference has to do with the kind of supervision that guides the therapeutic companion. If the supervisor uses a medical paradigm, then the job deals with what you have to do in order to keep the body well guarded and in good health. These medically oriented supervisions include the great majority of psychotherapies that arise from medical psychology. The ethics of medicine has to do with what is right or wrong for the organic body, the biological body. The ethics of psychoanalysis has to do with desire and not with body health. It has to do with what suits the soul. The psychoanalytic theories deal with the erotic body and not with the organic body. Many times these two theories go into conflict, and those are the times the patient suffers the consequences in his flesh.

The main clinical concept that we have to understand in any psychoanalytically oriented companion therapy, is what we can call a transferential link. A transferential link is an unconscious relation that is established from the patient to the companion. The forgotten childhood of a patient, reappears in the form of a relation. This transferential relation is a way to act what cannot be remembered. This is an actualization of the passions and

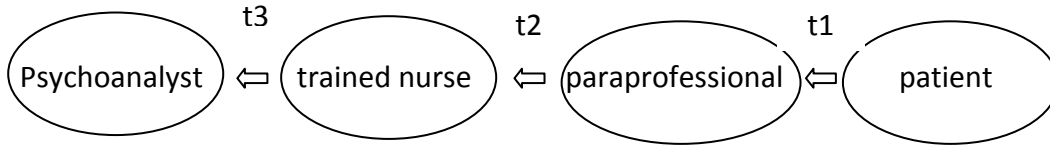
dreams that inhabit the patient. His lost history comes back to life in the form of feelings. In some way we can say that we love the person to whom we talk. The trick in establishing a transference link has to do with the ability to listen. Listening means giving up our knowledge as a way of discovering our neighbor human being. Listening is changing knowhow for wisdom. We talk of links instead of relations since companion therapy has to do with several aligned transference relations. All of them establish a chain of transference. And our job is to prevent this chain from breaking.

A therapeutic companion that is psychoanalytically oriented has to promote the formation of a transference link that goes from the patient to the companion. But at the same time the supervision of a companion with a psychoanalyst, promotes a second transference relation from the companion to the psychoanalyst.

The process constructs a chain of transference relations that point towards the analyst who is conducting the cure.

In a nursing home, where I implemented different models of companion therapy, especially with depressed patients, we had one model that included three aligned transference links. A paraprofessional that we call "cuidadora" would take care of the patient. This cuidadora promoted a transference link from the patient, and at the same time she was supervised by a nurse previously trained by a psychoanalyst; this last one supervising the nurse.

Figure 1 - Three links transference chain model



So we had a three link transference chain (fig. 1). Every link was pointing towards the psychoanalyst. This therapy model was being used as a pilot plan, besides the medical model using nurses supervised by a medical doctor. We were given the opportunity to apply our model in a critical case of anorexia in a 90 years old lady. The woman had not been eating for more than 15 days, and her death was imminent. In the first week that we changed the medical-nurse model to the psychoanalytic-paraprofessional model, the anorexia stopped and she began to eat again. The magic had to do with the transference chain that promotes in the patient a recovery of the power of language. This transference chain moved her away from the silent maladies that tortured her body. Transference promotes the palpitation of the psychic apparatus, facilitating the symbolic realization of desires. This process is the best vaccine against psychosomatic diseases and other silent maladies.

The only condition we have to assure in this kind of therapy is that every link in the transference chain stays in place. If by any reason one link breaks, the patient would be thrown to isolation like an astronaut floating in space, and his body would become the

target of silence: depression, psychosomatic diseases, mental illness, violence, and pharmacological addictions, will take the place of the broken link.

The transference companion model has also been applied to patients that are not institutionalized. Some colleagues have been using it for more than 15 years in Mexico with psychotic patients, including schizophrenia, autism and delirious obsession. They also apply this model with patients having organic conditions, melancholy, addictions, and also with disturbed children. It is strongly recommended that the therapeutic companion participates in a psychoanalytic therapy, especially when dealing with severe mental illnesses, since the mental health of the therapeutic companion is threatened by his job. Being in psychoanalysis, for a therapeutic companion, is not only a preventive practice for their mental health, but it also gives them the strongest tool they will ever get to cope with transference, without being compelled to break the link.

Developing a therapeutic companion program that enables the psychoanalytic model to be used with psychotic patients, should include a low cost psychoanalytic clinic for the companions. In less severe cases, supervision with an analyst may be enough. But ideally speaking, all companions should be in therapy with one analyst and in supervision with another one. Anyway, if we put in the head of the transference chain a psychoanalyst, chances are very high, even if the companions are not in therapy, that the transference link won't be broken. But in the other hand, if we put a medical doctor to conduct the cure, with the paradigms of medicine ruling the process, you will have 99 % chances that the transference chain will break in some link, and the patient will be condemned to suffer deep isolation.

I want to share with you an example of a non-institutionalized patient suffering a severe depression, and how she reacted to both models: the transference link model and the medical geronthological model.

A man comes to me for help in regard to his wife's severe depression. He has followed the psychiatric advice to put her in a series of electric shock therapy. She did not respond to this therapy so I suggested a therapeutic companion. The companion is a nurse I had been training for a few months in the transference model. She starts her work under my supervision. The patient lies in bed and does not want to move from it. She does not want to take a bath or talk with anybody. She only wants to stop existing. Life is unbearable for her. After a couple of weeks of this companion therapy, the patient gets out of bed, baths and finds the desire to get dress. For 10 months this therapy increased her joy for life. She loved to go to the market, to church, to drink coffee. Going to the market was not irrelevant, it was crucial, it was her link with life. For her, it was as important as the air she breathed. Unfortunately her husband was very concerned about her biological body, due to the fact that she was not exercising as much as doctors recommend. The husband, in some kind of virulent amnesia of her depression, and confident that he could push more on her, against our advice, decided to finish our therapy and moved to the medical-geronthological model. He artificially broke the link with the therapeutic companion, and hired a new therapeutic companion that was medically oriented. This new companion was mainly worried with what she ate and how much exercise she was doing. The companion pushed her under a demanding therapy and not one that hears her desires. All this "knowhow" of the body put on a side what the woman had to say, the words that came

from her belly were hushed once again. Silence and deception broke the transference chain and threw the patient back to depression. After a few months the woman got severely sick and died. I can not say that the change of model killed her. I can not affirm that if the therapeutic companion under the transference link model would have stayed, she might have lived longer. What I can surely affirm is that the woman was happy with her life with the first companion, and clearly sad with the second companion.

We can conclude from the Mexican experience with therapeutic companions in the last 15 years, that the main ingredient in order to accomplish a successful companion therapy is the application of the psychoanalytical transference model, instead of the medical model. A listening therapy proves to be better than an observational one. This means to have a psychoanalyst supervising the process as head of a linked transference chain. The impact of using professionals instead of paraprofessionals, did not seem to explain the therapeutic success or failure in companion therapy. What really made the difference, was the theory behind the clinical model we used.

Taking into account the fact that none of our countries has developed formal training for therapeutic companions using the psychoanalytic transference chain model, it is possible to say: that professionals arriving from medical and psychological disciplines are, in some way, paraprofessionals when they are confronted with a clinical model that is unknown to them. In this line of ideas we can say that the participation of paraprofessionals in companion therapy has a good chance of success when the paraprofessional is being supervised by a psychoanalyst. This is a good solution for our patients. Meanwhile we

Alejandro Salamonovitz Weinstock

should start developing training programs to form psychoanalytically oriented companion therapists.