Chapter 20
Commentary: The Coming of Age of Psychoanalytic Treatment Research

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There was a time when psychoanalytic clinicians, perhaps appropriately, could neglect findings of psychoanalytic treatment research. The chapters in this section clearly attest to the fact that those days are long gone. Indeed, as is demonstrated by each of these chapters, psychoanalytic treatment research not only may *inform* clinical practice, but also has the potential to *change* psychoanalytic practice. In fact, there is no point in denying that psychoanalytic practice *has* already changed under the influence of research findings, both explicitly and implicitly, and will continue to be changed by research.

Explicit Influences of Psychotherapy Research on Psychoanalytic Practice

The influence of research findings on psychoanalytic practice is manifold. For instance, as discussed in detail by Ken Levy and colleagues in their chapter (Chap. 24), a variety of psychoanalytically based treatments for both children and adolescents and adults have been influenced by attachment research. Transference-focused psychotherapy [1] and mentalization-based treatment [2] for borderline personality disorder are but two well-known examples.

However, the influence of attachment research – and psychotherapy research more generally – is not limited to these specific treatments. Indeed, Levy and colleagues convincingly argue that attachment theory and research may not only provide a guiding framework for psychotherapy, but may also inform the focus of treatment and may even be used to assess therapeutic outcome, regardless of the type of treatment. I believe many psychoanalytically trained clinicians would agree and use attachment-related concepts in their daily clinical practice. More generally, and further back in time, various psychodynamic treatments, including supportive-expressive therapy [3] and a range of brief dynamic treatments that were developed in the 1970s and the 1980s [4], have been strongly influenced and shaped by research findings and gave rise to a tradition that promoted a vivid exchange between clinical practice and empirical research. Again, it is very hard to deny the influence these ideas have had on psychoanalytic thought and practice.

And who would deny the influence of psychotherapy research on the way psychoanalytic treatments are conducted nowadays? In this context, Hilsenroth and colleagues (Chap. 22), in a very

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lucid, open and clinician-friendly style that perhaps is the most convincing demonstration yet of how research findings can be translated for clinicians, outline a number of detailed research-based recommendations that may foster the development of a positive therapeutic alliance. Both explicitly and as I will argue further below, also implicitly, over the last decades, these findings have permeated the hearts and minds of psychoanalysts and psychoanalytic therapists. For instance, a recent list of meta-competences that psychoanalytic therapists typically possess [5] shows considerable overlap with the recommendations by Hilsenroth and colleagues concerning aspects of a therapeutic stance that fosters a positive alliance. These meta-competences and attitudes differ in many ways from more "orthodox" analytic competences and attitudes as described in traditional handbooks and – I fear – still taught in some psychoanalytic societies. Yet, as also shown by studies using the Psychotherapy Process Q-set summarized in the chapter by Smith-Hansen, Ablon, R. Levy and colleagues (Chap. 23), many psychoanalytic practitioners adopt much more flexible attitudes in their daily clinical work, in line with systematic research findings. Likewise, studies on "master therapists" show that good therapists tend to be much more flexible in their attitudes and to use a variety of techniques depending on the specific needs of the patient [6]. In an interesting study of 65 analysts, similar findings emerged [7]. Gabbard and Ogden describe this process in "On Becoming a Psychoanalyst" in terms of "a painstaking effort to shed, over time, the shackles of orthodoxy, tradition and one's own unconscious irrational prohibitions"[8]. Fonagy [9] argues in this context that therapists should be able to liberate themselves of the "superstitious" aspects of the analytic frame.

Importantly, Hilsenroth and colleagues (Chap. 22) also discuss in this context the kinds of interventions and therapist attitudes that are likely to undermine the development of the therapeutic alliance. Perhaps, research concerning these latter interventions and attitudes is even more informative than studies concerning attitudes and characteristics that are associated with positive alliance, as these research findings point to a set of common factors that all effective therapists seem to share, but that are very hard to capture and describe. Freud [10], in his *Studies on Hysteria*, described these characteristics as follows: "One tries to do something for the patient in human terms, as far as is allowed by the capacity of one's own personality and the degree of sympathy that one can find for the case in question" (p. 284). However, he quickly hastened to add: "This is probably the point at which it ceases to be possible to express psychotherapeutic activity in formulas" (p. 284). Indeed, the chapter by Hilsenroth and colleagues illustrates how difficult it is to describe these therapist characteristics beyond a simple listing of characteristics and attitudes. Freud's description of doing something "human" out of "sympathy" for someone else seems to capture the essence, however, of such an attitude.

However, although psychoanalytic practice undeniably has changed under the influence of research, there is much that remains to be learned from research findings. As illustrated in the remarkably synthetic chapter by Smith-Hansen et al. (Chap. 23), for instance, both group and single-case studies with the Psychotherapy Process Q-set, developed by the late Enrico Jones, show that the "effective ingredients" of psychoanalytic treatments are not always the ones we theoretically presume to be effective and that are emphasized in psychoanalytic training and handbooks. This echoes Peter Fonagy's view that psychoanalytic treatments may possess many aspects that are based on superstition [9]. Much as Skinner's "superstitious" pigeons thought they could influence their environment by exhibiting certain behaviors, psychoanalytic therapists may continue to use some techniques or interventions because they once perceived them to be effective, while in reality they are not. Likewise, studies with the Psychotherapy Process Q-set show that the predominant techniques used in (psychoanalytic) treatments do not necessarily explain most of the variance in treatment outcome. Moreover, the emphasis by Smith-Hansen, Ablon, R. Levy and colleagues (Chap. 23) on the importance of the *co-creation* of the treatment process by both patient and therapist parallels the call by Luyten, Blatt, and Mayes (Chap. 21) to study the therapeutic dyad, rather than assuming that (psychoanalytic) therapy involves a therapist *doing something to* a patient.

It is clear, moreover, that research with the Psychotherapy Process Q-set allows researchers to enter into the "very private world of dyadic meaning" [11]. Hence, far from being reductionist and

being unable to bridge the nomothetic-idiographic gap, the chapter by Smith-Hansen, Ablon, R. Levy and colleagues (Chap. 23) shows that current psychoanalytic research is able to study what many psychoanalytic clinicians believe to be impossible, i.e., the typical meaning and interactional structures that emerge during the analytic process [12, 13].

In this context, in their chapter (Chap. 26), Hoglend and Gabbard advance perhaps the most provocative argument in this volume. Indeed, based on a review of the existing research literature, including an elegant dismantling study [14], they question the centrality and even the use of transference interpretations in psychoanalytic therapy. Although this position is congruent with some clinical writings, it challenges what many presume to be typical of psychoanalytic treatment. Yet, on closer reading, Hoglend and Gabbard actually suggest a tailor-made approach in that in some patients, and in some stages of treatment, transference interpretations may be productive, provided however that they are given with low frequency. Particularly in patients with relatively low levels of personality organization, low levels of transference interpretations might facilitate the therapeutic process. Yet, high levels of transference interpretations are clearly counterproductive, and "simple" interpersonal interpretations, without reference to the therapist, are clearly as productive if not more productive in most patients under most circumstances. These suggestions parallel the growing realization of the interpersonal nature of treatment process. From this perspective, not addressing transference reactions that hinder the therapeutic process may hamper treatment, but addressing transference too much or too intensely may be equally, if not more, harmful. According to their research, in patients with higher levels of personality organization, in particular, whether one uses transference interpretations or not does not seem to matter.

Yet, although many clinicians will be able to relate to these findings, more research is clearly needed, and it may be premature to generalize these findings. After all, they are only based on a very small number of studies, many of which have important methodological flaws. Indeed, taking research findings seriously also means being appropriately critical in interpreting these findings. In this context, I was struck by two issues. One is the great emphasis in the various chapters in this section, and particularly in the chapters by Hoglend and Gabbard (Chap. 26) and by Hilsenroth and collaborators (Chap. 22), on congruence, compatibility, and mutuality in the therapeutic relationship. To put it somewhat overly schematically: Research summarized in these chapters seems to suggest that as a therapist, one should always make sure that the therapeutic relationship is essentially positive and that interventions do not disturb this relationship too much. Although I am fully aware that I am oversimplifying, I could not help being reminded that psychoanalytic therapy, and particularly the long-term variants, also entails experiences of incompatibility, incongruence, and misunderstanding between therapist and patient. Indeed, as outlined by Blatt and Behrends [15], incompatibility and incongruence between therapist and patient may be as important to further the therapeutic process, much as in normal psychological development experiences of incompatibility are the *primum movens* of many developmental processes [16]. Such experiences, by necessity, disturb the therapeutic relationship, but may be needed to further the therapeutic process, depending of course on whether they occur in a context in which this can be borne by both the patient and the therapist. This is also suggested by research findings reviewed by K. Levy and colleagues (Chap. 24), showing that therapist–patient dyads with incongruent attachment styles seem to lead to most positive outcomes because in these cases, the therapist is better able to challenge the dominant attachment style of the patient. Similarly, Safran and colleagues have shown that particularly for some patients, rupture–repair cycles are part and parcel of the therapeutic process [17]. Moreover, in long-term psychoanalytic treatment and psychoanalysis in particular, it may be necessary to allow negative transference to develop over several weeks to months, before addressing the underlying issues. Prematurely "repairing" such negative transference in an attempt to restore the therapeutic alliance, may hamper, rather than facilitate, the therapeutic process, as it may prevent the discussion and working through of salient issues. Analyses by Thomä and Kächele of the so-called specimen case Amalia X provide a detailed illustration of these issues [12]. Further research is clearly needed concerning this issue, and particularly in what kind of treatments with which kind of patients different

interventions may be indicated with regard to the therapeutic alliance. It is highly likely, however, that such disruptions of the therapeutic alliance facilitate the therapeutic process only when they happen in the broader context of a relationship with an empathic, warm, and, as noted, "human" therapist. This, in fact, may point to an empirically based and therefore also quantifiable distinction between the therapeutic alliance (which may be more "reality based") and the transference relationship (which may be more based on distortions of the therapeutic relationship).

This leads me to a second issue that struck me while reading the chapters in this section, which also brings us closer again to research findings (after all, this is a volume dedicated to research!). The chapters in this section all suggest, as noted, that a "traditional" or "orthodox" analytic stance is not only practiced less by contemporary psychoanalytic therapists, but that it may also be counterproductive. This is congruent with findings in the famous Stockholm Outcome of Psychoanalysis and Psychotherapy (STOPP) study that compared long-term psychoanalytic treatment with psychoanalysis [18]. In this study, outcomes of patients in long-term psychoanalytic therapy were better when they had therapists that endorsed less orthodox attitudes compared to patients that had analysts with a more orthodox stance (e.g., greater emphasis on neutrality, little or no self-disclosure). Yet, in psychoanalysis, both patients with less and more "orthodox" therapists did equally well. Indeed, the wide divergence of analytic attitudes in successful *analytic* cases is also illustrated by research with the Psychotherapy Process Q-set research summarized by Smith-Hansen, Ablon, R. Levy and colleagues in their chapter (Chap. 23). This raises interesting questions concerning similarities and differences between the therapeutic stance and techniques in psychoanalysis and long-term psychoanalytic therapy [19]. The methods and theoretical approaches summarized in the chapters in this section could make a significant contribution to this debate.

Implicit Influences of Research on Psychoanalytic Practice

More than You'll Ever Know!

Not only have research findings changed psychoanalytic practice in many explicit ways, but also in many more subtle, implicit, and often unconscious ways. As the psychoanalyst Lewis Aron has convincingly argued, research findings have implicitly influenced psychoanalytic practice in many ways [20]. For instance, as already noted, psychoanalytic practice has become more interpersonal and intersubjective, which undeniably has been influenced by infant and attachment research. Moreover, most psychoanalysts have largely abandoned traditional conceptions of psychoanalytic treatment and its therapeutic action, perhaps with the exception of those that have closed themselves off – sometimes almost totally – from other branches of science. This precisely proves the point of the implicit influence of research on psychoanalysis. Again, the chapters by K. Levy and colleagues (Chap. 24) and Hilsenroth and collaborators (Chap. 19) illustrate these trends. Likewise, I wonder, for instance, how research findings would look should Smith-Hansen, Ablon, R. Levy and colleagues (Chap. 23) have studied psychoanalytic practice in the 1930s, the 1940s, or even perhaps the 1970s, using the Psychotherapy Process Q-sort. A view into some more orthodox psychoanalytic circles would have been interesting and revealing as well. I strongly believe that they would find much less emphasis on interpersonal and attachment issues, perhaps even on affect.

Clearly, changes in analytic practice have also been influenced by other factors, and perhaps the greatest influence has come from societal changes. It is hard to tell, however, as Arons points out, what has come first: studies on intersubjectivity and interpersonal factors, or societal changes that promoted such studies; most likely, they have reciprocally reinforced each other [20]. Moreover, the scope of psychoanalysis has broadened dramatically, and one should not forget that some of the

pioneers in psychoanalysis already questioned what they saw as "traditional" psychoanalytic technique. However, it is difficult to deny that when one reads traditional handbooks and case studies, with important exceptions, there is a difference in technique and theory. And the changes in theory have clearly influenced technique, as there is little reason to assume that they are relatively independent. In a simple but elegant study, Fonagy [21], for instance, demonstrated the massive decline in words referring to sexuality in the psychoanalytic literature, and one cannot help but wonder what influences this has had on the kinds of issues psychoanalysts focus on in their clinical practice.

Common Processes and Parallels Between the Therapeutic Process and Normal Developmental Processes

A final common theme that appears to emerge from chapters in this section has to do with the increasing realization of the importance of common factors across various therapeutic orientations, including psychoanalytic treatments. For a long time, psychoanalysts seem to have had a tendency to downplay the importance of these factors. Freud's struggle with the issue of suggestion [22] and his often misunderstood discussion of the yields of the "pure gold of analysis" and the "copper of direct suggestion" [23] has definitely set the stage for such an attitude. However, psychoanalysis appears to be finally coming to terms with the role of common factors. Perhaps not coincidentally, this is paralleled by an increasing interpersonal focus and a growing focus on conscious and preconscious thoughts and feelings rather than deeply unconscious themes. Again, the influence of attachment research and infant research in particular seems to be obvious in this context. On the other hand, these trends may also be related to the broadening scope of psychoanalysis and the growing emphasis on relatively brief treatments, which necessitate a more interpersonal focus.

Yet, an even more powerful trend may be underlying these changes in analytic practice and research, i.e., the increasing realization of parallels between the therapeutic process and developmental processes. With the growing realization of the intersubjective and interpersonal nature of human development – which opposes in many ways more traditional drive-based accounts – our understanding of the therapeutic process also appears to have become more interpersonal [24]. Both the chapters by K. Levy and colleagues (Chap. 24) and Luyten and colleagues (Chap. 21) are a good case in point, as both explicitly draw such parallels and suggest that developmental theories may provide a broad, encompassing theoretical framework to study the therapeutic process. Such views indeed open up many interesting new vistas, particularly as our understanding of the (neurobiological) underpinnings of attachment and relationships in relation to the development of the capacity to perceive ourselves and others in terms of mental states ("mentalization") is becoming increasingly clear [24, 25].

What's Next? Implications for Psychoanalytic Research and Training

One, and perhaps the most important, indication of the maturity of a science is its ability to leave behind – even long cherished – theories and assumptions. In this respect, the chapters in this volume can be taken as evidence for the growth of psychoanalytic research as a scientific enterprise.

Yet, this does not make it any easier for clinicians. Not only because many clinicians lack the tools and knowledge to critically interpret research findings, but even when they do have this knowledge and such skills, the question remains how clinicians can translate these findings to their clinical practice. Thus, psychoanalytic researchers are faced with the quite daunting task of doing such translational work. All the chapters in this section, but particularly the one by Hilsenroth and colleagues (Chap. 22), do an excellent job in this respect.

Yet, much more work is needed to change clinicians from interested bystanders into active consumers and users of research. Efforts in this context should not only come from researchers, however. Psychoanalytic societies and training institutes should include a clear research focus in their programs and should foster explicit efforts to facilitate the translation of research findings to clinical practice. This ideally involves collaborative work among clinicians and researchers [13, 26]. Otherwise, valuable clinical insights are threatened to be lost in an attempt to objectify and quantify the clinical process. Similarly, without an emphasis on research, psychoanalytic training programs may become safe havens for orthodoxy, rigidity, and stagnation. Yet, unfortunately, currently, few psychoanalytic training programs include an emphasis on research, and both researchers and clinicians can be held responsible for this. This is all the more reason for clinicians and researchers to join forces and, even better, to promote a scientist–practitioner model within psychoanalysis. Moreover, in an era in which the current scientific and political climate pushes us to adopt a number of assumptions and methods that do not always do justice to psychoanalytic treatment, research could play a crucial role in turning the tables. For instance, the DSM V Axis II Task Force has reintroduced psychoanalytic notions concerning the importance of disturbances in representations of self and other in the classification of personality disorders [27]. This is likely to have a dramatic impact on the assessment of therapeutic outcome in the near future, moving away from easily observable indicators of therapeutic outcome toward more underlying representational features. Psychoanalytic researchers, as illustrated by the chapters in this section, have developed systematic assessment methods to capture these dimensions. Both researchers and psychoanalytic organizations have a clear responsibility in this context to disseminate their findings to the wider scientific community.

They also have a clear responsibility to further promote psychoanalytic treatment research. Indeed, we are far from understanding the multiple complex interactions among therapist characteristics, interventions, techniques, and patient characteristics. Yet, such knowledge may not only change but even revolutionize psychoanalytic training and practice, and therefore more research attention is needed to address these complex interactions.

However, even then, it is likely that a gap will always remain between psychoanalytic treatment research and what is characteristic of psychoanalytic practice. The psychoanalyst Zvi Lothane, for example, in his typically eloquent style, describes how he once “caught” one of his patients rubbing a chair in the waiting room on which he just had spilled coffee. Initially, the patient reacted with much hostility and externalization. Yet, this event later turned out to be a major turning point in treatment, because it led the patient to realize this was his typical way of dealing with his aggression, and how this was related to his childhood and adolescence. Much of this working through occurred in the transference because, based on a discussion of the incident with the spilled coffee, he started to realize that he feared the analyst’s reaction in much the same way as he feared his father’s reaction, and had behaved for a very long time in exactly the same ambivalent way to his analyst as to his father in the past. Do such transference interpretations, often as a consequence of real events happening between therapist and patient, matter more than research findings currently appear to suggest? Or do they matter more in psychoanalysis as opposed to long-term and brief dynamic psychotherapy? Are such events really important as suggested by narratives of clinicians and research on sudden gains [28]? Perhaps, they are of little relevance, and they may simply be a small chain in the many events that lead to change. However, as a therapist, I often have the feeling that it is these “moments of meeting” that capture what (psychoanalytic) psychotherapy is about. Such moments are expressed in a brief exchange, for instance, when opening the door for the patient after a session, that communicates a mutual understanding, or a feeling of emerging understanding and mutuality that is hard to capture, but is definitely there. As many important things in life, such as love and friendship, these phenomena continue to elude us. However, the chapters in this section unmistakably show that we are able to capture indicators and proxies of such processes and current developments, as testified by these chapters, and that these promise to bring us closer to what constitutes and defines the psychoanalytic process. This is no mean achievement, and for me, personally, that is enough for now.

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