SCIENTIFIC RESEARCH, THE THERAPEUTIC COMMUNITY AND PSYCHODYNAMIC PSYCHOTHERAPY

Marco Chiesa, Peter Fonagy

Abstract

Objective: In this chapter we will discuss the relationship between scientific research and therapeutic community and psychodynamic psychotherapy approaches, two inter-related forms of treating mental health disorders that have found a stable place within national mental health services, complementing general psychiatry. We argue that these disciplines have been slow to build a research culture and integrate the findings of research into clinical practice.

Method: We present evidence from a prospective controlled outcome study of personality disorder and a multi-centre study of psychodynamically-informed therapies, carried out in a therapeutic community and in several psychotherapy services, respectively.

Results: We show that the prevailing cultural climate and strongly held beliefs systems within the therapeutic community and psychodynamic psychotherapy movements in the UK do not facilitate scientific research to take place and for important results to be taken on board to improve technical and theoretical development and changes in service provision.

Conclusions: Bridging the gap between scientific research and clinical practice, and building bridges with other allied disciplines would help reversing the steady decline that therapeutic community treatment and psychoanalysis have suffered in the last two decades within universities, psychology and the mental health field

Key Words: scientific research, therapeutic community, psychodynamic psychotherapy, outcome studies, research culture

Declaration of interest: none

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Therapeutic Community

Therapeutic communities are institutions that were originally developed as a therapeutic alternative to the dehumanising and alienating conditions of the psychiatric hospital Barton 1959, Goffman 1961. The programmes of treatment and rehabilitation that were developed regarded patients as active participants to the process of treatment and were in sharp contrast to the degrading and institutionalising environment of the psychiatric hospital. Sociotherapy, psychotherapy and social rehabilitation became the cornerstones of the treatment programmes operating within therapeutic communities. The hierarchical structure and the authoritarian, institutional culture that characterised the psychiatric hospital, were abandoned in favour of a more democratic structure and a culture characterised by permissiveness and other forms of collaboration between staff and patients. The traditional roles assigned to patients and staff — in which patients were regarded as passively ill individuals and staff were regarded as actively knowing what was best for patients and were responsible for administering treatment — changed dramatically. Patients had much more active roles within the therapeutic community and were asked to participate in both their own treatment and the treatment of other patients, in an atmosphere that facilitated and valued more open communication.

This milieu created a sense of belonging to a community of people (communalism) who lived together for a period of time with the aim of facilitating frank and honest interpersonal exchanges, in the hope of healing previous traumatic and troublesome experiences undergone by the patients. Within a therapeutic community, patients’ participation in the life of the hospital included a more empowered role in the selection of new patients and in other decision making processes relating to the management of other patients: in community meetings, patients might vote on whether a patient who broke the community rules should be given sanctions, for example. The emphasis was on active rehabilitation as opposed to custodial practices.

The rationale for admitting patients for relatively long periods of time (the expected range of stay varied from 6 to 24 months) was put forward in a number of publications: it emphasised the need to remove the patient from his or her broken-down, dysfunctional social environment and to expose the patient to an alternative experience that would function as a catalyst of change. In addition, the severity and frequency of
self-harming behaviour and other forms of acute acting-out was deemed to prevent psychotherapy from taking place safely in an outpatient setting Horwitz 1974, Norton and Hinshelwood 1996.

A hallmark of the rise of the therapeutic community and one of the cornerstones upon which the communities were built was held to be the development of a ‘culture of enquiry’, defined as “…the accumulation through time of the attitudes, beliefs, and behaviour patterns, common to a large part of the unit. This is arrived at as the result of considerable inquiry into the nature of these attitudes and an attempt is made to modify them to meet the treatment needs of the patients. The tendency is for these cultural patterns to be most clearly established in the more stable and permanent members of the community, i.e. staff” Jones 1976. The basic tenet of a culture of enquiry was to allow for the ongoing examination and discussion of staff and patients’ roles and role relationships, overt and covert group dynamics and projective fantasies, interpersonal and intra-system difficulties and other institutional defensive operations. This type of culture was expected to lead to constructive investigation concerning the functioning of the organisation, and the identification of deficiencies and flaws, in such a way that corrective measures can take place.

Surprisingly for an approach that claims to place a culture of enquiry at the centre of its practice, the therapeutic community movement has had a rather chequered relationship with scientific research. Given the emphasis on self-enquiry, one might expect that therapeutic communities would welcome the establishment of research studies that might help clarify issues which remain hazy, such as the expected level of improvement rates, the necessary length of stay in order to achieve improvement, the identification of anti-therapeutic aspects of clinical programmes and of clinical populations that might react unfavourably to the immersion in intensive treatment programmes. However, Rutter and Tyrer have remarked that ‘poor research evidence has made it difficult to ascertain who is being treated in TCs and which patients respond best to this type of treatment’. They conclude that, sadly, the question of the efficacy of the oldest treatment in use for personality disorder remains unanswered Rutter and Tyrer 2003.

In fact, only a handful of studies that have attempted to evaluate the effectiveness and cost effectiveness of the therapeutic community model of treatment for personality disordered population are available. Notably, one controlled longitudinal study compared outcome results of borderline core symptoms of 70 (out of a possible 228) patients admitted to the therapeutic community programme at Henderson Hospital in London, UK with that of 67 non admitted patients (patients who were either considered unsuitable at assessment, or did not attend the clinical assessment procedure or had their funding for treatment refused by their local District Health Authority) Dolan et al. 1997. This study showed that the Henderson sample had significantly greater clinical improvement (43%) compared to the non-treatment group (18%). Improvement was also found to be positively correlated with length of stay. However, a number of design limitations (possible selection bias, the suitability of

patients unsuitable for treatment and not funded by their Health Authority as control group and the time differential in follow-up ratings between the treated and untreated groups) limit the internal validity of the study.

A second prospective controlled study was carried out at the Cassel Hospital, Richmond, UK. This study compared outcome on a number of clinical variables (self-mutilation, suicide attempts and hospital readmissions) and dimensions of functioning (symptom severity, social adjustment, global assessment of mental health) in 3 different samples: a) a group of patients admitted to the long-term (12 months) inpatient programme with no planned follow-up treatment after discharge (one-stage sample); b) a second group of patients allocated to the step-down programme (6 months of inpatient stay followed by 18 months outpatient group psychotherapy and outreach community psychosocial nursing); and a third group of patients treated within a general psychiatric setting, matched to the Cassel samples. All 143 patients who agreed to participate in the study met the criteria for at least one personality disorder and presented with a high number of co-morbid psychiatric diagnoses, high rates of sexual and physical abuse by care-givers and a long history of unsuccessful previous psychiatric treatments.

Results at 24 and 36-month follow-up showed that significant improvements were found in severity of symptoms, social adjustment and global assessment of mental health in both Cassel samples compared to the patients in the general psychiatric group. Improvements in rates of self-mutilation, attempted suicide and readmission to psychiatric services were significant in the step-down programme compared to the one-stage and general psychiatric groups, which did not show significant changes in these dimensions Chiesa and Fonagy 2003. The clinical significance of improvement again showed consistent advantage in the step-down group compared to the other two models Chiesa et al. 2004. The findings at the 6-year follow-up confirmed that a specialist step-down model had achieved consistently better results than a long-term inpatient programme in the therapeutic community and a general psychiatric approach Chiesa et al. 2006.

This study indicates that the prognosis of a sample of individuals with severe personality disorder appears to improve over a 6-year period if treated with a phased approach, which combines an initial intense residential stage followed by medium intensity treatment as part of a long-term approach. The continuation of psychosocial treatment in the patient’s own community allows for the continued improvement of the patients exposed to the programme, four years after expected termination of treatment. Importantly, the study highlighted some of the problems associated with long-term residential care. These include regressive phenomena resulting from institutionalization and iatrogenic effects, such as increase in self-harm and acting-out behaviour in a sub-group of borderline patients. The difficulties of keeping patients in treatment were much greater in the group of patients who were expected to stay longer in the institution. In fact, we found significantly higher rates of dropout within 14 weeks from admission in the one-stage group (39%) than in step-down patients (22%), and a significant interaction between diagnosis of borderline personality

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disorder, treatment allocation and compliance with treatment Chiesa et al. 2000. These results pointed to likely flaws in the long-term therapeutic community programme and to the need to identify more accurately which patients might benefit from an inpatient programme and which patients might be harmed by prolonged admission to these programmes.

In this respect, the accumulation of results from well-designed empirical studies contributes to the validation of clinical programmes and assists in the identification of deficiencies in the organisation of treatment and service delivery. For clinical staff, this opens up opportunities for creative discussion and the potential for modifying components of the programme. For example, in the Cassel study we found that the high number of therapeutic inputs and level of intensity may have a de-stabilising and anti-therapeutic effect for some borderline patients. They experience such intense settings as engulfing, rigid and persecutory, which can lead to claustrophobic reactions in some patients. The pressure cooker atmosphere present in some therapeutic communities triggers non-reflective internal working models within the context of emotionally charged attachment relationships. When the acutely disorganised behaviour that may follow is inadequately responded to by staff — who unwittingly re-enact dysfunctional parental responses (frightened or frightening behaviour) — the patient feels abandoned. This in turn generates dissociative responses on the part of the patient, with an increase of interpersonal disturbance Fonagy and Target 2000. It is possible that structural imbalances present in the long-term residential treatment model may aggravate this situation instead of providing a containing framework for the borderline patient’s severe separation anxieties, flawed internal object-relationships and deficits in reflective functioning. A re-appraisal of the structural organisation of treatment and of the therapeutic programme aimed at correcting dysfunctions and tailoring them to the borderline patient’s psychopathology, may improve the efficiency and effectiveness of treatment.

The history of this research project is emblematic with regard to the relationship between research and therapeutic community. At the outset, the introduction of the combined hospital and community-based programme (step down model, SDM) and of the research project created a mixture of apprehension, anxiety, fear and hostility in the hospital. Several members of staff felt that two different programmes within the same unit might not be compatible as it could create difficulties in running the therapeutic community regime and stimulate competition and envy amongst patients. Staff also feared that the presence of two programmes with different length of residential stay would not be compatible within the same unit, that it might interfere with the workings of the therapeutic community and that it would create rivalry and conflict between patients.

In addition, it was felt that, although the SDM might make sense on clinical grounds for some, it was still an unknown entity and many believed that patients might suffer as a result of their exclusion from a fuller experience in the inpatient setting. It was also feared that there might be a negative impact on patients from the research programme, regarding potential splits between the clinical and research teams. Patients could be distracted away from the therapeutic programme or become disturbed as a consequence of undergoing structured and semi-structured interviews that delve into painful past experiences of neglect and abuse.

These reservations and other events threatened the survival of both the new clinical programme and the research project. As anxiety and ambivalence grew within the hospital, patients who refused to be part of the SDM were reallocated to the hospital-based programme and refused participation in the research. A growing overt and covert hostility expressed by influential sub-groups of patients and staff brought the research to the brink of failure. A series of meetings among senior staff and letters and informal talks from the Mental Health Trust Headquarters and the Charing Cross and Westminster Medical School (now Imperial College) helped to address some of the problems and restored a sense of purpose within the therapeutic community concerning the new developments. Gradually the situation improved. The potential value of the new programme was understood and a more tolerant attitude towards the research was established.

The serious difficulties of carrying out a major research project within the Cassel therapeutic community illustrate the importance of establishing a research culture within the institution Chiesa and Healy 2009. This can only be achieved through a painful but necessary process of working through of the issues, dynamics and transferences that the introduction of the research endeavour to the institution evokes. The creation of a relatively separate research team and the introduction of the practices and interactions that are necessary for the research to take place, are at first experienced as alien and threatening to the established practices and dominant institutional culture. The multi-faceted activities of the research team and indeed the values and ideas inherent in evaluative projects, become equated with an external, foreign object that could disrupt and threaten the clinically-based, familiar philosophy upon which the therapeutic community programme is founded. As such it evokes primitive transferences characterised by a mixture of suspicion and persecution that in turn mobilise hostility and attempts to extrude the alien and threatening entity. Indeed our experience suggests that beyond the initial verbal conscious agreement, powerful underlying forces, often expressed in a passive-aggressive fashion, were directed against the running of the project. An additional element was that the research ran simultaneously with the introduction of a newly introduced clinical programme, which in itself was a source of major anxieties, perceived as a threat to established practices.

More importantly for the subject of this paper, this study has had the effect of challenging widely held assumptions within the institution. Most staff believed that only the inpatient experience was responsible for clinical change. Therefore there was an expectation that the patients who had the longer exposure to the therapeutic community milieu would have the better outcome. The experience accumulated over the years the study took to complete and the results of the trial provide overwhelming evidence to contradict these
expectations and assumptions. The results have shown that a reduction of the duration of inpatient stay did not have adverse effects, and actually led to a better outcome when it was coupled with continuation treatment after discharge. Hence, by introducing a more effective new programme the patients’ prognosis was improved.

In addition we found that the research programme did not have adverse effects on patients’ mental state or level of engagement in the clinical programme, and the feared split between research and clinical teams did not materialise. In fact, most of the feedback received from patients suggested that they found participation helpful and complementary to the clinical programme. For the most part non-compliance with research assessments was a consequence of discontinuing clinical treatment, and only a small percentage of patients dropped-out of the research while continuing with the treatment programme.

Psychodynamic therapy

Fonagy et al. 2005 have remarked that ‘notwithstanding a history of over 100 years, psychoanalytically informed psychological therapies have a poor evidence base’. This was confirmed by the comprehensive review of outcome studies of psychoanalytically-oriented long-term therapies assembled by the Research Committee of the International Psychoanalytic Association, which concluded that existing studies have so far failed to unequivocally demonstrate the effectiveness of psychoanalysis compared to an alternative treatment.

The Review of NHS Psychotherapy Services in England commissioned by the Department of Health Parry and Richardson 1996 and the scientific review of research findings on the efficacy and effectiveness of the psychotherapies Roth and Fonagy 2005 highlighted the paucity of research into psychodynamic therapies in the UK and confirmed the relative lack of studies on psychodynamic models. These reports stimulated a group of psychodynamically-oriented clinicians, working in senior positions in the NHS and at University level, to set up a multi-centre study, involving several psychotherapy centres in England, to systematically collect intake and outcome information for the clinical population referred for psychotherapy. The study was planned in the Research & Development subcommittee of the Association for Psychoanalytic Psychotherapy in the NHS and a protocol outlining methodology and procedures was prepared. An enlarged Organising Committee (R&D subcommittee members and invited experts in the field) finalised the original study protocol and strategy Chiesa and Fonagy 1999. Several psychotherapy services in England were subsequently approached to participate in the study and fourteen agreed to join the protocol. This study was modelled on previous large scale surveys of psychotherapy Howard et al. 1995, Seligman 1995, with the additional advantages of being able to offer expected success rates and contribute to establishing benchmark marks for psychodynamic psychotherapy (clear national standards against which services can be evaluated), which are necessary for increasing the quality of service delivery.

The study tried to take on the challenge of investigating in a naturalistic and observational fashion the practice and delivery of psychoanalytically oriented psychotherapy in routine clinical practice in different NHS psychotherapy settings. Emphasis was therefore laid on the evaluation of the psychodynamic model of treatment (brief and longer-term, individual and group) using objective and standardised measures. This was the first wide-ranging, multi-centre study aiming to evaluate psychoanalytic therapy for a variety of psychiatric disorders that has ever been attempted in the United Kingdom. The aim of the proposed study was to evaluate the routine clinical practice of the different psychotherapies of psychodynamic orientation provided by collaborating centres, with regard to levels of psychiatric morbidity in the population referred for psychotherapy, appropriateness of the intervention, treatment pathways and outcome.

Data gathered from a large number of patients would yield important information concerning referral patterns, population profiles, rates of attrition, levels of staffing across centres, patterns of service delivery across centres and overall outcome. This information could help to formulate an estimation of the effects of therapy on the use of health services. In addition, information about the nature and severity of problems would help service planning and needs assessment procedures. The pooling of data from several centres would contribute to the creation of a national database of psychotherapy services, by obtaining data from a population representative of the population referred for psychotherapy, which would compensate for low sample sizes, giving greater power of inference.

The proposed investigation entailed all referred patients above the age of 18 who were considered suitable for psychotherapeutic intervention at the point of assessment, being naturalistically allocated to one of the psychotherapeutic modalities to be evaluated, following the clinical practices established in each participating centre. The psychotherapeutic modalities were: (a) long/medium term individual therapy, once or twice weekly for longer than 6 months; b) brief psychotherapy, involving one weekly sessions for up to 6 months, c) group psychotherapy of variable length, but not less than one year in duration; and d) other psychodynamic interventions (such as couple therapy, family therapy) involving extended consultations with variably specified duration. Consenting patients were given a set of self-rated instruments (Brief Symptom Inventory, Clinical Outcome in Routine Evaluation, Inventory of Interpersonal Problems and Community Adjustment Questionnaire) which were intended to be repeated at regular intervals from initial assessment, waiting list, and intake into treatment and through to follow-up. A senior clinician completed a set of rater-based measures to obtain information with regard to diagnostic, demographic, early history and past psychopathology variables. A Central Organising Committee was in charge of general co-ordination and strategic planning. A local co-ordinator nominated by each participating centre liaised with the organising committee and attended termly plenary meetings in which problems were shared and discussed, and contributions were made to help shape the project.

The successful completion of the study would have
given each psychotherapy service an indication of the impact of their service on their client groups, thus helping to identify the selective strengths and weaknesses of the service. The comparison of individual service profiles with national indicators derived from all centres would have made it possible to explore clinical practices and make modifications to enhance effectiveness. In addition, it would have provided valuable information to guide mental health service commissioners in commissioning clinically effective and cost-effective psychological treatments for specific client groups.

The study successfully recruited 1,136 patients, who completed the intake set of measures. Results from the study provided valuable information concerning the profiles of patients treated in psychotherapy departments. The results confirmed that NHS psychotherapy services deal with patients with moderate to severe mental health problems that date back two years or more. Previous psychiatric utilisation was found to be high, indicating a level of chronicity and difficult-to-treat psychopathology. In addition, the results of the standardised measures also demonstrated that the population referred for psychological treatment presented with a severe degree of psychiatric morbidity, comparable to that found in psychiatric secondary care samples. However, we also found that a high percentage of patients dropped out between the assessment stage and the actual date of starting treatment and also in the initial phases of treatment. These high rates of rejection of therapy at the assessment and waiting list stage raise questions about the degree of acceptability of psychodynamic psychotherapy for a proportion of individuals with mental disorders. This finding may prompt psychodynamic clinicians to modify the way psychodynamic therapy is presented and the way the initial phases of therapy are conducted Chiesa et al. 2009.

When compared with a sample of patients referred for primary care counselling, patients referred for specialist psychotherapy were found to be more dysfunctional. The results of this comparative study showed that patients referred to NHS secondary care psychotherapy services were on average significantly more likely to have a diagnosable psychiatric disorder, including a higher percentage of personality disorders, and to have more symptoms and interpersonal problems, than patients seen in primary care counselling services. In particular, we found that a combination of more psychotic symptoms, social inhibitions and a higher risk of self-harm effectively identified those referred to psychotherapy services, while patients exhibiting greater levels of somatic and anxiety symptoms and non-assertiveness were more likely to be seen in primary care settings Chiesa et al. 2007.

Although the number of patients recruited at intake was high, difficulties with following-up patients were evident. Three centres withdrew from the project after intake data collection, follow-up data was only partially returned from most sites and patients dropped out from the study at the follow-up stage. Consequently, completed data was available from 231 (20% of the study sample, 47% of those who started therapy) patients who had started in some form of psychodynamic psychotherapy at the 6 months follow-up assessment. The return at 12 and 24 months was so disappointing that no meaningful analyses could be carried out. The clearly insufficient data did not allow conclusions to be drawn with regard to the expected outcomes of psychodynamic therapies. However, the results through to the 6-month assessment on the available sample revealed a significant improvement in severity of symptoms and in interpersonal problems, as well as lower scores on the core outcome routine evaluation measure. However, the clinical significance of change, expressed in average pre/post effect sizes in each measure, was small. Individual medium-long-term and brief psychotherapy achieved relatively larger effect sizes on average than group therapy.

The mixed results obtained from this multicentre study for the evaluation of the effectiveness of psychodynamic psychotherapy within a National Health Service delivery context, suggested that there are several obstacles present in establishing systematic evaluation of treatment in psychodynamically-oriented psychotherapy departments. Scarce resources and inadequate funding, the difficulty of establishing dedicated time and/or personnel for research/audit purposes and the frequent reluctance to integrate research with clinical practice, are some of the possible issues.

Another reason for the paucity of psychoanalytic outcome research may be rooted in the perceived incompatibilities and epistemological differences between the views held by psychoanalysis and the tenets of natural and social science. Whittle (2000) has drawn attention to ‘a fault line running down the middle of psychology’. There are two cultures with completely different attitudes to empirical research. On the one side there are those in experimental psychology, cognitive neuroscience, neurobiology, human development and other sub-specialties of the ‘science of the mind’, who have embraced empirical research and benefit from a powerful, reasonably well-funded discipline that has progressed particularly rapidly over the last quarter of a century. This discipline prides itself in having a cumulative knowledge base, which is strong enough both to generate a range of technologies and to interface with neighbouring disciplines, and which is generally acclaimed as a relatively successful natural science. On the opposite tectonic plate, Whittle argues, psychoanalytic psychotherapists have historically restricted themselves to personal insight; that is, the objective study of subjectivity.

How is the existence of this fault line to be understood? In psychotherapy, communication, whether in writing or clinical discourse, is judged by its impact. In psychotherapy, we accept that something has been understood when the discourse about it elicits a response. Elusiveness and ambiguity are not only permissible in the context of a psychotherapeutic process, but they may also be critical to accurately depicting the complexity of a piece of human experience and its evolution. By contrast, the culture of systematic research particularly that of experimental psychology is governed by the principle of ‘cognitive asceticism’, as Whittle has termed it. From this perspective interpretation and theoretical constructions are temptations to be resisted: a position can justifiably be maintained only if it is demonstrable. Given these
constraints it is not easy for empirical psychologists to account for subjective experience, and they have largely preferred to steer clear of attempting to provide such accounts until quite recently, when functional magnetic resonance imaging has brought subjective experience and demonstrable phenomena (brain activity) into close contact again Eisenberger and Lieberman 2004, Pessiglione et al. 2007.

Nevertheless, incompatibilities remain between an approach that is essentially ‘first person’, concerned with individual subjective experience, and the third person observational stance characteristic of empirical science. Eminent psychoanalysts have expressed fears that the introduction of empirical research methods from this barren world risks the destruction of the phenomena they cherish. Brennan-Pick offered the ominous warning that ‘if this [scientific] research is privileged within psychoanalysis, we will, in order to placate and propitiate our enemies from without, succeed in destroying psychoanalysis from within’ Brennan-Pick 2000.

Cognitive asceticism seems to have little relevance to the clinician, whose principal task is to help the patient create a narrative that fills the gaps in their understanding of themselves and how they have come to be the way they are. Theory has a heuristic value, supporting a clinician’s understanding of particular cases. Psychoanalytic theories historically have not been bound by the constraints of empirical research methodology. They can be seen as acts of imagination about how our minds function, and which are judged principally according to how well they are felt to fit our own and our patients’ subjective experience. This is not to say that the theories are not true; rather, they are best understood as metaphoric approximations at a subjective level of certain types of deeply unconscious internal experience. We should not accept simplistic critiques of metaphorical thought in psychoanalysis. As Eisenberg (1992) and many others have noted, science uses metaphor in the absence of detailed knowledge of the underlying process. Provided that metaphor is not confused with a full understanding, or, to use Freud’s metaphor, provided that the scaffolding is not mistaken for the building Freud S 1900, p. 536, heuristic considerations outweigh any disadvantages of their use.

However, the problem of psychotherapeutic theorizing is precisely one of heuristics Foaenv 2003. The very fecundity of clinically rooted concepts is beginning to threaten the clinical enterprise. Psychotherapists appear to take special pride in producing new theories, fresh elaborations based on the same data. There are currently over 500 distinct clinical approaches to psychological therapy for children Kazdin 2003. It is hard to believe that all are necessary or indeed that all are working on different and distinct principles. This has led to an overabundance of ideas in the field. What we do less well is to test these ideas in meaningful ways that might help eliminate some of these suggestions. Psychotherapists, like all of us, are vulnerable to uncritical acceptance of charismatically presented new ideas, which then come to be pooled in an eclectic purée of clinical strategies and techniques that create increasing problems in the transmission of psychoanalytic knowledge and skills.

In defence of this overly liberal epistemology many fall back on the Freudian argument of ‘the inseparable bond’ between cure and research Freud 1926. Psychotherapeutic practice, like all clinical endeavours, has well-established limitations as a form of research. The chief problem with using clinical experience as research is the well known one of induction Wason and Johnson-Laird 1972. In our clinical activity we mostly tend to concentrate on confirming our theory-based expectations from our patient’s material, and data is not the plural of anecdote. A physician practising internal medicine learns from clinical observations, but is not under the illusion that they are engaged in research. However, we are entitled to expect that the physician’s work will be influenced by the results of research, and that his or her reasoning will have been disciplined by scientific training. It is fair to expect something comparable of psychoanalytic psychotherapists.

The difference in epistemic approach between psychoanalytic clinician and psychological researcher is largely explained by a distinction in the content of the enquiry. The clinical aims of psychotherapy and its firm grounding in the context of personal relationships inevitably push theory towards the elaboration and deep understanding of mental contents, which can be construed as the key themes that underpin reported experiences, feelings and ideas. On the other side of the fault line, the other sciences of mind such as experimental psychology and cognitive neuroscience are more concerned with mental processes, the way that the mind functions, and the machinery that gives rise to feelings and ideas. Each has its preferred focus. The legitimate concern of psychotherapists that our theories should hold meaning, not just for our patients and for other psychotherapists, but also for the broader social world, historically has led us to overlook the need to define mental processes, the mechanisms of the psychological world. Clinical observations cannot be replicated in the laboratory for a host of good reasons, but systematic observations can and should be used to inform us about the psychological processes underpinning clinical phenomena, which we currently use the metaphorical language of metapsychology to approximate.

It may seem there are good grounds for being sceptical about abandoning the divide between psychoanalysis and the other sciences of the mind. The price for participation is acceptance of the possibility of interference, the legitimate demand of colleagues to be involved in the goal-setting and leadership selection for psychoanalysis along the same lines as psychoanalysts might hope to benefit from their involvement in the hurly-burly of academe. The risks of in-breeding and sterility are exchanged for the possible dangers of contamination and assimilation Hoffman 2009. The objections thus range from the apparently legitimate (e.g. the conceptual chaos that could occur as a fallout of the inevitable reductionism from one level of analysis to another), through the pragmatic (e.g. the limited amount of insight which the average clinician can hope to gain from interdisciplinary dialogue), to arguments rooted in anxiety about survival (e.g. a simplistic social psychology will replace hard won insights concerning unconscious functioning).

Nevertheless, the argument that psychotherapeutic observations concerning human behaviour are in some
sense incommensurate with any other form of observation is untenable. The mind remains the mind whether it is in the consulting room or the laboratory Fonagy 2003. Moreover, maintaining the isolation of psychoanalysis from other disciplines entails risks that need careful consideration. What are the risks of isolation? Michels (1988) has offered some suggestions. Psychoanalysis risks intellectual stagnation in the absence of external scrutiny. The opportunity to be involved in the selection of the leaders in closely related disciplines and in the setting of goals for these disciplines will be lost. We shall be deprived of participation in a broader community of scholarship. We shall have little first-hand knowledge of the intellectual issues of burning importance in a range of disciplines of relevance to us. We will not be closely involved in setting criteria for academic accreditation. And there are many other instances of opportunity costs.

However, if integration of findings from other domains with psychotherapeutic observations is undertaken piecemeal, this leads us into the temptation to identify those sets of findings from neighbouring fields that best fit our pre-conceptions. Conceptual integration, like clinical work, is rarely truly without memory or desire Bion 1967. Contrary to the suggestion that closer proximity to neighbouring sciences may be damaging to psychotherapy, a strong case can be made that the rich insights from psychotherapy can be strengthened by closer integration with biological psychology and psychiatry if this is undertaken in a rigorous and systematic manner Kandel 1998. If we continue to isolate ourselves from important scientific advances in other fields, psychotherapy will become extinct, as leaders in the field have repeatedly pointed out Michels 1994, Olds and Cooper 1997. Systematic study of the relation of findings from other disciplines with psychotherapeutic insights could achieve a high level of integration and a great deal of increased sophistication in the way that psychotherapists talk about remembering, imagining, speaking, thinking, dreaming and so on. What is required for integrative initiatives is a broader range of methods and an openness to and excitement about new ideas. Gathering further evidence for psychotherapy through research is important, not only to improve support for existing practices but also to generate a change in our own attitudes from a culture of knowing and certainty to one of questioning, uncertainty and progress. We have been far too complacent about our technical knowledge and its application, and this has not yet changed enough Chiesa 2010.

Rather than fearing that research might destroy the unique insights offered by long term intensive individual therapy, psychoanalysts must embrace the rapidly evolving ‘knowledge chain’, focused at different levels of the study of brain–behaviour relationships Fonagy et al. 2005. Whatever the reasons for the difficulties that have characterised the relationship between psychoanalysis and research, they act to prevent psychoanalytic psychotherapy meeting the challenges posed by the demands of practice-based evidence Evans et al. 2003, Lambert 2005, Okishi et al. 2006.

Integrating research and clinical practice

The opponents of research within therapeutic community and psychodynamic psychotherapy argue that the methods and instruments used for undertaking research in those settings are too blunt to take into account the complexity, subtlety and uniqueness of both the analytic encounter and the therapeutic milieu. They contend that they fail to take into account the many aspects of the transference-countertransference dynamics that would make the results of research studies biased and ‘almost meaningless’ Green 1996.

While this objection may have had some merit in the past, in recent years we have seen marked improvements in the quality and sophistication of trial design, in the methods used in research studies, and in the available evaluative instruments and methods of data analysis, all of which have increased the validity and reliability of the results obtained in large-scale studies. For example, the definitions of recovery criteria have been improved to encompass primary and secondary outcome measures, clinical as well as statistical significance is taken into account when analysing data and the selection and quality of measures has increased and it is now possible to tailor a specific instrument to the chosen outcomes for a finer evaluation of change. Several measures of established reliability and validity with proven sensitivity to change in several key dimensions of functioning are now available. Means to ensure treatment integrity and adherence (i.e. that the treatment is delivered in its intended form) have been developed and to minimise bias, outcome is rated by trained, independent raters, blind as to treatment allocation. Important improvements have also been made in meta-analytic methods, including meta-regression and meta-analytic mixed-effects models Leichsenring and Leibing 2003.

In our view, greater emphasis on research and the integration of research and clinical practice may contribute to arresting and perhaps even reversing the steady decline that therapeutic community treatment and psychoanalysis have suffered in the last two decades within universities, within psychology and the mental health field Chiesa 2005, Quinodoz 2008. Furthermore, a research emphasis could help build bridges with the other disciplines of medicine, psychology and neuroscience. In addition, the development of a research culture that seeks to maximise negative evidence, test competing hypotheses and different explanatory variables in order to look for evidence that may contradict the positive evidence, gives rise to what Jimenez calls a new empirical attitude within which we constantly question our views and theories in light of fresh observations, as opposed to selecting events that simply tend to confirm our position Jimenez 2007. Jimenez puts forward the view that this attitude is helpful to combat the idealisation of received wisdom and to soften a tendency towards uncritical adherence to schools of thought. Ultimately, if left unchallenged, this tendency may lead to elevation of relative theoretical concepts, always in need of improvement and modification, into ideological constructs.
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References