

Izzivi sedanjosti - raziskave v psihoanalizi

Challenges of the present - psychoanalytic research

POVZETEK

V članku avtorja slediva razvoju koncepta empatije, ki je bil sprejet v psihoanalizo s polja estetike. Najti ga je že pri Freudu, kjer se skriva v besedi Einfühlung. Empatiji poskuša določiti točen pomen in ga jasno razločiti od kontratransferja in projektivne kontraidentifikacije. Kot novost vpeljeva perceptivno kakovost empatije, ki se izogne preveliki aktivnosti ali pasivnosti. Ugotavlja pastí empatij, ki izhajajo bodisi iz preohlapnega razumevanja koncepta bodisi iz poskusov forsiranja empatije. Uporabo pojma empatije razširiva na skupinsko analizo, pri kateri le-ta kaže posebnosti in se v »razviti« skupini izrazi kot empatija skupine kot celote.

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empatija, psihoanaliza, kontratransfer, perceptivnost, skupinska analiza.

ABSTRACT

In the article the authors trace the development of the concept of empathy which came to the field of psychoanalysis from aesthetics. For Freud it was part of the word Einfühlung. The authors try to define the exact meaning of empathy and to distinguish it clearly from countertransference and projective counteridentification. They introduce as a new concept the perceptive quality of empathy through which excessive activity as well as passivity can be avoided. They look at the pitfalls of empathy that result from a poor understanding of the concept on the one side and from unnatural, forced empathy on the other. They look at the specifics and the role of empathy in group analysis. In experienced groups empathy shows itself as the empathy of the group as a whole.

KEY WORDS

empathy, psychoanalysis, countertransference, perceptiveness, group analysis

Introduction

In psychoanalysis research has too often been neglected even from its inception. Sigmund Freud postulated his theoretical constructs on the basis of clinical observations which do not meet present scientific criteria. Research is a result of curiosity but curiosity alone is not enough. We have to know how to formulate a research question and how the question is then answered. In psychoanalysis the clinical relationship between therapist and patient is still very often seen as a delicate space of confidentiality in the service of the patient. Any other interests deriving out of the therapeutic situation are frequently seen as an unnecessary intrusion which can obstruct the relationship between the therapist and his patient. There is a notion that psychoanalysts often feel self-sufficient in their therapeutic activities and are poorly equipped to answer the questions that are now being asked in a scientifically relevant way. In professional conversations research is rarely mentioned and most clinicians are therefore blind in one eye; the existence of psychoanalytic research community is not sufficiently known or recognized. Today analysts are faced with the vital decision whether they will stick to their fixation to the past or whether they will recognize the importance of research into the position of their modality among other research-advanced modalities that are gaining ground in academic circles.

Should we psychoanalysts bother about such research? Our modality was after all the original psychotherapeutic system and has its own rich theoretical and clinical legacy. Psychoanalytic theoretical concepts have influenced and still remain a powerful influence in the realms of psychiatry, clinical psychology and developmental psychology. It is hard to imagine the direction art, sociology and philosophy would have taken in the 20th century without the contribution of psychoanalysis. Sigmund Freud is one of the most cited authors ever and has been stirring and inspiring intellectual circles for more than a hundred years.

Today the body of psychoanalysis consists of four major paradigms: the classical drive paradigm, the ego-psychology paradigm, the object relation paradigm and the self-psychology paradigm. They all represent a natural growth of Freud's thoughts which were always open to such further development. Caruso (1969) stated: "[...] Freud was a brilliant observer. His explicit hypotheses - admittedly of a mechanistic nature - contain the possibility for dialectical continuation. They further rest on live observation and have never lost multiple connection with a concrete life« (p. 72). Psychoanalysts can be justly proud at being the privileged recipients of such splendid theoretical richness. In recent years however an intersubjective approach has been gaining ground in psychoanalytic psychotherapy and the analyst of today is facing some serious questions about his assumed authoritative all-knowing position in the therapeutic process. An analyst does not have any objective knowledge about his patient's life or his psychological functions. The analyst is in possession of a "...subjective frame of reference of his own, deriving from a multiplicity of sources and formative experiences, through which he attempts to organize the analytic data into a set of coherent themes and interrelationships" (Stolorow, Brandschaft & Atwood, 2000; p. 6). "The observer has become the observed and the analyst's frame of experience [...] must not be elevated to the status of objective fact" (ibid.)

But this coin has another side that is not so bright. Psychoanalysis has always been subversive. A hundred years ago Freud had to defend his ideas about parental seduction, infantile sexuality, incestuous wishes... that scandalised Vienna's social and professional classes. Today a hundred years later psychoanalysis is still in a beleaguered state (Gabbard in Levy & Ablon, 2009). We have become used to hearing statements like: psychoanalysis is not a science, it is a religion; Freud was terminally wrong; psychoanalytic treatment is too long and too expensive

and has no research to support its efficacy; CBT is shorter, cheaper and has plenty of empirical studies supporting its efficacy; psychoanalytic concepts cannot be empirically studied because they're too vague .

Yalom (2003) states: "Freud bashing has become fashionable. [...] Psychoanalysis is attacked as a pseudoscience [...] a whole generation of mental health practitioners has been educated with a critical and wholly uninformed view of the man *whose ideas comprise the very foundation of psychotherapy* (ital. added)" (p. 217).

Gabbard (in Levy & Ablon, 2009) acknowledges pretty much the same fact: "...Freud is regularly killed off in the pages of *Times*, *Newsweek*, and *The New York Review of Books*, only to be resurrected. Hence a successive series of declarations that he is once again dead are required to keep him in his grave" (p. vii).

Acknowledging the prevalence of this same attitude towards psychoanalytic theoretical ideas Gabbard (ibid.) continues: "Perhaps the most persuasive evidence of the core truths inherent in psychoanalytic thinking can be found in this need to repeatedly proclaim their irrelevance and fundamental flaws in the theory."

The Rise of Empirically Supported Therapies

The demand for so-called empirically supported psychotherapies in recent years has further boosted these anti-analytic charges. Due to pressures for accountability and cost containment the mental health professions and funding agencies reacted by advocating the development and employment of empirically supported psychotherapies (Bergin & Garfield, 2009), which should be brief and strictly manualized. To provide the "market" with such empirically supported therapies and to emphasize the scientific basis of such psychological treatments *The American Psychological Association* (APA) responded in 1993 by establishing *12 Task Force (Society of Clinical Psychology)*. The goal of the Task Force was to identify particular treatments for particular disorders – "pure-form" treatments for a "specific disorder" (Lambert, Garfield, Bergin in Bergin & Garfield, 2009). In 1995 the Task Force issued *The Initial Task Force Report* and in 1998 Update on Empirically Validated Therapies, II (Chambless et al., 1998) was issued. It includes a list of *Examples of Empirically Supported Treatments (EST)* divided into two sub-groups: *Well Established Treatments and Probably Efficacious Treatments*. Currently there are 16 well established empirically supported therapies. Nearly all of them are pure CBT and behavioural therapies. Long term psychoanalytic or psychodynamic therapies, family therapies and eclectic therapies are omitted. There are 56 treatments that are probably efficacious; one of them is brief psychodynamic. For each specific therapeutic modality that has found itself excluded the question arises: what is the key that opens the door to inclusion onto this list of "scientific" psychotherapies ?

Randomized Controlled Trial (RCT) and Manualization of Psychotherapy

Currently the gold standard (Levy & Ablon, 2009), the key, is randomized controlled trial (RCT) which is considered the most legitimate and effective tool for providing sufficient proof that the therapy is efficacious for treating a given disorder. "The methodology and research design of the RCT derive from medication studies in which an active agent is shown to be more effective in the improvement of symptoms than a placebo [or no-treatment group]" (Gabbard; in Levy & Ablon; p.viii).

In RCT the only criterion for evaluating the therapeutic procedure is the interaction between the diagnosis and therapeutic techniques. Patients are carefully selected and they must meet the criteria for a single diagnosed disorder. Those with multiple disorders are excluded.

The therapeutic process is reduced to a series of techniques applied in a strict and rigid order prescribed by a therapeutic manual. Fidelity to these manuals is constantly maintained through the use of videotaped sessions. Therapeutic manuals do not take into account the whole personality of a patient but only his diagnosis. As we all know the diagnosis is only one of the many patient's variables. They also ignore the personality of the therapist and completely overlook the quality of the therapeutic relationship. The psychotherapist is treated as a completely impersonal element that operates in accordance with guidelines in the diagnostic manuals DSM-V or ICD-10 (Seligman, 1995).

The application of such objectivistic methodology to psychotherapy, a humanistic science, is questionable as there are some fundamental differences between medication and psychotherapy. According to Gabbard (in Levy & Ablon, 2009) "The most striking difficulty is that pills and psychotherapists are different:

- Pills are smaller than therapists.
- Pills are not living, breathing organisms like psychotherapists.
- Pills do not have personalities like psychotherapists.
- A pill and a patient do not have a complex human relationship in the way that a therapist and patient do". (p. viii).

The Consumer Report Study - Psychotherapy in Real Life Conditions

The Taskforce Report and Update caused a great stir within the psychotherapeutic community and many clinicians raised their voices against it. Irwin Yalom (2003) described the momentum: "Senior clinicians see an apparent avalanche of scientific evidence "proving" that their own approach is less effective than that offered by a junior (and inexpensive) therapist delivering manualized CBT in astoundingly brief periods of time. In their guts they know this is wrong [...] but have no evidentially based reply, and generally they have pulled in their horns and tried to go about their work hoping for the nightmare to pass" (p. 222).

According to Martin Seligman (1995), a prominent psychotherapy researcher, the most frequently practised modalities in real-life conditions (i.e. out of the laboratory) are not short-term manualized therapies but rather long term psychodynamic therapy, family psychotherapy and eclectic therapies, yet these have been left out from the list of the well-established (empirically validated) therapies. The reason is – according to Seligman – that they are too complex to be squeezed into the framework of efficacy¹ trials. Seligman noted certain features of real life psychotherapy that are absent in the artificial, laboratory conditions of RCT trials (Seligman, 1995).

- Psychotherapy in real life conditions doesn't stop after a limited number of sessions. It lasts until either the patient is markedly improved or he stops coming and it is *not in the nature of a fix*. Psychotherapy in the field is further not limited to single modality interventions and techniques. It is self-correcting and interventions are applied according to the patient's needs. Patients – in contrast to of the random assignment in RCT research - actively search and choose psychotherapists by themselves. They get psychotherapy treatment by *active shopping*. Psychotherapists in real life usually treat patients with

multiple problems as opposed to the artificial laboratory conditions of RCT where only individuals with a single diagnosis are selected. As a consequence psychotherapy in the field is often focused on an improvement in the *general functioning* of patients and not merely with specific symptom reduction.

Martin Seligman, a member of Division 12 Task force himself and originally RCT hardliner changed his mind about the validity of psychotherapy being studied in the laboratory following the *Consumer Reports Study* (1995).

The Consumer Reports (CR) is a journal and independent product testing organization which sends questionnaires to consumers about services and appliances. The magazine accepts no advertisements, pays for all the products that are tested and has no shareholders. In 1994 CR included a supplementary survey about psychotherapy and drugs in one version of its 1994 annual questionnaire, along with its customary inquiries about appliances and services. CR's 180,000 readers received this version, which included approximately 100 questions about automobiles and about mental health. CR asked readers to fill out the mental health section »*if at any time over the past three years you experienced stress or other emotional problems for which you sought help from any of the following: friends, relatives, or a member of the clergy; a mental health professional like a psychologist or a psychiatrist; your family doctor; or a support group?*« Overall 22.000 readers responded of whom 7000 readers responded to the questions in the mental health section and of those 4100 went to some combination of mental health professionals.

According to Seligman, the *Consumer Reports Study* was the most extensive study of psychotherapy effectiveness. Its main virtue was realism. It assessed the effectiveness of psychotherapy as it is usually performed in the field.

Here I will list just a few of the results which I consider of importance for psychoanalysis:

- Treatment given by mental health professionals works. Most of the responders were much better off at in the time of the survey.
- Long-term therapy produced more improvement than short-term.
- Active shoppers and active clients did better than passive recipients.
- No specific modality of psychotherapy did any better than any other for any problem.
- Respondents whose choice of therapist or duration of care was limited by their insurance coverage did worse (Seligman, 1995).

It is now becoming even clearer why this so-called scientific research, which is mainly positivistic quantitative research imported from naturalistic sciences, is not an appropriate scientific instrument for detecting many of the crucial elements of psychoanalytically oriented psychotherapies where the therapeutic relationship is its condition sine qua non. The RCT is a heavy sword instead of the fine scalpel that is needed for researching psychotherapy and psychoanalytic therapies in particular because it trivializes the personality of the therapist and the patient.

The systematization of techniques and manualization of therapies has of course some advantages: it enables research, reduces the costs of treatment and creates a seeming notion of clarity and simplicity which gives a good opportunity to acquire clinical experience for inexperienced therapists or beginners. Additionally it also offers a great variety of clearly defined and symptom - directed techniques which increase the confidence of the therapist and the patient but again, with the consequent trivialization of the patient and the therapeutic relationship. Finally, RCT may be the best scientific instrument for telling us whether the techniques are *likely to be effec-*

tive when transported from the laboratory to the field.

How to Bridge the Research-Practice Gap in Psychoanalysis?

Psychoanalysis has been in the field for more than a hundred years and yet “psychodynamic treatment remains scientifically speaking, the poor cousin to other treatments such as cognitive and behavioural therapies and pharmacological regimes for which the efficacy has well been established through empirical methods” (Levy & Ablon, 2009; p.xxv). Entry into the realm of psychotherapy research is not a simple step. It is a step into another world which demands laborious acclimatization. Researchers, methodologists and psycho-metricians in most cases breathe a different air from clinicians. Often the unfamiliar air makes practitioners so dizzy that they quickly return to the more familiar and safer world of patients and theory. But this is not solely the fault of the researchers. Admittedly among many psychoanalytic practitioners there still persists a notion that research should have nothing to do with psychoanalytic clinical work which is seemingly too complex to be squeezed into the narrow framework of scientific research. Research is also considered irrelevant to psychoanalytic treatment which belongs more to hermeneutics than to a science (Gabbard in Levy & Ablon, 2009). Psychoanalysts have shown unexpected fidelity to their “father” Sigmund Freud who saw no necessity to explore psychoanalytic theory by scientific or laboratory methods. He was satisfied with his clinically derived concepts - a step away from the positivistic spirit of his time. Freud’s attitude towards scientific research is evident from his correspondence with Saul Rosenzweig, where the young author presents to Freud his research *An Experimental Study of Memory in Relation to the Theory of Repression* (1934).

Freud responded in a very patronizing manner: “I have examined your experimental studies for the verification of psychoanalytic assertions with interest. I cannot put much value on these confirmations because of the wealth of reliable observations on which these assertions rest make them independent of experimental verification. Still, it can’t do any harm”. (Freud in Grünbaum, 1984). There are of course other factors constraining analytic practitioners from engaging in research. Psychotherapy research is still not sufficiently included into supervisory conversations and in psychoanalytic curricula. Students should be encouraged and assisted in reading and discussing research papers, which are – as is generally known (Shelder, 2010; Weiss in Levy & Ablon, 2009) – very poorly read. The primary goal should? would be that more future analysts would be able to read and understand research more competently and by that incorporate new findings into their clinical practice. Some of them may consequently feel the challenge to engage in research. Further, there is a notion that gathering data may threaten the analyst’s commitment to maintaining the frame of the clinical hour (Alonso in Levy & Ablon, 2009). The attention of the analyst may become unconsciously biased and as a result that research may intrude into the clinical process. Ira Lable (in Levy & Ablon, 2009) draws attention to another possible reason why psychoanalysts are still not fond of research: a fear that the research may inevitably question even such axiomatic postulates of psychoanalytic treatment as the use of the couch and therapist neutrality. Here analysts who are the “masters of change and the owners of burgeoning literature on how people change [...] fear the change and blindly try to remain [...] in the mire of symptomatic repetition” (p.381). Furthermore, research is in the opinion of many analysts still associated with quantitative research, based on a logical positivistic model.

And who’s not afraid of statistics? But there are other forms of research that are more compatible with the analytic process and which may be closer to clinicians: phenomenological study, single case research, narrative research and other qualitative methods.

The problem of professional language represents a great obstacle in communication between clinical and research professionals. Marvin Goldfried (2000) points out that researchers have developed a technical language which serves well in communication with other researchers but represents a barrier in communication with practitioners. Equally the theoretical jargon used by analysts is in most cases unintelligible to all but to their own inner circle.

Researchers again often feel self-sufficient and they forget that research should be written in a way that is comprehensible to practitioners and not only to their fellow researchers. Jonathan Shelder (2010) says: "Many investigators take for granted that clinical practitioners are the intended consumers of clinical research [...] but many of the psychotherapy outcome studies and meta-analyses [...] are clearly not written for practitioners. On the contrary, they are densely complex and technical and often seem written primarily for other psychotherapy researchers—a case of one hand writing for the other" (p. 107). Shelder further states that some studies are hard to understand even to experienced psychotherapy researchers. It is obvious that psychotherapy research in many cases sets off with a life of its own with no regard for its target consumers – the clinical practitioners.

Psychoanalysis is Not Scientifically Supported – A False Presumption

Anne Alonso (in Levy & Ablon, 2009) urges practitioners to be open and receptive to new research something that in her view is hardly optional but rather obligatory: "It is given in my mind that responsible practitioners, just as a matter of intellectual integrity and the spirit of a lifelong learning, will stay abreast of the newest thinking in our field" (p.385).

Psychoanalysts and psychodynamically oriented psychotherapists ought to be with familiar with information about psychoanalytic research to refine and sometimes reconsider their approach to a variety of clinical problems. Such information is also vital for maintaining and strengthening psychoanalytic identity; a body of scientific evidence showing that psychoanalytic psychotherapies are equally or sometimes even more efficacious and effective than too many times unjustly over-rated CBT. It is also the responsibility of psychoanalysts to be heard speaking out in support for their psychoanalytic modality with appropriate information which can be found in extensive research literature.

There is another reason why the psychoanalyst-practitioner should be up-to-date with the achievements of our colleague researchers. This concerns a fact "that everybody knows" that psychodynamic psychotherapy is not scientifically supported and that other treatments are more effective. According to Shelder (2010): "The belief appears to have taken on a life of its own. Academicians repeat it to one another, as do health care administrators, as do health care policymakers. With each repetition its apparent credibility grows. At some point there seems little need to question or revisit it because "everyone" knows it to be so" (p.98). But the truth supported by scientific evidence tells us a different story because there is considerable research data that supports the efficacy and effectiveness of psychodynamic therapy .

Jonathan Shelder in his article *The Efficacy of Psychodynamic Psychotherapy* (2010) lists some of the most outstanding and recent research proving the efficacy of short and long-term psychodynamic psychotherapy:

- Abbass, Hancock, Henderson & Kisely (2006) conducted meta-analysis of 23 RCT of short-term (<40 hours) psychodynamic therapy of 1.431 patients: After prolonged follow-up (>9months post treatment) research findings suggest that psychodynamic therapy sets

in motion psychological processes that lead to ongoing change, even after therapy has ended. The pre- to post-treatment effect size of 0.97 increased to 1.51 after follow-up. For changes in somatic symptoms the increase after follow-up improved from 0.81 to 2.21. The goals of psychodynamic psychotherapies include, but extend beyond, symptom remission alone. Successful treatment should not only relieve symptoms (i.e., get rid of something) but also foster the positive presence of psychological capacities and resources.

- The meta-analysis Leichsenring, Rabung & Leibing (2004) included 17 high-quality randomised controlled trials of short-term psychodynamic psychotherapy (average of 21 sessions). Patients receiving psychodynamic psychotherapy were »better off with regard to their target problems than 92% of the patients before therapy« (p.1213): The pre- to post-treatment effect size was 1.39 and raised to 1.59 after long-term follow up (13 months posttreatment).

- In a study of patients with borderline personality disorder (Clarkin, Levy, Lenzenweger, & Kernberg, 2007) who received psychodynamic psychotherapy, treatment benefits equalled or exceeded those of another evidence-based treatment, dialectical behaviour therapy (Linehan, 1993), with regard to changes in the underlying psychological mechanisms (intrapsychic processes) believed to mediate symptom change in borderline patients, specifically, changes in reflective function and attachment organization (Levy et al., 2006). These intrapsychic changes occurred in patients who received psychodynamic therapy but not in patients who received dialectical behaviour therapy.

- Leichsenring & Rabung (2008) made a comparison of long term psychodynamic therapy (1 year or 50 sessions) with shorter term therapies. In long-term follow up (average 23 months posttreatment) significant improvement was established at all five outcome domains assessed in the study: overall effectiveness, target problems, psychiatric symptoms, personality functioning, social functioning. The size effect of 1.03 increased to 1.25 after follow up.

De Maat, de Jonghe, Schoevers, & Dekker (2009) undertook an effectiveness study of long-term psychodynamic therapy (average of 150 sessions) for adult outpatients with a range of diagnoses.

Patients with mixed/moderate pathology received long-term follow-up of average 3,2 years post treatment. Pre- to post-treatment effect size was 0.78 for general symptom improvement which increased to 0.94 at follow up.

Patients with severe personality pathology received long-term follow-up of average of 5,2 years post treatment. An effect size pre- to post-treatment was 0.94 and increased to 1.02. after follow up.

Shelder (p. 102) concludes: "These meta-analyses represent the most recent and methodologically rigorous evaluations of psychodynamic therapy. Especially noteworthy is the recurring finding that the benefits of psychodynamic therapy not only endure but increase with time [...] In contrast, the benefits of other (non-psychodynamic) empirically supported therapies tend to decay over time for the most common disorders² (e.g., depression, generalized anxiety)".

Conclusion

"Bridging the gap"³ between researchers and clinicians will enable psychoanalysis to regain its position in the mental health field and to affirm the important role that psychodynamic treat-

ment has in modern psychiatry and psychology. This does not mean that all practitioners should struggle to become researchers or feel guilty if they don't. There are too many realistic obstacles for the majority of clinicians that would make such enterprise impossible. But what clinical practitioners can do almost without exception is to learn, inform themselves, and spend some precious time and energy in showing respect and interest for the achievements of our colleague researchers that have been publishing their papers for many years.

Researchers should not forget who their target public is and present their research findings in clinician-comprehensible language which would encourage clinicians to utilize empirical findings in their clinical practice. The majority of clinicians are ill informed as to the efforts of psychoanalytic researchers and as a result they are depriving themselves of the vast scientific wealth of psychoanalysis. The exploration of research literature is therefore a land to discover for every psychoanalyst in the field

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¹*In efficacy or explanatory trials the researchers try to establish whether a certain set of interventions or a particular psychotherapeutic modality produces important results in ideal, laboratory circumstances. In effectiveness or pragmatic trials the possible beneficial effects of psychotherapeutic interventions or modalities is measured in real life clinical settings.*

²*For specific anxiety conditions such as panic disorder and simple phobia short-term manualized treatment is clearly indicated and has a lasting effect.*

³*The expression is borrowed from the subtitle of another inspiring work dealing with psychodynamic practice and research: Evidence-Based Psychodynamic Psychotherapy: Bridging the Gap Between Science and Practice(2009) by Raymond a. Levy and J. Stuart Ablon.*