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A Brief Commentary on the Systematization of Psychoanalytic Therapy: History and Present Perspectives

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Abstract

The Authors outline the history of the systematization of psychoanalytic therapy and report on the recent development of a new Dynamic Interpersonal Therapy protocol for depression and anxiety disorders.

Keywords: Psychoanalysis; Systematization; Manualization; Time-limited psychotherapy; Dynamic interpersonal therapy

In recent years, The demand for evidence-based protocols in health care institutions (for research and funding reasons that we will not discuss) encouraged a process of systematization of all psychotherapeutic procedures, including psychoanalytic therapy.

Pioneer Systematizing Subjectivity

From the time he was first developing psychoanalysis, Freud tried to systematize its method in a series of papers on technique. Yet, by his own admission, he could only give an incomplete set of recommendations about what an analyst "should not do" and left the task of making positive suggestions about "what to do" to his case reports, the personal analysis, and the supervision of the youngers' case material by senior psychoanalysts. As Freud himself recognized, it was Sándor Ferenczi who arrived at a clearer statement of what a psychoanalyst should do in his/her practice. Here follows an excerpt of a letter from Freud to Ferenczi:

My recommendations on technique […] were essentially negative. I considered the most important thing to emphasize what one should not do […]. Almost everything that is positive that one should do I left to "tact," which has been introduced by you. But what I achieved in so doing was that the obedient ones didn't take notice of the elasticity of these dissuasions and subjected themselves to them as if they were taboos. That had to be revised at some time, without, of course, revoking the obligations. […] As true as what you say about "tact" is, this admission seems to me to be all the more questionable in this form. All those who have no tact will see in this a justification of arbitrariness, i.e., of the subjective factor [1].

This is the knotty dichotomy psychoanalysis struggled with since the beginning: that is, the subjectivity of the analyst vs. the objectivity of the technique. The exemplification of the two extremes are to be found in intersubjective psychoanalysts on the one side [2], and in the analyzing machines or instruments [3] on the other. According to the first position, the main therapeutic factor in psychoanalytic treatment is the analyst's subjective, authentic, personal and unique responsiveness to the patient. The second position, on the contrary, is shaped on the idea that any well-trained analyst should have his personality take one step back during treatment, so to let the psychoanalytic method work. In brief, the main therapeutic factor would be, in the first case, the subjectivity of the analyst, while in the second case it should be attributed to the objectivity of the analytic method.

Ferenczi's improvement of the psychoanalytic technique went on in both directions. In fact, the main goal of The Development of Psychoanalysis–the book he wrote with Otto Rank in 1924, which can be seen as the prototype psychoanalytic manuals–was to advocate for a more systematic use of the analyst's subjectivity [4]. By chance, that very book is regularly cited as the starting point of brief psychotherapy bacause the authors introduced a temporal limit to treatments, proposed a specific focus, and advocated for a more active attitude of the psychoanalyst. From then on, the history of time-limited treatments and the systematization of psychoanalysis have been closely related, since a time-limited treatment is much easier to systematize [5].

Middle Ages

The first manuals In the following years, Ferenczi's project to combine the systematization of analytical technique with the principle of flexibility was further developed by Franz Alexander at the Chicago Institute for Psychoanalysis [6] and by Michael Balint, Ferenczi's pupil, at the London Tavistock Clinic [7,8], where Balint's own pupil David Malan became one of the founding fathers of modern brief analytic psychotherapy [9-11].

Alexander was the analyst of Karl Menninger, the founder of an extraordinary clinical and research center in Topeka (Kansas): that is, the Menninger Clinic, Sanitarium, and later School of Psychiatry. From the 1940s to the 1970s, the Menninger Foundation was among the first institutions–possibly the very first one–to start testing psychoanalytic treatments by modern scientific standards.

The first manual for psychoanalytic therapy was compiled at the Menninger School of Psychiatry by Lester Luborsky in 1973, and it was published in 1979 [12]. On the same year, Aaron Beck published the first cognitive-therapy manual and, shortly after, also the first manual for interpersonal psychotherapy came out.

Present Times are Manuals Made for Research Only?

The following phases of the history of the manualization of psychotherapy was tracked back by Horst Kächele in a paper for a Special Issue of Psychoanalytic Inquiry dedicated to this topic [13]. Furthermore, for demonstrating how manualized psychodynamic

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treatments have undergone an extraordinary and exponential growth in recent years, Seybert, Erhardt, Levy and Kächele himself collected a list of all psychodynamic manuals that have appeared between 1980 and 2011 [14].

However, Kächele remarks

An extensive meta-analysis of ninety studies by Shadish et al. [15] showed that the application of naturalistic psychotherapy and manualized treatment were on par […]. Manuals are necessary for research purposes, but there is no evidence that they are superior in treating disorders compared to the experienced clinician. Therefore, the presentation of new manuals should include a specification of the degree of clinical expertise necessary for adequate implementation [13].

Seemingly, the old-fashioned psychoanalytic dichotomy between the subjectivity of the analyst (viz. the personal experience of the clinician) and the objectivity of the method (viz. adherence to the manual) resurfaces. But what about unexperienced clinicians? Would they do better following manuals? Are manuals necessary for research purposes only, or can they become useful training devices for "shaping" the subjectivity of the young psychotherapist?

There is no evidence on that. However, in our opinion, manuals should increasingly be employed in psychotherapy trainings–the first manual was developed by Luborsky under his students' request–for achieving a "more structured" use of the subjectivity of the therapist. In fact, in order to implement today's manualized treatments the clinican needs to be specifically trained to follow the manual.

Dynamic Interpersonal Therapy: A Case Report

Dynamic Interpersonal Therapy (DIT) is a good example of a recent manualized, psychoanalytically oriented treatment. It is a protocol for depression and anxiety disorders that was developed in London by Lemma, Target and Fonagy [16]. DIT follows in the best brief psychodynamic psychotherapy tradition, as we have just tracked it down, since its main features are: 1) its being time-limited (16 sessions), 2) the active attitude of the therapist, and 3) its being focused. In fact, in DIT the therapist and the patient work together for identifying and exploring a specific interpersonal-affective focus (IPAF), which includes a representation of the self linked, through a specific affect, to a representation of the object.

These features make DIT something different from classical psychoanalytic treatment, not something alternative to it. While classical psychoanalysis, due to the high frequency of sessions and long duration, interlaces with the life of the analysand, DIT aims at producing something of an "intense affective impact" for relaunching the vitality of the individual. In that sense, it could also be seen as an intensive, rather than brief, form of therapy.

The treatment's aim was to provide a form of intervention that could meet the standards of evidence-based medicine and the demand for accountability in terms of cost effectiveness to psychodynamic practitioners working in the National Health Service in England [17]. Subsequently, it was selected as the brief psychodynamic protocol that will be provided in the UK as part of the Improving Access to Psychological Therapies (IAPT) national programme, which was launched in May 2007 by the Department of Health [18].

In 2011 Lemma, Target and Fonagy published the results of a pilot study for examining the feasibility of the protocol in the context of primary care services in Great Britain, which use session-by-session outcome monitoring as part of the quality assurance standards (PHQ-9 for Major Depression and GAD-7 for Generalized Anxiety Disorder, since these measures were those currently in use for these services). Despite the limitations of the study (n = 16 with 2 dropouts), the authors concluded that "the data suggest that DIT was associated with a significant reduction in reported symptoms in all but one case, to below clinical level in 70% of the patients" [19]. We are now awaiting for follow-up data.

Conclusions

In our opinion, this is the right direction for psychoanalytic therapy to become accessible in some form to larger segments of population [20]. What should be accepted – in our view – is that such treatments would not "cure everything," but their focus should be limited to the most urgent needs of the patient. Treatments of this kind, then, can open the door to less focused and more structural psychotherapeutic interventions.

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