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# Brave New Worlds: A Psychoanalysis Fit for the Twenty-First Century

Psychoanalysis is a very robust animal. Psychoanalytic thinking has vibrancy and depth. It is, in my opinion, the most intellectually satisfying view of the mind. Yet psychoanalysis, despite recent advances, is still in crisis.

To a lay audience, and even to some well versed in psychoanalytic assumptions, the psychoanalyst is often seen as the one peddling ideas that are best laid to rest. Attempts to expose analytic ideas and the practice of psychoanalytic approaches to scientific evaluation are sometimes viewed with suspicion by some psychoanalytic clinicians. Psychoanalysis has traditionally adopted an arrogant attitude even towards other therapeutic models. At best, they are tolerated. At worst, they are regarded with a degree of contempt that perhaps masks a fear of the "other". A colleague once humorously captured this fear as she described psychoanalysis' view of Cognitive-behavioural Therapy (CBT) as "Darth Vader's therapeutic arm". To be fair psychoanalysis too is regarded by some CBT therapists in an equally irrational manner.

Psychoanalytic theory has traditionally evolved around the hearsay evidence of the treating therapist. As each therapist accumulates the so-called evidence, it becomes the grounds for establishing the truthfulness of psychoanalytic assumptions on the basis of a well-known logical error, namely, the argument of past co-occurrence. This refers to the logical fallacy of assuming that if it has happened once before, for example, if a patient expressed his anger by turning it into depression, and if this same pattern is observed again, this means that the theory is correct, that is, depression is anger turned inwards. This argument is compelling, but it has little probative value. Generally speaking, as clinicians we find it hardest to identify negative instances when the patient's reaction is *not* as we would have hypothesised it to be on the basis of the specific hypotheses or theories that guide our work.

The historical insularity of psychoanalysis and its inward-looking attitude have meant that until comparatively recently, it has lacked the kind of perspective that tempers omnipotence. Although research in psychoanalysis is ongoing,

it is by no means yet a well-integrated activity within its own field. Psychoanalytic therapy trainings, on the whole, teach psychoanalytic ideas with little more than token reference to research, viewing the latter as largely redundant to an understanding of the mind or the practice of psychotherapy. Exchange with other disciplines, such as neuro-psychoanalysis, that might provide other kinds of corroborative evidence of our therapeutic efforts have also aroused varying degrees of resistance.

The prevailing attitude to empiricism generally is questionable as if to invite science into the debate about the validity of analytic theories, or the effectiveness of psychoanalytic interventions, is equivalent to selling the analytic soul to the devil. To argue, as some psychoanalytic clinicians do, that psychoanalysis is not a science and that it is therefore meaningless to evaluate it by the standards of other scientific endeavours merely sidesteps a critical issue: if psychoanalysis and psychoanalytic therapy are treatments for psychological problems, we have a responsibility to ensure that we understand how they work and check if they are effective. I am far from being a diehard experimentalist: if psychoanalysis only claimed to be a philosophy, for example, experimental validation would not be an issue. Heidegger's or Nietzsche's views about human nature are important and help us think about ourselves and our lives. But neither Nietzsche nor Heidegger set themselves up to formally treat psychological problems, though they have a great deal to say about human nature that is enlightening. It is because psychoanalysis claims to be a treatment for psychological problems and it seeks public funding for its provision that we have a responsibility to evaluate its effectiveness notwithstanding the limitations of the methodologies currently available to us.

Having criticised psychoanalysis' ambivalent relationship to science, it is also important to address the narrow-minded conceptualisation of science espoused by the critics of psychoanalysis. The debate about the scientific status of psychoanalysis is by now well worn and circular. As Fonagy reminds us:

> Many disciplines are accepted as sciences, even if quantification is not instrumental and experiments are not possible to repeat as in palaeontology. Newton's theory is not falsifiable. Moreover, it is evidence that beyond a certain point of generality a theory is not possible to "prove"; it can only be accepted or not as organising a wide array of facts.
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> (Quoted in Fonagy *et al.*, 1999)

Science is all too often idealised as the only respectable path to knowledge. Yet, scientific endeavour is anything but neutral or dispassionate. Behind the statistics proving one theory and disproving another lie researchers fuelled by deep passions, as Luborsky (1999) highlighted in his study that showed how we could predict the conclusion of a paper on psychotherapeutic outcome just by knowing the theoretical orientation of its first author. This caution should not deter us, however, from exploring what may be helpful in the empirical tradition to the future of psychoanalysis.

Psychoanalysis allows us to make conjectures about the human mind. Many of these are hard to test empirically. Psychoanalytic concepts are complex, but

complexity is not a good enough reason to avoid operationalising our terms. There is little doubt – in my own mind at least – that psychoanalysis could try harder to operationalise its terms so that those gifted enough to find ingenious ways of researching concepts could do so more productively, and thereby provide an empirical base to psychoanalysis as a theory. In the absence of a more established empirical base, allegiances to particular theories develop because we are "grabbed" by an idea or because our psychoanalytic education has been conducted "in an atmosphere of indoctrination" (Kernberg, 1986: 799). The theories we subscribe to are then used to justify what we do with our patients.

All knowledge is subject to both rational and irrational forces. It is vital to counter some of the more simplistic notions about the status of scientific findings. Equally, however, if all knowledge is vulnerable to unconscious forces this alerts us to the fact that our "clinical knowledge" is similarly compromised so that from whatever perspective we approach the task of "understanding" a phenomenon we invariably need another perspective to act as a kind of corrective. Research can provide one such "other" perspective for the clinician, just as the clinician can alert the researcher to potential blind spots in his or her scientific field of vision.

Needless to say, adopting a scientific, rigorous approach to one's work does not necessarily entail personally engaging in research trials. However, I firmly believe that it is incumbent on all therapists, psychoanalytic or otherwise, to regard being familiar with research as one of the responsibilities inherent in our professional role. If you are in any doubt about this, ask yourself what your expectations would be of a doctor. Would you trust his recommendations knowing that he was only well read on a few doctors who practised a hundred years ago, or if he could not answer you in an informed manner about why he was opting for one procedure over another or could not tell you if his chosen intervention had been shown to be effective? Let us not forget that psychotherapy is a powerful tool, all the more so because we as yet understand so little about how it works.

Given the relative paucity of research on the effectiveness of specific psychoanalytic interventions, this book would be on the thin side if I restricted myself to presenting only those techniques supported by research. Incidentally, this would also be the case for a book on other types of psychotherapy. The fact that CBT has received good support from the psychotherapy outcome literature does not imply that we know which key interventions make a difference. If anything, what research suggests is that some of the key interventions associated with good outcome are those techniques that are traditionally associated with psychoanalytic practice (see Chapter 2).

## So ... Does It Work? Examining the Evidence Base for Psychoanalytic Psychotherapy

There is, as we know, more evidence for cognitive behaviour therapy than for psychoanalytic psychotherapy. Of course, absence of evidence is not evidence

of ineffectiveness. Moreover, there is *some* evidence now and the evidence base has increased since the first edition of this book.

In the current climate in the public health sector, research and psychoanalysis need to become better acquainted with each other because evidence-based practice, as a primary driver in healthcare, is here to stay. We have to engage with the demand this places on us as providers of psychoanalytic psychotherapy and demonstrate that what we offer can make a distinctive, effective contribution to Public Mental Health. The demand for public accountability urges us, with unprecedented force, to consider whether we want the psychoanalytic body of knowledge and its applications to be a relic of historical interest or at the cutting edge of mental health care.

Engagement with this demand requires that we try out different ways of doing things, which may feel alien to established practice (e.g. session-by-session outcome monitoring), and to many may seem altogether irrelevant to what transpires in the therapeutic situation. Arguably this also requires that we actively respond to this external culture from a vantage point that is distinctively psychoanalytic and practice-based so that we are not just "complying" with what we feel is imposed on us (though sometimes we have to do that too, of necessity), but rather we also contribute to the discourse about the varieties of scientific research, and the contributions and limitations of different kinds of methodologies.

If we look back at the history of psychotherapy research, it becomes apparent that psychoanalytic interventions have been competing in research trials where the changes measured are typically not relevant to the overarching goals of psychoanalysis and are better suited to those targeted by a medical intervention. Measures for the most part are arbitrary, but in an evidence-based practice culture they are considered to correspond to something of self-evident value in the outside world (Kazdin, 2006). But we do well to question the real-life significance of changes on many of the symptom questionnaires used to evaluate outcome. Arbitrary or not, our measures should be neutral in relation to the nature of treatment they intend to evaluate; otherwise, we might find treatments targeting the scales of measurement rather than the underlying pathological process (Fonagy, 2010).

The methodology we use to study the impact of our interventions also deserves scrutiny. Over the last couple of decades, the randomised controlled trial (RCT) has been held by many to be the gold standard in psychotherapy research. However, in his 2008 Harveian Oration at the Royal College of Physicians, Sir Michael Rawlins[1] (2008) cautioned against the over-valuation of RCTs in evidence-based medicine, focusing on whether the results of RCTs are generalisable. Indeed, the settings in which psychotherapy RCTs take place are quite different from the real clinical situation we are accustomed to as clinicians (La Greca *et al.*, 2009; Weiss *et al.*, 2009). Additionally, the treatment given in psychotherapy RCTs rarely fits clinical reality in terms of frequency of therapy, timing of administration, duration of therapy, inter-current treatments and the

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[1] The Director of the National Institute of Health and Clinical Excellence (NICE).

skills and commitment of the practitioners. There is therefore a real question about whether the assessment of benefit obtained from a trial can be applied to ordinary clinical settings.

Notwithstanding this cautionary preface, what does the extant evidence base tell us about our interventions?

The good news is that psychotherapy (in its generic sense) does work, with the average effect size of psychotherapy found to be 0.8 across probably over 1000 studies (Wampold, 2001, 2007). *Effect size* (ES) refers to the likelihood that a person treated with psychotherapy would be better off than a person in the control group if both were chosen at random (Cohen, 1962). It means that nearly three-quarters of patients who have psychotherapy are better off than those left to recover by themselves. Psychotherapy is mostly as effective as psychoactive medication, and there is evidence that additional benefit accrues from combining the two in some contexts (e.g. Cuijpers *et al.*, 2009). Not surprisingly, improvement rates relate to severity and treatment duration (Kopta *et al.*, 1999). On average, acute distress improves in three-quarters of cases within 25 sessions. But chronic disorders, defined in various ways, appear to require longer-term treatment.

For obvious reasons – not least economic ones - there is a strong interest in brief interventions not only from commissioners of mental health services but also in the private sector, where economic recessions and the exigencies of work make it hard for prospective patients to commit themselves to long-term interventions. Meta-analytic reviews have yielded powerful pre-post effects for psychodynamic psychotherapies for depression based on both RCTs and correlational studies (Abbass, 2007; Cuijpers, 2008; Knekt, 2008). There is evidence of comparable effectiveness with medication (Salminen, 2008) and its capacity to increase the effectiveness of antidepressant treatment (de Maat, 2008), although needing slightly longer to become clinically effective. It should be noted, however, that with sample sizes of 25 patients per arm, there was insufficient statistical power to be confident of detecting differences between treatments.

Comparison trials show that brief analytic interventions (also referred to as *short-term psychodynamic psychotherapy*) are less effective at end of therapy than other treatments regardless of study design (RCT vs. cohort studies), use of predominantly supportive or expressive techniques, the quality of blinding, the use of antidepressants, gender, age, the number of session, severity, community versus clinic recruitment and intent to treat versus completer analysis. Driessen *et al.* (2010) report that while psychoanalytic psychotherapy may be better than control conditions, it appears less efficacious when compared to other treatments at termination. At follow-ups (3-month and 9-month), however, there were no significant differences.

It seems that differences between brief analytic interventions and other therapies become smaller further away from termination (termination is classically recognised to cause the re-emergence of the presenting problems), and there is indication of publication bias, which, when adjusted for, removes

the statistical significance of the differences between the two modalities. The difference may also be exaggerated by the reactivity of some measures used. Careful reviews of quantitative studies (Fonagy, 2005, 2010) suggest similar conclusions, that is on balance the evidence favouring other therapies such as CBT and IPT over psychodynamic ones is accurate, but largely attributable to the lack of standardisation and coherence in the administration of brief psychodynamic therapy and *not* due to inherent problems with its effectiveness. For example, inferior effects from psychodynamic psychotherapy compared to CBT are observed when dynamic therapists apply methods from long-term intensive therapy in the context of short-term symptom oriented treatments (e.g. Durham, 1994).

A recent large study ($n = 341$) (Driessen *et al.*, 2013) compared the efficacy of psychodynamic therapy with that of CBT. No statistically significant treatment differences were found for any of the outcome measures. The average post-treatment remission rate was 22.7%. From another vantage point, even though this study demonstrated that psychodynamic psychotherapy was not inferior to CBT, they also showed that the outcomes of depressed outpatients were far from ideal, even when receiving good treatments from capable therapists (Thase, 2013) – a sobering reminder that psychotherapy irrespective of brand is no panacea.

Longer-term psychoanalytic interventions have posed a greater challenge to researchers, not least because of the problem of randomisation when this involves getting agreement to go without the preferred treatment for 18 months or more. Nevertheless, the de Maat *et al.* (2009) review collected together 27 studies, covering 5000 patients, where the impact of long-term therapy on symptom reduction was measured, and/or information on personality changes was collected. The effect sizes of outcome measures combined were between 0.8 and 1 and tended, if anything, to slightly increase on follow-up and were somewhat bigger for psychoanalysis than psychotherapy. The success rate on symptoms was around 70% based on clinicians' opinion and between 60% and 70% for patient self-report, when *success* was defined as at least moderate improvement.

The Leichsenring and Rabung (2008) meta-analysis was very ambitious and identified 23 studies. The studies concerned difficult problems, but pre-post effect sizes were consistently large. Controversially, the authors contrasted these effects with those normally obtained for similar client groups in short-term therapy and found a significant superiority for long-term treatment.

Such encouraging results were soon challenged (Beck & Bhar, 2009; Glass, 2008; Kriston *et al.*, 2009; Roepke & Renneberg, 2009; Thombs *et al.*, 2009). Indeed many of the studies reviewed were in effect uncontrolled and heterogeneous. In a subsequent study that tried to respond to these criticisms, they identified 10 controlled studies of long-term psychoanalytic psychotherapy versus other types of treatment (Bachar *et al.*, 1999; Bateman & Fonagy, 1999; Bateman & Fonagy, in press; Clarkin *et al.*, 2007; Dare *et al.*, 2001; Gregory *et al.*, 2008; Huber *et al.*, submitted; Korner *et al.*, 2006; Svartberg *et al.*, 2004) where

these treatments were used in the treatment of complex disorders, chiefly personality disorder (7), eating disorders (2) and depression (1). The comparisons are with CBT, DBT (Dialectical Behaviour Therapy), CAT (Cognitive Analytic Therapy), SCM (Structured Clinical Management) and TAU (Treatment as Usual). The treatments lasted on average 70 weeks offering 120 sessions. The findings were similar to the previous analysis. The average between-group effect size was 0.67, somewhat larger for target problems, 0.88, than general psychiatric symptoms, 0.54. These findings are important as they suggest that long-term psychodynamic psychotherapy is superior to less intensive treatments when directed towards complex mental disorders.

The Helsinki study (Knekt *et al.*, 2008) contrasted Solution-focused Therapy and psychodynamic psychotherapy with long-term psychodynamic psychotherapy for patients with mixed depression and anxiety problems. The patients were followed up over three years showing significant benefit from long-term treatment not at 18 months, or even at 24 months, but *only* at 36 months.

If we take stock of what has been reviewed so far, we would be justified in being optimistic: there is some evidence to support psychoanalytic therapy. However, the bad news is that it is not nearly enough to secure the future of such interventions as an integral part of mental health services. Moreover, although the research tells us that it does work, it does not yet help us to understand *how* it works. This will increasingly require an understanding of the moderators of therapeutic effectiveness.

Rapidly advancing biological research is providing persuasive evidence that there may be genetic limitations on how well therapy can work. Caspi and Moffitt (2003), for example, showed that the association between the number of stressful life events an individual experienced between 21 and 26 years and the probability of depression, suicidal ideation and suicide attempts was moderated by the 5HTT genotype. Only those who had two of the short alleles of this genotype were likely to respond to four life events with increased suicidal ideation. The association between life events and suicidal ideation of those with two long alleles was completely absent. Another study found that maternal sensitivity predicted infant security of attachment as it is supposed to *only* in infants with the short allele of the 5HTT genotype (Barry *et al.*, 2008). Infants with the long allele were equally likely to be secure regardless of maternal sensitivity. These studies raise the possibility that the mechanism by which therapy achieves its effect may be quite different for these constitutionally distinguishable groups of individuals.

## Applied Psychoanalytic Work: The Development of Dynamic Interpersonal Therapy (DIT)

The culture of EBM, as we have seen, has subjected the providers of psychodynamic psychotherapy to the requirement to justify the effectiveness of this mode of therapy. This culture may understandably be felt to be the "enemy", as it were, of psychodynamic practice, but as well as posing a threat it has, in

fact, also helpfully focused our attention not only on the importance of systematically evaluating what we do so as to monitor the quality of what we offer to patients, but also on the thorny question of therapists' competence: how we define it, hone it and assess it. In the United Kingdom, for example, the Department of Health has invested in the development of competences for a range of psychological therapies, including psychodynamic psychotherapy. The origins of DIT lie in this work. It is a short-term (16 sessions) individual psychodynamic therapy protocol for the treatment of mood disorders (specifically, depression and anxiety).

The Psychodynamic Competences Framework (Lemma *et al.*, 2008)[2,3] describes a model of psychodynamic competences based on empirical evidence of efficacy. It indicates the various areas of activity that, taken together, represent what has been proven to be good clinical practice as observed in outcome trials.

This work began by identifying those psychodynamic approaches with the strongest claims for evidence of efficacy, based on the outcome in controlled trials where a manual was available. In order to determine which studies to select, the reviews of psychological therapies conducted by Roth and Fonagy (2005), were combined with the trial and systematic review database held at the Centre for Outcomes, Research and Effectiveness, as part of scoping work for the National Institute for Health and Clinical Excellence (NICE). From the combined lists (in conjunction with an Expert Reference Group comprising senior clinicians and researchers representative of different analytic traditions), clinical trials of appropriate quality for inclusion in the framework were identified and the manuals used in these studies were located. Only trials where a manual could be accessed were included. These manuals were then studied carefully with a focus on what the therapists were expected to do. This qualitative analysis provided the basis for the articulation of the core, specific and meta-competences required to practice psychoanalytic psychotherapy (see Figure 1.1). These competences, where possible, were peer-reviewed by the originators of the manuals and also by an Expert Reference Group. To supplement these manuals, several widely cited texts that explicate psychoanalytic terminology, and provide clear descriptions of how these concepts translate into clinical practice, were also consulted (e.g. Bateman, 2000; Etchegoyen, 1999; Greenson, 1967).

The rationale for developing DIT was based on our collective experience as clinicians, trainers and researchers (Lemma, Target, & Fonagy, 2011), which persuaded us that the competence framework provided an opportunity to develop a protocol that integrates core, shared psychodynamic principles and techniques grounded in the extant evidence base, and that thus carries some

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[2]  The full list of competences can be accessed at www.ucl.ac.uk/CORE/.

[3]  The Improving Access to Psychological Therapies (IAPT) programme in the UK, which was launched in May 2007, provided the backdrop for the first wave of work on the development of competences for the practice of psychological therapies. The CBT competence model was specifically developed to be a "prototype" for articulating the competences associated with other psychological therapies (Roth & Pilling, 2008).

external or empirical credibility when applied with a specific focus on mood disorders (depression and anxiety). DIT thus deliberately uses methods taken from across the board of dynamic therapies, and we would therefore expect those who have been involved in the development of other brief dynamic models to find many familiar strategies and techniques in DIT. It is not intended to be a further new psychodynamic sub-modality. Rather, it is a treatment and training manual compiling key elements from implementations of psychodynamic psychotherapy recognised by NICE as contributing to its evidence base (e.g. de Maat, 2008; Salminen, 2008).[4]

DIT draws on a range of psychoanalytic traditions, most notably object relations theory, Sullivan's interpersonal psychoanalysis and attachment theory. In particular, Kernberg's (1980) integration of object relations theory with ego psychology in the theoretical frame of Transference-focused Psychotherapy (Clarkin *et al.*, 2006) is very close to the heart of DIT's theoretical basis and way of formulating a focus for the intervention.

The DIT therapist has two aims: (1) to help the patient understand the connection between his presenting symptoms and what is happening in his relationships by identifying a core, unconscious, repetitive pattern of relating; and (2) to encourage the patient's capacity to reflect on his own states of mind and enhance his ability to manage interpersonal difficulties.

The goal is not simply to work on an unconscious conflict, but to use the patient's reports of his interpersonal experiences as a way of helping him develop his own capacity for thinking and feeling his experience. This focus is fundamental to DIT, and it informs technique in so far as the helpfulness of the therapist's interventions (e.g. the interpretation of transference) is evaluated against the criterion of whether they help stimulate the patient's capacity to reflect on their own subjective experience. The DIT therapist is particularly interested in making explicit what has effectively become procedural so that the patient is better able to effect change in how he manages his relationships.

The DIT model can be conceptualised as consisting of three phases – an engagement/assessment phase (sessions 1–4), a middle phase (sessions 5–12) and an ending phase (sessions 13–16) – each one with its own distinctive strategies.

The primary task of the *initial phase* (sessions 1–4) is to identify one dominant and recurring unconscious interpersonal affective pattern (IPAF) that is connected with the onset and/or maintenance of the depressive symptoms. We understand this pattern as underpinned by a particular representation of self-in-relation-to-an-other that characterises the patient's interpersonal style and that leads to difficulties in his relationships because of the way in which it organises his behaviour. These representations are typically linked to particular affect(s) and defensive manoeuvres. Affects are understood to be responses to the activation of a specific self–other representation.

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[4]  In fact, 23 psychodynamic treatment trials for depression have been conducted (Driessen, 2010), although various, mostly non-overlapping, limitations have rightly prevented their consideration by NICE guideline development groups.

Past experiences are not the major focus of DIT. They are included in the formulation shared with the patient so as to frame his current difficulties in the context of his lived experience but they are not a central component of the therapeutic process. Rather, given the brief nature of the therapy, the focus is on a core segment of the patients' interpersonal functioning closely connected with the presenting symptom(s). The therapist identifies the most important current and past relationships but does so with emphasis on present. The therapist strives to establish the form of a relationship, the key processes employed in maintaining it, if it has changed over time and how it relates to problems.

The IPAF guides the therapist's interventions during the *middle phase* of the therapy (sessions 5–12). During this phase, the therapist helps the patient stay focused on the IPAF and think about new ways of resolving their interpersonal difficulties. A consistent effort is made to encourage and support the patient to make psychological sense of what is happening in his own mind, others' minds and important interactions. The last four constitute the *ending phase* (13–16) and are devoted to helping the patient explore the affective experience and unconscious meaning of ending the therapy, to review progress and to help him to anticipate future difficulties and vulnerabilities.

DIT is a comparatively new protocol first developed in 2009 such that at the time of writing the results of the first randomised trial are not yet available. The only published results to date refer to two small-scale pilot studies. The first (Lemma, Target, & Fonagy, 2011) set out to test DIT's acceptability and compatibility with session-by-session monitoring as a prelude to the ongoing RCT. Sixteen consecutively referred, depressed patients (aged 20–53) were offered 16 sessions of DIT. Patient outcomes were collected pre-post, and on a session-by-session basis, using the PHQ-9 and GAD-7. Therapist and supervision feedback indicates that this structured psychodynamic treatment could be effectively taught, and that the key competences involved were acquired and demonstrated in the clinical work supervised. Patients found the treatment acceptable and relevant to their problems. The treatment appeared compatible with session-by-session monitoring of symptoms of anxiety and depression. DIT was associated with a significant reduction in reported symptoms in all but one case, to below clinical levels in 70% of the patients. The results suggested that DIT was promising in its acceptability and effectiveness with an unselected group of primary care patients, and was easily acquired by psychodynamically trained clinicians.

The second published study focused on a pilot of an eight-session adaptation of DIT in a group format and delivered online (Lemma & Fonagy, 2012). Twenty-four participants were randomly assigned to three groups. Participants in Condition A ($N = 8$) took part in an online DIT group, with self-help materials, facilitated by a therapist. Participants in Condition B ($N = 8$) were given access to a closed virtual group space where they could interact with each other and were supplied with the same self-help materials used by participants in Condition A, but without online therapist facilitation. Participants in Condition C ($N = 8$) received no instructions or facilitation, but had access to an online mental well-being site where they could meet virtually

in a large, open, moderated virtual group space to discuss their psychological difficulties. This feasibility study was underpowered to detect significant differences in rates of change between facilitated and un-facilitated provision of material, but decline in symptoms appeared to be superior to control only for the facilitated group when the groups were considered separately. The response of the combined treated groups against control suggested that the DIT self-help materials may be helpful and appear to support the process of change. Further work is clearly required.

Within the public sector psychoanalysis' primary contribution has to be, and indeed should be, in applied form. At its best, the core of this applied contribution comprises a quality of thoughtfulness that is portable and that has broad relevance and accessibility. This contribution need not be expressed primarily in the provision of certain forms of psychotherapy, although these have an essential place. Instead, this model of applied work brings with it real flexibility and the possibility of radically rethinking how psychoanalysis might take up its place within healthcare economies. DIT is but one example of such an application of psychoanalysis.

## Is Neuroscience Relevant to Psychoanalysis?

For many years, I am ashamed to admit, any word prefixed by "neuro-" was enough to turn me into an "anti-brain" demonstrator. Biology and neuropsychology, I then believed, were irrelevant to an understanding of the human mind. I viewed them as reductionistic attempts that neglected the meaning and affective experiences that I was grappling with in my clinical work and within myself. I situated myself comfortably in the hermeneutic tradition, believing that psychoanalysis was, at the core, about finding meaning and that this had nothing to do with scientific testing or brain anatomy. Indeed, psychoanalysis is, amongst other things, about interpreting meaning. But it has never contented itself with this. Psychoanalytic theories are not simply evocative narratives: they expound universal claims about mental events. If psychoanalysis makes universal claims, it has to buttress them with evidence in order to be taken seriously. If, on the other hand, we shy away from this challenge and argue that all that psychoanalysis is about is the creation of more or less helpful narratives, psychoanalysis abandons finding answers to the questions that Freud initially posed. This, to my mind, would be our loss.

I now write this second edition more persuaded than I was even in the first edition that, in order to survive, psychoanalysis has to learn from other disciplines and has to engage in a dialogue with them to acquire new methodologies so as to assist us with the testing of some of its ideas. In particular, it needs to engage in a dialogue with biology and cognitive neuroscience. Recent advances in cognitive, affective and social neuroscience have enabled these fields to study aspects of the mind that are central to psychoanalysis. These developments raise a number of possibilities for psychoanalysis (Fonagy, 2004; Kernberg, 2004; Mayes, 2003; Michels & Roose, 2005; Nagera, 2001;

Northoff & Boeker, 2006; Panksepp, 1998; Semenza, 2001; Shevrin, 2002; Shulman & Reiser, 2004).

The rapprochement between psychoanalysis and the neurosciences has aroused anxiety and hostility on both sides (Blass & Carmeli, 2007; Brothers, 2002; Hobson, 2005; Mechelli, 2010; Pulver, 2003). Quite understandably, in my view, the concerns voiced by psychoanalytic practitioners centre on the neglect by several cognitive scientists and neuroscientists of subjectivity and first-person accounts in their theories and research. Neurobiology, for example, will never be able to give us another person's experience of an image or an emotion (Damasio, 1999). We may all look at the same picture, but we will each generate the experience according to our own unique developmental histories. A focus on the neurobiology of the mind does not mean that we reduce it to something that can ever be fully known objectively, thereby making psychoanalysis redundant.

It is true that there is no simple and straightforward relationship between psychoanalysis and neuroscience. Psychoanalysis discusses highly complex psychic processes that do not neatly map onto current knowledge in neuroscience. However, the attempts to bridge the gap that has existed for far too long are laudable: it is not about reducing psychoanalytic concepts to neurobiological ones, but is about recognising that "agendas overlap even if they are not identical" (Kandel, 1999).

The dichotomy between biological and psychogenetic influences on the mind is hard to uphold. A number of studies demonstrate that even patients with psychological problems in the absence of any brain (i.e. hardware) injury nevertheless have measurable neuronal abnormalities that influence the way their minds function (e.g. Alexander *et al.*, 2005; Bremner, 2005; Liotti & Mayberg, 2001).

The problem of the relationship between mind and brain is age worn, and I will not rehearse it here. Suffice to say that I root myself in the tradition that sustains that the mind and brain are one entity and that there is no such thing as a Freudian mind–brain or a Kleinian mind–brain. There is only one brain that we are all looking at and trying to understand. If we are to arrive at a real understanding of many of the problems our patients present with, then we will need a multi-perspectival approach. Fortunately, we can currently draw on an increasing range of neuro-scientific researchers who approach the study of the brain espousing the view that emotions and motivation, are embedded in the acting, sensing and feeling body, (e.g. Benedetti, 2010; Fotopoulou, 2012c; Gallese, 2009; Panksepp, 1998).

An important implication of such studies is that they reveal how mental meanings change brain processes just as much as brains can shape meanings (Kaplan-Solms & Solms, 2000). A neuro-psychoanalytic way of conceptualising the relationship between brain structure and mental function is not to approach this hierarchically privileging the neurological perspective but rather to give due weight to the way that a brain functions (this can be studied from two observational viewpoints – both of which are equally valid; see Solms & Turnbull, 2002).

For a number of years, we have also had non-reactive functional brain-imaging measures of outcome available (Carrig *et al.*, 2009; Wiswede *et al.*, 2014). The aim of this kind of research is not to make psychological accounts redundant by providing a biological explanation, but rather to be more specific about how therapy works. Multiple lines of evidence are likely to be needed to identify the mechanisms critical to particular types of intervention (Kazdin, 2008).

## Psychoanalysis in Times of Technoculture

Both EBP and the field of neuroscience have presented psychoanalysis with challenges and opportunities. Now psychoanalysis also has to engage with the way that the analytic setting itself is being transformed by new technologies. Not only this: the transition from an industrial economy to an information economy impacts not just the external structure of society and commerce, but also most likely internal psychic economies and indeed our brains (Greenfeld, 2014).

Technologies cannot be considered in isolation from the "landscapes of translation" (Wakefield, 1999) in which they are embedded, including when they are used within the analytic setting itself. As various communication systems have altered the way we communicate with each other, they inevitably and perhaps more silently and subtly have also permeated the psychoanalytic setting. However, we still don't really know how they have affected it. Have they changed the way we work? Have they really forged a new form of communication? Have they intruded on or complemented the analytic setting, which by definition relies on the subtle nuances of language, observation and a number of other sensorial experiences that are time-honoured instruments of the psychoanalytic profession?

Given that the Internet and other forms of virtual communication have been in place for at least 20 years or so, surprisingly little has been written about any of this in the psychoanalytical literature (Caparrotta & Lemma, 2014). Those analysts who do use new technologies to communicate with and treat patients, for example via texts and emails, or those bold enough to have braved Skype analysis, nevertheless do so careful not to advertise the fact too widely, with a few notable exceptions (Bonaminio, 2010; Carlino, 2010; Dini, 2009; Ermann, 2004; Fiorentini, 2011; Kilborne, 2011; Lingiardi, 2008; Scharff, 2014). Consequently, the literature in this area is very scarce indeed relative to the place that new technologies command in our personal and professional lives.

A preliminary survey of psychoanalysts' practice ($N = 62$) carried out by the British Psychoanalytic Society revealed that 31% of respondents had conducted telephone/Skype analysis (Fornari-Spoto, 2011). An interesting albeit controversial comment to this survey was made by Symington (2011) suggesting that for those analysts "whose foundation rests upon the instincts" this gives rise to ossification and restricted communication whereby the analytic process is seen to require the physical presence of analyst and patient in the consulting room. Whereas those analysts "whose foundation rests on communication" tend to remain open to its various forms, including Skype or

telephone. Clearly not all patients can be treated in these modified forms of analysis or psychotherapy. However, what Symington appears to be suggesting is that it may not only be that some patients are unsuitable, but also that some analysts cannot make good use of these new media.

Our reluctance to engage more fully with these developments in communication technology is all the more curious given that as psychoanalytic practitioners we are all too accustomed to the virtual nature of the real itself as it is filtered through a world of object relations – one in turn distorted by projective and introjective processes – that creates virtual others who carry emotional resonance within and inform how we experience and act in the world. The analytic setting itself is a form of virtual reality too, we might say, as is the transference.

Scharff (2014) has suggested that in many respects there is little difference between so-called tele-analysis and traditional analysis in the actual work done during the session. The dilemmas facing the analyst when working in this way inevitably engage us in considering the extent to which changing the setting to accommodate new technologies constitutes "true" analysis. Sabbadini (2014) has helpfully argued in this respect that "our analytic practice can be allowed a modicum of flexibility so long as we are able to maintain the analytic stance".

Technological developments are "developments" in the sense that they have created opportunities for extending learning and creativity that were unimaginable, for example, before the advent of the Internet. These new media also offer opportunities for increasing accessibility to mental health care including psychoanalytic interventions. Whilst this requires a sophisticated understanding of how to best create and safeguard the analytic setting, and we have much to learn in this respect, this does not mean that it is not possible to work psychoanalytically through these media.

It would be a mistake to only focus on the potential of new technologies to foster pseudo-intimacy. New technologies may also act as catalysts for social relationships, no different in their potential for binding people together than stories or bulletin boards (see Bingham, ibid.). For example, I have facilitated two online therapeutic groups using the DIT model, through an online therapeutic community called Big White Wall (see also Graham, 2012). These groups are rooted in psychodynamic ideas in terms of both their content and their thinking about the therapist's function in the group. The participants were physically located across several different continents, but came together in a closed group for a set number of sessions (set at eight for this pilot study). Needless to say, for a psychoanalyst, this at first felt like a step too far away from psychoanalytic practice and yet, like any new venture, once the analytic superego could be kept in check, this applied experience turned out to be very instructive and moving. Importantly, the intervention also appeared to help people with their experience of depression and anxiety, which had motivated the initial referral to the group (Lemma & Fonagy, 2014).

The individuals who joined the group were people who struggled to access mental health services and who were experiencing relatively high levels of distress, typically of an interpersonal nature. The group exchanges were non-synchronous, that is, there was a time delay between postings and response. This was an important feature of the group simultaneously exposing

the participants to the frustration of the immediacy typically characteristic of virtual exchanges *and* the containment provided by a therapeutic frame that supported space for reflection.

Over the course of the group, the participants developed important insights into a recurrent, often unconscious, relational pattern that was undermining their relationships. This pattern was discussed online, and at times enacted through the online interactions with the other group members and/or with the facilitator, which were then commented on by the facilitator. In other words, the transference was live and could be used to shed light on the patterns the participants were working on.

It is beyond the scope of this chapter to enter into a detailed discussion of this way of working and the implications for analytic technique. The main point I want to make is that the sense of community that was engendered by the group process, and the support that participants offered each other, was as "real" and as significant in its import for the well-being of its individual members, as any group process mobilised in traditional face-to-face group analytic therapy. By the end of both groups, participants reported that they had made important gains in insight and in how they were managing their lives, with some able to take the step to seeking face-to-face therapeutic help.

Such interventions, whilst departing dramatically from well-trodden psychoanalytic terrain, may yet turn out to be helpful stepping-stones towards therapeutic help for some individuals who would not otherwise avail themselves of help they desperately need. Despite the virtual nature of the medium through which they access help, I am suggesting that a therapeutic process informed by psychoanalytic principles enabled such individuals to approach reality in due course rather than representing a defensive retreat away from reality. For example, one participant, who had barely left his room for the preceding three years because he felt anxious and ashamed of himself, and who had managed to approach his local service for face-to-face therapy by the time the group ended, summed up what they had gained from the group thus:

> I've enjoyed having the closer interaction with a smaller group of people. It has certainly helped me to open up a bit more than usual. I think I can see an improvement in opening up and being honest with people about things rather than bottling them up. I think I try to think more rather than rushing in with a response. The biggest thing I think I've learnt here is that the problems I have are not my fault or anyone else's. I still don't like myself much as a person but I think that I don't hate myself like I did before.

Whilst it could be argued that this intervention was not strictly psychoanalytic, there are now enough people worldwide receiving Skype/telephone psychoanalysis for us to start to explore the benefits and limitations of working in this way as psychoanalysts, both intensively and less intensively. I am not advocating that online interventions should substitute longer-term psychoanalytic psychotherapy or psychoanalysis offered face-to-face; rather, we are suggesting that they may (a) increase accessibility to psychoanalytic treatment; and (b) for a minority of individuals who would find face-to-face therapy/analysis too

threatening to begin with, brief psychoanalytically informed online interventions may provide helpful "bridges" to accessing face-to-face help.

With each shifting automation, simulation and transmission we discover not only new technologies but also new facets of ourselves. Our modes of communication impact our concepts of space, place and time, such that as we change modalities of representation we also change our human perspective. This raises both possibilities for constructive change and progress as well as for evasion into psychotic psychic retreats of sorts, which can now be inhabited in virtual space. Even though virtual reality may be used to effect a retreat away from reality, we could equally argue for a notion of a virtuality that is not always about a "safe copy" of, or "alternative" to, the "real".

Because the individuals we see in our daily practices may be "misusing" new technologies to manage their troubled relationship to reality, it is all too easy to adopt a dystopic view of these developments. More generally, when faced with the so-called "new", it is also not uncommon to adopt a sceptical position.

I personally have many questions about the impact of new technologies and especially the domain of cyberspace on psychic structure, but I am quite clear about one thing: communication technologies ought to be of great interest to contemporary psychoanalytic practitioners. The very existence of communication networks that facilitate and regulate intimacy, with varying degrees of connection and disconnection, strikes at the heart of what we painstakingly try to understand with our patients in our daily practices: how to manage being-with-self-and-others. In so far as these technologies have the potential to perform such important psychic functions, it is incumbent on us to distinguish between the "properties of tools" and "what people do with them" (Chartier, 1997: 11).

We need to understand more about how these new technologies interact with the prerogatives of an individual's internal world, how they may alter psychic structure itself in fundamental ways and the implications of this for the individual's functioning and also for how a society operates.

## Conclusion

If our applied psychoanalytic work is to develop and evolve, we will have to face the inevitability of loss – loss of what we were, and felt ourselves to be before in this time. Such loss also brings with it, however, an opportunity for developmental transformation. One of the keys to the kind of transformation I have in mind is a genuine intercourse with the outside, a willingness to take something in, whether it be ideas or expertise in a manner that is itself transforming.

## Further Reading

Fotopoulou A., Conway M. & Pfaff D. (2012) *From the Couch to the Lab: Trends in Psychodynamic Neuroscience*. Oxford: Oxford University Press.
Lemma, A. & Caparrotta, L. (Eds.) (2014) *Psychoanalysis in Times of Technoculture*. London: Routledge