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Editorial: towards a secure theoretical and evidential base for psychoanalytic psychotherapy

Abstract
This special issue is a celebration and a stock-taking of contemporary psychoanalytic psychotherapy. Despite the hegemonic position of psychoanalysis, and the current political ascendancy of CBT, versions of psychoanalytic psychotherapy are among the most commonly practiced form of psychotherapy in the Western world (ROTH & FONAGY 2006). But what are the defining features of psychoanalytic psychotherapy? Is it no more than an attenuated form of psychoanalysis, or does it have its own distinctive profile, theoretically and technically? What are the growth points, stumbling blocks and research questions that preoccupy its leading practitioners? These are some of the questions that will be addressed here and in the contributions that follow.

O’NEILL (this issue) usefully takes up DONNET’S (2001) notion of the psychoanalytic ‘site’. A ‘site’ is a geographical metaphor referring to the constellation of procedures, together with their theoretical underpinning, which constitutes the essence, location, or ‘place’ of a particular cultural phenomenon. With varying degrees of success, psychoanalysts, under pressure to maintain their identity, try to differentiate psychoanalytic ‘site’ from that of psychoanalytic psychotherapy (e.g. KERNBERG 1999). If membership of the International Association for Psychoanalysis (IAPA) is the defining feature, as it is in the UK but not elsewhere in the world, then many respectable psychoanalysts are self-misnomers. If frequency of sessions is the crux, then what of analyses that take place five times a week but are predominantly supportive, or, conversely, once-weekly psychotherapies that involve the couch, focus on dreams and free association and transference interpretation? If ‘regression’ – in the sense of evocation of infantile feelings and dependencies – is the chosen differentiating feature then how do we identify regression, and can we be sure it is not equally to be found in psychoanalytic psychotherapy?

Given the plurality of theories and practices which currently comprise psychoanalysis the search for a ‘common ground’ (yet another geographical metaphor, WALLERSTEIN 1990) has also proved elusive. TUCKETT ET AL. (2008) show how challenging it is for individual psychoanalysts
from divergent traditions and nationalities to respect as ‘psychoanalysis’ methods of working that differ from their own, and, when faced with uncertainty, how charisma and arbitrary authority tend to replace exploration and open debate.

**TUCKETT ET AL.** have devised a methodology which attempts to understand and theorise what psychoanalysts actually do – as opposed to what they say, or think they do. They classify psychoanalytic interventions as

a) ‘housekeeping’/maintaining the basic setting (e.g. ‘reminding you that I shall be away next week’)

b) brief ‘unsaturated’/’polysemic’ (i.e. ambiguous) reflective comments that further the analytic process

c) questions and clarifications

d) various forms of interpretive comments either on the here-and-now situation with the analyst or through forging links between present and past

e) spontaneous, ‘mistakes’ (possibly induced enactments) on the part of the analyst, e.g. inappropriately reassuring comments, whose later exploration may bear analytic fruit.

Classifying and scrutinising interventions in this way helps tease out the implicit models used by practitioners, especially their definition of ‘the analytic situation’ and view of how analysis ‘works’.

A possible drawback of the Tuckett et al. schema, while it has strong internal validity, is that it does not readily map onto wider models of psychotherapeutic change. Drawing on three decades of psychotherapy outcome research, **CASTONGUAY & BEUTLER** (2006) define three broad components of all effective psychotherapies: the therapeutic relationship; meaning making; and change-promotion. Combining psychoanalytic and attachment perspectives, below and elsewhere **HOLMES** (2008), attempts to delineate a coherent developmental model of the psychoanalytic psychotherapy ‘site’, one to which the TUCKETT ET AL.’S (2008) features can readily be accommodated.

**Therapeutic relationship**

The therapeutic relationship is helpfully conceptualised in terms of Attachment – i.e. an intense engagement in which a distressed, threatened individual seeks help and security from an actual or symbolically ‘older’ and wiser figure. The client simultaneously seeks intimacy while bringing characteristic defences against such closeness, based on previous often adverse developmental experience. Forming an attachment relationship constitutes, in Tuckett et al.’s terms, ‘the analytic situation’. This engagement necessarily involves a ‘regressive’ element: the interpersonal patterns which typify both parent-child interaction and spousal interplay (**OBEGI & BERANT** 2008) reproduce themselves in the therapeutic relationship (**MCCluskey** 2005).
How do we characterise a ‘good’ therapeutic relationship? Extrapolating from care-giver-child research we can identify the following features:

a) contingency and marking,
b) rupture repair, and
c) free association.

Contingency and ‘marking’ (C&M) refers to a process identified by Gergely & Watson (1996) in which the care-giver (parent or therapist) follows the care-recipient’s initiative and then responds with a mirroring but exaggerated response, leading to enlivenment and mutual exploration. Tuckett et al.’s ‘unsaturated’ (i.e. open) comments have the quality of marking (often denoted in transcripts by exclamation marks). C&M is the prototype for the process whereby an individual in the course of development ‘finds’ her/himself and his feelings ‘in’ the reflective Other – thereby strengthening identity and sense of self (Fonagy et al. 2002). C&M form the basis of reflective ‘Rogerian’ psychotherapeutic interviewing.

A feature of secure relationships, whether parent-infant or spousal, is the presence of open communication (e.g. ‘I can say anything to my mum/husband and know she/he will listen without judging me’). Freud’s ‘fundamental rule’ (i.e. an invitation to the patient to say anything that comes into her/his mind however irrelevant or embarrassing it might seem) was an attempt to establish a similar culture within the consulting room. Much of the work of psychoanalytic psychotherapy revolves around identifying and removing barriers to such free communication. ‘Free association’ typically requires a contingent interactive culture in which the therapist awaits and follows the client’s lead free communication is unleashed once an atmosphere of security is established, often following the identification of, and challenge to, the client’s manifest defences against intimacy.

Bollas (this issue; see also Zeal this issue) bemoans the attrition of free association in current psychoanalytic practice, which he sees as having been driven out by an excessive preoccupation with transference interpretation. While excessive emphasis on ‘you mean me’ interpretations (Budd 2008) may bedevil some analyses, there is no intrinsic opposition between transference interpretation and free association. Indeed Freud viewed transference interpretations as necessary only when the flow of free associations was interrupted. To the extent that transference interpretations are means of identifying ways in which the patient feels insecure in the presence of the analyst, interpreting them may have the effect of facilitating exploration, once greater security/intimacy is established. This leads to another concept that bridges psychoanalytic and other approaches such as CBT: rupture and repair.

The capacity for rupture-and-repair (Safran & Muran 2000) is crucial to infant-parent, spousal and therapist-client relationships, arising out of the inevitable mis-attunements which arise when two human beings are trying to understand one another. When things go well these are
are attended to, and emotional connectedness re-established. As Tronic puts it: “The miscoordinated state is … a normal interactive communicative error” (TRONICK & WEINBERG, 1997, p. 63) “successful reparations … are associated with positive affective states” “In normal dyads, interactive errors are quickly repaired …. Normal interaction is a process of reparation” (p. 64)

Tuckett et al.’s category (e) (which they define as ‘sudden and glaring reactions not easy to relate to the analyst’s normal method’) can be seen as ruptures, comparable to the normal and expectable ruptures in parent infant connectedness, which in well-functioning parent-infant couples are ‘repaired’ as the parent responds to the child’s signals of distress. Identifying ruptures and repairing them is closely associated with a care-giver’s capacity for mentalisation (see below and ALLEN, this issue), i.e. the ability to put oneself in another’s shoes and to imagine the impact of one’s actions on them.

In summary, the therapeutic relationship is both the context for, and focus of much psychoanalytic work: its coherence and ‘line’ provides the possibility of emergent meaning, and is the central theme of that search for meaning. This self-reflexiveness is another defining feature of psychoanalytic work.

Meaning

Working with meaning is intrinsic to all therapeutic endeavour. A symptom or troublesome experience is ‘reframed’ (to use a metaphor from systemic therapy) into a new explanatory system or model, which helps ‘make sense’ of the sufferer’s mental (or physical) pain. The use of the word ‘sense’ here acknowledges that meaning transcends mere cognition and ultimately is derived from bodily experiences. Thus we speak of an explanation that is ‘satisfying’, resolving ‘tension’, ‘grasping a point’ etc (see FONAGY AND TARGET 2007). Psychoanalysis is centrally concerned with meaning, but in ways that are unique to the psychoanalytic ‘site’.

Unconscious meanings. First, the aim is the elucidation of unconscious meanings, i.e. thoughts and desires that are not just overlooked (i.e. preconscious), but are actively avoided, because of the associated pain becoming aware of them might entail. From that flows the need for defence-analysis, since it is only once sufferers become aware of the lengths they go to avoid feelings, that those feelings can begin to be felt.

It should be noted that the phrase ‘unconscious meanings’ is a highly contested concept within contemporary psychoanalysis. Full discussion of this is beyond the scope and competence of this editorial, but, in brief, at least four distinct meanings are associated with the idea of the unconscious. The Lacanian perspective (see ZEAL this issue) is probably closest to Freud’s original concept. This postulates an ur-trauma in which the infant encounters his/her power-
lessness in relation to the nurturing body of the mother. Awareness of that helplessness, together with dimly perceived but traumatic intrusion of her sexuality, results in primary repression and thus the creation of ‘the unconscious’, a psychic zone manifesting itself in dreams, psychosis and creative activity. The neo-Kleinian approach similarly assumes universal trauma, but here it is more the infant’s feelings of helpless rage and envy of the indispensable but autonomous and uncontrollable breast, rather than its sexual properties, that require repression.

For Jungians, and Winnicottian variants of Object Relations, primary processes are the well-spring of creativity and power: working in tandem with the secondary processes is the key to healthy/creative living. False Self living, which encompasses compliance, avoidance and un-assuagable hyperactivation of attachment needs, mean sacrificing that unconscious power for the sake of security.

Fourthly and more radically, relational and attachment-influenced approaches suggest that repression is not necessarily ubiquitous, but brought into play as an adverse developmental pathway when faced with environmental trauma or neglect. The ‘Freudian unconscious’ here is a relatively minor aspect of pervasive unconsciousness of mental processes, whether due to repression, or lack of mentalisation skills. In this secular version of psychoanalysis what is at stake is not so much unconsciousness, but consciousness itself. Current interest in mindfulness (Mace, this issue) and mentalisation (Allen, this issue) as therapeutic tools reflect this changed perspective. Here Freud’s dictum that the aim of psychoanalysis is to ‘make the unconscious conscious’ is reversed into the logically identical, but therapeutically subtly different, objective of ‘making consciousness aware of that which is unconscious’

Relational meaning. The meanings or patterns that form the basis of psychoanalytic work are essentially interpersonal or relational, i.e. they are concerned with what one person feels vis-à-vis another – envy, desire, hatred, inadequacy, fear etc. Even if the symptom to be elucidated is apparently intrapsychic, e.g. depression, that will be translated psychoanalytically into a relational context. Thus depression ‘becomes’ hostility towards another turned inwards, or despair following a sense of abandonment by a care-giver. From this follows the significance of transference since it is the relationship to the analyst that often provides the clue to the underlying relational constellation that troubles the patient. Whether every aspect of what the patient brings to the therapeutic table is grist for transferential interpretations is open to debate – it may be that transference interpretations achieve their positive effects because they provide a consistent and coherent rubric of meaning for the therapist, which in turn is reassuring for the patient. Meaning – based on any explanatory model – in itself provides a secure base, and once that security is achieved vitality affects (STERN 1985; MCCLUSKEY 2005) are liberated in the care-seeker.
Developmental meaning. Third, psychoanalytic meanings are typically developmental in that feelings which appear incomprehensible (i.e. meaning-less) in an adult, make sense when translated (a linguistic metaphor whose origin implies the movement of an object in space, but also time) into an infantile or childhood context. This provides the rationale for infant observation as part of psychoanalytic training in that the student learns how to make sense of the pre-verbal gestures and interactions of ‘one without speech’ (an in-fans). Kierkegaard’s oft-quoted observation that ‘life is lived forwards but understood backwards’ is relevant here. The role of infant and childhood trauma, which so often sets the scene for later psychological difficulty, will be understood both in terms of deficit in the child’s cognitive and affective apparatus fully to comprehend the trauma, and of the ‘environment’ (i.e. care-givers) to help process trauma, especially if they themselves are the perpetrators of that trauma (abuse or neglect). Therapy involves reawakening of painful affect, often via minor echoes of the traumatic situation in the transference, which can now can be ‘processed’ – understood and narrativised – in the context of a benign therapeutic relationship.

Implicit meaning. Unconscious meanings are by definition implicit, but in contrast to CBT, the psychoanalytic ‘explanatory framework’ is likewise implicit rather than explicit. Analysts do what they do, without necessarily being aware of what it is they are doing, or why (TUCKETT ET AL. 2008). Indeed the capacity to allow unconscious processes to operate outside of willed protocol is a valued skill of psychoanalytic work. The relationship between the explicit and implicit models, between rationale and action in psychoanalysis, is thus far from simple, with a significant gap between theoretical superstructure and quotidian practice.

Technique in eliciting meanings. Given that psychoanalysis works primarily with implicit rather than explicit meanings it is not surprising that much contemporary literature is concerned with the ways in which such meanings are arrived at. How do meanings emerge in the cut and thrust of psychoanalytic work? A number of aspects are discussed by our contributors, either directly or en passant.

First, analysts pay close attention to language – the client’s and their own. From the outset, Freud saw the inherent ambiguity of language as an entrée to the unconscious, viewing words as ‘switches’ or junction points between conscious and unconscious thoughts, or to use a contemporary metaphor, at nodal points in neural networks (GABBARD 2005). Analysis of linguistic ambiguity has been particularly emphasised in the British Independent tradition by authors such as SHARPE (1940) and RYCROFT (1985), and within Lacanian psychoanalysis (see ZEAL, this issue). The analyst has to be alert to the puns, polysemmism, and unsaturatedness of the words and phrases used by the patient, and to explore the meanings thereby revealed and concealed.
Main and Soloman’s (Hesse 2008) development of the Adult Attachment Interview provided evidence of the relationship between narrative style and security of attachment in adolescents and young adults. Mallinckrodt et al. (2005) interviewed therapists about their approach to clients with varying attachment styles, showing how therapists both accommodate to, and gradually attempt to modify, their clients’ linguistic habits – opening up the closed discourse of the dismissing client, and structuring that of their hyperactivating counterparts. Character reveals itself in the way people use language and tell stories: le style c'est l'homme. Avdi’s review (this issue) surveys a number of linguistic and narrative analyses of psychoanalytic therapies, showing how speech patterns and narrative style change in the course of therapy, often moving, for instance from rigid transference-driven ways of talking, to more polysemic and reflexive styles.

Two further dimensions concern the mental stance of the therapist herself if meanings are to be accurately and helpfully generated in the matrix of the consulting room. As suggested, Mace (this issue) focuses on the capacity for attention or ‘mindfulness’ as a psychological skill, for therapists and clients alike. CBT therapists have found that adding mindfulness training to conventional therapeutic strategies reduces relapse rates in chronic depression (Williams et al. 2000) and Borderline Personality Disorder (Linehan et al. 2006). Mace makes fascinating links between the ‘evenly suspended attention’ advocated for therapists by Freud (1912) and Bion’s admonition (1970) that analysts should abandon ‘memory and desire’ if they are to achieve receptiveness and spontaneity (c.f. Bolas this issue). There are pointers (reviewed Mace 2008a) suggesting that therapists who have undergone mindfulness training may get better results with their clients than those without such skills.

The effective therapist is sensitive to the nuances of language and narrative style, and is in a state of heightened attention and receptiveness – how then does she use these skills to generate new meanings? Attending to counter-transference feelings (see Kraemer, this issue) is the starting point, in what can be seen as a three-stage process. First, in a state of what Ogden calls ‘reverie’ (Ogden 1989), the therapist ‘tunes into’ her own affective and corporeal sensory-affective world – these might be vague feelings of tension, or boredom, disquiet, arousal or discomfort. Describing such sensations in words constitutes stage two which is a verbal description, or capturing of, in Bion’s terms (1970) stage one ‘preconceptions’ and transforming them into conceptions. This is self-mentalising (see Allen, this issue), in the sense of thinking about feelings, entering a state of ‘meta-cognition’ or mindfulness in which the object of attention becomes the subject’s own attention. Stage three, a much more complex mental action, involves weaving these stage two verbal descriptors of implicit mental states together with declarative knowledge about the client’s history into a pattern relevant to the internal world of the client and of the interpersonal situation generated in the in vitro atmosphere of the therapeutic relationship. Out of what Balint (1968) called this ‘mutual interpenetrative mixup’, an interpretation emerges.
Role responsiveness (Sandler 1976) or projective identification (Klein 1952) are how psychoanalysis theorises this process – the therapist finds herself imaginatively enacting (and sometimes behaviourally enacting) the inner world of the client; this can then be used to make a guess about a pattern of feeling or relationship characteristic of the patient, which is then verbalised in an interpretation (if the timing seems right) for them consider. For example: the therapist experiences in her reverie a feeling of ‘distance’ and disconnection with the client; that is then translated into a thought: ‘the client is pushing me away’; then follows an interpretation: ‘I wonder if you need to hold me at bay today, so that you won’t mind so much about the upcoming break, just as you did when you mother went into hospital when you were a child’. This is the interpersonal, other-mentalising aspect – generating hypotheses about what might be going on inside another person’s mind, and making this the object of discussion.

Promoting change

In contrast with most other therapies (Milan family therapy being an exception, see Kraemer this issue) a defining characteristic of psychoanalytic psychotherapy is that it eschews explicit efforts to produce change in clients, such efforts being dismissed – sometimes contemptuously – as ‘suggestion’ (Kernberg 1999). Yet, implicitly, psychoanalytic psychotherapy is no less concerned to produce change in its clients than any other therapy.

There are two distinct questions to be considered here: what sorts of change does psychoanalysis aim to achieve; and how might those changes be brought about? The alleviation of specific symptoms is generally seen to flow from the attainment of greater global psychic health. This is increasingly so, as contemporary psychoanalytic psychotherapy concerns itself more and more with problematic character traits rather than specific symptoms, the latter being treated, at least initially, pharmacologically or with CBT. See also Fonagy and Bateman (this issue) for psychoanalytically influenced treatment of Borderline conditions.

Different schools of psychoanalysis emphasise varying objectives and associated techniques. For classical psychoanalysis, and possibly still for the Lacanian track (see Zeal this issue), the aim is to help clients identify and express repressed emotions, especially oedipal desire and rage, which, it is presumed, once so liberated, no longer manifest themselves symptomatically. A contemporary version of this, exemplified in Intensive Short-term Dynamic Psychotherapy (ISTDP, Malan & della Selva 2006), sees de-repression both as enlivening the restricted personality, and enabling unmentalised traumata and losses to be reworked, mourned, and laid to rest. Repressed emotions are identified via transference analysis, dream-analysis, free association, linguistic analysis, and parapraxes. In contrast, say, to the reticence of the Lacanian analyst, ISTDP and other related brief therapies posit an active challenging therapist, confronting defences, and homing directly in on the repressed affects that lie behind them.
Object relations psychoanalysis, especially in its neo-Kleinian version (Steiner 1996), emphasises integration of the personality as its therapeutic goal, as the client re-assimilates projected parts of the personality, no longer extruding intolerable affects into those around him, this in turn leading to more harmonious interpersonal relationships and a strengthened sense of self and autonomy (Holmes and Lindley 1997). Here the analyst develops sensitivity to the ways in which the patient’s perceptions of, and dealings with, the external world, especially the analyst herself, are shaped by projective processes. Formulations about these are continuously fed back to the client as interpretations. The ‘insight’ which this facilitates is not just an intellectual event. The juxtaposition of the client’s self-experience, and an ‘external’ neutral account of its impact on the other (the analyst), creates an inner tension catalytic to personality restructuring.

These formulations link with other contemporary psychoanalytic tendencies. The Winnicottian version of Object Relations, privileges playfulness and creativity as a mark of psychic health. The therapist is a ‘transformational object’ (Bollas 2007), both ‘real’ and ‘unreal’ (and therefore available for projective processes), in which, in the play-space of the consulting room, the client begins to differentiate what belongs to the inner world, and what to reality. A major job of the analyst is ‘containment’ (Bion 1970), ‘holding’ (Winnicott, 1971), both of which precede interpretation, and without which interpretation is likely to fall on deaf ears. Containment and holding both loop back to the therapeutic relationship, and in Attachment terms, reflect the secure base that the therapist must provide if exploration is to be possible. A sense of security is a precondition for the exploration of other affective states such as sexuality and aggression.

A central concept in attachment influenced-psychoanalysis, already mentioned, is mentalisation (see Allen and Fonagy and Bateman, both this issue; Allen & Fonagy 2006). Perception of the world is filtered through the mind; experience is therefore inevitably influenced by affect and its associated defences, including projection and projective identification. In pre-mentalising states such as ‘equivalence mode’ (Fonagy 2006) the state of the world is taken to be identical with the state of the mind, which can for example lead to depressive paranoia. As the client develops mentalisation capacities she/he becomes more able to differentiate reality and perception of reality, and to see that miserable perceptions are no more (or less) than ‘points of view’, potentially replaceable by more positive angles on the self and others. In addition, the ability to mentalise oneself and others facilitates more effective interpersonal relationships. Here the close scrutiny of therapeutic relationship, especially the variety of miscommunications, misunderstandings and enactments that comprise ruptures is the crucible for fostering mentalisation skills.

The paradox of commitment to change without its explicit promotion reflects itself in differing analytic formulations of the role of the analyst. Most agree on the centrality of the therapeutic
relationship, both in its transferential and here-and-now aspects, based on FREUD’S formulation (1912) that ‘effigies cannot be destroyed in absentia’. In ISTDP as the client experiences problematic affect (anger, intimidation, avoidance) in relation to the therapist, so it becomes available for examination and transformation. Neo-Kleinian Object Relations advocates uncompromising neutrality on the part of the analyst, who offers herself as an empty vessel into which projections can be poured, but who is also able to identify and verbalise this process. But, as Caper (1999) shows, neutrality is never a fixed or stable position; the analyst is continuously pulled into minor (or sometimes major) enactments in which she is encouraging, rebuffing, cold, warm etc. Here again the mutative aspect of therapy can be seen as presenting the client with an inescapable bind. The therapist is simultaneously an archaic and a new object in the client’s inner world. The tension between therapist’s mentalising neutrality and client-induced pressure to enact a helpful or rebuffing role forces psychological restructuring, moving, via this ‘benign bind’, the client from dependency to self-understanding and autonomy.

Self psychology and relational psychoanalysts accept the inevitability and desirability of the therapeutic relationship as new experience. They see neutrality as an impossible ideal, with the unconsiouses of both therapist and patient brought into play, despite occupying different roles (Aron 2000). Limited self-revelation on the part of the therapist is positively connoted, helping to normalise client problematic experiences and exemplifying the skill of self-mentalisation which with which the client can identify and internalise.

The organising principle of the oedipal triangle, and its resonance in the transference guides each psychoanalytic approach to change, albeit in differing ways. For Malan & Della Selva (2006), in his neoclassical formulation, therapist, patient and significant Other play out the roles of mother, father and child; finding a connecting pattern enables the therapist to bring all three together in a ‘complete interpretation’. For the neo-Kleinians the child’s capacity to tolerate parental intercourse – and in its ‘translated’ version, the therapist’s separateness – is a first step towards objectivity and the ability to think and see situations from many sides. In Attachment terms ‘maternal’ (which can equally be provided by the father) security facilitates the liberation of ‘paternal’ playfulness and companionable interaction. Mentalisation can be seen in Bion’s terms as ‘intercourse’ between thoughts; its obverse, ‘attacks on linking’, as the envious denial of procreativity. For Ogden (1989) and relational psychoanalysts such as Benjamin (2004) the ‘analytic third’ is not so much an oedipal constellation as the analytic relationship itself, distinct from either participant, which, as a novel creation, is a first step towards the restoration of generativity in psychic life.
Outcomes in psychoanalytic psychotherapy

This editorial, and most of the articles that follow, are primarily concerned with psychoanalytic psychotherapy process, and the attempt to find a secure theoretical base from which to practice effectively. But the very use of the word effective raises the spectre of outcome research, conspicuous by its absence in this issue, and, with honourable exceptions (e.g. Malan & Della Selva 2006; Parry, Roth & Kerr 2005), in the psychoanalytic psychotherapy literature generally. Yet the fundamental question, beloved of third-part funders, and liable to strike fear in psychoanalytic practitioners especially if working in publicly-funded settings, ‘does psychoanalytic psychotherapy work?’ cannot finally be evaded.

A number of versions of psychoanalytic psychotherapy have been shown, via randomised controlled trials, to be effective in a wide range of conditions. These include mild to moderate depression (Shapiro et al. 1994), personality disorders (Bateman & Fonagy this issue, and 2004, 2008; Abbass et al. 2008) panic disorder (Milorod et al. 2007), somatisation disorders (Guthrie et al. 1991), and eating disorders (Dare et al. 2001). There are several cost-benefit studies (Gabbard et al. 1997) showing that psychoanalytic psychotherapy, while not cheap, ‘pays for itself’, given the savings in revenue – time spent in or visiting hospital, medication consumed, time spent unemployed – for patients undergoing psychoanalytic psychotherapy compared with ‘treatment as usual’. However, compared with CBT, the evidence for psychoanalytic psychotherapy is generally less impressive: smaller numbers of trials, based on fewer patients, lack of replication, powerful allegiance effects (Roth & Fonagy 2006).

In brief, there are three main ways in which psychoanalytic psychotherapists tend to respond to this critique (Gabbard 2005), and especially the unfavourable comparison with CBT. The first argues that for a number of reasons psychoanalytic psychotherapy is inherently less easy to research than other forms of treatment such as pharmacotherapy and CBT. Randomisation is contrary to the spirit of psychoanalytic psychotherapy in which motivation and finding the right therapy for the client is a fundamental principle of the assessment process. Psychoanalytic therapies tend to be prolonged which means that generating adequate research funding is problematic. Compared with brief therapies, intervening variables such as adverse life events are more likely to confound the impact of therapy. The aims of psychoanalytic psychotherapy go beyond symptom relief to structural changes in personality and are thus inherently more complex and time-consuming to study. The argument here is essentially that, given sufficient time and resources, psychoanalytic psychotherapy can and will be shown to be as effective as other modalities of therapy, if not more so, and that its unique indications are gradually emerging. An outstanding example of this is the Bateman & Fonagy (this issue; 2004; 2008) Borderline Personality Disorder project which shows impressive results, especially about the long-term and continuing benefits of psychoanalytic psychotherapy, compared with the possibly iatrogenic impact of treatment as usual, and the failure of cognitive approaches to demonstrate maintenance of gains (Levy 2008).
A second defense of psychoanalytic psychotherapy revives the famous ‘dodo-bird verdict’ of equal outcomes irrespective of therapy modality. On the whole head-to-head studies show few major differences in outcome for psychoanalytic psychotherapy compared with CBT (e.g. Shapiro et al. 1994), although those differences that do arise tend to favour CBT. The argument here is that the effects of ‘common factors’ on outcome far outweigh any specific model-based aspects (Wampold 2001). The weakness of this argument for psychoanalytic psychotherapy is that it can be used to justify cheaper, briefer therapies that require less training than psychoanalytic work. However there is also evidence that better outcomes from all forms of therapy, including psychoanalytic therapy, result from longer treatments (Seligman 1995); also, the most significant of the ‘common factors’ is the therapeutic relationship, including the ability of the therapist to instigate rupture repairs (see above, Safran & Muran 2000), both of which, as already stated, are key areas of expertise for psychoanalytic psychotherapists.

A third tack, paradoxically closest to the heart of psychoanalytic psychotherapy yet least likely to cut ice in the public arena, is the argument that the project of outcome evaluation is fundamentally misguided and contrary to the spirit of psychoanalysis, which is concerned with ideographic individual life stories, not normothetic, instrumentalist, ‘best buys’. This argument applies particularly to ‘full’ psychoanalysis, which has never been, and perhaps never will be, subject to a RCT although various methodological modifications can be used to evaluate its outcome, which, on the whole tend to be favourable (Sandell et al. 2000). While appearing at first sight to be an untenable ‘back-woods’ defence, there are growing hints of a wider dissatisfaction with over-technologised and compartmentalised healthcare, and an emerging interest in qualitative studies of narrative-based medicine (Greenhalgh & Hurwitz 1998; see Avdi this issue), with which psychoanalysis might usefully ally itself.

Summary: The psychoanalytic psychotherapy ‘site’

In sum, the psychoanalytic ‘site’ can be defined by a number of common aspects. Special features typify the different varieties of psychoanalytic work whether these be ‘full psychoanalysis’, weekly or twice weekly psychoanalytic psychotherapy, group analytic psychotherapy, or couple psychoanalytic psychotherapy. Common features include:

1. A therapeutic relationship with the following properties:
   a) intensity,
   b) contingency in that the analyst is primarily responsive to the client’s initiatives rather than agenda-initiating,
   c) being a ‘secure base’ in which the client sees the therapist as able to contain and assuage her anxieties however overwhelming these may be,
   d) once assuaged, enlivenment and ‘companionable interaction’ follow,
   e) continuously self-monitoring and self-repairing.
2. A primary task of meaning-making in which the analyst, and with the analyst’s help the client, begins to make sense of problematic or symptomatic experiences and behaviours of which the client has been heretofore unaware or unconscious. The primary data for this sense-making process are
a) free association in which the ‘material’ brought to the session by the client is seen not so much for its manifest content, but as a pointer to the client’s inner world,
b) dreams,
c) the therapeutic relationship itself, i.e. transference feelings and enactments evoked by the therapeutic process
d) patterns implicit in the client’s developmental history, in which the long-term implications of infantile and childhood trauma are explored.

3. Therapeutic action or change is brought about by inducing tension or a ‘benign bind’ which helps
a) promoting the client’s capacity to ‘mentalise’ his own feelings and actions and those of others, partly by observing the analyst’s mentalising, partly through jointly mentalising their interactions,
b) reintegrating repressed, disowned or projected affects or parts of the self with resulting greater sense of vitality efficacy and ‘real-ness’,
c) enhancing emotional articulacy, including mourning and processing past losses and traumata,
d) replacing rigidity and transference-driven repetitiveness, with more creative, fluid, interpersonal and narrative capacities.

Features characteristic of psychoanalytic psychotherapy include the above, but in addition include:
1. Acknowledging from the outset with the limitations of reality, in therapy that occurs no more than twice weekly, is often resource-limited, whether this be by time or money. As O’NEIL (this issue) points out however, third-party funded therapies may appear to escape from the limitations of reality, to which the client needs to be brought back if progress is to be made.
2. Working with Extra-transferential material, especially intimate relationships with partners.
3. Theoretical eclecticism. A wide range of different types of client and problem are brought for psychoanalytic psychotherapy and thus a degree of flexibility is required on the part of the therapist. Psychoanalytic psychotherapists need to assimilate a wide range of psychoanalytic perspectives and match them to client need.
4. Awareness of contributions from related disciplines. KRAEMER (this issue) shows how systemic therapists can usefully work with their counter-transference feelings in the context of family therapy. Conversely systemic and cognitive components are to be found in the repertoire of psychoanalytic psychotherapists.
5. Embracing transparency and the need for research, both qualitative (see Avdi this issue) and quantitative, to guide and improve outcomes for their clients.

6. Accepting the phases of the therapist’s developmental process, from early naïve enthusiasm, through the ‘straight and narrow’ of training and strict model-adherence, to more mature, relaxed and creative integrationism.

With all this in mind, it is hoped that the reader will find this issue sounds a distinct and self-confident voice for psychoanalytic psychotherapy in today’s polyphonic psychotherapeutic ensemble.

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