Psychoanalysis and psychotherapy: The Implication of a Unified View for Training

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Since its inception psychoanalysis has spread throughout the world as a scientific discipline and as a mode of treatment. Starting in the Western hemisphere it soon travelled from Vienna to Berlin, to Zurich and Budapest, to London and Moscow (Luria 1924; see Etkind 2000) and Calcutta (Bose 1924; see Vaidyanathan & Kripal 1999). Psychoanalytic training jumped over the atlantic ocean conquering North America by people trained by Freud himself (Shakow & Rapaport 1964). Already in 1911 Freud reviewed a paper by Greve, a Chilean physician, which contains the first reference to psychoanalysis in Latin America, but it was Matte Blanco´s great achievement to institutionalize psychoanalytic training since the forties (see Jiménez 2002, p. 83). The Japanese analyst Doi wrote about „the anatomy of dependence“ (1971) on which he spelled out the specific japanese concept of ‚amae' and was granted the M. Sigourney Award in 2005. After the downfall of the iron curtain the former countries of the Sovjet Union were quick to accept the missionaries of various psychoanalytic backgrounds. The Russian development with its own brand provided a special case when president Jelzin, in 1993, signed an official document for the re-installation of „Russian psychoanalysis“ (Reshetnikov 1996). Presently we witness the implantation of psychoanalysis in China promoted by various psychoanalytic groups that have been teaching in China for a number of years (Gerlach 2005; Varvin 2008).

Given these developments it seems fair to speak of a process of globalization of psychoanalysis and its treatment practices. At a closer view one cannot avoid to note quite a diversity of what is covered by the term psychoanalysis in respect to

treatment practice. Does it make sense to insist on a sharp distinction between psychoanalysis proper and psychoanalytic informed treatments and what would be the impact for training giving up the strict distinction?

Differences and similarities between psychoanalysis and potential offsprings have been discussed since Freud's times. On the one hand Freud spoke of „analyses which lead to a favourable conclusion in a short time" enhance the therapist's self-esteem. These shorter treatments – loosely called psychoanalytically informed or psychodynamic - have substantiated the medical impact of psychoanalysis, as they dominate the psychoanalytic therapies of today. To denounce them as „insignificant as regards the advancement of scientific knowledge" does not do justice to the importance of a scientific foundation of psychoanalytic treatment principles (Galatzer-Levi 2001; Kächele 2001). A variety of empirical studies on these treatments have contributed to a theory of therapy (Fonagy & Kächele 2009); they can further our understanding of the relationship between certain kinds of operations and interventions and the occurence or failure of certain kinds of specific change" (Eagle 1984, p.163). In contrast to such a medical, treatment oriented model Freud wanted true analysis to succeed „in descending into the deepest and most primitive strata of mental development and in gaining from there solutions for the problems of the later formations". (Freud 1918b, p. 10)

The same dichotomy – therapeutics versus truth - is still maintained years later: "I have told you that psycho-analysis began as a method of treatment; but I did not want to commend it to your interest as a method of treatment but on account of the truths it contains, on account of the information it gives us about what concerns human beings most of all — their own nature — and on account of the connections it discloses between the most different of their activities." (Freud 1933a, p. 156)

From early on Freud´s concern, that "the therapy will...destroy the science" (1927a, p. 254), led him to the (now rejected) assumption that strict, objective rules of investigation produce the best scientific conditions for the reconstruction of the

patient's earliest memories, and that uncovering the amnesia created the optimal conditions for therapy (1919e, p. 183). In another context Freud insisted on the creation of the most favorable circumstances for change in each individual analytic situation, i.e., he recognized the need for patient-oriented flexibility (1910d, p. 145).

The creation of a therapeutic situation is a prerequisite for gaining insight into unconscious psychic processes. Freud underestimated the scientific challenges for demonstrating therapeutic change and clarifying the curative factors. At one point he wrote: "A psycho-analysis is not an impartial scientific investigation, but a therapeutic measure. Its essence is not to prove anything, but merely to alter something" (1909b, p. 104). Opposing these two aspects – psychoanalysis cares for truth and psychotherapy for therapeutics - is questionable. Too many questions regarding the development of a disorder (etiology) cannot be clarified by analyzing patients in whatever frequency or setting. This does not reject the notion that clarification of biographical connections may be therapeutic; in the process of reviewing past experiences and exploring the patient´s unconscious, mental models of intersubjective experience are modified (Fonagy 1999, p. 1011).

The main concern of modern research into therapy is to show whether therapeutic changes occur in the course of psychoanalytic treatments and to clarify the relationship between these changes and the theories adhered to by the analyst (Sandler 1983).

The dissolution of the junktim position leads to the core question of this position statement; the discussions revolve around theoretical, practical, and political issues: Are the differences in indications, technique and processes mainly a matter of ‚degree' or ‚quality', the latter being a stricter distinction? This constitutes an important empirical issue; can they be empircially distinguished? The process of attempting to delineate (proper) psychoanalysis from (psychoanalytic) psychotherapy has taken up considerable amounts of energy and ink (Kächele 1994). Many discussions point to two options: One option votes for a categorical approach that holds psychoanalysis as different from psychoanalytic psychotherapy as Kernberg

(1999) carefully spells out; the other option prefers a dimensional approach that identifies empirical dimensions of clinical work (Wallerstein 1995). In this view, any practice fulfiling such criteria as discussed below may qualify as psychoanalytic to the degree to which the core concepts of the psychoanalytic theory of technique are realized.

Ever since Glover investigated the technique of psychoanalysts by distributing a simple questionaire among the members of the British Society (Glover & Brierley 1940), all empirical approaches lead to little systematic evidence for a strict distinction between psychoanalysis and analytic psychotherapy. In the mid-fifties of the last century Gill (1954) had suggested a definition of psychoanalysis distinguishing intrinsic and extrinsic criteria, which he revised in 1984. As “intrinsic criteria” he had postulated: the analysis of transference, a neutral analyst, the induction of a regressive transference neurosis and the resolution of this artifical neurosis by interpretation; as „extrinsic criteria“ he mentioned ”frequency of sessions, the use of the couch, a relatively well integrated (analysable) patient/…/, and a fully trained psychoanalyst”. However in my view these distinctions do not hold up under empirical scrutiny. The analysis of transference f.e. has been a major object of studies on psychoanalytic psychotherapies of all kind (Connolly et al. 1996, 1999; Luborsky & Crits-Christoph 1998; Hoeglund 2004). Furthermore the concept itself of transference neurosis has been questioned (Cooper 1987) and the issue of a resolution of the transference neurosis has been questioned by careful follow-up studies (Schlessinger & Robbins 1983). The concept of neutrality is debated intensely (Schachter & Kächele 2007). Likewise Gill´s extrinsic criteria have melted in the fire of debates among various groups. Frequency of sessions too often are dictated by economic or cultural factors; the use of the couch as an indispensible criterion also is put into question (Schachter & Kächele 2009).

For example the most ambitious project making a relevant comparison - the Psychotherapy Research Project (PRP) of the Menninger Foundation – led Wallerstein (1989) to a conclusion in favour of blurring the boundaries:

> "The therapeutic modalities of psychoanalysis, expressive psychotherapy, and supportive psychotherapy hardly exist in ideal or pure form in the real world of actual practice. /…/ (treatments) are intermingled blends of expressive-interpretative and supportive-stabilising elements…. and /…/ the overall outcomes achieved by more analytic and more supportive treatments converge more than our usual expectations for those differing modalities would portend; and the kinds of changes achieved in treatment from the two end of this spectrum are less different in nature and in permanence than is usually expected." (Wallerstein 1989, p. 205).

Thus, contrary to what was expected, there were no overwhelming differences in outcomes after supportive-expressive, analytic psychotherapy and psychoanalysis; the mean effects of either treatment were quite modest; supportive techniques were as powerful as more interpretative ones; and psychoanalysts used supportive techniques to a larger extent than what was usually assumed. Even if one would criticize these findings as ecological unvalid – as the kind of patients do not correspond to the usual case load of analysts in private practice – the results came as a surprise and led to secondary evaluations searching for moderating factors (Blatt 1992). Besides personality dispositions benevolent interpersonal schemas also faciltated therapeutic change in these patients (Sharar & Blatt 2005).

The point that quantitative, not categorical distinctions may be useful for differentiation has also been demonstrated by Ablon & Jones (2005) in their operational description of the "prototype of analytic process". Analytic process does take place in analytic psychotherapy, although significantly more in psychoanalytic treatment. Therefore Grant and Sandell (2004) believe „that the findings of the Menninger study have been vitalising to the discussion on the psychotherapy versus psychoanalysis issue by putting some empirical facts in focus. There is a need for more such empirical data" (p. 83).

Furthermore, putting aside the overlap between treatment categories, variation on analysts´ and therapists´ personality and style is huge and its impact on outcome is truely remarkable (Sandell 2007; Sandell et al. 2007).

Since there is no consensually agreed definition of psychoanalysis that has been

generally accepted, we end up defining psychoanalytic therapies by what psychoanalysts do in practice (Sandler 1982, p. 44). But who is entitled to call herself or himself a psychoanalyst? Has the International Psychoanalytic Association the privilege or power to solely define who should be called a psychoanalyst? Are the Non-IPA psychoanalysts in various countries f.e Italy, Germany, Great Britain a different species altogether? Are the Russian, or the Chinese, Associations for Psychoanalysis with its newly recruited members not (yet) really psychoanalytic?

Thomä & Kächele (1987) conceive „Psychoanalytic Practice“ as a task using the agreed upon technical recommendations in a variety of settings. Each of the recommendations leave ample space for patient-oriented modifications. This leads to the position that psychoanalytic practice covers a range of instantiations with no clear default value. Each of the instantiations may be more or less close to the prototype of analytic work as Ablon and Jones (2005) would put it; alas their prototype construction is based on a selection of analysts working in the frame of North American ego psychology. What about a Kohutian prototype, or a Kleinian, or even a Lacanian? To what extent would the representatives of the various schools share a minimum of basic notions of psychoanalytic therapy? The core concepts of clinical psychoanalysis – e.g. therapeutic relationship, transference, countertransference, resistance, insight, defense mechanisms – and the rules of the game – like inviting the patient to free association, inviting dream materials and focusing on the here-and-now interaction supplemented by an attentive attitude, reasonable neutrality of the analyst etc. – render it feasible that the argument can be reversed. Every therapist using these core concepts -- to whatever degree of perfection or intensity -- should be called a psychoanalytic therapist. But to be fair, the psychoanalytic therapists working in the intense mode have shaped the theoretical edifice, written the books and papers that most of us have studied carefully.

It is interesting to note that seen from outside the diverse groups of our profession

are lumped together as all constituting psychodynamic-psychoanalytic practice. A conceptual tool formulated by Ford & Urban (1963), „systems of psychotherapy“, could be utilized to identify the major systems as psychoanalytic, cognitive-behavioral, systemic etc. This conceptual distinction has guided the famous meta-analysis by Grawe et al. (1994) on the outcome of treatments. Short, middle range and longer psychoanalytic therapies belong for the open-minded spectator to the same system of psychotherapy. Is there a need to maintain differences among the various psychoanalytic worlds? As far as we can tell, these differences do not play a major role in patients´views and as far we can tell from research evidence on shorter treatments, the role of the specific technique, excluding the analyst´s personality and style, is not likely to play a substantial role for outcome (Wampold 2001).

Already the traditional analytic goal of searching for objective truth has been modified into a search for narrative truth (Spence 1982); the contemporary therapeutic goals are manifold as Gabbard and Westen (2003) pointed out: changing unconscious associational networks and altering conscious patterns of thought, feeling, motivation and affect regulation. Also the techniques to achieve these goals are not uni-dimensional: forstering insight, using the relationship as a vehicle of therapeutic action, and the use of other secondary strategies. Their description could be well endorsed by most therapists practising psychoanalytic therapy; the vital issue in this debate should be the assessment of therapeutic outcome for approaches characterized as different.

Occasionally ‚clinical pastoral work' and the ‚comprehension of the human mind' may be bedfellows (Freud 1927a, p. 256); there are treatments where this coincidence is fulfilled, and there are others where this does not seem to be the case. To postulate it as a constitutional claim for each and every psychoanalytic treatment seems an unlikely option given the contemporary demands of what constitutes research today. Research today requires that psychoanalytic narratives as epistemiological tools – as useful as they still may be for intragroup communication - have to be transformed into empirical single case research studies (Kächele et al.

2009) and large scale group studies (Fonagy et al. 2002). The German Follow-up study on a substantial sample on high and low frequency psychoanalytic therapies has supported the notion that intensity of treatment per se does not account for the quite satisfying lasting outcome (Leuzinger-Bohleber et al. 2003).

For any critical observer the present situation is marked by "the failure of practice to inform theory" (Fonagy 2006) which logically leads to the most recent call of "studying practice in its own right" (Jiménez 2009). But which practice are we talking of? The multiplicity of versions of psychoanalytic practice across continents, countries and even cities makes it abundantly clear that such a move to practice requires an open-minded psychoanalytic world allowing for theoretical and technical diversity. There is no longer one bible at hand and there are many prophets promoting one or the other version of psychoanalysis whether or not these claims are supported by evidence – and too often they are not. The history of psychoanalysis is rich on claims and poor on data.

Mapping out the global field of psychoanalytic practice by agreeing to basic assumptions seems to be timely. Instead of separating entities that hardly exist in real practice, we might better talk about conceptual families or at least close neighbors (Wallerstein 1995; Grant & Sandell 2004).

There is a traditional view that long psychoanalytic therapies are deep and short treatments are shallow. This view might not be correct. There are psychoanalytic treatments lasting much too long without substantial benefit for the patient. It may be that analyses which remain on familiar territory proceed more rapidly than those which break new ground. The analyst's mastery of his craft, the meaningful communication of his knowledge, ability, and experience — can even lead to an acceleration of therapy. Analytic treatments which lead to a favorable outcome in a short time, tend to be dismissed as clinically questionable and hardly contribute to the analyst's professional prestige. On the contrary, it seems, as if the longer an analysis, the more it is valued, although it is quite another matter whether the knowledge gained from it meets therapeutic and theoretical criteria.

Most analysts would no longer endorse the statement that it suffices to make the repressed material conscious and to uncover the resistances. There is ‚something

more' in the therapeutic task in all psychoanalytic therapies (Stern et al. 1998). It was Freud, who already, as early as 1919, asked: "Are we to leave it to the patient to deal alone with the resistances we have pointed out to him? Can we give him no other help in this besides the stimulus he gets from transference?" Freud (1919a, p. 162)

Schachter & Kächele (2007) share their impression that many analysts implicitly build their work on caring, support and consolation, while few are comfortable doing so explicitly, verbally, or exposing these interventions in public reports. Caring may be communicated implicitly by the analyst's expression or tone of voice, of which the analyst may or may not be conscious. And Akhtar (2004) describes Helmut Thomä's analytic work as "unabashedly therapeutic, flexible yet firm, supportive yet interpretive and deliberate yet spontaneous" all within a classical theoretical frame.

Therefore psychoanalytic work as a therapeutic enterprise should be covered by the term "psychoanalytic therapy" including a host of variations in setting and intensity; the boundaries of this inclusive term are loose stretching across numerous variations of psychoanalytic practice. The decisive criteria reside in the patient´s welfare by the convincing empirical demonstration that this treatment works (Fonagy et al. 2002). To overcome the dichotomy of the clinical application of psychoanalysis and its derivate forms of psychoanalytic psychotherapy by applying such a generic term would re-center the efforts of the psychoanalytic community.
What are the implications of this position for the goals of psychoanalytic training? To my mind we should encourage our candidates to treat a diversity of patients in a diversity of settings, learning and studying the various specialized psychoanalytically informed techniques that have been developed for specific patients´ needs (f.e. Clarkin et al. 1999; Bateman & Fonagy 2004; Milrod et al. 1997) and further their capacity to understand what is going on in the frame of the basic notions of a psychoanalytic theory of treatment. I would firmly reject the notion of basic, principal differences between analytic psychotherapy and psychoanalysis as not leading us where the battle really takes place. Training has to take into account disorder-oriented strategies and also moderating dimensions relevant for treatment (Luyten et al. 2006). If psychoanalysis still wants to maintain the claim to be *primus inter pares*,

this claim has to be supported by demonstration of our versality to match patients´ need and preferences by applying a psychoanalytic therapy that is as “unabashedly therapeutic, flexible yet firm, supportive yet interpretive and deliberate yet spontaneous”.

From the diverse, heterogenic kaleidoscope of psychoanalytic theories and practices, one conclusion emerges with reasonable certainty. All psychoanalytic therapists are urged to approach their work with a deep sense of humility. Weakly-based convictions about a particular analytic view may impede the monumental empirical assessment that lies before us.

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