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Psychoanalytic Controversies psychotherapy: Discussion

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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 Budapest, to London and Moscow (Luria, 1924; see Etkind, 2000) and Calcutta (Bose, 1924; see Vaidyanathan and Kripal, 1999). Psychoanalytic training crossed the Atlantic ocean conquering North America by people trained by Freud himself (Shakow and 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 1940s (see Jiménez, 2002, p. 83). The Japanese analyst Doi (1971) wrote about 'the anatomy of dependence' on which he spelled out the specific Japanese concept of 'amae', and for this was granted the M. Sigourney Award in 2005. After the downfall of the Iron Curtain the former countries of the Soviet Union were quick to accept the missionaries of various psychoanalytic backgrounds. The Russian development provided a special case when president Jelzin, in 1993, signed an official document for the re-installation of 'Russian psychoanalysis' (Reshetnikov, 1996). At present we are witnessing the implantation of psychoanalysis in China promoted by various psychoanalytic groups that have been teaching there 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 noting 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 psychoanalytically informed treatments, and what would be the impact for training by giving up the strict distinction?

Differences and similarities between psychoanalysis and potential offspring have been discussed since the time of Freud. On the one hand, Freud spoke of ''analyses which lead to a favourable conclusion in a short time'' enhancing the therapist's self-esteem (Freud, 1918, p. 10). These shorter treatments – later to be 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'' (as Freud referred to analyses that quickly ended favourably) does not do justice to the importance

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of a scientific foundation of psychoanalytic treatment principles (Galatzer-Levi *et al.*, 2001; Kächele, 2001). A variety of empirical studies on such treatments have contributed to a theory of therapy (Fonagy and Kächele, 2009); they can further our understanding of the relationship between certain kinds of operations and interventions and the occurrence 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, 1918, 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, 1933, p. 156)

From early on, Freud's concern that ''the therapy will ... destroy the science'' (Freud, 1927, 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 (Freud, 1919, p. 183). However Freud had also insisted on the creation of the most favourable circumstances for change in each individual analytic situation, i.e. he recognized the need for patient-oriented flexibility (Freud, 1910, p. 145). We may infer that he held on to both sides of the dichotomy.

Opposing these two aspects – psychoanalysis cares for truth and psychotherapy for therapeutics – is questionable. Too many questions regarding the development of a disorder (aetiology) cannot be clarified by analysing patients at whatever frequency or in whatever setting. Research outside the treatment setting is needed.

This does not refute 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 treatment research 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 Freud's well-known *Junktim* position[1] leads to the core question of this position statement. The discussions revolve around theoretical, practical and political issues: are the differences between psychoanalysis

[1]''In psychoanalysis there has existed from the very first an *inseparable bond between cure and research.* Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results. Our analytic procedure is the only one in which this precious conjunction is assured. It is only by carrying on our analytic *pastoral work* that we can deepen our dawning *comprehension* of the human mind. This prospect of scientific gain has been the proudest and happiest feature of analytic work'' (Freud, 1927, p. 256, emphasis added).

and psychotherapy in indications, technique and processes mainly a matter of 'degree' or 'quality', the latter entailing a stricter distinction? This constitutes an important empirical issue: can they be empirically distinguished? The process of attempting to delineate (proper) psychoanalysis from (psychoanalytic) psychotherapy has taken up a considerable amount 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 latter view, any clinical work fulfilling 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 techniques used by psychoanalysts by distributing a simple questionaire among the members of the British Society (Glover and Brierley, 1940), all empirical approaches have led to little systematic evidence for a strict distinction between psychoanalysis and analytic psychotherapy. In the mid-1950s Gill (1954) had suggested a definition of psychoanalysis distinguishing intrinsic and extrinsic criteria, which he revised in 1984 (Gill, 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'' (Gill, 1954). However in my view these distinctions 8
do not hold up under empirical scrutiny. The analysis of transference, for example, has been a major object of studies on all kinds of psychoanalytic psychotherapies (Connolly *et al*., 1996, 1999; Luborsky and Crits-Christoph, 1998; Hoeglund, 2004). Furthermore, the concept of transference neurosis has been questioned (Cooper, 1987) as well as the issue of a resolution of the transference neurosis by careful follow-up studies (Schlessinger and Robbins, 1983). The concept of neutrality is a subject of intense debate (Schachter and 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 has been put into question (Schachter and 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–stabilizing 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 usually assumed. Even if one criticized these findings as ecologically invalid – as the kind of patients who 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 facilitated therapeutic 9
change in these patients (Shahar and Blatt, 2005).

The point that quantitative, not categorical distinctions may be useful for differentiation has been demonstrated by Ablon and 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 vitalizing 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, variations in analysts' and therapists' personality and style are huge, and their impact on outcome is truly 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 solely to define who should be called a psychoanalyst? Are non-IPA psychoanalysts in various countries, for example, Italy, Germany and UK, a different species altogether? Are the Russian or the Chinese Associations for Psychoanalysis with their newly recruited members not (yet) really psychoanalytic?

In line with the position outlined in the textbook I wrote with Thomä, I conceive of 'Psychoanalytic Practice' as a task using agreed technical recommendations in a variety of settings (Thomä and Kächele, 1987). Each of the recommendations leaves 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 instantiation may be more or less close to the prototype of analytic work as Ablon and Jones (2005) put it. As their prototype construction is based on a selection of analysts working in the frame of North American ego psychology, one wonders what about a Kohutian, a Kleinian, or even a Lacanian prototype? 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 – for example, therapeutic relationship, transference, countertransference, resistance, insight, defence mechanisms – and the rules of the game – such as 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 – render it feasible that one could argue that 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 an intense mode have shaped the theoretical edifice and 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 altogether as constituting psychodynamic–psychoanalytic practice. A conceptual tool formulated by Ford and Urban (1963), 'systems of psychotherapy', was 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 in 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, fostering insight, but rather make use of the relationship as a vehicle of therapeutic action and of other secondary strategies. Their description could be well endorsed by most therapists practising psychoanalytic therapy. Accepting the multiplicity of theoretical stances the vital issue in this debate should be the assessment of therapeutic outcome.

Research today requires that psychoanalytic narratives as epistemological 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 of high and low frequency psychoanalytic therapies has supported the notion that intensity of treatment *per se* does not account for satisfying lasting outcome (Leuzinger-Bohleber *et al.*, 2003). 10

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 of which practice are we talking? The multiplicity of versions of psychoanalytic practice across continents, countries and even cities makes it abundantly clear that such a move to practise 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 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 of psychoanalytic therapies or at least close neighbours (Grant and Sandell, 2004; Wallerstein, 1995).

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 favourable 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 repressed material conscious and to uncover 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 the transference?'' (Freud, 1919, p. 162).

My impression is 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 (Schachter and Käche-
le, 2007). 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 **11**
''unabashedly therapeutic, flexible yet firm, supportive yet interpretive and deliberate yet spontaneous'' all within a classical theoretical frame.

I maintain that 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 loosely stretch over 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). Overcoming the dichotomy of the clinical application of psychoanalysis and its derivate forms of psychoanalytic psychotherapy by applying such a generic term would re-centre 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 (e.g. Bateman and Fonagy, 2004; Clarkin *et al*.,

1999; 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 must be supported by a demonstration of our versatility to match patients' need and preferences by applying a psychoanalytic therapy that is ''unabashedly therapeutic, flexible yet firm, supportive yet interpretive and deliberate yet spontaneous.

From the diverse, heterogenous 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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