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PSYCHOANALYSIS AND OTHER LONG-TERM DYNAMIC PSYCHOTHERAPIES

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Introduction

Basic assumptions

The term psychodynamic psychotherapy has no specific referrent. It denotes a very heterogenous range of psychological treatment approaches which arguably have in common an intellectual heritage of psychoanalytic theory. Psychoanalytic theory itself is no longer based on a unitary body of ideas [see 1 and chapters by Kernberg, Holmes, Gabbard, Ursano and Storr in this textbook]. Notwithstanding the range of conceptualisations for this form of treatment, a number of ideas stand out as core to the psychoanalytic psychodynamic approach. These notions are:

(a) Intra-psychic conflict is an all-pervasive aspect of human experience [2];
(b) The mind is organised to avoid unpleasure arising out of conflict and maximise the subjective sense of safety [3];
(c) Defensive strategies are adopted to manipulate ideas and experience in order to minimise unpleasure [4; 5];
(d) Psychological disturbance arises developmentally; an adaptation that was rational and reasonable at an earlier developmental phase leaves residues that cause maladjustment in adulthood [6];
(e) Social experience is organised into relationship representations; self and other are depicted in specific interactions charged by powerful emotional content [7-9].
(f) These relationship representations inevitably re-emerge in the course of psychoanalytic treatment [10].

Brief overview of theories

Psychoanalytic theory has evolved from the work of Freud following two broadly separate paths which only converged over the past 25 years. In the United States followers of the Vienna school evolved a systematic psychology of the ego, a conflict oriented complex psychological model of the mind and its disturbances [11; 12]. In Europe, only Anna Freud and her followers in London pursued this tradition of psychoanalytic thought [13]. Based on the Berlin school of Karl Abraham [14], Melanie Klein and her followers established a distinct approach focusing on the understanding of disturbance rooted in infantile destructiveness and sadism [15-17]. Some psychoanalysts, undoubtedly influenced by Klein and the idea of the pathogenic nature of the experiences of infancy, gradually discarded the mechanistic psychology of drives and psychology of internal structures in favour of theories of intrapsychic interpersonal relationships (object-relations theory) [18; 19].
As these schools developed in the UK, their influence travelled across the Atlantic. First, Kohut, strongly influenced by Winnicott (albeit without explicit acknowledgement), evolved a psychoanalytic psychology of the self [20-22] and, shortly after, Kernberg arrived at an imaginative integration of ego-psychological and Kleinian ideas [23-25]. In the meantime, in the UK, the Kleinian movement rapidly progressed in their understanding of psychoanalytic clinical experience, moving beyond Klein's original work and integrating some of the key features of the Anna Freudian and the British object-relations traditions [26-28]. In the US, disillusionment with the false certainty provided by ego-psychology became intense

throughout the late 1970s and early 1980s [29-31] and an interpersonalist tradition rooted in the work of Harry Stack-Sullivan [32] became increasingly popular [33; 34].
There are many other new psychoanalytic theoretical approaches, bringing the field increasingly close to total fragmentation. This is because the emergence of new approaches in no way signals the demise of any previous orientations, most of which continue to enjoy considerable popularity among specific groups of psychoanalysts. Psychoanalysis has become a diverse and heterogeneous body of ideas which may indeed defy any genuine attempt at integration [35-37].

Psychoanalysis as treatment

The picture of the development of psychoanalysis as a therapeutic approach is rather different. Broadly speaking, it may be argued that psychoanalysis and other long-term psychodynamic therapies are predominantly verbal, interpretive, insight-oriented approaches which aim at the modification or re-structuring of maladaptive relationship representations. As these infantile or child-like relationship representations are considered to lie at the root of psychological disturbance, it is believed that their modification, primarily but not exclusively, through the use of insight, leads to improved adjustment to the demands of the social world.
Psychoanalysis is the most intensive form of these long-term therapies. The analysand attends treatment three or more times a week over a period of years. The use of the couch and the instruction to the analysand to free associate have been considered hallmarks. There is considerable controversy in most Western countries concerning the number of sessions per week which unequivocally define psychoanalytic treatment. In France three sessions per week is considered standard, in the United States four and in the UK five. Notwithstanding these variations across countries, the distinction between psychoanalysis and other forms of psychotherapy is normally made in terms of the frequency of sessions rather than in terms of the therapeutic stance of the analyst. It is difficult to avoid the conclusion that in the absence of plausible, theoretically based criteria for what is or is not psychoanalytic, against the background of an overwhelming diversity of theoretical frameworks, psychoanalysts have attempted to find common ground in readily identifiable treatment parameters. This problem arises as a consequence of an extremely loose relationship between psychoanalytic theory and clinical practice [38]. It is an indisputable fact that, whereas theory has evolved extremely rapidly in the last half of the 20th century, psychoanalytic practice has changed surprisingly little and continues to provide the core of the psychoanalytic identity.
In this chapter we will not consider the theoretical richness of this field but instead will focus on the clinical constructs which run across the diverse intellectual approaches. The intersection of the two is perhaps clearest in one area which we shall consider in some detail – namely, the therapeutic action of long-term psychoanalytically oriented psychotherapeutic treatment.

Background

Historical development of the psychoanalytic approach to treatment

As is well-known, Freud's discovery of the talking cure [39; 40] was really that of an intelligent patient (Anna O) and her physician (Breuer). The patient found out for herself that certain symptoms disappeared when she succeeded in linking up fragments of what she said and did in an altered state of consciousness (which we would now call dissociative) with

forgotten impressions from her waking life. Breuer's remarkable contribution was that he had faith in the reality of the memories which emerged and did not dismiss the patient's associations as products of a deranged mind. Breuer, of course, left the therapeutic battlefield as soon as his patient's speech and behaviours started to go beyond the boundaries marked out by turn-of-the-century Viennese society. The manifestations of uninhibited instinctual life caused him to abandon both the patient and the method.

Psychotherapy had to wait for a more powerful intellect who would not take fright at the instinctual and animal elements in the psychological world of so-called civilised man. Freud at first rigorously pursued the traumatogenic origins of the neurosis and later, when confronted by evidently incorrect statements, modified his theory assuming consistency between recollection and childhood psychic reality rather than physical reality [41; 42]. The issue of accuracy of memories of childhood sexual trauma remains controversial, although its relevance to psychoanalytic technique is at best tangential [43]. Freud's technique, however, was dramatically modified by his discoveries. The intense emotional relationship between patient and physician, which had its roots in catharsis following hypnotic suggestion, had gradually subsided into what was principally an intellectual exercise reminiscent of association experiments. Patient and physician were working in intellectual partnership to reconstruct the repressed causes of psychiatric disturbance from the fragments of material derived from the patient's associations. It was a highly mechanistic approach reminiscent of a complex crossword puzzle. In the light of therapeutic failures, however, Freud once more restored the emotional charge into the patient-physician relationship, which he had for a time perhaps unduly neglected [44; 45]. However, in place of hypnosis and suggestion, he used the patient's emotion, signs of transference of affect and affective resistance which were manifest in the analytic relationship.

Freud's early clinical work evidently lacked some of the rigour which came to characterise classical psychoanalysis [46]. His occasional encouragement to his patients to join him on holiday might now be considered boundary violations [47]. What is perhaps less well-known is that Freud remained somewhat sceptical about the effectiveness of psychoanalysis as a method of treatment [48]. Autobiographies of some of his patients testify to his great flexibility as a clinician and use of non-psychoanalytic techniques. For example, the famous Viennese conductor, Bruno Walter, describes in his autobiography [49] that Freud decided to treat the hysterical paralysis of his right arm, not by psychoanalysis but by a combination of behavioural methods which today's psychologists would describe as non-graded exposure with response prevention. He simply instructed Walter to go back and conduct as best he could and to observe how the quality of the music did not suffer from his disability as Walter had anticipated [50]. Nor was Freud the only clinician to use psychoanalytic ideas flexibly. The Hungarian analyst Sandor Ferenczi should be credited with the discovery of the treatment of phobic disorders by relaxation and exposure [51].

The technique of psychoanalysis after Freud's death came to be codified, with those (such as Alexander and French and Freda Fromm-Reichmann) who attempted to revive or retain Freud's original clinical flexibility being subjected to powerful intellectual rebuttals [e.g. 52]. In reality, psychoanalysts probably continued to vary in the extent to which they observed the ideals of therapeutic neutrality, abstinence, and a primarily interpretive stance. But these deviations could no longer be exposed to public scrutiny for fear of the forceful condemnation from their colleagues that what they were practising could not be considered psychoanalysis. Personal accounts of analyses with leading figures yield fascinating insights into variations in technique, principally in terms of the extent to which the analyst made use of personal relationship. For example, Guntrip's [53] classic paper on his two analyses with Fairbairn and Winnicott suggests that he felt he benefited as much from the more intellectual, interpretive approach employed by Ronald Fairbairn as from Donald Winnicott's more relationship-oriented approach. In the last 10 years, the pluralistic approach of modern

psychoanalysis has brought out into the open many important dimensions along which psychoanalysts' techniques may vary. In particular, the recent trend to consider analyst and patient as equal partners engaged in a mutual exploration of meaning [54] directly challenged many of the classical constructs. This controversy is too fresh to permit a conclusive assessment. It is evident, however, that fairly fundamental reconsideration of the aims and techniques of psychoanalytic therapy is currently underway.

The role of insight versus the role of the relationship

There has been an ongoing dialectic throughout the history of psychodynamic approaches between those who emphasise interpretation and insight and those who stress the unique emotional relationship between patient and therapist as the primary vehicle of change. The controversy dates back to disputes concerning the work of Ferenczi and Rank [55] but re-emerged with the first papers of Balint and Winnicott in London opposing a Freudian and Kleinian tradition, and somewhat later in the United State with Kohut opposing classical ego psychology. The dichotomy is evidently artificial. It is impossible to envision any effective psychodynamic therapy without both a relationship and an interpretive component [56]. In fact, since the work of Loewald [57], the importance of the relationship perspective has been increasingly recognised, even by ego psychologists. The techniques of psychodynamic psychotherapy can all be placed somewhere along this dimension which Winnicott [58] aptly referred to as "being with" versus "doing to".

Technique – Principal features

Neutrality and abstinence

Based in the classical framework of libidinal theory, Freud made an explicit injunction against the analyst giving in to the temptation of gratifying the patient's sexual desire [59]. Obviously, this is primarily an ethical issue. However, within the psychoanalytic context it also justifies the analyst's stance of resisting the patient's curiosity or using the therapeutic relationship in any way that consciously or unconsciously could be seen as motivated by the need to gratify their own hidden desires. Within this classical frame of reference, the patient must also agree to forgo significant life changes where these could be seen as relevant to current psychotherapeutic work. Such abstinence on the part of the patient is more commonly encountered in the breach rather than the observance. Yet long-term psychodynamic treatment may founder if the emotional experiences of the therapy are obscured by the upheavals of significant life events.

The primary function of abstinence is to ensure the neutrality of the therapist. A cardinal rule of psychodynamic therapy is for the therapist to resist the temptation to direct the patient's association and to remain neutral irrespective of the subject matter of the patient's experiences or fantasies. While it is easy to take this issue too lightly, (and it is perhaps this aspect of the psychoanalyst's therapeutic stance which makes them most vulnerable to ridicule), it is probably genuinely critical for the therapist to retain emotional distance from the patient to a degree which enables the latter to bring fantasies and fears of which they feel uncertain. Nevertheless, neutrality at its worst denies the possibility of sensitivity; recent literature on the process and outcome of psychotherapy makes it clear that the therapist's genuine concern for the patient must become manifest if significant therapeutic change is to be achieved.

Mechanisms of defence

Within classical psychoanalytical theory and its modern equivalent (ego psychology), conflict is seen as at the core of mental functioning [2]. Here defences are seen as adaptations to intra-psychic conflict. Within object relations theories, defences are seen as helpful to the individual to maintain an authentic or "true" self representation [60] or a nuclear self [22]. Within attachment theory, defences are construed as assisting in the maintenance of desirable relationships [61]. The Klein-Bion model makes limited use of the notion of defence mechanisms but uses the term in the context of more complex hypothetical structures called defensive organisations [27]. The term underscores the relative inflexibility of some defensive structures which are thus best conceived of as personality types. For example, narcissistic personality disorder combines idealisation and destructiveness; genuine love and truth are devalued. Such a personality type may have been protective to the individual at an earlier developmental stage, and has now acquired a stability or autonomy which must be rooted in the emotional gratification which such a self-limiting form of adaptation provides [62-64].

Irrespective of the theoretical frame of reference, from a therapeutic viewpoint clinicians tend to differentiate between so-called primitive and mature defences based on the cognitive complexity entailed in their functioning [5]. In clinical work, primitive defences are often noted together in the same individual. For example, individuals loosely considered "borderline" tend to idealise and then derogate the therapist. Thus they maintain their self-esteem by using splitting (clear separation of good from bad self-perception) and then projection. Projective identification [65] is an elaboration of the process of projection. An individual may ascribe an undesirable mental state to the other through projection but when the other can be unconsciously forced to accept the projection and experience its impact, the defence becomes far more powerful and stable. Ogden [66] offers a particularly clear description of this clinical concept. Current clinical use of the term is an extension of the original Kleinian meaning which simply entailed the patient unconsciously fantasising that the recipient of the projection now possessed a part of the patient's self. Projective identification, whereby the analyst is forced to experience a fragment of the patient's self state, has in recent years been considered an essential part of therapeutic understanding [67]. Elizabeth Spillius [68] suggested a useful clarification, denoting projective identification that invited the therapist to actualise the projection as "evocative projective identification". Whether in fantasy or in actualised form, through projective identification the patient can experience a primitive mode of control over the therapist [69]. Wilfred Bion argued that when the self is experienced as being within another person (the therapist) the patient frequently attempts to exert total control over the recipient of the projection as part of an attempt to control split-off aspects of the self. Bion [70] also argued that not all such externalisations were of "bad" parts of the self. Desirable aspects of the self may also be projected, and thus projective identification can be seen as a primitive mode of communication in infancy. There are other aspects of projective identification which we commonly encounter clinically. These include the acquisition of the object's attributes in fantasy, the protection of a valued aspect of the self from internal persecution through its evacuation into the object, and the avoidance or denial of separateness. It is thus a fundamental aspect of interpersonal relationship focused on unconscious fantasy and its appreciation is critical for the adequate practice of long-term psychotherapy.

Some mechanisms of defence are thought to be more characteristic of the less severe psychological disorders (e.g. depression, anxiety, obsessive-compulsive disorders etc.). It is beyond the scope of this chapter to consider in detail the various defence mechanisms a clinician is likely to encounter in ordinary practice. Since Anna Freud's classical work [4]

these defence mechanisms have become fairly generally accepted, if only as terms of mild rebuke between mental health professionals. Thus we generally accept that motivated repression may be associated with momentary forgetting of conflictual contents, that denial may be invoked by individuals wishing to disavow the emotional significance of an experience, that reaction formation is helpful in turning terror into aggression and that identification with the aggressor may be the only solution available to a maltreated child who becomes an abuser in adolescence.

The diagnostic significance of defence mechanisms is controversial. Some researchers have claimed that an individual's habitual mode of defence has predictive value beyond that of psychiatric diagnosis [5; 71]. Given the theoretical ambiguity which surrounds the concept, it is unlikely that its use as part of a diagnostic formulation is justified. It does, however, assist the psychoanalytic clinician in conceptualising the patient's reactions. In particular, these defences are likely to be encountered in the course of psychoanalytic treatment at moments of intense emotional resistance. For example, it is common to observe patients experiencing considerable difficulty in recalling the contents of treatment sessions, yet their memory for other less central aspects of their lives appears to be exceptional. Being alert to the presence of defences is important, not because it provides an opportunity for confrontation with ideas which the patient seems reluctant to acknowledge, but rather because it alerts the analyst to the presence of underlying anxieties which need to be tackled if resistance to the therapy is to be overcome.

Transference

Freud's initial desire to uncover the traumatogenic origins of hysteria led him to see the patient's intense emotional reaction to the therapist as an interference with what was essentially a verbal method [39]. Within a few years Freud fully recognised the importance of transference as a representation of earlier relationship experiences which could make the reconstruction of those experiences highly meaningful to that individual [72].

Patients may experience a whole range of feelings about an analyst including love, admiration, excitement or anger, disappointment and suspicion. The feelings appear to have little to do with the therapist's actual personality as different patients are likely to bring quite disparate feelings about the same analyst at the same time. While clearly not realistic, the actual nature of transference experience is quite controversial. Object relations theorists consider the analyst a vehicle onto which an internal object (a person, an aspect of a person, the self or an aspect of the self) is projected [e.g. 73]. Clearly internal objets are representations which are heavily distorted by both fantasy and defensive processes.

For John Bowlby [8] such feelings are based on expectations gathered through past relationship experience with an attachment figure. They resist understanding of the past relationship by insisting on repeating it [74]. Many analysts do not accept such an isomorphism between past and present. Rather, they see it as something which gives coherence to the patient's experience of the analytic relationship – an aspect of narrative rather than a representation of the historical realities of the patient's experience [75; 76]. By contrast to these workers who see transference as a current construction with little relationship to the past, analysts who work in the Klein-Bion frame of reference see transference as providing an inevitably accurate picture of the patient's current internal world [e.g. 10]. For example, a transference where the analyst is idealised may reflect psychotic anxieties in the patient linked to an intensification of the death instinct. The idealisation serves to protect both the patient and the analyst from fantasised destruction which threatens to engulf them both. Marcia Cavell [77] demonstrated that these alternative models of transference have their philosophical roots in the debate between correspondence and coherence models of truth.

Countertransference

Countertransference is a somewhat controversial concept in psychoanalytic clinical work. The therapist during the course of an intensive long-term treatment is likely to have a range of feelings which are related to the patient's current experience but which may serve to either illuminate or obscure this. Some countertransference experiences may be instances of projective identification and thus can be appropriately attributed to the patient whereas others are likely to be the analyst's neurotic emotional reactions to the patient's behaviour or the material he or she brings [78]. For Freud [79] countertransference was always of this latter type, a neurotic reaction which was likely to obstruct psychoanalytic treatment. It was not until Paula Heimann [80] pointed out that the analyst's feelings and thoughts about the patient at any one time could contain important clues about the patient's unconscious mental state that countertransference started to be seriously considered as part of the analyst's therapeutic armamentarium. Those following an interpersonalist tradition [e.g. 32] saw the recognition of the complementarity of the therapeutic relationship as highly appropriate. From this point of view, the assumption of perfect neutrality on the part of the analyst who is a participant as well as an observer is both an anathema and an anachronism [81].

Indications and contraindications and selection procedures

Medical treatments normally have indications and contraindications. In psychodynamic treatment the term "suitability" indicates a looser notion of the appropriateness of the approach [82]. Nevertheless, based primarily on clinical experience, some writers have arrived at specific criteria for long-term psychodynamic therapy [83]. Some authors have also suggested relatively systematic methods of assessment yielding both diagnostic and prognostic information. Again, the evidence is principally clinical [84]. The majority of psychodynamic clinicians, however, rely on clinical judgements based on interpersonal aspects of their first meeting with the patient [85]. The three areas of assessment are personal history, the content of the interview and the style of the presentation.

A history of one good relationship has been traditionally regarded as a good indicator [86]. By contrast, a history of psychotic breakdown, severe obsessional states, somatisation and lack of frustration tolerance are generally considered contraindications. However, increasingly, as "easy" patients are referred for briefer therapies, long-term psychodynamic therapy has come to be seen as a therapy of last resort. There are case reports of successful treatments of individuals with psychosis [87], learning disabilities [88] and chronically poorly controlled diabetic patients [89].

The content of interviews is harder to judge. In general, the presence of some kind of "mutuality" between therapist and patient is a positive indicator. Some clinicians offer "trial interpretations" which summarise their initial impressions, and a positive thoughtful response to these is regarded a good indication. The capacity to respond emotionally within the assessment session to allow anxiety, sadness or anger to become manifest is a further indicator [90]. Motivation for treatment is harder to ascertain. Most patients express enthusiasm for the treatment, which falls away once they are asked to confront unpleasant or unflattering parts of themselves.

More recently, psychodynamic therapists have given increasing consideration to the style of the patient's discourse during assessment rather than its content. Holmes [91], for example, attempts to identify whether patients' narrative styles are avoidant (sparse and dismissing of interpersonal issues) or enmeshed and entangled (excessive current anger about past hurts and insults). There is one study with findings which indicate that, in a severely personality

disordered population at least, the avoidant type of patient has a better prognosis in psychodynamic therapy [92]. A further relevant capacity often reflected in narrative has been variously described as seeing oneself from the outside [93], reflecting on one's inner world [83] or having fluidity of thought [94]. Holmes [95] considers these aspects under the heading of autobiographical competence.

Managing treatment

Starting treatment

Establishing parameters

Most psychodynamic therapists, explicitly or implicitly, convey objectives and expectations to their patients. The details of this agreement normally include arrangements for a time and a place as well as the length and frequency of sessions. Usually a tentative idea is offered as to the likely duration of therapy: "It is likely to take years rather than months." Most therapists also describe the expected behaviour of the patient and the therapist: "I would like you to be as open and honest with me as possible and say absolutely everything that comes into your mind. This is the fundamental rule." In fact it is very likely, in view of the variety of such agreements that tend to be made, that its emotional context is more relevant than the specific items agreed upon. Such a "contract" implies recognition by both patient and therapist that the process of therapy needs protecting and that it is important enough to require a sacrifice from both parties.

In the treatment of severe personality disorders, contracts may have an additional important function – that of protecting the therapy from incessant enactments, self-harming, parasuicidal gestures and so on. In Otto Kernberg's approach to the treatment of borderline patients the patient formally enters into a contract whereby they undertake not to seek the therapist's help outside of office hours, not to engage in acts of violence and to deal with self-destructive acts through normal medical channels [96]. Whilst such agreements are commonly made in long-term therapy it is by no means clear that they are either essential or useful. A recent study reported by Cheuvas and colleagues [97] found no difference between the effectiveness of psychotherapy with or without the use of contracts.

Formulation of patients' problems

An important part of initiating any psychosocial treatment is arriving at least at a preliminary formulation of the patient's problems. In the case of psychodynamic therapies this represents a special challenge because of the diversity of the possible theories to draw on. In principal, psychodynamic formulations would identify key unconscious conflicts, central maladaptive defences, unhelpful unconscious fantasies and expectations, deficits in personal development and so on. The complexity of such formulations is such that agreements are hard to arrive at even when clinicians follow similar orientations [98]. Some standardised approaches have, however, been offered [71; 99]. In the absence of a generally accepted format for formulating the patient's problems, a list of key parameters may be offered:

(a) the maturity of relationship representations (three or more persons versus just a self-other dimension) [100] ;

(b) the maturity of psychic defences [5];

(c) the extent of whole as opposed to part object relations (e.g. whether a person is represented as performing more than a single function for the patient) [73];

(d) the general mutuality of the relationship patterns described; the quality of attachment to others [101].

It should be noted that that psychodynamic formulations tend to change as treatment progresses. Winnicott described psychoanalysis as "an extended form of history taking" [60].

The middle phase

Supportive and directive interventions in psychodynamic therapy

Supportive techniques are used both explicitly and implicitly in psychodynamic treatment. They include offering explicit support and affirmation; offering reassurances concerning, for example, irrational anxieties about the therapeutic arrangements; expressing concern and sympathy to a patient who has suffered a recent loss; and general empathy for the patient's anxieties and struggles with the treatment.

From a psychodynamic point of view, such supportive interventions are by no means straightforward. For example, Feldman [102] illustrated how patients may experience the therapist's submission to a demand for reassurance as a source of anxiety rather than comfort. They may be unconsciously aware that the therapist's true stance is not compatible with responding with palliatives and therefore face genuine anxieties about their omnipotence in having shifted the therapist as well as about the therapist's weakness in allowing themselves to be manipulated. By contrast, Kohut's [22] emphasis on interpersonal empathy was probably a welcome antidote to the somewhat rigid interpretive stance of American ego psychologists, particularly those whose history of psychosocial deprivation meant that they had experienced little by way of genuine warmth or concern in the past.

The most common use of supportive and directive techniques in psychodynamic psychotherapy are in the service of the therapy itself. Elaborative techniques (e.g. the simple question: "Could you tell me more?") are undoubtedly directive in specifying a topic of interest, but at the same time may be crucial antecedants to interpretive work. Clarification stands in between supportive and interpretive interventions. It is a restatement in the therapist's words of the patient's communication. It may also be crucial in offering a verbal (symbolic) label for a confused set of internal experiences which the patient is poorly equipped to coherently represent. Confrontation is also in between a directive and an interpretive approach. At its gentlest, confrontation may involve the therapist simply identifying an inconsistency in the patient's communication and bringing this to the patient's attention in a generally supportive yet firm way. For example: "You seem to express no sadness about this loss, yet in the past you claimed to have cared a great deal for him".

Regression

An important facet of psychoanalysis and long-term psychodynamic therapy is the activation and exploration of parts of the patient's personality which may be normally hidden behind an over-riding demand to adapt to the demands of every day life. Access to these aspects of personality is achieved through the process of regression. It has been suggested that rather than encouraging regression, the process is best conceived of as inhibiting "an anti-regressive function" in much the same way that certain intimate interpersonal experiences, large group situations and alcohol appear to bring out the more infantile aspects of our character [103]. Some psychoanalysts consider regression to be crucial to successful psychoanalytic treatment [58; 104]. The extent to which a particular treatment involves significant regression appears to be a function of the patient's personality as well as the therapist's particular approach. Fear of regression is an important source of resistance to long-term psychotherapy, particularly amongst those with previous experience of psychotic episodes [103; 105].

Resistance

Resistance is inevitably encountered in any long-term psychodynamic treatment. In fact, the presence of resistance is implied by the term dynamic, which suggests psychic forces both pulling against and pushing towards change. Like regression, resistance fluctuates in the middle stage of treatment. In borderline and narcissistic disorders, the patient's intense resistance signals the patient's desperation to protect extremely fragile self-esteem [22; 106]. In less severe cases, what appears to be at issue is preventing a painful integration of experience, such as the integration of love and hate directed towards the same object [107]. In clinical practice resistance takes a variety of forms. In repression resistance, the patient may experience a temporary difficulty in gaining access to particular ideas and feelings; for example, failing to remember dreams. In transference resistance the patient may appear to wish to keep their relationship with their therapist at an extremely superficial level. In a negative therapeutic reaction the increase of symptomatology occurs alongside therapeutic progress. In Freud's formulation this may be attributed to unconscious guilt. It is quite likely that in at least some patients this form of resistance against psychotherapy is part of a pervasive envious predisposition to eradicate any aspect of their life that they experience as 'good' but beyond their immediate control [24; 108].

The experience of the transference

There is significant debate regarding from what point and how much psychoanalytic therapists should work 'in the transference'. Some analysts are inclined to see transference as pertinent to every aspect of the psychoanalytic situation. For example, Joseph [10] considers the therapeutic situation in toto as mirroring the internal state of the patient. Thus the therapeutic alliance [109] or the 'real relationship' [57] are regarded as subsumed under the transference relationship. In this context it makes little sense to interpret anything other than the transference from the very beginning of the analysis. By contrast, Strachey [110] understood transference as an attempted externalisation of the patient's superego. Unlike other people in the patient's life, the analyst does not accept this externalisation, whether it is idealised, denigratory or judgmental. The analyst conveys his or her understanding of the externalisation by a so-called "mutative interpretation". While Strachey implied that only interpretation of the transference is therapeutic, his view clearly admits other aspects of the therapeutic relationship. Other therapists, particularly Freudian psychoanalysts, regard transference interpretations as an important but not uniquely therapeutic way of providing the patient with insight [109].

The nature of the transference appears to systematically relate to specific clinical groups and hence may have an aetiological significance. For example, specific transference patterns appear to characterise particular groups of narcissistic patients [22]. The 'mirroring' transference is one where patients crave for the approbation and admiration of the therapist which may be a consequence of the failure of the original selfobjects (parents) in their mirroring function. If this transference is undermined by premature interpretations, an opportunity for restoring self-esteem is lost. The 'idealising' transference also enables the patient to address a deficiency in self-esteem by secretly identifying with the object of admiration (the analyst). If the analyst destroys this idealised image within Kohut's framework this is equivalent to a direct attack on the patient's self regard. Other analysts would suspect that behind such an exaggeratedly positive image, lies the patient's true image of the analyst as frustrating or inadequate, which is simply placed out of harm's way by the idealisation.

Commonly, transference includes an erotic component, regardless of the age or even the gender of the analyst. Admitting to such feelings may border on the unacceptable for some patients although it is generally agreed that in these instances sexual feelings are brought forward as a defence against painful recognition of irreparable harm felt to have been perpetrated upon the object or a divergence from recognising the fragmented state of the self

[e.g.64]. Attachment theorists may suggest that sexual fantasies are used in the service of obtaining the attention of an unresponsive attachment figure [111]. Eroticised transference, relatively common in severely traumatised patients, represents an expression of a need for sexual gratification which, in the context of the therapy, is not considered by the patient as unrealistic [85]. Some view this phenomenon as an indication of an immature mode of representing internal reality [112] where only the physically observable outcome is believed to be real. The patient experiences the mere statement of positive intentions as meaningless.

Experience of the countertransference

Intensive psychotherapy inevitably elicits emotional experiences for the therapist and its is often helpful to be able to think systematically about these. The therapist's feelings may be either complementary to or concordant with those of the patient [113]. Concordant countertransferences are the product of primitive, empathic processes within the therapist who "feels" for the patient, who may unconsciously react to experiences implied but not yet verbalised by the patient; for example, inexplicable overwhelming sadness. Complementary countertransferences tend to occur when the patient treats the analyst in a manner consistent with interpersonal interactions within a past relationship. Most commonly this occurs when the patient treats the therapist as he or she experienced being treated as a child. This is known as the "reverse transference" [114].

The mechanisms of countertransference are poorly understood. To assert that countertransference functions via projective identification merely brings one poorly understood phenomenon to account for a second even less well understood one. Sandler [115] suggested that an instantaneous process of automatic mirroring of one's partner in an act of communication accounted for concordant countertransference. The process, which he termed primary identification, was non-conscious and could be brought into awareness only upon reflection. The literature on the observation of infants and their mothers offers some evidence in support of such a process [116]. An alternative account is offered by Fónagy and Fonagy [117]. These authors suggest that a secondary mode of encoding is available within language whereby the use of a language of pretend gestures at the phonemic, syntactic or even semantic level enables the communicator to directly address the unconscious of the recipient of the communication. In other words, anything that can be said in gestures may be communicated unconsciously through language, through phonemic distortion, intonation and other paralinguistic features.

When either concordant or complementary countertransferences mobilise defensive processes within the analyst, countertransference is in danger of becoming disruptive to therapeutic understanding. The analyst may react by unconsciously withdrawing from the therapeutic relationship [118]. For example, in the case of a concordant countertransference where the patient's feelings of inadequacy create a similar feeling in the analyst, the analyst's vulnerability in this area may lead him or her to become defensively angry or excessively motivated to demonstrate his or her efficacy. There may be no simple way of regulating such reactions and the only reasonable strategy might be to carefully monitor one's style of relating, noting anything that is unusual. A number of analysts have pointed to the importance of reflectiveness in this context. Bion [70] highlighted the importance of metabolising and feeding back projections; Sandler [119] pointed to the need for the analyst to allow themselves sufficient freedoms to enact the patient's projections before responding to these analytically; Brenman-Pick [120] suggested that analysts must work through their countertransference identifications, engaging sufficiently with the patient's experience such that the analyst's wish not to know is turned into a potential for knowing.

Some feelings in relation to the patient are not provoked either by the patient's projections or the neurotic feelings these give rise to in the therapist. It required someone of the stature of Donald Winnicott [121] to make the self-evident observation that the provocative behaviour

of certain patients (particularly those in the borderline spectrum) can lead to a normal reaction of "objective hate". The patient's provocative behaviour combined with the therapist's self-imposed helplessness, dictated by the stance of therapeutic neutrality, activates primitive aspects of the therapist's personality [73]. These reactions are merely indications of the therapist's humanity. Analytic understanding of these sometimes intense reaction to patients helps, but models of countertransference ill-fit such experiences.

Countertransference is an interpersonal phenomenon occurring between two mutually influencing psychological systems [122]. The influences are not exclusively, but are predominantly, non-conscious [123]. More recently, it has been suggested that patient and therapist share the unconscious fantasy of having created an inter-subjective field between them [124]. Interpersonalist psychoanalysts stress that the therapeutic relationship generates meaning within a matrix constituted by dialectical tensions [54]. Regardless of the accuracy of such formulations, it is clearly no longer possible to consider the therapist as strictly neutral. The psychotherapeutic process is more accurately viewed as a complex mixture of complementary interpersonal processes which establish themselves in "custom designed" configurations in each treatment [54, p.58].

Interpretation

Interpretive interventions are at the core of psychoanalytic and psychodynamic treatment. Its importance, however, is often exaggerated in relation to other aspects of the therapy. It is a sobering reminder that follow-up studies of long-term psychodynamic therapies invariably demonstrate that patients remember their analyst not for their interpretive interventions, rarely remembering individual interpretations, but rather for their "emotional presence", regardless of the analyst's therapeutic perspective. In 1998 Adam Gopnick wrote a touching article in the New Yorker magazine about his experience of psychoanalytic therapy with an 86 year old analyst. The analyst appeared to have little interest in the patient's problems and in fact had the greatest difficulty in staying awake unless Gopnick fed him with salacious gossip. The interpretations were few and far between and when they occurred they appeared to be by and large platitudinous. Nevertheless, Gopnick recounts that he was deeply moved when he heard about the death of the analyst and felt that he had learned from him to the extent of identifying with him and actually behaving like him.

Interpretations may be classified according to the aspect of a conflict they aim to address [125]: the defence, the anxiety or the underlying wish or feeling. Similarly, the content of the interpretation may be used in classifying interpretations: whether it relates to external reality, the transference relationship or childhood relationships. In principal, in the earliest phases of treatment interpretations relating to current events are most common and, as the treatment progresses, transference issues and the patient's past may increasingly take over as foci of analytic work. Interpretations should start with the patient's anxiety by identifying the defence used by the patient to protect himself from repudiated wishes and affects. In reality, these are guidelines that are rarely followed in practice. For example, very long-term treatments tend to end up being principally supportive exploration of the patient's current experience [126]. Furthermore, interpretations of the distant past tend to be least helpful to individuals with severe personality disorders. Working in the here and now is more effective with these patients whose representation of the past is unreliable and distorted.

Since Strachey's [110] landmark paper, transference interpretations have had a unique place in psychodynamic work. Strachey's justification for giving primacy to such interventions was in terms of the mutative aspect of the patient internalising the analyst as a benign object in place of the patient's excessively harsh superego. Other analysts have justified the focus on the transference differently. Hoffa [127] emphasised the opportunity such interpretations created for the patient to internalise the thinking function of the therapist; Kohut [21] saw such interventions as opportunities for the analyst to undo the damage which experience with

inadequate self-object created. Loewald [57] and Klauber [128] both stressed the importance of transference as a context in which relationships with the analyst as a new object may be established. We have suggested that transference interpretations assist in the development of a representation of other minds and also encourage the adaptation of alternative perspectives [112].

Steiner [129] distinguished analyst-centered and patient-centered interpretations. The former refers to comments on the patient's reactions in terms of what the patient thinks may be going on in the analyst's mind, while the latter directly addresses the analyst's perception of the patient's non-conscious mental state. In either case the patient is directly learning about how minds interact in the context of social relationships [130]. The distinction is important since when patient-centered interpretations are used exclusively the therapist may appear to be persecutory and not to be cognisant of the patient's genuine difficulties in being in an intimate relationship with another person.

The idealisation of the transference has led some therapists to neglect interpretation of the patient's behaviour outside of the therapy. Most clinicians now agree that a balance needs to be struck between these two approaches [131]. Treatment which is over-focussed on the transference becomes a claustrophobic enclave [132]. In certain instances, the direct communication of the therapist's experience of frustration (objective hate in Winnicott's terms) may help to break a rigid repetitive pattern in the therapy [133; 134].

Modes of therapeutic action

The primary mode of the therapeutic action of psychoanalytic psychotherapy is considered to be insight. Insight may be defined as the conscious recognition of the role of unconscious factors on current experience and behaviour. Unconscious factors encompass unconscious feelings, experiences and fantasies. Insight is more than mere intellectual knowledge [135]. Thomä and Kächele [107] consider insight to be equidistant from emotional experience and intellect. Etchygoen [85] distinguished descriptive insights from demonstrated (ostensive) insights which represent a more direct form of knowing, implying emotional contact with an event one has experienced previously.

Although specific formulations of the effect of insight depend on the theoretical framework in which explanations are couched, there is general agreement that insight has its therapeutic effect by in some way integrating mental structures [107]. Hanna Segal [136] sees the healing of defensively created splits in the patient's representation of self and others as crucial. Sam Abrams [137] stresses the reintegration of developmentally more primitive representation into mature schemata as central. One may be more specific by specifying split or part-objects as isolated representations of intentional beings whose motivation is insufficiently well understood for these to be seen as coherent beings [138]. In this case insight could be seen as a development of the capacity to understand internal and external objects in mental state terms, thus lending them coherence and consistency. The same phenomenon may be described as an increasing willingness on the part of the patient to see the interpersonal world from a third person perspective [139; 140]. Those who consider interpretations to occur in a transitional space between subjective and objective objects are probably discussing a similar process [141; 142].

A simple demonstration to the patient of such an integrated picture of self or others is not thought to be sufficient [72]. The patient needs to "work through" a newly arrived at integration. Working through is a process of both unlearning and learning: actively discarding prior misconceptions and assimilating learning to work with new constructions. The technique of working through is not well described in the literature. Yet it represents the critical advantage of long-term over short-term therapy. Working through should be systematic and much of the advantage of long-term treatment may be lost if the therapist does not follow through insights in a relatively consistent and coherent manner. Of course as

psychoanalytic understanding becomes increasingly complex, insight is correspondingly more diverse. One can understand the therapist's difficulty in attempting to sustain an old theme as opposed to pursuing new and exciting discoveries.

In contrast to the emphasis on insight and working through are those clinicians who, as we have seen, emphasize the relationship aspect of psychoanalytic therapy (Balint, Winnicott, Loewald, Mitchell and many others). This aspect of psychoanalytic therapy was perhaps most eloquently described by Hans Loewald when he wrote about the process of change as: "set in motion, not simply by the technical skill of the analyst but by the fact that the analyst makes himself available for the development of a new 'object-relationship' between the patient and the analyst…." [57, p.224-225]. Sandler and Dreher [143] have recently observed "while insight is aimed for it is no longer regarded as an absolutely necessary requirement without which the analysis cannot proceed". There is general agreement that the past polarisation of interpretation and insight on the one hand, and bringing about change by presenting the patient with a new relationship on the other, was unhelpful. It seems that patients require both and both may be required for either to be effective [144-148]. As Pulver [148] put it, a relationship that is therapeutic is unlikely to be sustained unless there is insight into what is going on in the relationship. The interdependence of relationship and interpretive perspective was well summarised by the Sandlers when they wrote, "The analyst has to provide, through his interpretations and the way he gives them, an atmosphere of tolerance of the infantile, the perverse and the ridiculous, an atmosphere which the patient can make part of his own attitudes towards himself, which he can internalize along with the understanding he has reached in his joint work with the analyst" [149, p.423].

It has been suggested that change in analysis will always be individualised according to the characteristics of the patient or the analyst [147]. For example, Blatt's re-analysis [150] of the Menninger Psychotherapy Research Project [151] suggested that patients who were "introjective" (preoccupied with establishing and maintaining a viable self-concept rather than establishing intimacy) were more responsive to interpretation and insight. By contrast, anaclytic patients (more concerned with issues of relatedness than of self-development) were more likely to benefit from the quality of the therapeutic relationship than from interpretation.

Ending treatment

The ending of psychoanalytic therapy is often idealised in clinical descriptions. As there is little agreement on the goals of psychoanalytic therapy [143], it is hardly surprising that there is little general agreement about when ending is appropriate. Desirable final outcomes are mostly stated in terms of the process of treatment and are thus mostly specified in theoretical terms (e.g. increased awareness of impulses and fantasies [152], a reintegration of aspects of the self lost through projective identification [153], the capacity to engage in self analysis [154] etc.). All these, even if observable in the course of treatment, are only loosely related to the aims the patient might have in concluding a lengthy treatment process.

The patient's own goals tend to be outcome rather than process goals and are more easily defined: the decline of symptoms, improved relationships, greater wellbeing, increased capacity for work, higher self-esteem, a capacity for assertiveness. As such changes are clearly achievable without psychodynamic treatment, many psychodynamic clinicians erroneously regard such criteria for ending as superficial. Independent evidence will be required to show that the achievement of process aims results in a more permanent or general achievement of outcome aims, in order to validate process aims as an appropriate criterion for ending.

Ending itself, of course, is a process. There is significant disagreement between authors, however, as to its nature. Authors have labelled the ending of therapy a mourning [155], a new beginning [104], a weaning [156], a detachment [85] and a maturation [157]. It is

inevitable that there is disappointment and disillusion at the ending of long-term therapy as what is achieved is never quite the same as what has been hoped for [158]. Also, the patient loses the object who has been available as a receptacle for projections [129]. It is not surprising then, that symptoms sometimes return, even if only briefly, as part of the process of termination. There is general agreement, however, that with these unconscious issues worked through the ending of therapy requires no special form of intervention on the part of the therapist.

Efficacy

It is often said that there are no studies on the effectiveness of psychoanalysis and long-term psychodynamic psychotherapy. In fact, this is not true. In a recent review undertaken by the International Psychoanalytic Association of outcome studies in psychoanalysis and long-term psychodynamic psychotherapy [159], four case record studies, 13 naturalistic pre-post or quasi-experimental studies, nine follow-up studies and nine experimental studies were identified. In addition, six process-outcome studies were also reviewed.

There have been quite comprehensive reviews of such studies carried out before [e.g. 160; 161-163] and they tend to come to quite different conclusions. It is of course easy to be critical of psychoanalytic studies. There are no definitive studies which show psychoanalysis to be unequivocally effective to an active placebo or even an alternative method of treatment. In fact, there are no methods available that would unequivocally indicate the existence of a psychoanalytic process. Most studies have significant limitations which would lead critics of the discipline to discount their results. Amongst the most common problems are lack of standardised diagnoses, inadequate specification of the treatment procedures, lack of control on selection biases in sampling, the use of inexperienced therapists, unstandardised methods of assessment, lack of statistical power, failures of randomisation, reliance on retrospectively collected data etc. Notwithstanding these severe limitations, many of the studies are impressive for the following reasons: they report results which other psychotherapies have not been able to achieve; some studies show very long-term benefits from psychoanalytic treatment; the results tend to be highly consistent across studies; some of the populations studied have been larger than most better controlled treatment trials. So whereas it is true to say that little that is definite can be stated about the outcome of psychoanalysis, a number of suggestive conclusions may be drawn and these are listed below.

Across a number of studies and measures psychoanalysis has been shown to benefit the majority of those who are offered this treatment [159] and can bring the functioning of a clinical group to the level of the normal population [e.g. 164; 165; 166]. Completed treatments tend to be associated with greater benefits [e.g.167; 168]. On the whole longer treatments have better outcomes [e.g.169; 170; 171]. Intensive psychoanalytic treatment is generally more effective than psychoanalytic psychotherapy [e.g.172; 173; 174], but its superiority sometimes only becomes apparent on long-term follow-up [165]. Psychoanalysis can lead to a reduction in health care related use and expenditure [166; 175] and this is maintained for a number of years after therapy ends [176]. Psychoanalytic treatment can lead to a reduction in the use of psychotropic medication amongst in-patients [177]. Long-term psychoanalytic therapy can reduce symptomatology in severe personality disorder such as BPD [178-180] and these improvements are maintained [181; 182]. Psychoanalysis may be an effective treatment for severe psychosomatic disorders [89; 177; 183; 184].

Training

Training in psychoanalytic psychotherapy and psychoanalysis has three components: a personal psychoanalytic psychotherapy, theoretical training and supervised clinical practice. There are a variety of trainings available, although in most countries there is only one training

organisation that is recognised by the International Psychoanalytic Association. Training is long, chiefly because of the length of supervised treatments. Training standards are carefully monitored by national and international bodies.

Conclusion

Psychoanalysis is hardly a practical treatment alternative for the 21st century. The principles derived from this treatment, however, powerfully influenced other psychotherapeutic approaches, whether long-term or short-term therapy or psychiatric care more generally, particularly in the United States. At the time of its invention, it was the unique effective psychosocial treatment method for psychiatric disorder which offered a genuine alternative to the sometimes barbaric and generally ineffective treatment methods available. Not surprisingly, its proponents adopted an almost religious zeal in defending its value against alternative approaches. While understandable, such an attitude has no place in the sophisticated evidence base underpinning multi-agency service planning. Psychoanalytic clinicians have a challenge in identifying their niche in the complex mental health care delivery systems of the 21st century.

REFERENCES

1. Fonagy, P., Target, M., Steele, M. and Gerber, A. (1995). Psychoanalytic perspectives on developmental psychopathology. In *Developmental Psychopathology: Theory and Methods* (ed. D. Cicchetti & D. J. Cohen), Vol. 1, pp. 504-554. New York: John Wiley & Sons, Inc.
2. Brenner, C. *The Mind in Conflict*. New York: International University Press, 1982.
3. Sandler, J. (1960). The background of safety. In *From safety to superego: Selected papers of Joseph Sandler* pp. 1-8. London: Karnac, 1987.
4. Freud, A. *The Ego and the Mechanisms of Defence*. New York: International Universities Press, 1946, 1936.
5. Vaillant, G. E. *Ego mechanisms of defense: A guide for clinicians and researchers*. Washington, DC: American Psychiatric Association Press, 1992.
6. Settlage, C. F., Curtis, Z., Lozoff, M., Silberschatz, G. and Simburg, E. (1988). Conceptualizing adult development. *Journal of the American Psychoanalytic Association* **60**, 347-370.
7. Kernberg, O. F. *Internal world and external reality: Object relations theory applied*. New York: Aronson, 1980.
8. Bowlby, J. *Attachment and Loss, Vol. 3: Loss: Sadness and Depression*. London: Hogarth Press and Institute of Psycho-Analysis, 1980.
9. Horowitz, M. J., Eells, T., Singer, J. and Salovey, P. (1995). Role-relationship models for case formulation. *Archives of General Psychiatry* **52**, 625-632.
10. Joseph, B. (1985). Transference: The total situation. *International Journal of Psycho-Analysis* **66**, 447-454.
11. Hartmann, H. *Ego Psychology and the Problem of Adaptation*. New York: International Universities Press, 1939/1958.
12. Arlow, J. A. and Brenner, C. *Psychoanalytic Concepts and the Structural Theory*. New York: International University Press, 1964.
13. Freud, A. *Normality and pathology in childhood*. Harmondsworth: Penguin Books, 1965.
14. Abraham, K. *Selected Papers of Karl Abraham*. New York: Brunner/Mazel, 1927/1979.
15. Klein, M. (1945). The Oedipus complex in the light of early anxieties. In *The Writings of Melanie Klein* pp. 370-419. London: Hogarth Press, 1975.
16. Klein, M. (1933). The early development of conscience in the child. In *Contributions to Psycho-Analysis, 1921-1945* (ed. M. Klein) . London: Hogarth Press, 1948.
17. Klein, M. (1948). On the theory of anxiety and guilt. In *Envy and gratitude and other works, 1946-1963* . New York: Delacorte Press, 1975.
18. Fairbairn, W. R. D. *An Object-Relations Theory of the Personality*. New York: Basic Books, 1952.
19. Winnicott, D. W. *Collected papers: Through paediatrics to psycho-analysis*. London: Tavistock, 1958.
20. Kohut, H. *The Analysis of the Self*. New York: International Universities Press, 1971.
21. Kohut, H. *The Restoration of the Self*. New York: International Universities Press, 1977.
22. Kohut, H. *How does analysis cure?* Chicago: University of Chicago Press, 1984.
23. Kernberg, O. F. *Object Relations Theory and Clinical Psychoanalysis*. New York: Aronson, 1976.
24. Kernberg, O. F. *Borderline Conditions and Pathological Narcissism*. New York: Aronson, 1975.
25. Kernberg, O. F. (1985). Neurosis, psychosis and the borderline states. In *Comprehensive Textbook of Psychiatry* (ed. H. I. Kaplan & B. J. Saddock) pp. 621-630. Baltimore MD: Williams and Wilkins.

26. Bion, W. R. (1977). Learning from experience. In *Seven Servants: Four Works by Wilfred R. Bion* (ed. W. R. Bion) . New York: Jason Aronson.
27. Rosenfeld, H. *Impasse and Interpretation*. London: Tavistock Publications, 1987.
28. Spillius, E. B. (1988). Vol. 1. Mainly Theory; Vol. 2. Mainly Practice. In *Melanie Klein Today: Developments in Theory and Practice* (ed. E.B.Spillius) . London: Routledge.
29. Schafer, R. *A new language for psychoanalysis*. New Haven, CT: Yale University Press, 1976.
30. Klein, G. *Psychoanalytic theory: An exploration of essentials*. New York: International University Press, 1976.
31. Schlessinger, N. and Robbins, F. *A Developmental View of the Psychoanalytic Process*. New York: Int. Univ. Press, 1983.
32. Sullivan, H. S. *The Interpersonal Theory of Psychiatry*. New York: Norton, 1953.
33. Mitchell, S. A. *Relational concepts in psychoanalysis: An integration*. Cambridge, MA: Harvard University Press, 1988.
34. Aron, A. and Aron, E. N. (1996). Self and self-expansion in relationships. In *Knowledge structures and interaction in close relationships* (ed. G. J. O. Fletcher & J. Fitness) pp. 325-344. Hillsdale, N.J.: Erlbaum.
35. Pine, F. *Drive, Ego, Object and Self: A Synthesis for Clinical Work*. New York, N.Y.: BasicBooks, Inc., 1990.
36. Greenberg, J. R. and Mitchell, S. A. *Psychoanalysis and Object Relations Theory*. New York: Basic Books, 1983.
37. Wallerstein, R. S. *Psychoanalysis: The common ground*, 1989.
38. Fonagy, P. (in press). The relationship of theory and practice in psychodynamic therapy. *Journal of Clinical Child Psychology*.
39. Breuer, J. and Freud, S. *Studies on Hysteria*. London: Hogarth Press, 1895.
40. Freud, S. and Breuer, J. (1895). Studies on hysteria. In *The standard edition of the complete psychological works of Sigmund Freud* (ed. J.Strachey), Vol. 2, pp. 1-305. London: Hogarth Press.
41. Freud, S. (1899). Screen memories. In *The standard edition of the complete psychological works of Sigmund Freud* (ed. J.Strachey), Vol. 3, pp. 301-322. London: Hogarth Press.
42. Freud, S. (1900). The interpretation of dreams. In *The standard edition of the complete psychological works of Sigmund Freud* (ed. J.Strachey), Vol. 4-5, pp. 1-715. London: Hogarth Press.
43. Fonagy, P. and Target, M. (1997). Perspectives on the recovered memories debate. In *Recovered Memories of Abuse: True or False?* (ed. J. Sandler & P. Fonagy) pp. 183-216. London: Karnac Books.
44. Freud, S. (1904). Freud's psychoanalytic procedure. In *The standard edition of the complete psychological works of Sigmund Freud* (ed. J. Strachey), Vol. 7, pp. 247-254. London: Hogarth Press.
45. Freud, S. (1912). The dynamics of transference. In *The standard edition of the complete psychological works of Sigmund Freud* (ed. J. Strachey), Vol. 12, pp. 97-109. London: Hogarth Press and the Institute of Psycho-Analysis.
46. Jones, E. *The life and work of Sigmund Freud*. (Vol. I). New York: Basic Books, 1953.
47. Gabbard, G. O. (1994). Sexual excitement and countertransference love in the analyst. *Journal of the American Psychoanalytic Association* **42**, 1083-1106.
48. Freud, S. (1937). Analysis terminable and interminable. In *The standard edition of the complete psychological works of Sigmund Freud* (ed. J.Strachey), Vol. 23, pp. 209-253. London: Hogarth Press.
49. Walter, B. *Theme and Variations*. New York: Knopf, 1946.

50. Sterba, R. (1951). A case of brief psychotherapy by Sigmund Freud. *Psychoanalytic Review* **38**, 75–80.
51. Ferenczi, S. (1930). The principle of relaxation and neocatharsis. *International Journal of Psychoanalysis* **11**, 428-443.
52. Eissler, K. R. (1953). The effect of the structure of the ego on psychoanalytic technique. *Journal of the American Psychoanalytic Association* **1**, 104-143.
53. Guntrip, H. (1975). My experience of analysis with Fairbairn and Winnicott. *International Review of Psychoanalysis* **2**, 145-156.
54. Mitchell, S. A. *Influence and autonomy in psychoanalysis*. Hillsdale, N.J.: Analytic Press, 1997.
55. Ferenczi, S. and Rank, O. *The development of psychoanalysis*. Madison, CT: International Universities Press, 1986, 1925.
56. Wallerstein, R. (Ed.). *The common ground of psychoanalysis*. New Jersey: Jason Aronson, 1992.
57. Loewald, H. W. (1960). On the therapeutic action of psycho-analysis. *International Journal of Psycho-Analysis* **41**, 16-33.
58. Winnicott, D. W. *Playing and reality*. London: Tavistock, 1971.
59. Freud, S. (1915). Observations on transference love. In *The standard edition of the complete psychological works of Sigmund Freud* (ed. J. Strachey), Vol. 12, pp. 157-171. London: Hogarth Press.
60. Winnicott, D. W. *The maturational process and the facilitating environment*. London: Hogarth Press, 1965.
61. Holmes, J. *John Bowlby and attachment theory*. London: Routledge, 1993.
62. Rosenfeld, H. (1964). On the psychopathology of narcissism: A clinical approach. *International Journal of Psycho-Analysis* **45**, 332-337.
63. Rosenfeld, H. (1971). A clinical approach to the psychoanalytic theory of the life and death instincts: an investigation into to the aggressive aspects of narcissism. *International Journal of Psycho-Analysis* **52**, 169-178.
64. Steiner, J. (1982). Perverse relationships between parts of the self: A clinical illustration. *International Journal of Psycho-Analysis* **63**, 241-251.
65. Klein, M. (1946). Notes on some schizoid mechanisms. In *Developments in psychoanalysis* (ed. M. Klein, P. Heimann, S. Isaacs, & J. Riviere) pp. 292-320. London: Hogarth Press.
66. Ogden, T. H. (1979). On projective identification. *International Journal of Psycho-Analysis* **60**, 357-373.
67. Heimann, P. (1956). Dynamics of transference interpretation. *International Journal Psycho-Analysis* **37**, 303-310.
68. Spillius, E. B. (1994). Developments in Kleinian thought: Overview and personal view. *Psychoanalytic Inquiry* **14**, 324-364.
69. Bion, W. R. (1955). Language and the schizophrenic. In *New directions of psychoanalysis* (ed. M. Klein, P. Heimann, & R. Money-Kyrle) pp. 220-239. London: Tavistock Publications.
70. Bion, W. R. *Learning from Experience*. London: Heinemann, 1962.
71. Perry, J., Luborsky, L., Silberschatz, G. and Popp, C. (1989). An examination of three methods of psychodynamic formulation based on the same videotaped interview. *Psychiatry* **52**, 302-323.
72. Freud, S. (1914). Remembering, repeating, and working through. In *The standard edition of the complete psychological works of Sigmund Freud* (ed. J. Strachey), Vol. 12, pp. 145-156. London: Hogarth Press.
73. Kernberg, O. F. *Severe personality disorders: Psychotherapeutic strategies*. New Haven, CT: Yale University Press, 1984.

74. Levenson, E. *The ambiguity of change*. New York: Basic Books, 1983.
75. Gill, M. M. *Analysis of Transference, Vol I: Theory and technique*. New York: International Universities Press, 1982.
76. Spence, D. P. *Narrative truth and historical truth. Meaning and interpretation in psychoanalysis*. New York/London: Norton, 1982.
77. Cavell, M. *The Psychoanalytic Mind*. Cambridge, MA: Harvard University Press, 1994.
78. Langs, R. *The bipersonal field*. New York: Jason Aronson, 1976.
79. Freud, S. (1912). Recommendations to physicians practising psychoanalysis. In *The standard edition of the complete psychological works of Sigmund Freud* (ed. J. Strachey), Vol. 12, pp. 109-120. London: Hogarth Press.
80. Heimann, P. (1950). On countertransference. *International Journal of Psycho-Analysis* **31**, 81-84.
81. Renik, O. (1993). Analytic interaction: Conceptualizing technique in the light of the analyst's irreducable subjectivity. *Psychoanalytic Quarterly* **62**, 553-571.
82. Tyson, A. and Sandler, J. (1971). Problems in the selection of patients for psychoanalysis: comments on the application of concepts of 'indications', 'suitability', and 'analyzability'. *British Journal of Medical Psychology* **44**, 211-228.
83. Coltart, N. (1988). Diagnosis and assessment for suitability for psycho-analytic psychotherapy. *British Journal of Psychotherapy* **4**, 127-134.
84. Kernberg, O. F. (1981). Structural interviewing. *Psychiatric Clinics of North America* **4**, 169-195.
85. Etchegoyen, H. *The Fundamentals of Psychoanalytic Technique*. London: Karnac, 1991.
86. Malan, D. H. (1980). Criteria for selection. In *Short-term dynamic psychotherapy* (ed. H. Davanloo) pp. 169-189. New York: Jason Aronson.
87. Rosenfeld, H. (1952). Transference phenomena and transference analysis in an acute catatonic schizophrenic patient. *International Journal of Psycho-Analysis* **33**, 457-464.
88. Sinason, V. *Mental handicap and the human condition*. London: Free Association Books, 1992.
89. Moran, G., Fonagy, P., Kurtz, A., Bolton, A. and Brook, C. (1991). A controlled study of the psychoanalytic treatment of brittle diabetes. *Journal of the American Academy of Child and Adolescent Psychiatry* **30**, 926-935.
90. Orlinsky, D. E., Grawe, K. and Parks, B. K. (1994). Process and outcome in psychotherapy. In *Handbook of psychotherapy and behaviour change* (ed. A. E. Bergin & S. L. Garfield) pp. 270-378. New York: Wiley.
91. Holmes, J. (1995). How I assess for psychoanalytic psychotherapy. In *The art and science of assessment in psychotherapy* (ed. C. Mace) pp. 25-48. London: Routledge.
92. Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Mattoon, G., Target, M. and Gerber, A. (1996). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology* **64**, 22-31.
93. Sandler, J., Dare, C. and Holder, A. *The patient and the analyst*. (2 ed.). London: Karnac, 1992.
94. Limentani, A. (1972). The assessment of analysability: A major hazard in selection for psychoanalysis. *International Journal of Psycho-Analysis* **53**, 351-361.
95. Holmes, J. *Between art and science: Essays in psychotherapy and psychiatry*. London: Routledge, 1992.
96. Clarkin, J. F., Kernberg, O. F. and Yeomans, F. *Transference-Focused Psychotherapy for Borderline Personality Disorder Patients*. New York, NY: Guilford Press, 1999.
97. Chuevas, P. and Lopez, D. *The use of contracts in transference oriented therapy for borderline patients*. Paper presented at the LXI reunion anual y congreso internacional conmemorativo: Sociedad Mexicana de Neurologia y Psyquiatria, Mexico, 1999.

98. Horowitz, L. M., Rosenberg, S. E., Ureño, G., Kalehzan, M. and O'Halloran, P. (1989). Psychodynamic formulation, consensual response method, and interpersonal problems. *Journal of Consulting and Clinical Psychology* **57**, 599-606.
99. Perry, J., Cooper, A. and Michels, R. (1987). The psychodynamic formulation. *American Journal of Psychiatry* **144**, 543-550.
100. Karasu, T. (1990). Towards a clinical model of psychotherapy for depression. *American Journal of Psychiatry* **147**, 269-278.
101. Holmes, J. (1997). Attachment, autonomy, intimacy: Some clinical implications of attachment theory. *British Journal of Medical Psychology* **70**, 231-248.
102. Feldman, M. (1993). The dynamics of reassurance. *International Journal of Psycho-Analysis* **74**, 275-285.
103. Sandler, J. and Sandler, A.-M. (1994). Theoretical and technical comments on regression and anti-regression. *International Journal of Psycho-Analysis* **75**, 431-439.
104. Balint, M. (1949). On the termination of analysis. *International Journal of Psycho-Analysis* **31**, 196-199.
105. Winnicott, D. W. (1973). Fear of breakdown. *International Review of Psycho-Analysis* **1**, 103-107.
106. Kernberg, O. F. (1988). Object relations theory in clinical practice. *Psychoanalytic Quarterly* **57**, 481-504.
107. Thomä, H. and Kächele, H. *Psychoanalytic practice. I: Principles*. New York: Springer-Verlag, 1987.
108. Rosenfeld, H. (1975). Negative therapeutic reaction. In *Tactics and techniques in psychoanalytic therapy* (ed. P. L. Giovacchini), Vol. 2, pp. 217-228. London: Hogarth.
109. Greenson, R. R. *The Technique and Practice of Psychoanalysis*. New York: International Universities Press, 1967.
110. Strachey, J. (1934). The nature of the therapeutic action of psychoanalysis. *International Journal of Psycho-Analysis* **50**, 275-292.
111. Bowlby, J. (1977). The making and breaking of affectional bonds II: Some principles of psychotherapy. *British Journal of Psychiatry* **130**, 421-431.
112. Fonagy, P. and Target, M. (1996). Playing with reality: I. Theory of mind and the normal development of psychic reality. *International Journal of Psycho-Analysis* **77**, 217-233.
113. Racker, H. *Transference and countertransference*. New York: International University Press, 1968.
114. King, P. (1978). Affective response of the analyst to the patient's communications. *International Journal of Psycho-Analysis* **59**, 329-334.
115. Sandler, J. (1993). Communication from patient to analyst: Not everything is projective identification. *British Psycho-Analytical Society Bulletin* **29**, 8-16.
116. Beebe, B., Lachmann, F. and Jaffe, J. (1997). Mother - infant interaction structures and presymbolic self and object representations. *Psychoanalytic Dialogues* **7**, 113-182.
117. Fónagy, I. and Fonagy, P. (1995). Communication with pretend actions in language, literature and psychoanalysis. *Psychoanalysis and Contemporary Thought* **18**, 363-418.
118. Grinberg, L. (1962). On a specific aspect of countertransference due to the patient's projective identification. *International Journal of Psycho-Analysis* **43**, 436-440.
119. Sandler, J. (1976). Countertransference and role-responsiveness. *International Review of Psycho-Analysis* **3**, 43-47.
120. Brenman-Pick, I. (1985). Working through in the countertransference. *International Journal of Psycho-Analysis* **66**, 157-166.
121. Winnicott, D. W. (1949). Hate in the countertransference. *International Journal of Psycho-Analysis* **30**, 69-75.
122. Langs, R. (1978). Some communicative properties of the bipersonal field. *International Journal of Psychoanalytic Psychotherapy* **7**, 87-135.

123.Arlow, J. A. (1993). Discussion of Baranger's paper on "The mind of the analyst: From listening to interpretation". *International Journal of Psycho-Analysis* **74**, 1147-1154.
124.Baranger, M. (1993). The mind of the analyst: From listening to interpretation. *International Journal of Psycho-Analysis* **74**, 15-24.
125.Menninger, K. *Theory of psychoanalytic technique*. New York: Basic Books, 1958.
126.Blum, H. P. (1989). The concept of termination and the evolution of psychoanalytic thought. Annual meeting of the American Psychoanalytic Association (1987, Montreal, Canada). *Journal of the American Psychoanalytic Association* **37**, 275-295.
127.Hoffer, W. (1950). Three psychological criteria for the termination of treatment. *International Journal of Psycho-Analysis* **31**, 194-195.
128.Klauber, J. (1972). On the relationship of transference and interpretation in psychoanalytic therapy. *International Journal of Psycho-Analysis* **53**, 385-391.
129.Steiner, J. *Psychic retreats: Pathological organisations in psychotic, neurotic and borderline patients*. London: Routledge, 1993.
130.Fonagy, P., Moran, G. S. and Target, M. (1993). Aggression and the psychological self. *International Journal of Psycho-Analysis* **74**, 471-485.
131.Stewart, H. (1989). Technique at the basic fault: Regression. *International Journal of Psycho-Analysis* **70**, 221-230.
132.O'Shaughnessy, E. (1992). Enclaves and excursions. *International Journal of Psycho-Analysis* **73**, 603-611.
133.Symington, N. (1983). The analyst's act of freedom as agent of therapeutic change. *International Review of Psycho-Analysis* **10**, 783-792.
134.Coltart, N. (1986). Slouching towards Bethlehem - or thinking the unthinkable in psychoanalysis. In *The British School of Psychoanalysis* (ed. G. Kohon) pp. 185-199. London: Free Association Books.
135.Zilboorg, G. (1952). The emotional problem and the therapeutic role of insight. *Psychoanalytic Quarterly* **21**, 1-24.
136.Segal, H. (1962). The curative factors in psycho-analysis. *International Journal of Psycho-Analysis* **43**, 212-227.
137.Abrams, S. (1990). The psychoanalytic process: The developmental and the integrative. *Psychoanalytic Quarterly* **59**, 650-677.
138.Gergely, G. (in press). Reapproaching Mahler: New perspectives on normal autism, normal symbiosis, splitting and libidinal object constancy from cognitive developmental theory. *Journal of the American Psychoanalytic Association*.
139.Britton, R. (1989). The missing link: Parental sexuality in the Oedipus complex. In *The Oedipus Complex today: Clinical Implications* (ed. R. Britton, M. Feldman, & E. O'Shaughnessy) pp. 83-102. London: Karnac Books.
140.Britton, R. (1992). The Oedipus situation and the depressive position. In *Clinical lectures on Klein and Bion* (ed. R.Anderson) pp. 34-45. London: Routledge.
141.Ogden, T. H. (1989). Playing, dreaming, and interpreting experience: Comments on potential space. In *The Facilitating Environment: Clinical Applications of Winnicott's Theory* (ed. M. G. Fromm & B. L. Smith) pp. 255-278. Madison, CT: International Universities Press.
142.Ogden, T. H. (1992). The dialectically constituted/decentred subject of psychoanalysis II. The contributions of Klein and Winnicott. *International Journal of Psycho-Analysis,* **73**, 613-626.
143.Sandler, J. and Dreher, A. U. *What do psychoanalysts want? The problem of aims in psychoanalysis*. (Vol. 24). London and New York: Routledge, 1996.
144.Cooper, A. M. (1992). Psychic change: development in the theory of psychoanalytic technique. *International Journal of Psychoanalysis* **73**, 245-250.

145.Gabbard, G. O. *Psychodynamic psychiatry in clinical practice: The DSM-IV edition*. Washington, DC: American Psychiatric Press, 1994.
146.Jacobs, T. J. (1990). The corrective emotional experience - its place in current technique. *Psychoanalytic Inquiry* **10**, 433-454.
147.Pine, F. *Diversity and direction in psychoanalytic technique*. New Haven CT: Yale University Press, 1998.
148.Pulver, S. E. (1992). Psychic change: Insight or relationship? *International Journal of Psychoanalysis* **73**, 199-208.
149.Sandler, J. and Sandler, A.-M. (1983). "The second censorship", "the three-box model" and some technical implications. *International Journal of Psychoanalysis* **64**, 413-425.
150.Blatt, S. J. (1992). The differential affect of psychotherapy and psychoanalysis with anaclitic and introjective patients: The Menninger Psychotherapy Research Project revisited. *Journal of the American Psychoanalytic Association* **40**, 691-724.
151.Wallerstein, R. S. *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy*. New York: Guildford Press, 1986.
152.Brenner, C. *An elementary textbook of psychoanalysis*. New York: International Universities Press, 1955.
153.Steiner, J. (1989). The aim of psychoanalysis. *Psychoanalytic Psychotherapy* **4**, 109-120.
154.Busch, F. *The ego at the center of clinical technique*. Northvale, N.J.: Jason Aronson, 1995.
155.Klein, M. (1950). On the criteria for the termination of a psychoanalysis. *International Journal of Psycho-Analysis* **31**, 78-80.
156.Meltzer, D. *The psychoanalytical process*. London: Heinemann, 1967.
157.Payne, S. (1950). Short communication on criteria for terminating analysis. *International Journal of Psycho-Analysis* **31**, 205.
158.Pedder, J. (1988). Termination reconsidered. *International Journal of Psycho-Analysis* **69**, 495-505.
159.Fonagy, P., Kächele, H., Krause, R., Jones, E., Perron, R. and Lopez, L. (1999). *An open door review of outcome studies in psychoanalysis*. London: International Psychoanalytical Association.
160.Lazar, S. G. (Ed.). *Extended Dynamic Psychotherapy: Making the case in an era of managed care*. Hillsdale, New Jersey: Analytic Press, 1997.
161.Roth, A. and Fonagy, P. *What works for whom? A Critical Review of Psychotherapy Research*. New York: Guilford Press, 1996.
162.Crits-Christoph, P. (1992). The efficacy of brief dynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry* **159**, 325-333.
163.Bachrach, H. M., Galatzer-Levy, R., Skolnikoff, A. and Waldron, S. J. (1991). On the efficacy of psychoanalysis. *Journal American Psychoanalytic Association* **39**, 871-916.
164.Teufel, R. and Volk, W. (1988). Erfolg und Indikation stationärer psychotherapeutischer Langzeittherapie. In *Bio-psycho-soziale Medizin* (ed. W. Ehlers, H. C. Traue, & D. Czogalik) pp. 331-346. Berlin: Springer- PSZ.Drucke.
165.Sandell, R., Blomberg, J., Lazar, A., Carlsson, J., Schubert, J. and Broberg, J. *Findings of the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPPP)*. Paper presented at the Annual Meeting of the Society for Psychotherapy Research, Geilo, Norway, 1997.
166.Keller, W., Westhoff, G., Dilg, R. and Rohner, H. H. Studt & the study group on empirical psychotherapy research in analytical psychology. (1998). Berlin: Department of Psychosomatics and Psychotherapy, University Medical Center Benjamin Franklin, Free University of Berlin.

167. Weber, J. J., Bachrach, H. M. and Solomon, M. (1985). Factors associated with the outcome of psychoanalysis. Report of the Columbia Psychoanalytic Center Research Project (II). *International Review of Psychoanalysis* **12**, 127-141.
168. Bachrach, H. M., Weber, J. J. and Murray, S. (1985). Factors associated with the outcome of psychoanalysis. Report of the Columbia Psychoanalytic Research Center (IV). *International Review of Psychoanalysis* **12**, 379-389.
169. Erle, J. (1979). An approach to the study of analyzability and the analysis: The course of forty consecutive cases selected for supervised analysis. *Psychoanalytic Quarterly* **48**, 198-228.
170. Erle, J. and Goldberg, D. (1984). Observations on assessment of analyzability by experienced analysts. *Journal of the American Psychoanalytical Association* **32**, 715-737.
171. Erle, J. B. and Goldberg, D. A. (1979). Problems in the assessment of analyzability. *Psychoanalytic Quarterly* **48**, 48-84.
172. Rudolf, G., Manz, R. and Ori, C. (1994). Ergebnisse der psychoanalytischen Therapien. *Zeitschrift fur Psychosomatische Medizin und Psychoanalyse* **40**, 25-40.
173. Heinicke, C. M. (1965). Frequency of psychotherapeutic session as a factor affecting the child's developmental status. *The Psychoanalytic Study of the Child* **20**, 42-98.
174. Heinicke, C. M. and Ramsey-Klee, D. M. (1986). Outcome of child psychotherapy as a function of frequency of sessions. *Journal of the American Academy of Child Psychiatry* **25**, 247-253.
175. Dührssen, A. (1962). Katamnestische Ergebnisse bei 1004 Patienten nach analytischer Psychotherapie. *Zeitschrift fur Psychosomatische Medizin und Psychoanalyse* **8**, 94-113.
176. Breyer, F., Heinzel, R. and Klein, T. (1997). Kosten und Nutzen ambulanter Psychoanalyse in Deutschland (Cost and benefits of outpatient psychoanalytic therapy in Germany). *Gesundheitsökonomie und Quality Management* **2**, 59-73.
177. Rudolf, G. (1991). Free University of Berlin: Berlin Psychotherapy Study. In *Psychotherapy Research. An International Review of Programmatic Studies*. (ed. L. Beutler & M. Crago) . Washington: American Psychological Association.
178. Bateman, A. and Fonagy, P. (in press). The effectiveness of partial hospitalization in the treatment of borderline personality disorder - a randomised controlled trial. *American Journal of Psychiatry*.
179. Monsen, J., Odland, T., Faugli, A., Daae, E. and Eilersten, D. E. (1995). Personality disorders and psychosocial changes after intensive psychotherapy: A prospective follow-up study of an outpatient psychotherapy project, 5 years after the end of treatment. *Scandinavian Journal of Psychology* **36**, 256.268.
180. Monsen, J., Odland, T., Faugli, A., Daae, E. and Eilersten, D. E. (1995). Personality disorders: Changes and stability after intensive psychotherapy focussing on affect consciousness. *Psychotherapy Research* **5**, 33-48.
181. Stevenson, J. and Meares, R. (1992). An outcome study of psychotherapy for patients with borderline personality disorder. *American Journal of Psychiatry* **149**, 358-362.
182. Stevenson, J. and Meares, R. *Borderline patients at 5 year follow-up*. Paper presented at the Annual Congress of the Royal Australia-New Zealand College of Psychiatrists, Cairns, Australia, 1995.
183. Fonagy, P. and Moran, G. S. (1991). Studies of the efficacy of child psychoanalysis. *Journal of Consulting and Clinical Psychology* **58**, 684-695.
184. Moran, G. S. and Fonagy, P. (1987). Psychoanalysis and diabetic control: A single-case study. *British Journal of Medical Psychology* **60**, 357-372.

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