PSYCHOANALYSIS AND OTHER LONG-TERM DYNAMIC PSYCHOTHERAPIES

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Introduction

Basic assumptions

The term psychodynamic psychotherapy has no specific referrent. It denotes a very heterogenous range of psychological treatment approaches which arguably have in common an intellectual heritage of psychoanalytic theory. Psychoanalytic theory itself is no longer based on a unitary body of ideas (Fonagy & Target, 2003) but a number of ideas appear to be core to most psychodynamic approaches. These notions are:

(a) A shared notion of psychological causation, that mental disorders can be meaningfully conceived of as specific organizations of an individual's conscious or unconscious beliefs, thoughts and feelings .

(b) Psychological causation extends to the non-conscious part of the mind, and to understand conscious experiences, we need to refer to other mental states of which the individual is unaware.

(c) The mind is organised to avoid unpleasure arising out of conflict (Smith, 2003b) in order to maximise a subjective sense of safety (Sandler, 2003);

(d) Defensive strategies are a class of mental operations that seem to distort mental states to reduce their capacity to generate anxiety, distress or displeasure. Individual differences in the predisposition to specific strategies have often been used as a method for categorizing individuals or mental disorders (Bond, 2004; Lenzenweger, Clarkin, Kernberg, & Foelsch, 2001);

(e) Varying assumptions are made concerning normal and abnormal child and adolescent development but therapists are invariably oriented to the

developmental aspects of their patients' presenting problems (Fonagy, Target, & Gergely, 2006).

(f) Relationship representations linked with childhood experience are assumed to influence interpersonal social expectations including the transference relationship with the therapist (e.g. Brumbaugh & Fraley, 2006) and to shape the representations of the self (Adler & Buie, 1979; Eagle, 2003; Mikulincer & Shaver, 2004; Winnicott, 1958)

(g) These relationship representations inevitably re-emerge in the course of psychodynamic treatments (Westen & Gabbard, 2002).

Brief overview of theories

Psychoanalytic theory has evolved from the work of Freud following two broadly separate paths which converged over the past 25 years only to separate again. In the United States followers of the Vienna school in the 1950s and 1960s evolved a systematic psychology of the ego, a conflict-oriented complex psychological model of the mind and its disturbances (Hartmann, 1939). In Europe, only Anna Freud and her followers in London pursued this tradition of psychoanalytic thought (Freud, 1965). Based on the Berlin school of Karl Abraham, Melanie Klein and her followers established a distinct approach focusing on the understanding of disturbance rooted in infantile destructiveness and sadism (Klein, 1948). Some psychoanalysts, influenced by Klein and the idea of the pathogenic nature of the experiences of infancy, gradually discarded the mechanistic psychology of drives and psychology of internal structures in favour of theories of intrapsychic interpersonal relationships (object-relations theory) (Fairbairn, 1952).

As these schools developed in the UK, their influence travelled across the Atlantic. First, Kohut, strongly influenced by Winnicott (albeit without explicit acknowledgement), evolved a psychoanalytic psychology of the self (Kohut, 1984). Shortly after, Kernberg arrived at an imaginative integration of ego-psychological and Kleinian ideas (Kernberg, 1976). In the meantime, in the UK, the Kleinian movement rapidly progressed in their understanding of psychoanalytic clinical experience, moving beyond Klein's original work and integrating some of the key features of the Anna Freudian and the British object-relations traditions (Rosenfeld, 1987). In the US, disillusionment with the false certainty provided by ego-psychology became intense throughout the late 1970s and early 1980s and a radical change in psychoanalytic thinking took place with the emergence of the interpersonal relational perspective, which is in part rooted in the work of Harry Stack Sullivan (Aron & Harris, 2005; Sullivan, 1953). The relational psychoanalysis of the 1980s and 1990s consolidated several lines of thought initiated by justified critiques of traditional analytic theory; (Mitchell & Aron, 1999), including feminism, the hermeneutic-constructivist critique of the analyst's authority, infancy research, and, closely related to this, the intersubjectivist-phenomenological philosophy of mind – as well as a general political movement to improve and democratize access to analytic ideas and training (Seligman, 2003)..

There are many other new psychoanalytic theoretical approaches, bringing the field increasingly close to total fragmentation (Fonagy, 2003). This is because the emergence of new approaches in no way signals the demise of any previous orientations, most of which continue to enjoy considerable popularity among specific groups of psychoanalysts.

Psychoanalytic therapy as treatment

The history of psychoanalysis as a therapeutic approach is rather different. Broadly speaking, it may be argued that psychoanalysis and other long-term psychodynamic therapies are predominantly verbal, interpretive, insight-oriented approaches which aim to modify or re-structure maladaptive relationship representations. It is implicitly assumed that genetic and early environmental factors give rise to partial, unintegrated and generally troublesome relationship representations (e.g. a helpless 'infant' requiring total care from an adult, a self with exaggerated sense of power and entitlement requiring constant confirmation from outside) that lie at the root of psychological disturbance. It is believed that the integration of these partial representations into more complex schemata, primarily but not exclusively through the use of insight, leads to improved internal and social adjustment.

Psychoanalysis is the most intensive form of these long-term therapies. The analysand attends treatment three or more times a week over a period of years. The use of the couch and the instruction to the analysand to free associate have been considered hallmarks. The distinction between psychoanalysis and other forms of psychotherapy is normally made in terms of the frequency of sessions rather than in terms of the therapeutic stance of the analyst. It is difficult to avoid the conclusion that in the absence of plausible, theoretically based criteria for what is or is not psychoanalytic, against the background of an overwhelming diversity of theoretical frameworks, psychoanalysts have attempted to find common ground in readily identifiable treatment parameters. This problem arises as a consequence of an extremely loose relationship between psychoanalytic theory and clinical practice (Fonagy, 2003). It is an indisputable fact that, whereas theory has evolved extremely

rapidly in the last half of the 20th century and continues to change, psychoanalytic practice has, until recently, changed surprisingly little and continues to provide the core of the psychoanalytic identity. On the other hand, the follow-along study by Sandell et al. (Sandell, Blomberg, & Lazar, 2002) found that psychoanalysis and psychoanalytic psychotherapy were "separate things". When psychotherapy was performed using mainly psychoanalytic techniques, it was less effective than psychotherapy performed with modified and adjusted techniques (that is, not performed as an "as-if analysis"). The findings from the Stockholm study suggest that psychoanalysis and psychoanalytic psychotherapy may be separate endeavours, although how exactly they differ is far from clear.

In this chapter we will not consider the theoretical richness of this field but instead will focus on the clinical constructs which run across the diverse intellectual approaches. The intersection of the two is perhaps clearest in one area which we shall consider in some detail – namely, the therapeutic action of long-term psychoanalytically oriented psychotherapeutic treatment.

Background

Historical development of the psychoanalytic approach to treatment

As is well-known, Freud's discovery of the talking cure (Freud & Breuer, 1895) was really that of an intelligent patient (Anna O) and her physician (Breuer). The patient reported that certain symptoms disappeared when she succeeded in linking up fragments of what she said and did in an altered state of consciousness (which we might now call dissociative) with forgotten impressions from her waking life. Breuer's remarkable contribution was that he had faith in the reality of the memories which emerged and did not dismiss the patient's associations as products of

a deranged mind. The patient's response to treatment was probably less complete than Breuer and the young Freud had hoped (Castelnuovo-Tedesco, 1994) but the 'treatment' defined the basic elements of the 'cathartic' method linking memory of trauma (the circumstances of her experience of father's death) to her many symptoms.

At first Freud rigorously pursued the traumatogenic origins of neuroses. Later, when confronted by evidently incorrect statements, he modified his theory, assuming consistency between recollection and childhood psychic reality rather than physical reality (Freud, 1899). The issue of accuracy of memories of childhood sexual trauma remains controversial, although its relevance to psychoanalytic technique is at best tangential (Fonagy & Target, 1997). Freud's technique, however, was dramatically modified by his discoveries. The intense emotional relationship between patient and physician, which had its roots in catharsis following hypnotic suggestion, had gradually subsided into what was principally an intellectual exercise to reconstruct the repressed causes of psychiatric disturbance from the fragments of material derived from the patient's associations. It was a highly mechanistic approach reminiscent of a complex crossword puzzle. In the light of therapeutic failures, however, Freud once more restored the emotional charge into the patient-physician relationship (Freud, 1912a). However, in place of hypnosis and suggestion, he used the patient's emotion, signs of transference of affect and affective resistance which were manifest in the analytic relationship. Instead of seeing the patient's intense emotional reaction to the therapist as an interference, Freud came to recognise the importance of transference as a representation of earlier relationship experiences which could make the reconstruction of those experiences in analysis highly meaningful to that individual (Freud, 1914).

Freud's early clinical work evidently lacked some of the rigour which came to characterise classical psychoanalysis (Jones, 1953). His occasional encouragement to his patients to join him on holiday might now be considered boundary violations (Celenza & Gabbard, 2003). What is perhaps less well-known is that Freud remained somewhat sceptical about the effectiveness of psychoanalysis as a method of treatment (Freud, 1937). Indeed, autobiographies of some of his patients testify to his great flexibility as a clinician and use of non-psychoanalytic techniques, including behavioural methods (Walter, 1946). Nor was Freud the only clinician to use psychoanalytic ideas flexibly. The Hungarian analyst Sandór Ferenczi should be credited with the discovery of the treatment of phobic disorders by relaxation and exposure (Ferenczi, 1930) although many of his well intentioned actions were criticised by contemporaries and more recently on arguable ethical grounds (Szecsödi, in press).

The technique of psychoanalysis after Freud's death came to be codified. Those (such as Alexander and French and Freda Fromm-Reichmann) who attempted to revive or retain Freud's original clinical flexibility were subjected to powerful intellectual rebuttals (Eissler, 1953). In reality, psychoanalysts probably continued to vary in the extent to which they observed the ideals of therapeutic neutrality, abstinence, and a primarily interpretive stance, but these deviations could no longer be exposed to public scrutiny for fear of colleagues' forceful condemnation. Personal accounts of analyses with leading figures yield fascinating insights into variations in technique, principally in terms of the extent to which the analyst made use of personal relationship (Guntrip, 1975). There has been an ongoing dialectic throughout the history of psychodynamic approaches between those who emphasise interpretation and insight and those who stress the unique emotional relationship between patient

and therapist as the primary vehicle of change. The controversy dates back to disputes concerning the work of Ferenczi and Rank (1925) but re-emerged with the first papers of Balint and Winnicott in London opposing a Freudian and Kleinian tradition, and somewhat later in the United State with Kohut and more subtly Loewald opposing classical ego psychology.

In the last two decades, the pluralistic approach of modern psychoanalysis has brought out into the open many important dimensions along which psychoanalysts' techniques may vary. In particular, the recent trend to consider analyst and patient as equal partners engaged in a mutual exploration of meaning (Altman, Briggs, Frankel, Gensler, & Pantone, 2002) directly challenged many of the classical constructs. The emphasis on the mutual influence of infant and caregiver shaped the emerging relational model of therapy as a two-person process in which there was little room for a detached analyst with pretensions of "objectivity". Drawing on the assumption that humans are predisposed towards two-person co-constructed systems that provide a context for psychic change, the quality of engagement between therapist and patient became the core of therapeutic action. What changes the mind is not the insights gained but learning from the interactional experience of being with another person. Neither the analyst nor the patient can be considered as forging meaning; rather, meaning is co-constructed.

Technique – Principal features

Neutrality and abstinence

Based in the classical framework of libidinal theory, Freud made an explicit injunction against the analyst giving in to the temptation of gratifying the patient's sexual desire (Freud, 1915). Obviously, this is primarily an ethical issue. However,

within the psychoanalytic context it also justifies the analyst's stance of resisting the patient's curiosity or using the therapeutic relationship in any way that consciously or unconsciously could be seen as motivated by the need to gratify their own hidden desires. Within this classical frame of reference, the patient must also agree to forgo significant life changes where these could be seen as relevant to current psychotherapeutic work. In practice, such abstinence on the part of the patient is rare. Yet long-term psychodynamic treatment may founder if the emotional experiences of the therapy are obscured by the upheavals of significant life events.

The primary function of abstinence is to ensure the neutrality of the therapist. The analyst assumes an attitude of open curiosity, empathy and concern in relation to the patient. The therapist resists the temptation to direct the patient's associations and remains neutral irrespective of the subject matter of the patient's experiences or fantasies. While it is easy to take this issue too lightly, (and it is perhaps this aspect of the psychoanalyst's therapeutic stance which makes them most vulnerable to ridicule), it is probably genuinely critical for the therapist to retain emotional distance from the patient to a degree which enables the latter to bring fantasies and fears of which they feel uncertain. Nevertheless, neutrality at its worst denies the possibility of sensitivity; recent literature on the process and outcome of psychotherapy makes it clear that the therapist's genuine concern for the patient must become manifest if significant therapeutic change is to be achieved (Lambert, 2004). The quality of the alliance is one of the better predictors of outcome (Orlinksy, Ronnestad, & Willutski, 2004) and alliance is impacted by the patient's attachment style and quality of object relations (e.g. Pinsker-Aspen, Stein, & Hilsenroth, 2007)

Mechanisms of defence

The term 'psychic defenses' may risk reification and anthropomorphism (precisely who is defending whom against what?) yet the existence of self-serving distortions of mental states relative to an external or internal reality is generally accepted, and frequently demonstrated experimentally (Blagov & Singer, 2004; Lyons-Ruth, 2003; Shamir-Essakow, Ungerer, Rapee, & Safier, 2004). Within classical psychoanalytical theory and its modern equivalent (ego psychology), intra-psychic conflict is seen as at the core of mental functioning (Brenner, 1982). Here defences are seen as adaptations to reduce conflict. Within many object relations theories, defences are seen as helpful to the individual to maintain an authentic or "true" self-representation or a nuclear self (Kohut, 1984). Models of representations of relationships are of course often defensive. Traumatic experiences may give rise to omnipotent internal working models to address a feeling of helplessness. Within attachment theory, defences are construed as assisting in the maintenance of desirable relationships (Walins, 2007). The Klein-Bion model makes limited use of the notion of defence mechanisms but uses the term in the context of more complex hypothetical structures called defensive organisations (Rosenfeld, 1987). The term underscores the relative inflexibility of some defensive structures, which are thus best conceived of as personality types. For example, narcissistic personality disorder combines idealisation and destructiveness; genuine love and truth are devalued. Such a personality type may have been protective to the individual at an earlier developmental stage, and has now acquired a stability or autonomy which must be rooted in the emotional gratification which such a self-limiting form of adaptation provides (Steiner, 2000).

Irrespective of the theoretical frame of reference, from a therapeutic viewpoint clinicians tend to differentiate between so-called primitive and mature defences based

on the cognitive complexity entailed in their functioning (Vaillant, 1992). In clinical work, primitive defences are often noted together in the same individual. For example, individuals loosely considered "borderline" tend to idealise and then derogate the therapist. Thus they maintain their self-esteem by using splitting (clear separation of good from bad self-perception) and then projection. Projective identification (Klein, 1946) is an elaboration of the process of projection. An individual may ascribe an undesirable mental state to the other through projection but when the other can be unconsciously forced to accept the projection and experience its impact, the defence becomes far more powerful and stable. The analyst's experiencing of a fragment of the patient's self state, has in recent years been considered an essential part of therapeutic understanding (Heimann, 1956).

Whether in fantasy or in actualised form, through projective identification the patient can experience a primitive mode of control over the therapist. Bion argued that when the self is experienced as being within another person (the therapist) the patient frequently attempts to exert total control over the recipient of the projection as part of an attempt to control split-off aspects of the self. Bion (1962) also argued that not all such externalisations were of "bad" parts of the self. Desirable aspects of the self may also be projected, and thus projective identification can be seen as a primitive mode of communication in infancy. There are other aspects of projective identification which we commonly encounter clinically. These include the acquisition of the object's attributes in fantasy, the protection of a valued aspect of the self from internal persecution through its evacuation into the object, and the avoidance or denial of separateness. It is thus a fundamental aspect of interpersonal relationship focused on unconscious fantasy and its appreciation is critical for the adequate practice of long-term psychotherapy (Greatrex, 2002).

Classifications of defenses have been frequently attempted (Fraiberg, 1982; Freud, 1936; Horowitz, 1995; Kaye & Shea, 2000; Spitz, 1961; Vaillant, 1992) and often as a method for categorizing individuals or mental disorders (Bond, 2004; Lenzenweger et al., 2001). An attachment theory based classification rooted in the notion of habitual deactivation or hyperactivation of the attachment system ('attachment style') has achieved general acceptance (Cassidy & Kobak, 1988; Mikulincer & Shaver, 2003). Deactivating ('avoidant' or 'dismissing') strategies include suppression of ideas related to painful attachment experiences, repressing painful memories, minimizing stress and distress, segregated mental systems that result in the defensive exclusion of distressing material from the stream of consciousness (Bowlby, 1980; George & West, 2001). Ingenious experimental studies have shown that individuals who habitually use avoidant defenses are more efficient, when instructed, at suppressing conscious thoughts and associated feelings about a romantic partner leaving them for someone else (Fraley & Shaver, 1997) and are more likely to attribute their own unwanted traits to others (projection) which serves to both increase self-other differentiation and enhance self-worth. (Mikulincer & Horesh, 1999). In a further, remarkable study the same group of researchers demonstrated that the above advantages of the suppression strategy of those using avoidant defense fall away in the laboratory situation if a cognitive load is placed on the participant which then leaves them literally defenseless so that they experience a heightened rebound of previously suppressed thought about painful separation (Mikulincer, Dolev, & Shaver, 2004). The cognitive and sociocognitive strategies associated with reducing anxiety or displeasure and enhancing safety, which both the attachment theory and psychoanalytic literatures tend to refer to as defenses, are perhaps better thought of not as independent classes of mental activity or psychological entities but as a

pervasive dynamic aspect of complex cognition interfacing with attachment relationships and emotional experience. Some mechanisms of defence are thought to be more characteristic of the less severe psychological disorders (e.g. depression, anxiety, obsessive-compulsive disorders etc.). It is beyond the scope of this chapter to consider the various defence mechanisms in detail.

Modes of therapeutic action

The primary mode of the therapeutic action of psychoanalytic psychotherapy is generally considered to be insight (PDM Task Force, 2006). Insight may be defined as the conscious recognition of the role of unconscious factors on current experience and behaviour. Unconscious factors encompass unconscious feelings, experiences and fantasies. The psychodynamic model has been seen as a model of the mind that emphasises repudiated wishes and ideas which have been warded off, defensively excluded from conscious experience. In our view this is a narrow and somewhat misleading way to define the therapeutic mechanism for approaches that are considered as psychodynamic. The psychodynamic approach is better seen as a stance taken to human subjectivity that is comprehensive, and aimed at understanding all aspects of the individual's relationship with her or his environment, external and internal. Freud's great discovery ("where id was, there ego shall be", Freud, 1933 p.80), often misinterpreted, points to the power of the conscious mind radically to alter its position with respect to aspects of its own functions, including the capacity to end its own existence through killing the body. Psychodynamic, in our view, refers to this extraordinary potential for dynamic self-alteration and self-correction – seemingly totally outside the reach of nonhuman species. Engaging with this potential to bring change through understanding, is the science and the art of the psychodynamic clinician.

Conscious insight is more than mere intellectual knowledge (Etchegoyen, 1991; Thomä & Kächele, 1987) or descriptive insights. Prototypically, psychodynamic therapy achieves demonstrated or ostensive insights which represent a more direct form of knowing, implying emotional contact with an event one has experienced previously. Working with what is non-conscious is at the heart of the dynamic approach to bringing about psychological change because of the force that awareness of unconscious expectations can bring to the interpretation of behaviour. Although specific formulations of the effect of insight depend on the theoretical framework in which explanations are couched, there is general agreement that insight has its therapeutic effect by in some way integrating mental structures (Thomä & Kächele, 1987). Kleinian analysts (e.g. Spillius, 2001) tend to see the healing of defensively created splits in the patient's representation of self and others as crucial. Split or part-objects may also be understood as isolated representations of intentional beings whose motivation is insufficiently well understood for these to be seen as coherent beings (Gergely, 2000). In this case insight could be seen as a development of the capacity to understand internal and external objects in mental state terms, thus lending them coherence and consistency (Allen, 2006). The same phenomenon may be described as an increasing willingness on the part of the patient to see the interpersonal world from a third person perspective (Britton, 1998).

A simple demonstration to the patient of such an integrated picture of self or others is not thought to be sufficient (Freud, 1914). The patient needs to <u>work through</u> a newly arrived at integration. Working through is a process of both unlearning and learning: actively discarding prior misconceptions and assimilating learning to work with new constructions. The technique of working through is not well described in the literature, yet it represents the critical advantage of long-term

over short-term therapy (Lipsius, 2001). Working through should be systematic and much of the advantage of long-term treatment may be lost if the therapist does not follow through insights in a relatively consistent and coherent manner.

In contrast to the emphasis on insight and working through are those clinicians who, as we have seen, emphasize the relationship aspect of psychoanalytic therapy (Balint, Winnicott, Loewald, Mitchell and many others). This aspect of psychoanalytic therapy was perhaps most eloquently described by Loewald when he wrote about the process of change as: "set in motion, not simply by the technical skill of the analyst but by the fact that the analyst makes himself available for the development of a new 'object-relationship' between the patient and the analyst…." (Loewald, 1960, p.224-225). Sandler and Dreher (1996) have recently observed "while insight is aimed for it is no longer regarded as an absolutely necessary requirement without which the analysis cannot proceed". There is general agreement that the past polarisation of interpretation and insight on the one hand, and bringing about change by presenting the patient with a new relationship on the other, was unhelpful. It seems that patients require both and both may be required for either to be effective (Chodorow, 2003).

Controversy remains even if all accept that neutrality is an impossible and undesirable fiction and that patient and therapist affect each other in myriad mutually-influencing ways. Projective identification is seen as occurring in a bidirectional interpersonal field between analyst and patient – a model clearly adapted from Kleinian approaches to infant-caregiver interaction (Seligman, 2003). If we take this perspective seriously, we have to concede that all analytic interventions change the situations into which they are introduced, and their content and style always reflect the analyst's countertransference/response to the treatment situation (e.g. Hoffman,

2006). Relational psychoanalysis advocates making the interactional influence of analyst upon patient explicit. As Levenson (1983, p. ix) put it, the key therapeutic question is not "what does this mean?" but rather "what is going on around here?" The therapist will "act" on the patient; this is not a therapeutic disaster but rather a potentially progressive and certainly inevitable part of the process.

It has been suggested that change in analysis will always be individualised according to the characteristics of the patient or the analyst (Pine, 1998). For example, Blatt (Blatt, 2004) suggested that patients who were "introjective" (preoccupied with establishing and maintaining a viable self-concept rather than establishing intimacy) were more responsive to interpretation and insight. By contrast, anaclitic patients (more concerned with issues of relatedness than of self-development) were more likely to benefit from the quality of the therapeutic relationship than from interpretation. Taking a second look at large scale outcome investigations Blatt found strong evidence for the oft made but rarely demonstrated claim of patient personality – therapeutic technique fit (Blatt, Auerbach, Zuroff, & Shahar, 2006).

Indications and contraindications and selection procedures

Medical treatments normally have indications and contraindications. In psychodynamic treatment the term "suitability" indicates a looser notion of the appropriateness of the approach (Varvin, 2003). Nevertheless, based primarily on clinical experience, some writers have arrived at specific criteria for long-term psychodynamic therapy (Coltart, 1988). Some authors have also suggested relatively systematic methods of assessment yielding both diagnostic and prognostic

information (Kernberg, 1981). The majority of psychodynamic clinicians, however, rely on clinical judgements based on interpersonal aspects of their first meeting with the patient (Etchegoyen, 1991). The three areas of assessment are personal history, the content of the interview and the style of the presentation.

A history of one good relationship has been traditionally regarded as a good indicator (Piper, Ogrodniczuk, McCallum, Joyce, & Rosie, 2003). By contrast, a history of psychotic breakdown, severe obsessional states, somatisation and lack of frustration tolerance are generally considered contraindications. For example, a challenging set of re-analyses of the Treatment of Depression Collaborative Research Program found that the trait of perfectionism was associated with poor outcome, and could undermine the therapeutic alliance and the patient's satisfaction with social relations, limiting their improvement in the course of brief treatment for depression (Shahar, Blatt, Zuroff, & Pilkonis, 2003).

Empirical literature, to the meagre extent that this is available, suggests that many of the presuppositions about suitability are unfounded. It was, for example, assumed that patients who manifested more serious mental illness, especially disturbances in reality testing, were unsuitable for psychoanalysis; however, a recent study showed that some patients with serious disturbances in reality testing were able to benefit from psychoanalysis when their analysts were able to tolerate and analyse this level of psychopathology (Leuzinger-Bohleber, 2002). What does seem to be consistent is that severity of symptoms, as well as functional levels in work and relationships, are correlated with the outcome of psychotherapy (Clarkin & Levy, 2004) – although no single patient variable is a strong predictor of outcome. This is why the effects of psychotherapy, good and bad, can sometimes be surprising.

Predicition based on the content of assessment interviews is hard. In general, the presence of some kind of "mutuality" between therapist and patient is a positive indicator. Some clinicians offer "trial interpretations" which summarise their initial impressions, and a positive thoughtful response to these is regarded a good indication. The capacity to respond emotionally within the assessment session is a further indicator (Piper, Joyce, Azim, & Rosie, 1994). Motivation for treatment is harder to ascertain. Most patients express enthusiasm for the treatment, which falls away once they are asked to confront unpleasant or unflattering parts of themselves.

More recently, psychodynamic therapists have given increasing consideration to the style of the patient's discourse during assessment rather than its content. Holmes (2003), for example, attempts to identify whether patients' narrative styles are avoidant (sparse and dismissing of interpersonal issues) or enmeshed and entangled (excessive current anger about past hurts and insults). The findings of one study indicate that, in a severely personality disordered population at least, the avoidant type of patient has a better prognosis in psychodynamic therapy (Fonagy et al., 1996). A further relevant capacity is reflective function or mentalization, often reflected in narrative; this has been variously described as seeing oneself from the outside (Sandler, Dare, & Holder, 1992), reflecting on one's inner world (Coltart, 1988) or having fluidity of thought (Limentani, 1972).

Managing treatment

Starting treatment

Establishing parameters

Most psychodynamic therapists, explicitly or implicitly, convey objectives and expectations to their patients. The details of this agreement normally include arrangements for a time and a place as well as the length and frequency of sessions.

Usually a tentative idea is offered as to the likely duration of therapy: "It is likely to take years rather than months." Most therapists also describe the expected behaviour of the patient and the therapist: "I would like you to be as open and honest with me as possible and say absolutely everything that comes into your mind. This is the fundamental rule." In fact it is very likely, in view of the variety of such agreements that tend to be made, that its emotional context is more relevant than the specific items agreed upon. Such a "contract" implies recognition by both patient and therapist that the process of therapy needs protecting and that it is important enough to require a sacrifice from both parties.

In the treatment of severe personality disorders, contracts may have an additional important function – that of protecting the therapy from incessant enactments, self-harming, parasuicidal gestures and so on. In Kernberg's approach to the treatment of borderline patients, the patient formally undertakes not to seek the therapist's help outside of office hours, not to engage in acts of violence and to deal with self-destructive acts through normal medical channels (Kernberg, Clarkin, & Yeomans, 2002). Whilst such agreements are commonly made in long-term therapy, it is by no means clear that they are either essential or useful. For example, in an alternative form of psychodynamic therapy, Mentalization-Based Treatment (MBT), contracts are not recommended (Bateman & Fonagy, 2004b).

Formulation of patients' problems

An important part of initiating any psychosocial treatment is arriving at least at a preliminary formulation of the patient's problems. In the case of psychodynamic therapies this represents a special challenge because of the diversity of the possible theories to draw on. In principle, psychodynamic formulations would identify key unconscious conflicts, central maladaptive defences, unhelpful unconscious fantasies

and expectations, deficits in personal development and so on. The complexity of such formulations is such that agreements are hard to arrive at even when clinicians follow similar orientations. In the absence of a generally accepted format for formulating the patient's problems, a list of key parameters for the level of maturity of personality organisation may be offered:

(a) the maturity of relationship representations (three or more persons versus just a self-other dimension);

(b) the maturity of psychic defences (primarily based on projective vs internalizing processes);

(c) the extent of whole as opposed to part object relations (e.g. whether a person is represented as performing more than a single function for the patient);

(d) the general mutuality of the relationship patterns described; the quality of attachment to others.

It should be noted that psychodynamic formulations tend to change as treatment progresses. Indeed, Winnicott described psychoanalysis as "an extended form of history taking" (Winnicott, 1965). Within certain psychodynamic approaches formulation is communicated formally to patients (e.g. by letter in cognitive analytic therapy Ryle, 2004).

The middle phase

Supportive and directive interventions in psychodynamic therapy

Supportive techniques are used both explicitly and implicitly in psychodynamic treatment. They include offering explicit support and affirmation; offering reassurances concerning, for example, irrational anxieties about the therapeutic arrangements; expressing concern and sympathy to a patient who has

suffered a recent loss; and general empathy for the patient's anxieties and struggles with the treatment (Gorman, 2002)..

From a psychodynamic point of view, such supportive interventions are by no means straightforward. For example, Feldman (1993) illustrated how patients may sometimes experience the therapist's submission to a demand for reassurance as a source of anxiety rather than comfort. They may be unconsciously aware that the therapist's true stance is not compatible with reassurance and therefore face anxieties about the therapist's weakness in allowing themselves to be manipulated. By contrast, Kohut's (1984) emphasis on interpersonal empathy was probably a welcome antidote to the somewhat rigid interpretive stance of American ego psychologists, particularly for those whose history of psychosocial deprivation meant that they had experienced little by way of genuine warmth or concern in the past.

The most common use of supportive and directive techniques in psychodynamic psychotherapy are in the service of the therapy itself. Elaborative techniques (e.g. the simple question: "Could you tell me more?") are undoubtedly directive in specifying a topic of interest, but at the same time may be crucial antecedents to interpretive work. Clarification stands in between supportive and interpretive interventions. It is a restatement in the therapist's words of the patient's communication. It may also be crucial in offering a verbal (symbolic) label for a confused set of internal experiences which the patient is poorly equipped to coherently represent. Confrontation is also in between a directive and an interpretive approach. At its gentlest, confrontation may involve the therapist simply identifying an inconsistency in the patient's communication and bringing this to the patient's attention. For example: "You seem to express no sadness about this loss, yet in the past you claimed to have cared a great deal for him".

Regression

An important facet of psychoanalysis and long-term psychodynamic therapy is the activation and exploration of parts of the patient's personality which may be normally hidden behind an over-riding demand to adapt to the demands of every day life. Access to these aspects of personality is achieved through the process of regression. It has been suggested that rather than encouraging regression, the process is best conceived of as inhibiting "an anti-regressive function" in much the same way that certain intimate interpersonal experiences, large group situations and alcohol appear to bring out the more infantile aspects of our character (Sandler & Sandler, 1994). Some psychoanalysts consider regression to be crucial to successful psychoanalytic treatment, but others consider the concept and its clinical application outmoded and counterproductive (Inderbitzin & Levy, 2000). The extent to which a particular treatment involves significant regression appears to be a function of the patient's personality as well as the therapist's particular approach. Fear of regression is an important source of resistance to long-term psychotherapy, particularly amongst those with previous experience of psychotic episodes (Sandler & Sandler, 1994).

Resistance

Resistance is inevitably encountered in any long-term psychodynamic treatment. In fact, the presence of resistance is implied by the term dynamic, which suggests psychic forces both pulling against and pushing towards change. Like regression, resistance fluctuates in the middle stage of treatment. In borderline and narcissistic disorders, the patient's intense resistance signals the patient's desperation to protect extremely fragile self-esteem. In less severe cases, what appears to be at issue is preventing a painful integration of experience, such as the integration of love and hate directed towards the same object (Smith, 1997).

In clinical practice resistance takes a variety of forms. In repression resistance, the patient may experience a temporary difficulty in gaining access to particular ideas and feelings; for example, failing to remember dreams. In transference resistance the patient may appear to wish to keep their relationship with their therapist at an extremely superficial level. In a negative therapeutic reaction the increase of symptomatology occurs alongside therapeutic progress. In Freud's formulation this may be attributed to unconscious guilt. It is quite likely that in at least some patients this form of resistance against psychotherapy is part of a pervasive so called 'envious' predisposition to eradicate any aspect of their life that they experience as 'good' but beyond their immediate control (Cairo-Chiarandini, 2001).

The experience of the transference

Patients may experience a whole range of feelings about an analyst including love, admiration, excitement or anger, disappointment and suspicion. The feelings appear to have little to do with the therapist's actual personality as different patients are likely to bring quite disparate feelings about the same analyst at the same time. While clearly not realistic, the actual nature of transference experience and its use in therapy is quite controversial (Smith, 2003a). Object relations theorists consider the analyst a vehicle onto which an internal object (a person, an aspect of a person, the self or an aspect of the self) is projected (Kernberg, 1984). Clearly internal objets are representations which are heavily distorted by both fantasy and defensive processes.

For John Bowlby (1980) transference feelings are based on expectations gathered through past relationship experience with an attachment figure. Patients resist understanding of the past relationship by insisting on repeating it. Bowlby's (1988) suggestion that therapists function as secure bases implies that psychodynamic therapists are, in part, conducting attachment therapy as inevitably they serve as

attachment figures for their patients. There is accumulating evidence for this claim (Diamond, Stovall-McClough, Clarkin, & Levy, 2003; Farber, Lippert, & Nevas, 1995; Mallincrodt, Porter, & Kivlighan, 2005; Parish & Eagle, 2003) with a number of studies linking specific transference schemas and attachment (Bradley, Heim, & Westen, 2005; Eames & Roth, 2000; Waldinger et al., 2003). Many analysts do not accept such an isomorphism between past and present. Rather, they see it as something which gives coherence to the patient's experience of the analytic relationship – an aspect of narrative rather than a representation of the historical realities of the patient's experience (Spence, 1982). In contrast, analysts who work in the Klein-Bion frame of reference see transference as providing an inevitably accurate picture of the patient's current internal world (Joseph, 1985). For example, a transference where the analyst is idealised may reflect psychotic anxieties in the patient linked to an intensification of the death instinct. The idealisation serves to protect both the patient and the analyst from fantasised destruction which threatens to engulf them both. Marcia Cavell (1994) demonstrated that these alternative models of transference have their philosophical roots in the debate between correspondence and coherence models of truth.

There is significant debate regarding from what point and how much psychoanalytic therapists should work 'in the transference'. Some analysts are inclined to see transference as pertinent to every aspect of the psychoanalytic situation. For example, Joseph (1985) considers the therapeutic situation in toto as mirroring the internal state of the patient. Thus the therapeutic alliance or the 'real relationship' (Hausner, 2000) are regarded as subsumed under the transference relationship. In this context it makes little sense to interpret anything other than the transference from the very beginning of the analysis. By contrast, Strachey (1934)

understood transference as an attempted externalisation of the patient's superego. Unlike other people in the patient's life, the analyst does not accept this externalisation, whether it is idealised, denigratory or judgmental. The analyst conveys his or her understanding of the externalisation by a so-called "mutative interpretation". While Strachey implied that only interpretation of the transference is therapeutic, his view clearly admits other aspects of the therapeutic relationship. Other therapists, particularly Freudian psychoanalysts, regard transference interpretations as an important but not uniquely therapeutic way of providing the patient with insight and consider the almost exclusive reliance on understanding the patient through their thoughts and feelings about their therapists as unhelpful and even dangerous (Couch, 2002). The only systematic investigation of this technical controversy, where patients were randomly assigned to a transference and a non-transference oriented psychological therapy, could not show a significant difference between the overall effectiveness of these two treatments, although there was a tendency for those with more dysfunctional object relationship representations to do better in therapy which used transference interpretations (Hoglend et al., 2006; Hoglend, Johansson, Marble, Bogwald, & Amlo, 2007).

The nature of the transference appears to systematically relate to specific clinical groups and hence may have an aetiological significance. For example, specific transference patterns appear to characterise particular groups of narcissistic patients (Kohut, 1984). The 'mirroring' transference is one where patients crave the approbation and admiration of the therapist. This may be a consequence of the failure of the original self-objects (parents) in their mirroring function. If this transference is undermined by premature interpretations, an opportunity for restoring self-esteem is lost. The 'idealising' transference also enables the patient to address a deficiency in

self-esteem by secretly identifying with the object of admiration (the analyst). If the analyst destroys this idealised image, within Kohut's framework, this is equivalent to a direct attack on the patient's self-regard. Other analysts would suspect that behind such an exaggeratedly positive image lies the patient's true image of the analyst as frustrating or inadequate, an image which is simply placed out of harm's way by the idealisation. An interesting empirical study of clinicians' experience of the transference with personality disordered patients was reported from Drew Westen's laboratory (Bradley et al., 2005). The study identified five transference dimensions: angry/entitled, anxious/preoccupied, avoidant/counterdependent, secure/engaged and sexualised which were associated in predictable ways with Axis II pathology and confirmed that the way patients interact with their therapists can provide important data about their personality, attachment patterns and interpersonal functioning.

Commonly, transference includes an erotic component, regardless of the age or even the gender of the analyst (Bollas, 1994). Admitting to such feelings may border on the unacceptable for some patients. Attachment theorists may suggest that sexual fantasies are used in the service of obtaining the attention of an unresponsive attachment figure (Bowlby, 1977). Eroticised transference, relatively common in severely traumatised patients, represents an expression of a need for sexual gratification which, in the context of the therapy, is not considered by the patient as unrealistic (Etchegoyen, 1991). Some view this phenomenon as an indication of an immature mode of representing internal reality, where only the physically observable outcome is believed to be real (Fonagy, Gergely, Jurist, & Target, 2002).

Experience of the countertransference

Countertransference is a somewhat controversial concept in psychoanalytic clinical work. The therapist during the course of an intensive long-term treatment is

likely to have a range of feelings which are related to the patient's current experience but which may serve to either illuminate or obscure this. Some countertransference experiences may be instances of projective identification and thus can be appropriately attributed to the patient (Spillius, 1992), whereas others are likely to be the analyst's neurotic emotional reactions to the patient's behaviour or the material he or she brings. For Freud (1912b), countertransference was always of this latter type, a neurotic reaction which was likely to obstruct psychoanalytic treatment. It was not until Paula Heimann (1950) pointed out that the analyst's feelings and thoughts could contain important clues about the patient's unconscious mental state that countertransference started to be seriously considered as part of the analyst's therapeutic armamentarium. Those following an interpersonalist tradition saw the recognition of the complementarity of the therapeutic relationship as highly appropriate. From this point of view, the assumption of perfect neutrality on the part of the analyst who is a participant as well as an observer is both an anathema and an anachronism (Renik, 1998). The psychotherapeutic process is more accurately viewed as a complex mixture of complementary interpersonal processes which establish themselves in "custom designed" configurations in each treatment (Mitchell, 1997, p.58).

The therapist's feelings may be either complementary to or concordant with those of the patient (Racker, 1968). Concordant countertransferences are the product of primitive, empathic processes within the therapist who "feels" for the patient, who may unconsciously react to experiences implied but not yet verbalised by the patient; for example, inexplicable overwhelming sadness. Complementary countertransferences tend to occur when the patient treats the analyst in a manner consistent with interpersonal interactions within a past relationship. Most commonly

this occurs when the patient treats the therapist as he or she experienced being treated as a child. This is known as the "reverse transference" (King, 1978).

The mechanisms of countertransference are poorly understood. To assert that countertransference functions via projective identification merely brings one poorly understood phenomenon to account for a second even less well understood one. Sandler (1993) suggested that an instantaneous process of automatic mirroring of one's partner in an act of communication accounted for concordant countertransference. The process, which he termed primary identification, was non-conscious and could be brought into awareness only upon reflection. Recent work on the mirror neurone system (Gallese, Keysers, & Rizzolatti, 2004; Rizzolatti & Craighero, 2004) suggests that the fundamental mechanism that allows us to understand the actions and emotions of others involves the activation of the mirror neurone system for actions and the activation of viscero-motor centres for the understanding of affect. An alternative account suggests that a secondary mode of encoding is available within language whereby the use of a language of pretend gestures at the phonemic, syntactic or even semantic level enables the communicator to directly address the unconscious of the recipient of the communication (Fonagy & Target, 2007). In other words, anything that can be said in gestures may be communicated unconsciously through language, through phonemic distortion, intonation and other paralinguistic features and picked up impressionistically by the therapist.

When either concordant or complementary countertransferences mobilise defensive processes within the analyst, countertransference is in danger of becoming disruptive to therapeutic understanding. The analyst may react by unconsciously withdrawing from the therapeutic relationship. For example, in the case of a

concordant countertransference where the patient's feelings of inadequacy create a similar feeling in the analyst, the analyst's vulnerability in this area may lead him or her to become defensively angry or excessively motivated to demonstrate his or her efficacy. There may be no simple way of regulating such reactions and the only reasonable strategy might be to carefully monitor one's style of relating, noting anything that is unusual. A number of analysts have pointed to the importance of reflectiveness in this context.

Some feelings in relation to the patient are not provoked either by the patient's projections or the neurotic feelings these give rise to in the therapist. It required someone of the stature of Donald Winnicott (1949) to make the self-evident observation that the provocative behaviour of certain patients (particularly those in the borderline spectrum) can lead to a normal reaction of "objective hate". These reactions are merely indications of the therapist's humanity. Analytic understanding of these sometimes intense reactions to patients helps, but models of countertransference ill-fit such experiences. The objective study of countertransference has had to wait for a recent ingenious methodological development from Westen's laboratory (Betan, Heim, Zittel Conklin, & Westen, 2005). The Countertransference Questionnaire yielded eight clinically and conceptually coherent factors that were independent of clinicians' theoretical orientation: 1) overwhelmed/disorganized, 2) helpless/inadequate, 3) positive, 4) special/overinvolved, 5) sexualized, 6) disengaged, 7) parental/protective, and 8) criticized/mistreated. Countertransference patterns were systematically related to patients' personality pathology across therapeutic approaches, suggesting that clinicians, regardless of therapeutic orientation, can make diagnostic and therapeutic use of their own responses to the patient.

Interpretation

Interpretive interventions are at the core of psychoanalytic and psychodynamic treatment. However, the importance of interpretation is often exaggerated in relation to other aspects of the therapy. It is a sobering reminder that follow-up studies of long-term psychodynamic therapies invariably demonstrate that patients remember their analyst not for their interpretive interventions, rarely remembering individual interpretations, but rather for their "emotional presence", regardless of the analyst's therapeutic perspective (Leuzinger-Bohleber, Stuhr, Ruger, & Beutel, 2003a).

Interpretations may be classified according to the aspect of a conflict they aim to address: the defence, the anxiety or the underlying wish or feeling. Similarly, the content of the interpretation may be used in classifying interpretations: whether it relates to external reality, the transference relationship or childhood relationships. In principle, in the earliest phases of treatment interpretations relating to current events are most common and, as the treatment progresses, transference issues and the patient's past may increasingly take over as foci of analytic work. Interpretations should start with the patient's anxiety, by identifying the defence used by the patient to protect himself from repudiated wishes and affects. In reality, these are guidelines that are rarely followed in practice. For example, very long-term treatments tend to end up being principally supportive explorations of the patient's current experience (Blum, 1989). Furthermore, interpretations of the distant past tend to be least helpful to individuals with severe personality disorders (Bateman & Fonagy, 2006). Working in the so called 'here and now' is more effective with those patients whose representation of the past is unreliable and distorted (Fonagy, 1999).

Steiner (1993) distinguished analyst-centered from patient-centered interpretations. The former refers to comments on the patient's reactions in terms of what the patient thinks may be going on in the analyst's mind, while the latter directly

addresses the analyst's perception of the patient's non-conscious mental state. In either case the patient is directly learning about how minds interact in the context of social relationships. The distinction is important since when patient-centered interpretations are used exclusively the therapist may appear to be persecutory and not to be cognisant of the patient's genuine difficulties in being in an intimate relationship with another person. Others have argued, that at least in the case of severe personality disorder, interpretations, if they were to have therapeutic value, should focus on the patient's understanding of thoughts and feelings in themselves or in others at the level of what was conscious rather than unconscious, what patients could discover for themselves rather what they received as a communication from a 'mind expert' (Fonagy & Bateman, 2006). This implies that interpretation of the transference is about helping the patient represent their own and their therapist's mental states in the treatment room in all their complexity but with a stance conveying enquiry and playful curiosity about something that is not readily knowable (the mental state of the other is always opaque) with the aim of making thinking about thoughts and feelings safe again rather than communicating powerful insights.

The idealisation of the transference has led some therapists to neglect interpretation of the patient's behaviour outside of the therapy. Most clinicians now agree that a balance needs to be struck between these two approaches. Treatment which is over-focussed on the transference becomes a claustrophobic enclave (O'Shaughnessy, 1992). In certain instances, the direct communication of the therapist's experience of frustration (objective hate in Winnicott's terms) may help to break a rigid repetitive pattern in the therapy (Symington, 1983). Disclosing the therapist's experience is one of the cutting edges of the relational approach to psychodynamic therapy (Ehrenberg, 1993). In cases where the therapeutic alliance

falters, perhaps following an empathic failure on the part of the therapist, it turns out that the recovery of the alliance may have particular therapeutic value both in showing the possibility of repair (Safran, 2003) but also as an opportunity to understand misunderstanding, an ideal opportunity for the recovery of mentalization (Bateman & Fonagy, 2004a).

Ending treatment

The ending of psychoanalytic therapy is often idealised in clinical descriptions. As there is little agreement on the goals of psychoanalytic therapy (Sandler & Dreher, 1996), it is hardly surprising that there is little general agreement about when ending is appropriate. Desirable final outcomes are mostly stated in terms of the process of treatment and are thus mostly specified in theoretical terms (e.g. increased awareness of impulses and fantasies, a reintegration of aspects of the self lost through projective identification, the capacity to engage in self-analysis etc.). All these, even if observable in the course of treatment, are only loosely related to the aims the patient might have in concluding a lengthy treatment process.

The patient's own goals tend to be outcome rather than process goals and are more easily defined: the decline of symptoms, improved relationships, greater wellbeing, increased capacity for work, higher self-esteem, a capacity for assertiveness. As such changes are clearly achievable without psychodynamic treatment, many psychodynamic clinicians erroneously regard such criteria for ending as superficial. Independent evidence will be required to show that the achievement of process aims results in a more permanent or general achievement of outcome aims, in order to validate process aims as an appropriate criterion for ending.

Ending itself, of course, is a process. There is significant disagreement between authors, however, as to its nature; it has been labelled among other things as

a mourning (Klein, 1950), a detachment (Etchegoyen, 1991) and a maturation (Payne, 1950). It is inevitable that there is disappointment and disillusionment at the ending of long-term therapy as what is achieved is never quite the same as what has been hoped for (Pedder, 1988). Also, the patient loses the object who has been available as a receptacle for projections (Steiner, 1993). It is not surprising then, that symptoms sometimes return, even if only briefly, as part of the process of termination and the full benefit is not seen until some months after termination (Sandell et al., 2002). There is general agreement, however, that with these unconscious issues worked through the ending of therapy requires no special form of intervention on the part of the therapist.

Efficacy

It is often said that there are no studies on the effectiveness of psychoanalysis and long-term psychodynamic psychotherapy. In fact, this is not true. There are a number of comprehensive reviews (e.g. Bachrach, Galatzer-Levy, Skolnikoff, & Waldron, 1991; Fonagy, Kachele et al., 2002; Lazar, 1997; Leuzinger-Bohleber & Target, 2002; Richardson, Kachele, & Renlund, 2004) and they tend to come to similar conclusions. There is considerable evidence for the effectiveness of psychoanalytic approaches but definitive randomized controlled trials of its efficacy are still lacking.

The Boston Psychotherapy Study (Stanton et al., 1984) compared long term psychoanalytic therapy (two or more times a week) with supportive therapy for clients with schizophrenia in a randomized controlled design. On the whole clients who received psychoanalytic therapy fared no better than those who received supportive treatment. In a partial-hospital RCT (Bateman & Fonagy, 1999, 2001) the

psychoanalytic arm of the treatment included therapy groups three times a week as well as individual therapy once or twice a week over an 18 month period.

The Stockholm Outcome of Psychotherapy and Psychoanalysis Project (Blomberg, Lazar, & Sandell, 2001; Grant & Sandell, 2004; Sandell et al., 2000) followed 756 persons who received national insurance funded treatment for up to three years in psychoanalysis or psychoanalytic psychotherapy. The groups were matched on many clinical variables. Four or five times weekly analysis had similar outcomes at termination when compared with one to two sessions per week psychotherapy. During the follow-up period, psychotherapy patients did not change but those who had had psychoanalysis continued to improve, almost to a point where their scores were indistinguishable from those obtained from a non-clinical Swedish sample.

The German Psychoanalytic Association undertook a major follow-up study (n = 401) of psychoanalytic treatments undertaken in that country between 1990 and 1993 (Leuzinger-Bohleber, Stuhr, Ruger, & Beutel, 2003b; Leuzinger-Bohleber & Target, 2002). Between 70 and 80 per cent of the patients achieved (average 6.5 years after the end of treatment) good and stable psychic changes according to the evaluations of the patients, their analysts, independent psychoanalytic and non-psychoanalytic experts, and questionnaires commonly applied in psychotherapy research. The evaluation of mental health costs showed a cost reduction through fewer days of sick leave during the seven years following the end of long-term psychoanalytic treatments. In the absence of pre-treatment measures it is impossible to estimate the size of the treatment effect.

The Research Committee of the International Psychoanalytic Association recently prepared a comprehensive review of North American and European outcome

studies of psychoanalytic treatment (Fonagy, Kachele et al., 2002). Four case record studies, 13 naturalistic pre-post or quasi-experimental studies, nine follow-up studies and nine experimental studies were identified. In addition, six process-outcome studies were also reviewed. The committee concluded that existing studies failed to unequivocally demonstrate the efficacy of psychoanalysis relative to either alternative treatment or active placebo. Studies showed a range of methodological and design problems including absence of intent to treat controls, heterogeneous patient groups, lack of random assignments, failure to use independently administered standardized measures of outcome, etc.

Another overview (Gabbard, Gunderson, & Fonagy, 2002) suggested that psychoanalytic treatments may be necessary when other treatments proved to be ineffective. The authors concluded that psychoanalysis appears to be consistently helpful to patients with milder disorders and somewhat helpful to those with more severe disturbances. More controlled studies are necessary to confirm these impressions. A number of studies testing psychoanalysis with 'state of the art' methodology are ongoing and are likely to produce more compelling evidence over the next years. Despite the limitations of the completed studies, evidence across a significant number of pre-post investigations suggests that psychoanalysis appears to be consistently helpful to patients with milder (neurotic) disorders and somewhat less consistently so for other, more severe groups. Across a range of uncontrolled or poorly controlled cohort studies, mostly carried out in Europe, longer intensive treatments tended to have better outcomes than shorter, non-intensive treatments (demonstration of a dose-effect relationship). The impact of psychoanalysis was apparent beyond symptomatology, in measures of work functioning and reductions in health care costs. Studies report results which other psychotherapies have not been

able to achieve; some studies show very long-term benefits from psychoanalytic treatment; the results tend to be highly consistent across studies; some of the populations studied have been larger than most better controlled treatment trials. So whereas it is true to say that little that is definite can be stated about the outcome of psychoanalysis, a number of suggestive conclusions may be drawn and these are listed below.

Across a number of studies and measures psychoanalysis has been shown to benefit the majority of those who are offered this treatment (Fonagy, 2006) and can bring the functioning of a clinical group to the level of the normal population (Leuzinger-Bohleber et al., 2003b). Completed treatments tend to be associated with greater benefits (Bachrach, Weber, & Murray, 1985). On the whole longer treatments have better outcomes (Erle & Goldberg, 1984) and intensive psychoanalytic treatment is generally more effective than psychoanalytic psychotherapy (Sandell et al., 2002), but its superiority sometimes only becomes apparent on long-term follow-up (Sandell et al., 1997). Psychoanalysis can lead to a reduction in health care related use and expenditure (Dührssen, 1962) and this is maintained for a number of years after therapy ends (Breyer, Heinzel, & Klein, 1997) but it does not invariably achieve this (Sandell et al., 2000). Psychoanalytic treatment can lead to a reduction in the use of psychotropic medication amongst in-patients (Bateman & Fonagy, 2003). Long-term psychoanalytic therapy can reduce symptomatology in severe personality disorders such as BPD (Bateman & Fonagy, 1999; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Giesen-Bloo et al., 2006) and these improvements are maintained (Bateman & Fonagy, 2001).

Training

Training in psychoanalytic psychotherapy and psychoanalysis has three components: a personal psychoanalytic psychotherapy, theoretical training and supervised clinical practice. A variety of trainings are available, although in most countries there is only one training organisation that is recognised by the International Psychoanalytic Association. Training is long, chiefly because of the length of supervised treatments. Training standards are carefully monitored by national and international bodies.

Conclusion

Psychoanalysis is hardly a practical treatment alternative for the 21st century. The principles derived from this treatment, however, have powerfully influenced other psychotherapeutic approaches, whether long-term or short-term therapy or psychiatric care more generally, particularly in the United States. At the time of its invention, it was the unique effective psychosocial treatment method for psychiatric disorder which offered a genuine alternative to the sometimes barbaric and generally ineffective treatment methods available. Not surprisingly, its proponents adopted an almost religious zeal in defending its value against alternative approaches. While understandable, such an attitude has no place in the sophisticated evidence base underpinning multi-agency service planning. Psychoanalytic clinicians face a challenge in identifying their niche in the complex mental health care delivery systems of the 21st century.

further information

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