Jiménez JP (2007) Can research influence clinical practice. Int J Psychoanal 88: 661-679

Can research influence clinical practice?[1][2]

JUAN PABLO JIMÉNEZ
Departamento de Psiquiatría y Salud Mental Oriente, Universidad de Chile, Av. Salvador 486, Santiago, Chile—jjimenez@med.uchile.cl
(Final version accepted 12 October 2005)

After briefly reviewing the unfavourable reception accorded empirical research by parts of the psychoanalytic community, as well as some of the benefits to clinical practice of analysts being involved in research activities, the author examines whether the findings of process and outcome research in psychotherapy and psychoanalysis can help identify the most appropriate forms of intervention for producing therapeutic change, given the specific condition of the patient and the relationship that the individual establishes with the analyst. It is argued that research findings can influence clinical practice on various levels and in different areas, and the paper goes on to examine a number of related issues: the specificity of therapeutic interventions versus the relevance of common curative factors; the dyadic conception of technique and ways of understanding the therapeutic action of the treatment alliance; and the strategic or heuristic conception in psychoanalytic therapy. Finally, clinical material is presented with the aim of illustrating how the knowledge acquired through research can be applied to psychoanalytic treatment.

Key words: research and clinical practice, process and outcome research, adaptive technique, therapeutic factors, therapeutic alliance, psychotherapy and psychoanalysis

¿Puede la investigación influir en la práctica clínica? Después de revisar someramente la difícil recepción de la investigación empírica en la comunidad psicoanalítica y algunos de los efectos beneficiosos en la práctica clínica de la participación de analistas en actividades de investigación, el autor examina si los hallazgos de investigación en proceso y resultados en psicoterapia y psicoanálisis tienen algo que aportar en la respuesta a la pregunta de qué formas de intervención pueden resultar más apropiadas para producir el cambio terapéutico, dadas determinadas condiciones del paciente y de la relación que éste establece con su analista. Se plantea que los hallazgos de investigación pueden influir en la práctica clínica en diferentes niveles y áreas. Así, se pasa revista al asunto de la especificidad de las intervenciones terapéuticas versus el alcance de los factores curativos comunes en terapia; a la concepción diádica de la técnica y la manera de entender la acción terapéutica de la alianza; y a la concepción estratégica o heurística en terapia psicoanalítica. Finalmente, se presenta un caso clínico a través del cual se busca ejemplificar cómo el conocimiento adquirido por investigación puede aplicarse al tratamiento psicoanalítico.

[1]Translated by Alan J Nance.

[2]Dedicated to Horst Kächele

Introduction: Research and psychoanalytic practice

The relationship between research and clinical practice in psychoanalysis continues to be a controversial one. In this regard, Fonagy (2000) is suggestive. Through the 'grasping the nettle' metaphor of his title, Fonagy alludes to the difficult situation in which analysts who are committed to research find themselves, i.e. frequently frustrated and with a sense of futility as regards their clinical colleagues who tend to reject passionately the arguments and findings of research.

The hiatus between research and psychoanalytic practice illustrates the complexity of the relationship between theory and practice. Although researchers and clinicians are ostensibly pursuing the same objective, namely, the improvement of treatment techniques, this commonality has been said to be more apparent than real. Whereas research seeks to reveal the causal relationships between interventions and improvement through the application of methodological controls, the attitude of clinicians is much more pragmatic: they are less interested in identifying the active ingredient than in achieving change itself. Thus, it can be said that the researcher seeks to maximize negative evidence, i.e. to increase the degree of questioning and critique of findings, while the clinician does the opposite, namely, maximize positive evidence in order to be able to act coherently in the therapeutic situation (Bowlby, 1979).

In my experience, however, this apparently radical difference does not actually appear in the way that one would imagine in light of what was said above. Moreover, during the years in which I was in close contact with research activity and full-time researchers at the University of Ulm (1985–90), I observed in my own clinical work the completely opposite effect to what I had expected. After a brief period in which the clinical beliefs I had acquired during my psychotherapeutic and psychoanalytic training in Chile were subjected to systematic questioning within the highly critical context of the research group (this being a time during which I was overcome by strong feelings of uncertainty and contradiction), I soon became aware of notable changes taking place in many areas of my clinical work. These changes are consistent with what Safran and Muran have called 'clinical byproducts of research' (1994, p. 219).

The first of these concerns the emergence of a new empirical attitude, in other words, a habit of evaluating one's own theories in light of observed phenomena rather than selecting events with the—obviously preconscious—aim of propping up these theories. The widespread tendency to idealize the psychoanalytic method quickly gives way when a clinician gets involved in research activity. In my university department, those among the teaching staff who are also practising psychoanalysts regularly conduct clinical interviews and psychotherapies behind a one-way mirror, while being observed by colleagues as well as students, psychologists, and psychiatrists undergoing training in psychoanalytic psychotherapy. We believe that regular exposure to supervision by peers and trainees is of enormous educational value to those of us who undertake it; indeed, it is the best antidote against the idealization of teachers, of ideologies and an uncritical adherence to schools of psychotherapy. The experience of seeing expert psychoanalysts becoming aware of different aspects of their work with patients highlights the hiatus between real psychotherapeutic practice and the idealization of such practice that is transmitted through traditional clinical presentations and reports (Jiménez, 2005).

The second gain made by clinicians who get more closely involved in research is greater conceptual clarity. The need to operationalize our own concepts and set out the evidence for and against a research hypothesis plays a decisive role in defining what can be called 'clinical', in contrast to metapsychological, theory, which

is more removed from phenomena and therefore more prone to being infiltrated uncritically by the ideology associated with one or more schools of thought. This conceptual clarity heightens the capacity to make explicit our own implicit theories (Sandler, 1983), something which is indispensable when it comes to fostering productive dialogue in the clinical context.

What is notable about this change of attitude regarding clinical work and our own therapeutic theories and ideologies is that rather than leading to a kind of paralysis when faced with patients it produces just the opposite effect. In my experience, it increases the freedom to think with patients about the technical interventions best suited to helping them. The pragmatism involved, which could lead to a form of theoretical opportunism, is compensated for by the need to find a rational basis for our therapeutic interventions; in this regard, the findings show that the best outcomes in the clinical domain of hypothesis generation are achieved through a combination of intuitive and analytic–rational processes (Caspar, 1997). Thus, research training facilitates the best combinations as regards the processes of information-gathering and decision-making at the clinical level.

However, in order for it to be transformed into useful knowledge, empirical research must be integrated into clinical judgement. The crucial question in terms of integration lies in the type of empirical research that may be used clinically. Indeed, at present most research is widely regarded as not being applicable in practice. The insistence on testing the efficacy of certain techniques through methodologies that seek to standardize populations undermines the possibility of generalization and the ecological validity of outcomes; the gain in internal validity is achieved at the cost of reduced external validity.

Nevertheless, the inability of research to influence practice denounced by Luborsky (1969) has weakened over the last decade. Indeed, since the publication of the psychodynamic treatment research handbook (Miller et al., 1993), psychoanalytic research has gone some way to meeting the complex needs of therapeutic practice (Kächele, 1995).

The aim of this paper is to assess whether the findings of research into psychotherapy and psychoanalysis might indicate which forms of intervention are most appropriate in terms of producing therapeutic change, given the characteristics of the patient and the relationship established with the analyst. Obviously, this issue has been a long-standing concern of psychoanalysts and is also—or should be—a central issue in the everyday practice of all therapists who are sensitive to the variety that exists among their particular patients. Theoretical and practical diversity, as well as the current permeability of interdisciplinary findings in neuroscience and research into psychotherapy process and outcome and the early mother–infant relationship, have freed the development of psychoanalysis from ideological burdens in such a way that the question posed becomes enormously important. We have moved on from the time when institutional authority and official psychoanalytic training promoted a standard technique, which seemed to be geared more toward the defence of professional identity in the face of burgeoning schools and currents (both within and outside psychoanalysis) rather than seeking to perfect the treatment of our patients. Standard technique increasingly limited the indications for psychoanalysis and all our efforts went into finding patients to suit the method, since a technique that is idealized in this way demands a selective attitude with respect to indication, it being the patient who must adjust to the method and not vice versa. In contrast, modified techniques allow for a flexible set of indications whereby the treatment is adapted to the characteristics of each patient (Thomä and Kächele, 1987). Naturally, such a position conflicts with a uniform definition of psychoanalysis. However, this ongoing debate about what is proper and specific to psychoanalysis has, in my view, become a sterile one. Fortunately, new voices are being heard within the

psychoanalytic community and I agree entirely with Gabbard and Westen, who suggest

> deferring the question of whether these principles or techniques are analytic and focusing instead on whether they are *therapeutic*. If the answer to that question is affirmative, the next question is how to integrate them into psychoanalytic or psychotherapeutic practice in a way that is most helpful to the patient. (2003, p. 826, original italics)

For these authors a modern theory of therapeutic action must describe both *what* changes (the treatment goals) and the *strategies* that are most likely to be useful in facilitating these changes (technique). We have reached a stage where unilateral theories of therapeutic action, however complex they may be, are likely to be of little use due to the variety of change objectives and the diversity of effective methods available for reaching them.

The challenge we are faced with is therefore one of integration. The current task of clinical, theoretical and empirical research is to integrate in a coherent way the range of different therapeutic options. In this paper, I discuss certain aspects of this issue from the perspective of process and outcome research in psychotherapy and psychoanalysis, and illustrate my arguments with material from the psychoanalytic treatment of a depressed patient. However, in my opinion there are a number of questions that need to be clarified beforehand if the goal is to obtain a coherent integration that enables a reformulation of the relationship between the nature of things psychoanalytic and psychotherapeutic. Prior to presenting clinical material therefore, I discuss: first, the issue of the specificity of therapeutic interventions versus the scope of common curative factors in therapy; second, the dyadic conception of technique and ways of understanding the therapeutic action of the treatment alliance; and third, the strategic or heuristic conception in psychoanalytic therapy.

At this point, I briefly introduce a theoretical framework to facilitate the analysis required. According to Goldfried (1980), in order to analyse the role of therapeutic technique, it is necessary to distinguish three different levels: one of therapeutic interventions (technique in the strict sense): a second of therapeutic strategies; and a third concerning theoretical approaches or orientations. Each level poses particular questions for theory and research, but often the debate about the specificity of technique becomes obscured by the lack of distinction between them. For instance, on the highest level of abstraction, that concerning theoretical approaches or orientations, the question which *outcome* research must answer is whether, for example, psychoanalysis as a form of therapy is more or less effective than the various forms of psychoanalytic psychotherapy and, of course, whether psychoanalytic therapies are as or more effective than therapies of other orientations; if the answer is yes, the question is then whether this greater efficacy is uniformly observed with all types of patient. This is a burning issue at present and is related to the question of whether there are specific interventions for specific psychopathological disorders. This latter question has complex links with the sociology and economy of psychotherapy in that the answer to it depends on the possibility of there being ‘empirically supported treatments’ and an ‘evidence-based psychotherapy’. The response we give at this point therefore has a series of consequences that affect the possibility of psychoanalytic therapies being funded by insurance companies, and also affects the relationship that psychoanalysis has with medicine and psychiatry. However, at this level of abstraction there is another question of even greater interest which refers to *process* research, and that is whether a psychoanalyst undertaking psychoanalytic therapy (and guided, naturally, by psychoanalytic theory) *only* offers interventions prescribed by the psychoanalytic theory of treatment or, without realizing it, also applies techniques that do not

explicitly belong to the therapeutic arsenal of psychoanalysis per se. This is a critical point of great importance for the analysis here as it introduces a surprise element into the debate about the specificity of psychoanalytic interventions and has dramatic consequences in terms of the wish of psychoanalysts to differentiate themselves from therapists of other orientations.

Specific intervention versus common curative factors

In this regard, Ablon and Jones (1998) have shown that it is possible, even in manual-based psychotherapies, to detect elements borrowed from other therapeutic orientations and that these common techniques may even be the active ingredients responsible for promoting positive change in the patient. For example, these authors have demonstrated that brief psychoanalytic treatments include various sets of interventions in which therapists, in addition to applying strategies considered to be psychodynamic in nature, also make significant use of technical interventions that are usually associated with the cognitive–behavioural approach (for example, examining 'false beliefs' or irrational thoughts). In other words, there is a significant overlap in terms of the way in which therapists from different orientations apply their treatments, among theoretical models which are assumed to correspond to different intervention strategies. In line with these findings, other authors (Goldfried et al., 1998) have reported a broad overlap between interpersonal psychodynamic therapies and cognitive–behavioural therapy (CBT), *when these were carried out by expert therapists*. In a well-studied sample of treatments, Jones and Pulos (1993) observed that CBT practitioners occasionally use psychodynamic strategies and that it was precisely these techniques which were responsible for change in the patient. In this study, the use of techniques not prescribed by CBT, which probably went undetected by scales designed to measure adherence to the manual, were significantly correlated with change in the patient. At all events, there were important differences between the two approaches. CBT promoted the control of negative affects through the use of intellect and rationality, in combination with strong encouragement, support and reinforcement on the part of therapists. In psychodynamic psychotherapies the emphasis was placed on the evocation of affects, on bringing disturbing feelings into consciousness and on integrating current difficulties within the context of past experience, using the therapeutic relationship as the agent of change.

In a more recent study, Ablon and Jones (2002) applied their research method to transcribed sessions of interpersonal and CBT conducted as part of the National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (TDCRP) (Elkin et al., 1989). Using the Psychotherapy Process Q-Set, an instrument designed to offer a standard language that enables different therapeutic processes to be described, expert therapists developed protocols of ideal treatment regimes for brief interpersonal and CBT. Groups of independent, blind judges reported that the sessions of both interpersonal and CBT adhered more closely to the prototype of the latter. Moreover, in both types of treatment, adherence to the cognitive–behavioural prototype produced stronger positive correlations with outcome measures. The authors conclude that *'brand names' in psychotherapy may deceive* and that the basic premise of randomized controlled trials, namely, that the interventions compared *actually* represent separate and distinct treatments, was not satisfied in the NIMH TDCRP.

In this regard it is illustrative to review the findings of an open clinical trial in which 21 patients diagnosed with panic disorder were treated with manual-based psychoanalytic therapy (Klein et al., 2003). Analysis of the process-outcome correlations revealed that an early focus on the transference had negative effects, whereas a later emphasis was correlated with a successful outcome. However, the most interesting finding in terms of this paper was that two 'specific' process

variables (*Therapist focus on panic dynamics* and *Patient exploration*) were not correlated with outcome. Even more interesting was the fact that 8 of the 21 patients, who simultaneously met the criteria for major depression, also improved despite the fact that the manual did not prescribe the explicit working through of the dynamics that psychoanalytic theory assumes to be associated with depression. As an explanation of these findings, the authors suggest that there are notable areas of overlap:

> In reviewing our videotaped psychodynamic study treatments, it became apparent that interventions that helped patients acknowledge their conflicted aggression seemed to ease anxiety and unconscious guilt. When shame about anxiety was mitigated through improvements in autonomous function, the self-devaluation triggering depressive responses eventually improved. When patients understood their avoidance of independent, competitive situations perceived as dangerous and aggressive, and began to tolerate these fantasies and actions, guilt and narcissistic devaluation were secondarily relieved. (Rudden et al., 2003, p. 1002)

These findings may be one of the reasons for what is known as the 'equivalence paradox' (Stiles et al., 1986), in which it was not possible to demonstrate superiority among different psychotherapeutic approaches. Another explanation that has been put forward concerns the so-called 'common factors'. In the most recent review of this issue, Wampold (2001) concludes that no more than 8% of the variance in psychotherapy outcomes is explained by specific factors ('psychoanalytic' or 'cognitive–behavioural' technique, etc.), and that 70% of the variance is due to general effects, with 22% of variance being unexplained (probably as a result of differences between patients). Thus, the willingness of the patient and the therapist as a person emerge as powerful, common curative factors in all types of psychotherapy.

The power of the therapeutic alliance

Both factors come together in the establishment of the therapeutic alliance, which thus appears as the generic and central factor behind change. Blatt and Shahar (2004) reanalysed the results of the Menninger project (which was unable to distinguish between the outcomes of psychoanalysis and psychoanalytic psychotherapy) and those of the NIMH TDCRP (which also failed to demonstrate differences in the efficacy of cognitive–behavioural and interpersonal therapies). These authors found that the difference lay in the type of patient. Reinterpreting the session protocols and the psychometric tests, Blatt and Ford (1994) distinguished between anaclitic and introjective patients, thus referring to two general dimensions of psychopathology that cut across DSM diagnostic categories. According to Blatt and Shahar (2004), anaclitic patients benefit from relationship-centred therapies and may do well in shorter-term psychotherapy. In contrast, patients who are predominantly introjective respond better to long-term and more frequent interpretative therapies. As regards the mechanism of change the authors argue that psychotherapy is more effective with anaclitic patients (who are affectively labile and emotionally overwhelmed) because it provides a supportive and containing context which leads to a reduction in associative activity during treatment. Psychoanalysis, in contrast, would be more effective in reducing maladaptive interpersonal tendencies and facilitating more adaptive ones, especially in more distant and isolated introjective patients, because its interpretations and explorations more fully engage such patients, thus increasing associative activity during the treatment process.

The findings of the Stockholm psychoanalysis and psychotherapy outcome study showed that

> a significant part of the outcome differences between patients in psychoanalysis and in psychotherapy could be explained by the adoption, in a large group of therapists, of orthodox psychoanalytic attitudes that seemed to be counterproductive in the practice of psychotherapy but not in psychoanalysis. (Sandell et al., 2000, p. 921)

Obviously, this does not mean that neutrality, as a resource, or insight, as an objective, are inadequate. The critical point seems to be that the classical psychoanalytic perspective, under the pretext of the rule of abstinence, appears not to ascribe much value to warmth, to an intense relationship and making patients feel they are being looked after. This does seem to matter in the classical psychoanalytic setting but is of relevance in psychotherapy.

Similar findings were reported in a retrospective study of 763 cases of psychoanalysis and psychotherapy with children at the Anna Freud Centre, London, UK (Fonagy and Target, 1996). The most helpful interventions for the most complex cases differed from those usually described as central in terms of child psychotherapy technique. In particular, interpretations of unconscious conflict aimed at promoting insight, which for many years were regarded as the main feature of this approach, seem to be of limited value in the more severe cases. In contrast, less disturbed young people appear to benefit from an interpretative approach.

The above suggests that it makes no sense to discuss the effectiveness of psychoanalytic technique in abstract terms: for example whether psychoanalysis or psychotherapy, or a given therapeutic approach, is better. Outcome, i.e. the success or failure of treatment, would appear to depend on the coming together of a type of willing patient and an analyst with certain personal and professional characteristics who is able to reach out to this patient. In this regard, the findings of the Boston psychoanalysis outcome study (Kantrowitz, 1993) support the notion that, rather than the personal characteristics of the patient and the analyst being important in isolation, it is the match between them that matters:

> while there may be some characteristics of particular patients and analysts that seem to make them either well- or ill-suited partners from the outset, the dynamic aspect of their interactions, their resonances and dissonances, and their joint capacity or limitation in expanding the ‘blind spots’ or bridging the differences that develop over the course of the analytic work are likely to be central to the outcome. (p. 327)

Ablon and Jones (2005) sought recently to identify and evaluate the process of change in psychoanalytic treatments. As in previous studies, they applied the Psychotherapy Process Q-Set methodology to different samples of treatment session transcriptions, this time, from psychoanalysis, long-term psychoanalytic psychotherapy and brief psychodynamic therapies. The results showed that the construct ‘psychoanalytic process’ featured significantly more often in psychoanalysis compared with long-term analytic therapies, and that the same construct was favoured significantly more often in the latter kind of therapy as compared to brief psychodynamic therapies. A second investigation showed that despite the consensus regarding the nature of the psychoanalytic process *there is no single and universal analytic process*, and processes of change are specific to each analytic dyad. Each analytic partnership has a unique interaction pattern and these patterns are linked to the progress of treatment. These unique dyadic processes constitute recurrent patterns of interaction of analyst and analysand, who influence one another reciprocally. The experience, recognition and comprehension of these repetitive interactions are shown in this study to be fundamental components of therapeutic action. Thus, the authors propose a two-person model that bridges the gap between theories of change focused on insight and self-knowledge, and those which emphasize the experience that the patient has of the therapist.

In light of these findings, it is worth asking whether the standard technique has been little more than an illusion, something which never existed in real practice, at least not among more thoughtful analysts able to demonstrate a reasonable rate of therapeutic success. These considerations lead to an extension of the concept of treatment technique to cover *the set of rules that enable curative factors to be maximized and iatrogenic ones to be minimized*, and to a definition of the 'good therapeutic intervention' as the intervention *offered by a skilled therapist, i.e. one who knows how to integrate knowledge and empathy, to a patient who is willing to receive it.*

What is clear is that there is an enormous amount of empirical evidence and a growing clinical consensus in favour of regarding the quality of the therapeutic bond as a powerful predictive factor in treatment outcome. Obviously there remains the question (which should be resolved through further research) of whether the therapeutic alliance is *in itself* the curative component of therapy or whether the relationship creates the interpersonal context in which other therapeutic elements can take effect (Horvath, 2005). At all events, the idea is that the resistances and counterresistances, produced out of the interaction of transference and countertransference, permanently subvert the 'best possible bond' between analyst and patient (Orlinsky, 1994).

Recently I have had the experience of supervising analytic cases guided by the process categories that arise from empirical findings regarding the characteristics of the 'good therapeutic bond' (Orlinsky et al., 2004). Obviously, there are different traditions in terms of the style of analytic supervision, but personally I follow the recommendations of Szecsödy (1990), which are based on empirical research. These involve creating, in the relationship with supervisees, a situation of *mutative learning* in which they learn to recognize the system of interaction they establish with patients. Within this framework I suggest to supervisees that they review the state of the therapeutic bond before trying to elucidate, for example, the characteristics of the unconscious fantasy being represented in the session under consideration. The following example may serve as an illustration.

The supervisee was a candidate at an advanced stage of analytic training and was supervising his second control case. The patient, a young man aged 21, was a law student who had sought help due to obsessive ideation (irrational fears of having AIDS), diffuse anxiety, shyness, difficulties with interpersonal contact, and fears regarding homosexuality. The start of the analysis was difficult, with a forceful display of obsessive defences encapsulated by a situation of 'not touching oneself', which rapidly became characterized as like 'being inside a tube'. Associations referred almost exclusively to the obsessive symptoms and there was no reference to other situations or affects in relation to third parties or the analyst. For his part, the analyst felt that his interpretations were going to break the patient and he noted that excessive caution on his part increased the patient's anxiety.

Monitoring the bond in accordance with the model based on research findings quickly led us to detect problems related to the interactive co-ordination of the respective roles. The patient took refuge in a kind of controlling passivity and the therapist found himself adopting a stance that allowed this control to occur. The suggestion that this situation should be interpreted directly led, initially, to a 'breaking of the tube', which took the form of a panic attack suffered by the patient during a weekend. Interpretative work in this area enabled the patient–analyst dyad to move progressively out of the 'tube', and with this the material became more emotional, firstly in relation to external relationships (his family and girlfriend) and later with respect to the analyst himself.

After a period in which the working team was consolidated, the model-based monitoring revealed that other aspects of the relationship were becoming important.

For example, there were long periods in which the most important problem was to be found in the area of empathic resonance. The analyst felt isolated from the patient, and the material made no sense to him. It seemed that the 'tube' had been transferred to the analyst's countertransference. Indeed, it was reflection upon this (counter)resistance that led to the discovery of certain countertransferential fantasies and enabled the process to continue. Later, the analyst noted the appearance of positive feelings with respect to the patient, which, in accordance with the model, was understood as a favourable indicator of the analytic process. With this example, I merely wish to illustrate the use of the empirical model's categories in monitoring, from a *formal* point of view, the session-by-session state of the therapeutic bond. The model's categories facilitate the prompt detection of the problem, and thus enable it to be overcome through suitable interventions.

From the point of view of a strategic conception of therapy, it is extremely important not to lose sight of the characteristics of a good therapeutic bond, since the promotion of these features enables them to become heuristic, in other words, they become technical principles and strategic objectives that co-determine interventions according to the rules of good therapeutic practice. However, empirical research into the psychotherapeutic process has gone a step further in order to focus on the micro-processes involved in the therapist–patient interchange. The study of affective interchange processes shows that the empathic encounter takes a non-verbal form, through visual contact, body postures and adjustments in the tone of voice (Beebe and Lachmann, 2001). Various German studies of singular psychopathological conditions and varied therapeutic situations have shown that facial contact, especially the affective facial behaviour of patient and therapist in their interaction, is an indicator of the affective bond and a significant predictor of therapeutic outcome (Krause, 1990, 1998; Benecke et al., 2001, 2005). Benecke and Krause (2005) suggest that the general processes of productive therapeutic work should be modified according to the specific disorder and, in turn, the type of relationship offered by the patient who comes for treatment. These studies open up promising avenues for the development of adaptive techniques, whereby the therapeutic interaction can be modified depending on the specific disorder and the corresponding relational offer of the patient.

Benecke and Krause (2005) analysed the psychoanalytic psychotherapy treatment offered to 20 patients with panic disorder. In terms of affective facial behaviour the results fell into two clusters. A type I patient showed high total activity, with a predominance of expressions of happiness but with simultaneous negative affects and relational behaviours experienced as manipulative. If the therapist frequently responded to their relational offer with a smile, the prognosis was poor. In contrast, abstinence on the part of the therapist with respect to this offer improved the prognosis. A type II patient showed reduced facial activity, except for happiness, sadness and contempt, and the expressive sobriety appeared to indicate a relational deficit. In this cluster, the frequency of the therapist's smile was correlated with a good prognosis. It seems that with type I, the therapist's smile served the function of giving support and avoiding conflict, whereas with type II, it would be a prerequisite for establishing a relationship. In both groups, the successful therapists behaved in a way that was contrary to the patient's attempts to instigate a given relational pattern. It is thought that the therapist's behaviour enabled patients to achieve a new relational experience in such a way that the pathogenic relationship patterns and the underlying conflicts and affects could be worked through.

Evidently, the possibility of implementing a specific modification of the treatment technique in line with the characteristics of each individual patient will depend on the ability of analysts to adapt their own characteristics, both personal (empathy) and professional (therapeutic style), so that they enter the encounter in a way that is

matched therapeutically with the relational offer brought to therapy by the patient. This would seem to be an empirical question that must be addressed for each therapeutic dyad. However, a pluralistic psychoanalytic training that considers clinical knowledge from a critical perspective based on the diversity of psychoanalytic theory, on the findings of cognitive neuroscience, and on research into the process and outcome of psychotherapy and psychoanalysis, as well as the early mother–infant relationship, should foster the development of a flexible psychoanalytic attitude and disposition.

The strategic conception in psychoanalytic therapy

Between the level of analysts' approaches or orientations and their particular technical interventions, there is an intermediate level consisting of clinical strategies, which function as heuristics that implicitly guide therapists' efforts. Therapists' interventions are here defined both by specific goals and the methods through which an attempt is made to achieve them. The goals in question are not the ultimate treatment objectives, such as remission of a depressive disorder or resolution of a marital conflict, but rather involve strategies for developing psychological states and skills that may induce change or help patients produce the desired changes in themselves or in certain aspects of their lives. Ambühl and Grawe (1988) distinguished between four procedural heuristics: 1) strengthening the alliance; 2) promoting reflexive abstraction; 3) in-depth exploration of emotional processes; and 4) improving conflict resolution skills. Recently, Fonagy et al. (2002) have proposed the promotion of 'mentalized affectivity' as a basic strategy in psychoanalytic therapy with more disturbed patients.

Typically, a given strategic objective may be met through one or a combination of various techniques: e.g. reflexive abstraction may be achieved by means of interpretation, exploration or experiential confrontation. A specific technique may also be used to meet several heuristic objectives, such as interpretation to promote reflexive abstraction and in-depth exploration of emotional processes or strengthening of the therapeutic alliance. The achievement of goals implicit within the various therapeutic heuristics may be the result of a series of intrasession impacts on the patient. For example, a strengthened alliance should lift the patient's mood; mentalization should broaden the patient's awareness of his affective processes; improved conflict resolution skills should promote a sense of self-efficacy, etc.

According to empirical findings, of the four heuristics identified by Ambühl and Grawe (1998), only 'promoting the therapeutic relationship' with the patient is directly linked to the overall outcome. This heuristic includes the objectives of helping patients feel more comfortable in therapy, to develop trust in the therapist, and to feel more positive in themselves. The skill of the therapist in this heuristic is also significantly associated with outcome, thus suggesting that its effect on outcome is mediated by the therapist's ability to improve the quality of the therapeutic bond. The other three heuristics are not directly related to outcome, although the efforts made by therapists in 'promoting reflexive abstraction', 'promoting emotional processes' and 'improving competency' in their patients are positively correlated with outcome, provided that patients show a specific receptivity to this type of impact.

In this way, the particular techniques or methods used by therapists may be conceived of as tactical interventions designed to implement strategic objectives. These vary according to the treatment model being followed, the technical skills and preferences of the therapist and, ideally, the needs and abilities of the patient.

How can knowledge from practice and research in psychotherapy and psychoanalysis be related to specific patients?

Mrs M, aged 50, seeks help due to a dysthymic disorder of late onset and moderate intensity. Her condition is complicated by major depression, characterized by difficulties in falling and remaining asleep, lack of energy, pessimism as regards the future, a tendency towards irritability and a readiness to cry, lack of appetite, intense feelings of guilt, and a feeling of not getting as much done as she could. Professionally she works in a field that requires a quick response and mental agility, as well as the ability to establish interpersonal relationships; she feels diminished in her capacity and work output. She has been married for 25 years and has three children; she already visualizes the moment when they will begin to become more independent and leave home. The family environment is very competitive, and all its members are highly intelligent. The depression worsened (becoming a double depression) a few months after the death of her mother (a little over 2 years previously), with whom she had always had a poor relationship, although she says that this never bothered her much. Now, however, she is tortured by the idea of having behaved badly toward her mother, of not having loved her enough, and she feels very guilty. In fact, her past is an enormous burden on her and she is almost permanently taken up with terrible memories of her life which she thought she had completely forgotten. Her parents had emigrated from Europe, and she and her brother were born in Chile. She always felt very ashamed of her parents' customs, of their difficulties with the language, their peculiar behaviour, etc. Since early childhood she struggled to achieve beyond her means and behave as would an older girl. She excelled in her studies. Now she feels she has not achieved what she aimed for, and in passing expresses certain resentment at the male chauvinist world that doesn't allow women to be successful. She feels exploited by her husband and her children. Everything must be perfect at home. She must be the best housewife, the best spouse and the best mother, but she feels she no longer has the energy for this and is very angry that her family fail to understand her situation. However, neither does she wish to give up on the satisfaction she obtains when, at home or at work, people admire her and take note of her great efficiency and skills. When I put it to her that she is depressed and needs a combined treatment of psychotherapy and antidepressants, she says that under no circumstances will she take medication as she wishes to prove to herself that she will get by solely through talking to me. I suspect that behind her comment lies an important narcissistic component, as well as intense paranoid anxieties. Her depression is predominantly introjective in nature (Blatt, 2004). I believe that she feels great mistrust and an intense fear of becoming even more depressed, of losing what remains of her autonomy and breaking down completely.

For modern psychoanalysis, depression is a varied and complex syndrome associated with different signs and symptoms, which may manifest as well-defined disorders that fit within current classification systems and which can be arrived at in different ways. The latter can be organized according to a series of causes ranging from the biological or constitutional to the psychogenic (Winograd, 2005), and the aim of diagnosis is to discover, with patients, the particular way in which they became depressed.

The central conflict that took shape in my mind during the initial sessions with Mrs M focused on her desire to be perfect, loved, admired, etc. This desire, which she could not give up, was not being satisfied (Bleichmar, 1996). Although Mrs M interpreted this situation partly as a product of the refusal of others to recognize her merits, at a deeper level she experienced it as the natural outcome of her own

inability and, ultimately, as an unconscious conviction regarding her guilt and lack of worth for the damage she had caused in her life. She was immersed in a state that oscillated between resentment and rage against those close to her and an intense feeling of worthlessness and impotence accompanied by self-recrimination. The death of her mother had triggered a pathological mourning process that clearly revealed the enormous ambivalence she felt toward her parent, and which saw the emergence of all the rage she had built up over the years but had taken little notice of; prior to the death, the aggressive feelings towards her mother had been denied and dissociated. The pathological mourning brought out in Mrs M a series of negative emotions and thoughts, as well as feelings of anger, which did not correspond to the ideal image she had of herself. This constituted an attack on the way she saw herself and on her self-esteem, and triggered the depression. This attack immediately activated attempts at restoration and she sought to be more efficient, e.g. by becoming especially concerned about her elderly father. In this way, however, the gap between reality and her ideals merely got wider, until, feeling she was living on borrowed time, she decided to seek help. I was able to observe many vicious circles, which through a series of feedback loops maintained and deepened her depression. Obviously, the mere fact of feeling depressed, without appetite or energy, and recognizing this in front of me produced a narcissistic wound that damaged her self-esteem. The anger and guilt which were activated in the mourning process also left her feeling bad about herself, imperfect. She was unable to set limits with her children and husband and ask them to help more around the home, as this was tantamount to accepting imperfection. When, after many doubts, she was finally able to do so, she was so surprised and bemused by her children's response that she was left feeling irritated, and this served to heighten her guilt and the feeling that she was losing control of her emotions. I offered her twice weekly exploratory psychotherapy, centred on the issues described above. Although I thought antidepressants were indeed indicated, I understood her reasoning, precisely in relation to the dynamics of her depression, in which narcissistic components played an important role. I put it to her that I understood and accepted her reasoning, adding that I hoped that at some point she would come to see the potential benefits to her of antidepressant medication. In addition to refusing medication, she had also said she didn't need psychoanalysis as she couldn't bear not to see my face or come more than twice a week. I responded by saying that a twice weekly, face-to-face therapy was precisely what was indicated. At this point, I thought that with the development of the therapeutic process, the psychotherapy could acquire increasingly expressive characteristics, in other words, I hoped that it would turn into psychoanalysis as a result of the immanent evolution of the treatment.

Stages of the psychotherapeutic process

As regards the sequential stages of treatment, empirical studies indicate that there are qualitative differences between them (Howard et al., 1993). The first outcome to appear is *remoralization*, in other words, the instillation of hope in the patient that the problem which led to treatment being sought may be resolved with the help of this therapist. It is in this stage that the therapeutic alliance is established. When work shifts to therapeutic exploration, the stage of *remediation* is entered, which culminates in the disappearance of symptoms. In the final stage, *rehabilitation*, the working-through of unconscious conflicts leads to the patient giving up old and maladaptive dispositions. In the treatment of depressive patients, this stage is very important in terms of preventing relapse.

The first stage of treatment with Mrs M was centred on establishing the working alliance. Although my main objective was to listen to her and seek to empathize with the underlying reasons for the depression, certain interpretations inevitably proved to

be premature and were received as criticisms. I will never forget the occasions on which Mrs M—without saying a word—received, with tears in her eyes, i.e. with intense pain and humiliation, some of my interventions that sought to make her aware of the dynamics of her depression. Later in the therapy, when she felt calmer, she was able to speak about this pain and also the intense guilt she felt when thinking of her dead mother. For my part, during these episodes I felt myself to be clumsy, poorly empathic and guilty.

Clinical experience shows us that the oversusceptibility and narcissistic vulnerability of depressed patients is something which must always be borne in mind. Any empathic failure on my part, such as a prolonged silence, a short delay or an unscheduled—or even scheduled—interruption, was reason enough for Mrs M to feel abandoned, rejected and believe that I had not the slightest interest in her. At times, not even the intense separation anxiety that infiltrated the therapeutic bond could manifest itself: Mrs M would react first by withdrawing and blaming herself. This obviously constituted an important countertransference burden that placed great demands on me.

During this stage I was able to specify further the dynamic focus, that is, to formulate in greater detail an explanation of the underlying reasons for the depression. Alongside this process of empathic understanding and development of an intellectual explanation in my mind, the patient began to display forms of attachment transference. In this way, the relationships based on domination which Mrs M established with significant others in her life were reproduced with me: thus I became a ‘dominant other’ (Arieti, 1977).

Once we had established a ‘sufficiently strong’ bond that was able to withstand the vicissitudes of the transference, therapy entered a more expressive stage. The objective of this second stage was to enable awareness of the conflicts underlying the symptoms and the relationships based on domination established by the patient. As Mrs M was basically an introjective patient, this stage was particularly important. Here I sought to show her how the same behaviour pattern and relationships based on domination appeared in all significant areas of her life (in family relationships, with friends, at work, etc.), and this enabled the discovery of the infantile roots of her object relations. The main therapeutic objective was to redirect the symptoms, and the object relations underlying them, toward the interpersonal domain which had given rise to and maintained them. This working-through naturally led to the transference relationship, especially the interpretation of unconscious hostility and to negative transference. Thus, at one point, Mrs M began to see me as someone who ‘intimidated’ or demanded too much of her. An overly supportive attitude, which led me to validate each step forward she made, thus became a trap as such confirmations were experienced as demands for even greater achievements. Sooner or later, I came to feel that I had not been supportive enough, that I had left Mrs M in the lurch and not given her all she needed. I felt that she regarded me with contempt and rage, this being an expression of her disappointment with the treatment, and she was able to begin expressing her anger somewhat more directly. At times she felt that our relationship was strong enough, and at these points such expressions of anger were welcome as she regarded it as positive that she was able to recognize negative emotions towards me, at the same time as feeling sure that I was able to contain them without returning them to her or becoming offended. With the repetition of many such cycles Mrs M slowly came to the conviction that I respected and valued her, and that I was genuinely interested in her. An important issue at this point involved working through the pathological mourning which formed part of her experience. The key here was becoming aware of the prior ambivalence towards the loss of her dead mother. Work with memories and feelings related to her mother

opened up aspects of the past that had been completely shut away, and yet which shed considerable light on her present life.

The introduction of the latest generation of antidepressants, which have fewer side effects, has enabled psychotherapy to be offered to severely depressed patients, and under medication these patients are able to tolerate psychotherapeutic exploration with less susceptibility. When, after a few months, Mrs M accepted medication she began to be able to think about herself without suffering the emotional lability and readiness to cry that impeded any exploration which went beyond non-verbal accompaniment. Alongside her increased tolerance I felt less overwhelmed by her emotional states.

The 'remediation' stage, which coincided with the disappearance of symptoms and analysis of the 'ideology of domination', slowly gave way to a third stage whose goal was the modification of maladaptive behaviour patterns, i.e. of the internal object relations underlying the desires whose irremediable frustration led the patient to become depressed. Obviously, it is not easy to modify idealized aspirations to such an extent that they can be fulfilled, or given up and replaced by more realistic life goals; indeed, this is generally a slow and gradual process. Another patient once said to me that nothing had changed, and that she continued to feel she fell short of the demands she made of herself but that this no longer mattered as before; a change began to take effect in her harsh superego and she was able to tolerate better her own limitations. In the case of Mrs M, however, treatment was interrupted precisely, in my view, because she was unable to tolerate giving up her idealized and largely unrealistic aspirations. After a little over a year of treatment, she reached a point of feeling better, less depressed and did not wish to go on exploring her unconscious expectations of life. Her perfectionism and inflated ego-ideal, which formed the nucleus of her narcissistic pathology, did not allow her to continue with a treatment that was a source of permanent humiliation. For my part, what happened with Mrs M confronted me with the repeated experience of having to give up, once again, my own ideas regarding the goals that patients should reach through analytic treatment.

Conclusion

The information that I have reviewed, which comes from process and outcome research in psychotherapy and psychoanalysis, strongly supports the idea of a flexible and adaptive therapy. The clinical material has aimed to show how research, in turn, can throw light on psychoanalytic treatment. Furthermore, recent findings in neuroscience enrich enormously a strategic view of therapy, such as that developed by Thomä and Kächele (1987) or by Bleichmar (1997, 2004). The latter proposes a modular approach to psychoanalysis, the idea being that the mind is formed by a set of modules or systems that obey different regulations that evolve in parallel (asynchronically), which in their complex interrelationships yield and undergo transformations, and which require multiple forms of intervention in order to be modified. In this regard, I agree with Gabbard and Westen (2003) that the current challenge lies in developing a psychoanalytic technique that is active and flexible in its multiple forms of intervention, and which takes on board the findings of process and outcome research in psychotherapy and psychoanalysis, as well as the knowledge provided by cognitive neuroscience and research into the early mother–infant relationship.

References

Ablon JS, Jones EE (1998). How expert clinicians' prototypes of an ideal treatment correlate with outcome in psychodynamic and cognitive–behavioral therapy. *Psychother Res* **8**:71–83.

Ablon JS, Jones EE (2002). Validity of controlled clinical trials of psychotherapy: Findings from the NIMH Treatment of Depression Collaborative Research Program. *Am J Psychiatry* **159**:775–83.

Ablon JS, Jones EE (2005). On analytic process. *J Am Psychoanal Assoc* **53**:541–68.

Ambühl H, Grawe K (1988). Die Wirkungen von Psychotherapien als Ergebnis der Wechselwirkung zwischen therapeutischem Angebot und Aufnahmebereitschaft der Klient/inn/en [The outcome of psychotherapies as a result of the mutual effect of the therapeutic offer and client readiness to receive]. *Z Klin Psychol Psychopathol Psychother* **36**:308–27.

Arieti S (1977). Psychotherapy of severe depression. *Am J Psychiatry* **134**:864–8.

Beebe B, Lachmann FM (2001). *Infant research and adult treatment: A dyadic systems approach.* Hillsdale, NJ: Analytic Press. 272 p.

Benecke C, Krause R (2005). Facial affective relationship offers of patients with panic disorder. *Psychother Res* **15**:178–87.

Benecke C, Merten J, Krause R (2001). Über die Bedeutung des intersubjektiven Feldes in der Psychotherapie [On the significance of the intersubjective field in psychotherapy]. *Psychotherapie* **6**:73–80.

Benecke C, Peham D, Bänninger-Huber E (2005). Nonverbal relationship regulation in psychotherapy. *Psychother Res* **15**:81–90.

Blatt SJ (2004). Experiences of depression: Theoretical, clinical, and research perspectives. Washington, DC: American Psychological Association. 359 p.

Blatt SJ, Ford RQ (1994). *Therapeutic change: An object relations perspective*. New York: Plenum. 298 p.

Blatt SJ, Shahar G (2004). Psychoanalysis: For what, with whom, and how? A comparison with psychotherapy. *J Am Psychoanal Assoc* **52**:393–447.

Bleichmar HB (1996). Some subtypes of depression and their implications for psychoanalytic treatment. *Int J Psychoanal* **77**:935–61.

Bleichmar HB (1997). *Avances en psicoterapia psicoanalítica. Hacia una técnica de intervenciones específicas* [Advances in psychoanalytic psychotherapy. Towards a specific intervention technique]. Barcelona: Paidós. 416 p.

Bleichmar HB (2004). Making conscious the unconscious in order to modify unconscious processing: Some mechanisms of therapeutic change. *Int J Psychoanal* **85**:1379–400.

Bowlby J (1979). Psychoanalysis as art and science. *Int Rev Psychoanal* **6**:3–14.

Caspar F (1997). What goes on in a psychotherapist's mind? *Psychother Res* **7**:105–25.

Elkin I, Shea MT, Watkins JT, Imber SD, Sotsky SM, Collins JF, et al. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Program: General effectiveness of treatments. *Arch Gen Psychiatry* **46**:971–82.

Fonagy P (2000). Grasping the nettle: Or why psychoanalytic research is such an irritant. *Br Psychoanal Soc Bull* **36**:28–36.

Fonagy P, Target M (1996). Predictors of outcome in child psychoanalysis: A retrospective study of 763 cases at the Anna Freud Centre. *J Am Psychoanal Assoc* **44**:27–77.

Fonagy P, Gergely G, Jurist EL, Target M (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press. 577 p.

Gabbard GO, Westen D (2003). Rethinking therapeutic action. *Int J Psychoanal* **84**:823–41.

Goldfried MR (1980). Toward the delineation of therapeutic change principles. *Am Psychol* **35**:991–9.

Goldfried MR, Raue PJ, Castonguay LG (1998). The therapeutic focus in significant sessions of master therapists: A comparison of cognitive–behavioral and psychodynamic–interpersonal interventions. *J Consult Clin Psychol* **66**:803–10.

Horvath AO (2005). The therapeutic relationship: Research and theory. *Psychother Res* **15**:3–7.
Howard KI, Lueger RJ, Maling MS, Martinovich Z (1993). A phase model of psychotherapy outcome: Causal mediation of change. *J Consult Clin Psychol* **61**:678–85.
Jiménez JP (2005). The search for integration or how to work as a pluralist psychoanalyst. *Psychoanal Inq* **25**:602–34.
Jones EE, Pulos SM (1993). Comparing the process in psychodynamic and cognitive–behavioral therapies. *J Consult Clin Psychol* **61**:306–16.
Kächele H (1995). Klaus Grawes Konfession und die psychoanalytische Profession [The confession of Klaus Grawe and the psychoanalytic profession]. *Psyche—Z Psychoanal* **49**:481—92.
Kantrowitz JL (1993). Outcome research in psychoanalysis: Review and reconsideration. *J Am Psychoanal Assoc* **41**(Suppl):313–28.
Klein C, Milrod B, Busch FN, Levy KN, Shapiro T (2003). A process-outcome study of panic-focused psychodynamic psychotherapy. *Psychoanal Inq* **23**:308–31.
Krause R (1990). Psychodynamik der Emotionsströrungen [Psychodynamics of emotional disorders]. In: Scherer KR, editor. *Psychologie der Emotionen. Enzyklopädie der Psychologie* [Psychology of the emotions. Encyclopaedia of psychology], Vol 4, p. 630–705. Göttingen: Hogrefe.
Krause R (1998). *Allgemeine psychoanalytische Krankheitslehre* [General psychoanalytical theory of illness], Vol 1: *Grundlagen* [Fundamentals]. Stuttgart: Kohlhammer. 195 p.
Luborsky L (1969). Critical evaluation of Strupp and Bergin. Research cannot yet influence clinical practice. *Int J Psychiatry* **7**:135–40.
Miller NE, Luborsky L, Barber JP, Docherty JP (1993). *Psychodynamic treatment research: A handbook for clinical practice*. New York: Basic Books. 577 p.
Orlinsky DE (1994). Research-based knowledge as the emergent foundation for clinical practice in psychotherapy. In: Talley PF, Strupp HH, Butler SF, editors. *Psychotherapy research and practice: Bridging the gap*, pp. 99–23. New York: Basic Books.
Orlinsky DE, Rønnestad MH, Willutzki U (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In: Lambert MJ, editor. *Bergin and Garfield's handbook of psychotherapy and behavior change*, 5th edition, p. 307–89. New York: Wiley.
Rudden M, Busch FN, Milrod B, Singer M, Aronson A, Roiphe J, et al. (2003). Panic disorder and depression: A psychodynamic exploration of comorbidity. *Int J Psychoanal* **84**:997–1015.
Safran JD, Muran JC (1994). Toward a working alliance between research and practice. In: Talley PF, Strupp HH, Butler SF, editors. *Psychotherapy research and practice: Bridging the gap*, p. 206–26. New York: Basic Books.
Sandell R, Blomberg J, Lazar A, Carlsson J, Broberg J, Schubert J (2000). Varieties of long-term outcome among patients in psychoanalysis and long-term psychotherapy: A review of findings in the Stockholm outcome of psychoanalysis and psychotherapy project (STOPPP). *Int J Psychoanal* **81**:921–42.
Sandler J (1983). Reflections on some relations between psychoanalytic concepts and psychoanalytic practice. *Int J Psychoanal* **64**:35–45.
Szecsödy I (1990). *The learning process in psychotherapy supervision.* Stockholm: Karolinska Institutet. 221 p.
Stiles WB, Shapiro DA, Elliot R (1986). Are all psychotherapies equivalent? *Am Psychol* **41**:165–80.
Thomä H, Kächele H (1987). *Psychoanalytic practice*, Vol 1: *Principles*, Wilson M, Roseveare D, translators. New York, NY: Springer. 421 p.
Wampold BE (2001). The great psychotherapy debate: Models, methods, and findings. Mahwah, NJ: Erlbaum. 263 p.
Winograd B (2005). *Depresión: ¿Enfermedad o crisis? Una perspectiva psicoanalítica* [Depression: Illness or crisis? A psychoanalytical perspective]. Buenos Aires, Paidós. 312 p.