

Applied psychoanalysis in mental health: Can we reconcile the pragmatism and the poetics of practice?

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Introduction

There is arguably a deep paradox at the heart of psychoanalysis¹ and it is one that can easily be caught sight of. Thus, on the one hand, one is confronted with the undoubted significance and importance of psychoanalysis which, ardent critics aside, is arguably alone among the psychologies in being capable of reaching deeply and intensely into the human soul. It achieves this via a theory and clinical process that is at once complex, reflexive, richly descriptive and finely differentiated in its approach to human subjectivity. Indeed its significance and impact extends well beyond this, especially when one sees how psychoanalysis has left, and continues to leave, its impress on so many areas of human endeavour; ranging from developmental psychology to psychological treatment, from feminism and identity politics to social theory, from art and media studies to philosophy, and so on. Despite this it can be fairly stated that psychoanalysis today is in crisis and especially so in the English speaking world. This is evident when one considers, firstly, the sheer level of what might be termed “Freud bashing” in the popular media, secondly, the diminishing numbers of trainees in psychoanalytic institutions and/or interested students within the Universities, thirdly, the lack of public demand for psychoanalysis as a therapy, and, fourthly, its marginalisation in terms of having neither a well established public funding base nor a meaningful and influential voice within society at large. Given this paradox (of being simultaneously valued and dismissed), and more particularly the nature of the above mentioned crisis, it is essential that this state of affairs is both understood and addressed - especially by psychoanalysts. The idea that psychoanalysis, at least as we know it today, could disappear needs to be treated as a simple reality which exists on the horizon of possibility. Moreover, it needs to be recognised that the sources of its demise are potentially multiple. Consider, for example, the inevitable progress of psychopharmacological interventions, the growth in alternative therapies such as cognitive-behavioural therapy, cognitive-analytic therapy, dialectical-behavioural therapy, and the many so called “brief” and “narrative” therapies (to mention but a few), alongside the economic, moral, and political forces at play in the arena of mental health and the possibility of such a marginalisation in this essential field of practice, seems more than just a mere possibility.² While this latter area will form the main focus for this paper it is worthwhile, at least initially, to consider the nature of this crisis from within a broader perspective.

¹ For the sake of this paper I use the term psychoanalysis in a general sense to cover all orientations and schools unless otherwise stated. Moreover, it is important to note that the arguments presented apply equally to psychoanalytic psychotherapy as indeed is alluded to in the text. Arguably, this “common ground” between psychoanalysis and psychoanalytic psychotherapy is, at least, if not more, important than the often-heated debates about their differences, though I personally do not deny the latter.

² It is interesting to note how almost all of the above mentioned therapies are very explicitly concerned to establish their “evidence base”.

At the most general level, one can note a growing tendency to reject and repress the most fundamental insight of psychoanalysis, namely, its portrayal of the human subject as a maker of meanings and as fundamentally caught and implicated in such meanings in ways that invariably exceed a particular subject's grasp. Freud called this the unconscious, thus giving air and import to the notion of a subject who remains opaque to him or herself, and is also essentially at labour in relation to the desires of others, which, in turn, are fundamentally "inmixed" with those of the subject. However, the modern citizen, it seems, longs for just the opposite - for assurance, for self-transparency, for clarity, control and accountability, in place of the troubling engagement one faces when a Socratic-like question mark is held over one's life choices and decisions. This of course goes hand in hand with the commodification of the human soul which proposes to each and every subject fulfilment through multiple and ever changing identities, continuously offered in the market place via the technologies of branding, free choice and instant gratification, that, as shifting ego identifications, evade any encounter with the problems of subjectivity, and with the nature of *jouissance*/the drive. Such a process is reinforced at every level and to take one topical example, one can note how vital issues and choices, in this case in international affairs and politics, are increasingly framed in an either/or logic of good and bad, exemplified most recently in the disheartening rhetoric surrounding the so called Iraq crisis.

A second problem for psychoanalysis arises in relation to the range of attacks made not only on Freud's ideas, but on Freud the man, and more generally on the whole psychoanalytic enterprise, attacks which have steadily intensified over the past twenty to thirty years. Interestingly, however, some elements of this critique are clearly justifiable. For example, institutionalised psychoanalysis has frequently been its own worst enemy and moreover often appears to embody - willingly or unwillingly - an anti-psychoanalytic ethic, namely, one that seeks to subvert the subversive and restless nature of unconscious life. Other elements of this critique may also be welcomed and even considered healthy, for example, when placed in opposition to some of the untenable and distorting idealisations and transference effects present in this or that psychoanalytic community. Nevertheless it is also the case, that, in numerous instances, Freud is simply misappropriated and/or scapegoated.

His loudest critics (e.g., and to mention just a few, Masson (1984), Grunbaum (1984), and Crews (1995)) have built careers on criticising Freud by ignoring one or other aspect of his theory and/or its essential complexity as has been amply demonstrated by the much less well highlighted rebuttals these critics have in turn been exposed to (e.g. Robinson; 1993). Of course, here too a certain culpability must lie at the door of the psychoanalytic community itself, which even today, and with a hundred year history behind it, is clearly multiple rather than singular, bedevilled by splits, in ongoing dispute over the meaning of key terms, and, moreover, continues to struggle to coherently define its own boundaries. Indeed it is this very situation that provides such easy pickings for the sceptic and would be critic. However, at this point let us turn to a more concrete example, namely the troubled place and increasing marginalisation of psychoanalysis in mental health, which is both extensive and has potentially far-reaching and deep consequences.

Psychoanalysis in mental health: a case for treatment?

To begin on a positive note it is undoubtedly true to say that the contribution of psychoanalysis within this arena has been enormous. Psychoanalysts have worked extensively with all of the clinical populations within mental health and have

published a rich, engaging and informative account of this work, which is both theoretically developed and clinically insightful. To pluck an example at random one can take the case of the suicidal patient, a patient who typically arouses great anxiety in mental health professionals who must, in today's terminology, be seen to actively "manage the risk", and, at least in the UK, act in a context where the Government has set specific targets for a reduction in cases of suicide within mental health as part of its centralised NHS planning framework. Given this, such patients are invariably treated multi-professionally, closely monitored and medicated, with all aspects of their treatment being recorded and normally agreed with the patient as part of their "care plan". Yet the question arises as to how we might understand such patients and it is interesting here to note that as early as 1933, Menninger, among others, pointed to the intense internal dynamic at work in such cases. To simplify, he argued that in thinking about the suicidal act we can neither build an analogy with murder nor can we appeal to a simple form of regression such as the wish to sleep or shut out a world experienced as overwhelming or cruel. Rather we must look to understanding within the patient both the element of killing and of being killed, and their relationship to fantasy structures in such acts. Clinically such a view has immediate significance in that it tells us we must deeply engage with such material rather than (as "managing the risk" suggests) suppress such expressions of human despair. In doing so one must also tackle the issue of who, or what, exactly, is being killed as well as confront the clinical phenomenon that the active killer element in fantasy commonly lives on beyond the suicidal act itself.

Psychoanalysis has also contributed greatly to the development of other therapies within the mental health field and indeed the "founding fathers" of both cognitive therapy and family therapy were themselves, by and large, psychoanalysts. There are other developments too, like that of "crisis theory" (Caplan, 1964), which are equally significant in their legacy within the field of mental health while in this latter case staying closer to the core ideas of psychoanalysis. In a similar way it needs to be recognised that in such settings psychoanalysts have made many key contributions beyond the level of direct patient care. Thus, and to again take an early example, there is the work of Menzies-Lyth (1960) on institutional defences against anxiety which is of continuing relevance if those in mental health are to avoid acting out the projected fantasies of patients in ways that are invariably unhelpful. Added to this one needs to recognise the extensive psychoanalytic input to teaching, consultation and supervision within mental health.

However, all of this has not been achieved without problems emerging. Some early criticisms that still bite deep concern the effects of the privileged place that psychoanalysis has (especially in the past) often held in such institutions. Some have argued, for example, that this effect frequently resulted in a change within clinical priorities in mental health whereby the original goals of serving those with greatest need, or at greatest risk in the community, became subordinated to the goal of serving those who appeared most likely to respond to treatment. The point here is not to get into an argument about theory or particular cases but rather to ask the question whether psychoanalysis can successfully demonstrate its work with marginalized, deprived and minority populations when statistics consistently show a bias towards treating middle and upper class patients, sometimes pejoratively referred to as the "worried well" (Hollingshed & Redlich, 1958; Culberg & Steffanson, 1994). Another aspect of this criticism, which concerns equity of access to public funded health care, revolves around the distribution of what are, and will always be, scarce resources. Let me put it in stark if simplified terms. If an analyst has available, for the sake of example, 540 or 720 therapy hours over a three year period, does he

or she devote these hours to seeing one severely in need patient three or four times per week or offer say seven equally needy patients a hundred hours of treatment each, given that it is usual, at least in the NHS, for patients to wait up to twelve months to be seen by a psychoanalytic psychotherapist or psychoanalyst?³ Here I do not want to give the impression that there are easy answers for there are not. However, it seems to me that we must be involved in these sorts of debates, and able, in doing so, to put our position forward to both the commissioners and users of healthcare. Yet as we will now see the problems facing psychoanalysis run deeper still.

To begin with some context it is essential to appreciate that something of a sea change has occurred in many first world health care delivery systems since the early 1990's. This started in Canada and the US under the slogan of "evidence based medicine" and has been adopted in many other countries since that time being called in the UK "evidence based practice". What is this? It is simply the idea that all clinical health professionals should base their daily clinical practice on "sound" research evidence about the effectiveness of the interventions they use. Prior to this, health care decision-making had been guided by the principle of "professional autonomy" whereby decisions were left to professionals and to their ability to do the best they could with the resources available to them. It is interesting, and important, to note here that many variables fed into this development. These included: a growing sophistication in research and health data collection, a greater need for Government and health commissioners to be accountable for the public funds they used, a less publicised agenda to control costs, and consumer demand/pressure in relation to consistently receiving optimum level health care. Indeed, and to take just the latter point, routine statistical analyses of health care data have frequently thrown up huge and unjustifiable differences in health care outcomes for similar populations attending different parts of the same health care system, with some of these cases, for example in the UK, becoming a national scandal and a major embarrassment to Government. In practice what this change has meant is, firstly, that some agreement had to be reached on what constituted "sound" research, and secondly, organisational mechanisms needed to be identified to ensure that professionals utilised such evidence in their practice, leading to what I will describe in greater detail below as the production of both clinical assessment and treatment guidelines and audit procedures.

To take the question of sound research first there now exists in healthcare settings a highly influential categorisation of health care outcomes, which is based on a so-called "hierarchy of evidence". What this means is that evidence is divided into five to six categories representing strong to weak evidence in favour of a particular clinical intervention (see: Eccles & Mason, 2001). The strongest evidence is seen to be produced from single large randomised trials or groups of smaller randomised controlled trials with the weakest form of evidence coming from respected authorities in the field and/ or expert opinion. The implications for psychoanalysis and psychoanalytic therapy have been stark. Why? The reason is not simply due to the

³ This very issue of course marks another "blackhole" in the research literature in so far as there is almost no research on the "dose-effect" question when it comes to psychoanalytic treatment. We thus cannot even yet attempt an answer to the question of how much analysis a patient should be offered, for example, in health care settings where this is a significant question. Here many services operate on a mere rule of thumb basis in offering up to two years of once per week treatment.

demise of the expert or to the lack of empirical studies within the psychoanalytic domain (and there is a real lack here), but, more significantly, to the fact that where such studies do exist there is little in them that supports the view that psychoanalytic treatment can deliver significant clinical outcomes.

Thus Kantrowitz (1993a) in reviewing a total of six US based quantitative studies on psychoanalytic treatment outcome, from, interestingly, terminated full analyses of 550 patients, reached the following rather weak conclusions:

1) that motivated neurotic subjects received some benefit, 2) that only 40% of these patients were considered to have reached an analytic conclusion to their treatment as in transference resolution, and 3) that it was not possible to predict in advance which patients would benefit or retain benefit from their treatment. In a similar vein Wallerstein (1986), reporting on the extensive Menninger Foundation study which followed a cohort of treated patients for up to thirty years, found that differences in outcome could not be established between those patients receiving psychoanalysis, psychoanalytic psychotherapy and so called supportive therapy and, moreover, that psychoanalytic psychotherapy had poorer outcomes than expected while supportive therapy had better outcomes than expected. Given such findings it is not surprising to find critics of psychoanalysis claiming it is a largely ineffective treatment, that is, moreover, expensive, drawn out and essentially unreliable. The point here is not so much that these outcomes studies, and many others like them, prove or disprove the efficacy of psychoanalysis for there is surely more happening in the complexity and subtlety of the psychoanalytic encounter than such outcome studies can or do capture, and, of course, the nature of such studies can in turn be criticised (see below). Rather the point is to recognise their significance as well as the very real challenge they present.

Yet before turning directly to this issue it is important to also mention so called "process studies" of psychoanalysis and psychoanalytic psychotherapy as much of this research focus arose as a response to the disappointing findings of outcome research. Process research represents an attempt to capture those features of the actual interactions between therapist and patient that lead to significant movement in the therapy both within and between sessions and that then in turn can be related to overall outcome. There are now literally several thousand such studies and findings have been of two major types. More generally findings have indicated that it is broadly aspects of the relationship established between the therapist and patient that seems to account for the most significant portion of clinical improvement across a range of therapeutic settings. Here such things as the setting up of the initial "therapeutic contract" covering therapeutic focus and aims, the quality of the bond formed between the therapist and patient and the ability to focus on core affective issues in the patients life are all associated with greater levels of change and a more positive overall outcome (see: Bergin & Garfield, 1994). More specifically as Henry et al (1994) indicate when psychoanalytic variables are explicitly examined findings emerge which range from those that are potentially interesting to those that, at best, remain fundamentally inconclusive. For example, there is evidence to suggest that frequency of transference interpretations is in fact linked to poorer outcomes (which certainly should pose a challenge, for example, to the Kleinian model, though one has to doubt if this data has impacted on the practice of many clinicians) while other evidence indicates that therapist accuracy in interpretation may be much lower than expected. Without yet disputing the significance of these various studies it is important to note their impact (or indeed lack of impact).

Recently in the UK the National Institute for Clinical Excellence (NICE) has published its first set of guidelines covering the treatment of schizophrenia (NICE 2002) and will shortly publish a range of similar guidelines covering the major areas of mental health intervention including depression, eating disorders, personality disorders etc. Within these guidelines it is explicitly stated that “health professionals working in the NHS are expected to follow NICE’s clinical guidelines. But there will be times when treatments recommended will not be suitable for some people because of their specific medical condition...” (p.36). The guidelines themselves are comprehensive and cover both pharmacological and psychological interventions as well as the optimum organisation of services for people with schizophrenia. They are of course based on “evidence based practice” and the above-mentioned “hierarchy of evidence”. What is interesting to note here is that while these guidelines mandate a significant augmentation in psychological treatment provision to this patient group there is no mention of psychoanalysis or psychoanalytic psychotherapy. Rather, the guidelines state that all (note all) such patients should receive more than ten sessions of CBT over more than a six-month period and moreover they set a similar guideline in relation to family intervention (i.e. more than ten sessions over more than six months). Mental Health Services will also be subject to systematic audit in relation to these guidelines which themselves will be reviewed after four years and reissued after six years. The key point here is that such guidelines are likely to change the nature of mental health care provision radically in the UK, and by implication, elsewhere in the world where they have been, are, or are likely to be implemented. For example, it is easy to see how the provision of psychoanalytic or psychoanalytic psychotherapy services are increasingly less likely to be seen as a core part of mental health provision and with a diminishing physical presence in these settings it will be increasingly difficult to even articulate or argue for the importance of this perspective. In addition, recruitment and training efforts will go towards meeting the guidelines and the down line significance of this is that fewer and fewer health professionals will either engage with or see as relevant the psychoanalytic perspective. These developments will also impact on the public view of psychoanalysis and potentially, over time, create a direct impact on the long-term viability of private practice in psychoanalysis. Given this scenario it is not too far fetched to see emerging a vicious downward spiral with the legacy of psychoanalysis remaining in the hands of an ever decreasing though committed group of believers, who, however, are seen as a rather esoteric and, dare I say it, even a somewhat odd bunch of people out of touch with the realities of the wider world. However, this is perhaps a too pessimistic picture given the ongoing intellectual presence and appeal of psychoanalysis combined with its ability to engage both with cultural issues (arguably now a more vital than ever agenda) and with alternative and important research agendas within the human sciences arena. A case in point here being the growth in importance of the neurosciences and the potential relationships between neuroscience and psychoanalysis (see; Kaplan-Solms & Solms, 2000). Yet, arguably, what cannot be denied is that psychoanalysts and psychoanalytic institutions must begin to more actively engage with these issues.

The hidden beauty of pragmatism

A recent systematic review on the effects of psychoanalysis and psychodynamic therapy for people with schizophrenia or severe mental illness that searched all evidence based databases including unpublished evidence on a world-wide scale concluded that “No trials of a psychoanalytic approach were identified”. The review went on to state that “there was no evidence of any positive effect of psychodynamic therapy and the possibility of adverse effects seems never to have been considered”

(Cochrane Review, 2003). The question arises as to what type of response can be made. The answer is: quite a detailed one. Moreover, it is one that psychoanalysis/the psychoanalytic community should, at this point, be strongly addressing but in many cases remains largely silent. What is involved here is nothing less than the task of putting in question the unduly elevated position that randomised controlled trials have in outcome studies within the so called "hierarchy of evidence" and here there are strong arguments that can be appealed to. One of the most significant involves pointing to the gap between clinical efficacy and clinical effectiveness. In other words it may be the case that a study can show that a particular treatment approach is efficacious in the treatment of say depression. However when one now takes this into the clinical situation one can still find that it is ineffective. Why is this? It is simply because in the control condition a particular symptom is usually isolated, and a "purified" and measurable form of treatment offered (in the psychotherapy research area this increasingly means a short-term and manualised form of treatment). The overall profile of the research sample (who are often university students) may also have little in common with a typical multidimensional clinical population. Add to this the fact that most such studies are based on treatments administered not by trained therapists but usually by mental health professionals in training, that there is an over-reliance on questionable change measures, and that follow-up tends to be limited, it is little wonder that many practising clinicians are not all that convinced by such evidence. To take a simple example, imagine meeting a single depressed mother, who is binge eating, has a history of broken relationships and drug abuse, is actively self-harming and who arrives in your office stating that she is worried about the effect she is having on her child. In such circumstances it surely makes little sense to think in terms of treatment protocols! Moreover, in many instances the clinical reality is that the evidence base is either non-existent or says very little of use, a case in point here being evidence that might suggest to a clinician the optimum measures to be deployed in responding to suicidal behaviour (and this despite the Government targets on suicide reduction mentioned earlier). However, here a caveat is important. Randomised trials may with time get more sophisticated and be carried out with samples much more like the patients we meet in our clinical practice, so this argument may weaken. Moreover, it is extremely unlikely that such trials will disappear as a research methodology, rather they are set to become more significant and influential, which is a point that I will come back to.

It is important to also realise that process studies tend to suffer from a similar range of problems. Some of these problems as outlined by Stiles and Shapiro (1989) include the following. Firstly, the assumption that process and outcome exist in a simple cause-effect relationship to each other, which can be sharply contrasted with how non-linear the psychoanalytic process is, (and, of course, this is enshrined in Freud's important concept of deferred action). Secondly, the assumption that the components of a therapeutic process are not only measurable, but consistent in both scope and content, can again be contrasted with, for example, how very different particular psychoanalytic interpretations can be in scope and content. Thirdly, there is the assumption that the active ingredients of a treatment are known and contained in the therapists behaviours and actions, with the patient in a correspondingly passive role, which can be contrasted with the psychoanalytic view that it is rather the analysands unconscious that interprets, and so on. At this point most psychoanalysts may be rightly groaning under the weight of this mechanistic, consequentialist, and disembodied view of the human subject, perhaps recalling with Lacan (1988) that this form of psychological viewpoint "is itself an error of perspective on the human being" (p.278). The point to be made here, however, is

subtly different. As indicated earlier, the stakes are high, and thus we must be prepared to argue our corner at the very place where we may feel tempted to turn our back on an enterprise that appears to offer so little of interest. There is it seems a delicate balance to be maintained here and it is worth remembering how unprepared, surprised, and later devastated (if that is not too strong a word) the American Psychoanalytic Association were when insurance companies on mass began refusing to fund psychoanalytic treatments in the 1990's on the basis that there was no evidence that they were effective.

Of course there is more at stake here than a simple debate on the value and place of quantitative and empirically grounded methodologies within healthcare. Behind this and informing this whole trend lies a conception of science as capable of objective knowledge, as impartially seeking after truth, as progressive and ever more unifying and as value free. This too needs to be disputed. At this juncture we are deep in familiar Lacanian territory for the psychoanalytic subversion does not stop with the subject who longs for certainty but instantiates itself in science itself and most particularly in the anti-Cartesian break that Lacan insisted on between knowledge and truth (though it must be noted that even Descartes needed the notion of a veridical God to keep these two together!). Freud too sensed this when he wrote: "science is based on observations and experiences arrived at through the medium of our psychical apparatus. But since our science has as its subject that apparatus itself, the analogy ends here" (Freud, 1940a: 159). In other words, and as Lacan stated, we operate in the field of the conjectural sciences. Yet the point to be made here is more radical still for Lacan is not simply, or solely, arguing in favour of some special status in relation to psychoanalytic knowledge, rather he is arguing for an expanded notion of science itself. In other words science needs to be seen in terms of an activity that embodies systematic classification, detailed description and reasoned explanation that in turn takes into account the symbolic universe of the subject "doing" the science. What this means is that methodologies must be seen for what they are, namely, methods for the production of data. The real task of science lies in their scrutiny, in their acceptance or rejection, and here what comes into play are questions of observation and logic that are common across many disciplines. This is an important point in an age when advanced and complex technologies risk validating the role of the technician who understands and implements such technologies as against the role of the scientist who must evaluate them. It is even more so the case when increasingly we live in a world whereby what one can call the lack in science is (or in some cases should be) exposed, for science, in making defensible knowledge claims, aspires to rather than presents that which is objective. Moreover, it is also imbued with values and interests that need to be made transparent, and is itself, while operating within a particular paradigm always open to cross paradigm challenges. The bottom line here is that outcome studies, for example, must be interpreted in a context of theory, applicability and usability rather than accepted at face value, though arguably this is not yet taking place on the sort of scale that is likely to make a significant impact on mental health policy. This leads on to the question of what else might be done in this field.

Here the biggest question seems to revolve around whether or not psychoanalysts and/or their institutions are going to take the need for empirical and quantitative research seriously despite the many potential problems and issues this raises. In my own opinion it is important to find a way into this field while not necessarily embracing it and thus I would argue that the response should be a cautious yes. It is also potentially instructive to see what might be achieved by examining other studies, a case in point being The London Depression Intervention Trial (Leff et al.

2000; Asen & Jones 2000). This study compared the optimum regime of antidepressants with couple therapy delivered by experienced family-systemic therapists over a period of one year with a one-year follow-up. The results were striking and indicated that couple therapy was superior to antidepressants both for the treatment phase and for the maintenance phase. Moreover, the study showed that whereas the dropout rate for couples therapy was 15% the corresponding figure for the antidepressant treatment group was quite staggering at almost 57%. In addition an interesting comparison of costs showed that while the couple therapy as a direct intervention was approximately double that of the drug condition, when overall levels of health service use were taken into account this difference more or less levelled off. In other words those in the couple trial did not significantly access other health service professional time whereas those receiving the drug treatment did (though the authors caution here on the small sample size used to make this comparison). So in this case what we have is an empirical study that strongly supports the clinical effectiveness of couple therapy in the treatment of depression and one has to wonder if psychoanalytic researchers could not be similarly involved in designing potentially significant and meaningful research projects. A final point worth noting is that though the senior family-systemic therapists involved did produce a manualized version of their approach to intervention this was in no way prescribed in a session-by-session manner and thus reflected closely the way real therapists might work in the real world of clinical practice.

A second area of research potential concerns so called qualitative research. This uses techniques such as discourse analysis to examine what a given therapist actually does in clinical practice and sets this practice alongside the theoretical accounts of what it is that that therapy says it is doing. This again is an area for development and moreover is one that promises to bring considerable reflexivity to the clinical practice of psychoanalysts and psychoanalytic psychotherapists as well as offering a scientifically framed counterpoint to quantitative studies. The need for such a form of research seems self-evidently to be there in so far as there seems to be relatively little that successfully bridges the gap between theory and everyday clinical practice within much of psychoanalysis. Indeed Fonagy (1999) goes so far as to say “the discrepancy in rates of progress between theory and practice is staggering and would be hard to understand were it not for the relative independence of these two fields” (p.14). This is a gap that applied psychoanalysis needs to address itself to, though not in a naive way. If on the one hand one can seriously put a question mark over the lack of good psychoanalytic books on technique, one must at the same time balance this with the dangers involved. Freud himself was well aware of this problem and, for example, though he planned, at one point, to produce a book with the title “A General Account of Psychoanalytic Technique” he later abandoned this idea and instead between 1911 and 1915 published a small selection of just six papers on this topic. His reticence was it seemed justified as by 1928 in a letter to Ferenczi he wrote:

“The “Recommendations on Technique” I wrote long ago were essentially of a negative nature. I considered the most important thing was to emphasise what one should not do, and to point out the temptations in directions contrary to analysis. Almost everything positive that one should do I left to “tact”.... The result was that the docile analysts did not perceive the elasticity of the rules I had laid down, and submitted to them as if they were taboos. Sometime all that must be revised, without, it is true, doing away with the obligations I had mentioned” (in: Jones 1955, p.241).

The problem here is one that is familiar. Psychoanalysis deals with the subject, with the absolute particularity of any given subject, and in terms of technique, therefore embodies a technique that is premised on the notion of firstly, unique clinical outcomes and secondly, on the analysts responsibility in relation to the psychoanalytic act. Indeed these two points are explicitly linked, for example by Lacan, who insists that psychoanalysis strictly embodies a mode of functioning that reveals the absolute particularity of a given subject based on the specificity of the desire of the analyst.⁴ It is why as I will argue later there is a link to be made between psychoanalysis and poetry. At the same time one can, and should, ask is it not the case that that Freud himself might have been interested in qualitative research? For what is involved here is not a set of rules or procedures but rather a method which promises an open ended and reflexive examination of actual clinical practice that in turn is a prompt to theory building. Many analysts will insist, however, that any such methodology will itself interfere with the analytic process, with the development of transference etc., yet here I believe we have to ask, are these barriers exaggerated? And even more to the point, have such assumptions been tested?

We cannot of course leave this topic without a reference to psychoanalytic case studies, which are highly informative in relation to both technique and theory. They allow for the rich description of complex material wherein both conscious and unconscious variables can be simultaneously explored and tracked. Nevertheless, it is also the case that it is difficult to justify any generalisation to a broader clinical population based on single case studies where both the material presented and the individual patient are highly and non-systematically selected (indeed it should be remembered this was never their prime purpose, and here Freud himself led the way, as he clearly presented his case studies as a way of exemplifying the nature of psychoanalysis rather than as proof of this or that clinical fact). Moreover, an intervention that shows itself to be efficacious in the single case setting is further undermined by the fact that to prove its efficacy one needs this particular intervention to be contrasted with an alternative that *did not* or failed to produce similar results. Without evidence such as this we are back in the realms of Wittgenstein's infamous critique of psychoanalysis wherein he argued that a psychoanalytic interpretation worked by supplying to the analysand a "wonderful representation", or metaphor, for their suffering which helped them cope better with their lives but in no way dissolved or re-worked the root cause of such suffering. In finishing this section it is also relevant to say something about clinical vignettes for these certainly offer almost no evidence at all in terms of clinical efficacy, despite the fact that many authors appear to use vignettes in precisely this way. They should, however, be seen for what they are, namely, as decontextualized descriptions, which an author is free to weave into his or her discourse to support by way of illustration just about any clinical point he or she wants to make. This is not to say that they should not exist, much psychoanalytic writing would be very dull without them, but rather to make the point that we should not be deceived into thinking that their presence adds any evidential weight to what an author is saying.

⁴ It is perhaps worth labouring the point here that for Lacan the person of the analyst is here not the issue (e.g., that he or she embodies the good of a well functioning ego with which the analysand can identify) but rather that the analyst can function as analyst and thus as cause of desire in relation to the unconscious of the analysand. Moreover, the person of the analysand is equally not the focus (i.e. one again does not seek their good), but, rather works to reveal their own unconscious functioning and fantasy structure.

The necessity of poetics

Having already alluded to the issues of subjectivity and the necessary tie between subjectivity and unique clinical outcomes let me say a little more by way of asking, what does psychoanalysis aim at? As Lacan never tired of pointing out analysis does not aim at the good but rather at truth, by which he meant (unconscious) truth as semblant, truth without guarantee. There is thus an essential subjective production or point of creation, in relation to, what one might term, ones "lived aspirations", within and via analysis, which can also be thought of as a point at which conscious knowledge is disrupted. Here a reference to poetry is useful even if it is recognised that it is primarily evocative (other analogies could potentially be used). It is thus interesting to note how poetry essentially focuses on the unrealised and on the construction of new realities aimed at perceiving or taking hold of some profound moment, or truth, of human subjectivity. Shakespeare was surely attuned to this when he wrote:

"And as imagination bodies forth
The form of things unknown, the poets pen
Turns them to shapes, and gives to airy nothing
A local habitation and a name"

(Shakespeare, 1969:125)

In this quote one gets a sense of the poet who must have the courage to use his or her mind without the comfort of another's guidance, something which is clearly central to the psychoanalytic act and the responsibility an analyst has for this. Otherwise, as Lacan himself put it, we are left merely with a "dispiriting formalism that discourages initiative by penalising risk, and turns the reign of the opinion of the learned into a principle of docile prudence in which the authenticity of research is blunted before it finally dries up" (Lacan, 1977: 31-32). One can further note how poetry, like analysis, seeks after an effect, but one that is transformational, whereby our experience of the world is in some sense fundamentally altered as a result of an encounter with what is as yet unrealised. Of major significance too is the fact that both the poetic imagination and psychoanalysis actively seek a beyond of the socially valued and/or social conventions as an end in themselves. They focus rather on what the subject can do in, and make of, their world and the fabric of lived experience it entails, and, one can add, from a psychoanalytic perspective the point of departure is the subject's symptom. It is in this sense that a subject must produce or grasp him or herself in the world as a result of an analysis, which happens via the immediate data of their own speech, or in other words in the presence of the unconscious. It is why interpretations in analysis must in turn focus on the emergence of the absent subject of the unconscious, on the subjects disbeing, rather than be guided by some increase in one's sense of unifying self-knowledge, which, all too often feeds the subject's ego as source of misrecognition. Lacan (1989) elaborated on this in his discussion of Aristotle's four causes (i.e., efficient, formal, final and material cause) whereby he linked the truth of analysis to Aristotle's material cause, which in the life of the individual is nothing other than the effects of the signifying chain in that dimension in which it is barred from consciousness. Moreover, as analysis invariably deals with *jouissance*, which clinically amounts to shifting *jouissance* as a mode of enjoyment in a subject burdened with its effects, and, in so far as this needs to be understood in terms of emergent properties (as against the monotonous repetition of what has been), so again does this allusion to poetry and the creative act receive a further clinical echo. The implication should be

clear, there can be no reduction in what is here termed the “poetry” of psychoanalysis, and yet the world of empirical research must it seems be dealt with.

However, continuing for the moment with this analogy, it can also be argued that the poetry of analysis manifests itself in more mundane ways and I would like to highlight just two of these by way of returning to the so-called “scientific paradigm” with which much of this paper has been concerned. Poetry gives access to what was not there before, and here, though the link may be somewhat tenuous, so does theory. In other words evidence can only tell us what to do, but not why. To take a simple example, the effectiveness of a particular treatment, say the use of SSRIs (tricyclic antidepressants) in a particular disorder does not and cannot lead to the conclusions that such problems are caused by serotonin deficiencies (though sadly such reasoning is common enough). In other words real progress in our field requires good theory and moreover a theory that can make room for what is novel and emergent in the field of clinical practice and in relation to new and varied forms of human suffering that appear with some regularity every few decades. This is, and needs to be viewed as, an ongoing demand on the psychoanalytic imagination, something that needs to be actively engaged with, and with just as much a sense of pressure as the poet experiences before his or her “creative imperative”. In other words we need a living theory and must be wary of putting too much emphasis on the “already there” no matter how vital the latter might in itself be, and surely this is how the best in psychoanalysis emerges, to which Lacan’s own work is ample testimony.

We should at least also note how this attention to theory has, what might be termed, a further defensive potential, which is none the less important, even vital. For example, we need to consider becoming good historians of the evidence based practice movement, as a pathway to showing up, what, one can speculate, will be inevitable inconsistencies in a body of knowledge largely devoid of theoretical scaffolding. In a similar way we need to focus on what the “evidence base” currently says, and will come to say, about what doesn’t work, for here there is the opportunity (and task) to open peoples minds (perhaps especially those who focus exclusively on the so called “brief therapies”)⁵ to the complexities of human suffering and via this to psychoanalytic thinking.

Clearly though, at least in the field of mental health, what is most pressing is the need to develop theory and research around specific and important areas of practice, for example, in relation to the “endings” or “terminations” of analysis, to mention just one of many possible examples. In mental health such endings are multiple and almost never amount to an end of analysis as traditionally thought of, and yet, here psychoanalytic theory seems surprisingly weak and even absent. There is, nevertheless, empirical evidence that there are often major improvements in such treatments, the disappearance of the symptom (and here the evidence clearly disputes the old analytic idea of symptom substitution in such cases), and/or

⁵ There are a number of points that could be made here. Clearly sometimes a subject may attend a therapist and, for example, develop some new perspectives/ideas which allows them to shift their relationship to their presenting complaint. Okay, there is a legitimate place for this - a form of problem solving. However, one must wonder if brief therapists seriously think they have a model of psychic functioning, a model of the mind, of subjectivity etc. One also suspects that a brief therapist may not go to another brief therapist to explore their own psychic suffering/functioning (a problem common to all technique based therapies). This latter point raises a question of ethics which should be, but usually is not, seen as central in any discussion of therapy and its use.

a change in subjective position. I mention this just to point to an area where empirical work needs to be done and where creativity and theory building will also have a potentially crucial role to play. It is this marriage that as psychoanalysts we need to both face up to and foster and indeed there is a potentially long road ahead. Immediate questions arise here in relation to how psychoanalytic communities and institutions are actively facilitating and/or sponsoring such research agendas. Should it not, for example, be a priority for all psychoanalytic organisations to be actively engaged in some form of research? One can also raise questions about training. Is it not in some sense odd that one can train as a psychoanalyst or psychoanalytic psychotherapist and learn almost nothing about how to read/evaluate empirical research or indeed carry out such research oneself? Questions also arise in relation to how we research psychoanalysis and it is important that we learn from others when it comes to the design of studies. Thus and speaking broadly we need research that focuses not just on the symptom but on the subject, that is multi-variable, and that is, where possible, longitudinal, sensitive to context, and done with the aim of achieving cross cultural comparisons. This of course is easy to say, actually implementing such research is however a big task, especially given the problems of successfully operationalizing key psychoanalytic concepts. In finishing it is worth making two further brief points. The first concerns Lacan's invention of the pass (which involves giving oral testimony concerning one's experience of analysis) as a procedure for being given the (elevated) title of "Analyst of the School" within the Lacanian School, which, some have argued, is a form of ongoing research into psychoanalysis and its effects. It has certainly led to the development of some interesting ideas about the nature, for example, of the end of an analysis, though here there have been also radical disagreements between different committees of the pass and indeed many Lacanian analysts have argued against the use of any such procedure (see: Safouan, 1999). What is perhaps most interesting to note here is that Lacan was surely on the right track, from a research perspective, in putting the speaking subject at the centre of this procedure and thus one can see an attempt to specify (and validate) an outcome based on psychoanalytic variables. The difficulty is that as an empirical research methodology the pass is simply hopeless and meets none of the criteria essential to such research.⁶ It is perhaps sobering to realise that any "results" from such research will, and can only be, classified as, at best, "expert opinion" which counts for almost nothing within the research field of today (and of course as the pass procedure itself shows experts will invariably disagree!). This leads me to my final point concerning research. Invariably if a serious research agenda is embarked upon one of the predictable outcomes is that the findings of such research will with time become more and more conclusive (remembering here, however, that science lacks a conclusion). This is no doubt a good thing, though one needs to recognise that there is a clear implication, namely, that through this process key psychoanalytic concepts will be tested and challenged and some will be found wanting. We thus need to face the fact that some of our most cherished theoretical and clinical concepts will need to go, or be subject to significant modification. This, of course, is not an easy thing to do, especially as one implication of this is that we are already employing, at least some, and possibly many, false and

⁶ This of course does not imply that there is anything necessarily wrong with this form of research as a form of research. For example, there is evidence that such research is good for theory building. Fundamental questions arise; however, in relation both to the status of the knowledge claims that arise based on such research and in relation to the lack of any (arguably essential) iterative process between such theory building and empirical research.

unsustainable constructs both in our work and in our theory.⁷

In essence, and by way of conclusion, this paper has argued against the presence of any “either/or” logic when we come to consider both the pragmatics and poetry of psychoanalytic practice. To thrive psychoanalysis (and psychoanalytic psychotherapy) will need both. It will also, in my opinion, need to grasp this particular nettle at the start of this century if it is to see itself survive into the next.

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⁷ Maybe this is one source of resistance to such research, as, understandably, clinicians tend to need or at least want to see their theoretical and clinical framework as at least mostly right!

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