Integrating research with NHS clinical practice:

Unwelcome intrusion or constructive triangulation?

HeatherWood

Consultant Adult Psychotherapist and Research Lead, Portman Clinic

Tavistock and Portman NHS Foundation Trust

Abstract

When embarking on research into the efficacy of psychoanalytic psychotherapy in the NHS or the application of psychoanalytic principles, researchers come up against a number of hurdles: many clinicians still see empirical research as antithetical or disruptive to the practice of psychoanalytic psychotherapy; psychoanalytic psychotherapy has previously fared poorly in evidence-based policy guidelines and this can discourage ambition, and there are technical problems of research design, measurement and standardisation. Nevertheless, in a political climate which stresses service evaluation, measurable outcomes and empirical evidence, psychoanalytic psychotherapy must participate to survive. But there may be gains from conducting research beyond simply meeting the requirement to provide evidence of efficacy. Research may be viewed by some clinicians as an unwelcome intruder but it may have the potential to offer triangulation, the perspective of the "third", and so strengthen the foundations of clinical practice and the development of psychoanalytic thought.

Key words: NICE, evidence-base, triangulation, "third"

In an article entitled “Who’s afraid of psychoanalytic research?”, Schacter and Luborsky (1998) report taking three psychoanalytic journals with a total of 48 articles, and checking what proportion of the references referred to research papers. Of 1767 references, just five were research reports. They then sent psychoanalysts some sample abstracts from clinical and research papers and asked which they would be likely to read. Of those psychoanalysts claiming a high degree of conviction in their rationales and techniques, only 11% said they would read the research reports. Of those with lower degrees of conviction, 23% said they would read the research reports. Since psychoanalysis embraces varied and competing theoretical perspectives and methods, Schacter and Luborsky conclude that high degrees of conviction must reflect a **defensive** adherence to the model, and an unhealthy reluctance to contemplate other perspectives or frameworks. As a research study this is flawed, with very low rates of return of the questionnaires (19%), and the findings are open to a range of interpretations, but it is notable that, even amongst those admitting lower degrees of conviction, fewer than a quarter of the psychoanalysts sampled reported that they would read research reports.

Ten years later, similar attitudes still abound and there are still psychoanalytically-oriented therapists who will claim not to be interested in or to believe in research.

Presumably, in their mistrust of research, clinicians are trying to protect all those things which we know to be invaluable to effective clinical practice: the primacy of a secure frame, concern to avoid any impingements on the transference, and concern to avoid anything that might jeopardise therapist neutrality such as making ratings of patients' progress. The notion of the unconscious is one distinguishing feature of psychoanalytic model, yet that which is unconscious is not amenable to easy study or measurement, and empirical investigations which do not tap unconscious factors may be seen to neglect the essence of the work. In clinical work the theories of psychoanalysis provide a uniquely rich and complex model of the functioning of the psyche, and we prize being able to draw from this model in a meticulous and creative way that is uniquely tailored to the individual patient, yet this flexibility may be seen to conflict with establishing consistency in the delivery of treatment as required by research. From a clinical point of view it may be optimal to exercise discretion about the duration of treatment and frequency of sessions if the organisational context allows this, yet again this flexibility conflicts with assessing the impact of a specific "dose" of therapy. Training in psychoanalysis or psychoanalytic psychotherapy entails the acquisition of a core body of knowledge, but also much more nebulous changes such as a shift in professional identity, an increased capacity for containment, personal development, and the adoption of a new way of being with patients that involves free-floating attention, attention to unconscious communication, and interpretation rather than a more conversational style of interaction. All of these things are integral to the approach and invaluable to the clinical method, yet are not easily defined in objective terms and subject to reliable measurable.

If psychoanalytic psychotherapy were only offered in private practice it might well be possible to perpetuate these traditions undisturbed and those potential patients who chose to purchase this could do so. But the painful reality is that, if we want to practice in the public sector, there are accommodations which have to be made. In many European countries and the US, insurance companies funding healthcare require evidence of effectiveness (see Leuzinger-Bohleber et al (2003)), and in the UK, the NHS places a similar emphasis on evidence-based practice. Some of the psychoanalytic traditions and principles which are prized represent obstacles to the research which is required if psychoanalytic psychotherapy is to survive in the public sector.

The NHS is currently fixated on a model of treatment in which quantifiable units of care that have been empirically demonstrated to be effective in major trials are dispended according to standardised guidelines. The "patient choice" agenda reflects a shift from an a la carte menu to a cafeteria model, where patients can see what is on offer and can pick and choose between services or treatments, but is still assumed that what is on offer is a standardised dish on a plate. This mechanistic notion of the dispensing of treatments neglects the interpersonal nature of a therapeutic relationship and the unpredictability of the "chemical reaction" which results when two complex elements, the patient and the therapist, are mixed together in the consulting room. But however alien this contemporary culture is to psychoanalytic psychotherapists, if they themselves were diagnosed with a serious physical illness, would psychotherapists not want a treatment that had been demonstrated to be the most effective for the particular diagnosis? Would they not want to know that it was being delivered according to agreed guidelines, and not

at the discretion of their consultant? And might they not like the opportunity to make an informed choice between invasive treatments? A person would need to feel very trusting of his or her clinician or to have reached the end of the road in terms of treatment options before he or she would be willing to try a treatment for which the effects and side-effects were un-researched, where the procedure for administration was at the discretion of their consultant, and the treatment was of an indeterminate duration. Although uncomfortable and inconvenient, it is understandable that policy makers, commissioners and patient representatives want to measure psychotherapy by the same yardsticks as are being applied to treatments for physical disorders.

In the current climate, to refuse to embrace the agenda of evidence-based practice would be professional suicide. Psychoanalytic psychotherapy faces a crisis in the NHS because it fared very badly in the first round of NICE guidelines, and the IAPT agenda is focusing very considerable new resources mainly on CBT. Other approaches are now being considered for inclusion in IAPT – IPT, brief psychodynamic psychotherapy, behavioural couple therapy and counselling – but these other therapies will only be considered if they are rooted in documented competencies, are manualised, and have been piloted using IAPT measures. These are the rules of the game for those who wish to participate.

What can be done to mobilise an increased involvement in research? Anxiety is a great motivator and there are grounds for being nervous. The results of a word search are tabled below (see Table 1) for the terms “psychoanalytic psychotherapy” and “psychodynamic psychotherapy” in six of the original NICE guidelines on areas

including depression and anxiety that you would have thought would be the forte of psychoanalytic psychotherapists.

Table 1: References to psychoanalytic psychotherapy and psychodynamic psychotherapy in selected NICE guidelines

NICE guideline	Date	References to psychoanalytic psychotherapy	References to psychodynamic psychotherapy
Anxiety	2004	0	5
Depression	2004	0	21
BPD	2009	3	5
PTSD	2005	0	0
Self harm	2004	0	1
Eating Disorders	2004	3	0

The fact that there are some figures in this table might inspire a misguided complacency. In the BPD guidelines, for example, of the three references to psychoanalytic psychotherapy, one was a definition, one related to a member of the expert advisors who was a member of the APP, and one was a reference to the journal of the APP, Psychoanalytic Psychotherapy. In the NICE guidance documents which specify what commissioners should be purchasing the figures are even more stark (see Table 2).

Table 2: Reference to psychoanalytic psychotherapy and psychodynamic psychotherapy in NICE Guidance Documents

NICE **Guidance** Documents	References to Psychoanalytic Psychotherapy	References to Psychodynamic Psychotherapy
Anxiety	0	0
Depression	0	3
BPD	0	0
E Disorders	0	0
Self harm	0	0
PTSD	0	0

The NICE guidance in the original document on depression from 2004 is:

- Psychodynamic psychotherapy may be considered for treatment of the comorbidities that may be present along with depression (C)

Note that psychodynamic psychotherapy is not recommended for the treatment of depression per se. And “C” denotes “Directly applicable studies of good quality are not available”. This is guidance based on expert advice, not empirical studies.

In the 2009 NICE guideline update on depression, short-term psychodynamic psychotherapy is now included, recommended in the form of 16-20 sessions over a 4-6 month period. This is suggested for people with mild to moderate depression who decline an anti-depressant, CBT, IPT, behavioural activation and behavioural couples therapy. The guideline also recommends the evaluation of this treatment in an RCT as "CBT is not effective for everyone". This important inclusion of psychodynamic therapy at least allows it to be considered for patients who reject other approaches.

An alternative way of mobilising an interest in research might be to interpret the resistance to research. There will be many possible interpretations, and this is but one suggestion: We are used to thinking about the therapeutic relationship as analogous to the mother-infant couple, and often supervision is regarded as the "third" in the Oedipal triangle, the alternative perspective representing the father at the third point of the Oedipal triangle. This is like the father that Winnicott (1962) briefly describes, acting as protector of the mother/infant couple. But perhaps supervision is actually much more akin to the grandmother's role, where someone experienced in the mothering / therapeutic role, draws on her experience to support, contain and guide the novice, or even the experienced mother. From a Kleinian perspective (e.g. Britton, Feldman and O'Shaughnessey, 1989) the point about the Oedipal father, the true "third", is that he embodies difference, and may be seen as an outsider, a potential threat to the intimacy of the two-person relationship, and a potential intruder. It is only when this difference is integrated that one has a true Oedipal triangle. Indeed Britton (1989) describes how "The

initial recognition of the parental sexual relationship involves the relinquishing of the sole and permanent possession of the mother and leads to a profound sense of loss, which, if not tolerated, may become a sense of persecution" (p. 84). He goes on to describe how, in the "tragic version of the Oedipus complex the discovery of the oedipal triangle is felt to be the death of the couple: the nursing couple or the parental couple. In this fantasy the arrival of the notion of a third always murders the dyadic relationship" (p100). In this configuration, research might be the true "third", the uncomfortably different paradigm that we wish to shun and expel that is seen as threatening to damage if not destroy the therapeutic "nursing" couple. But this is a "third" that brings a genuinely different perspective, that may challenge the cloistered exclusivity of psychoanalytic thinking and language, and that has the potential to offer a much more secure anchorage in the broader field of mental health and psychology.

The true third brings, not just a different perception or viewpoint on the particular issue, but a different set of assumptions and concepts with which to understand it. Fonagy (2010), for example, provides a review of the impact of research on psychoanalytic clinical practice, and draws attention to recent studies which suggest that life events have a differential effect depending on the person's genotype; he raises the interesting possibility that people may differ in their response to psychotherapy and the mode of operation of psychotherapy depending on their genetic constitution.

"Research is there not simply to defend the boundaries of our exiting domains, but to help us to deliver the forms of care that are best for our patients. To do this we have to

understand better which causal mechanisms play a role in achieving patient benefit and also what circumstances can interfere with a treatment working.…Science, particularly neuroscience, will give us better ideas about how we can help our patients in more differentiated ways as it evolves". (Fonagy, 2010, p.38)

It may be inevitable that the true third intrudes and disturbs the intimacy of the therapeutic relationship, as the father comes between the mother and child. But if managed carefully, this "intrusion" may open up perspective-taking and thought and may foster development, rather than damaging the original attachment. Some patients interviewed by researchers about their experience of forensic psychotherapy, for example, returned to their therapy sessions and recounted how moved they had been to describe and acknowledge the therapeutic experience they had undergone (Yakeley and Wood, under review). The research interview prompted a stepping back and reflection on the experience of therapy which was novel and potentially developmental. Another expressed more paranoid fantasies about the researcher before meeting her face to face, but this led to fruitful exploration in his therapy. Thus there is the possibility of a creative interplay between the therapist, the patient, and the research.

If raising anxiety or using interpretation does not effect change, it may be necessary to resort to behavioural strategies. In my experience the development of a research programme in a psychoanalytically-oriented psychotherapy clinic required solid management support, financial resources to create a small group of clinician / researchers and research assistants, but also a gradual process of culture change. In effect, this

process of culture-change entailed slowly desensitising clinicians to the notions of quantification and measurement. As this progressed clinicians became more tolerant of patients participating in research interviews and even, eventually, the videotaping of group therapy sessions. In the early days, simple audits of casenote information that did not intrude on patients or require patient consent provided profiles of the clinic's activity and had a very significant political impact within the NHS Trust and with commissioners (e.g. Wood et al, in press). These audits were invaluable in winning recognition amongst clinicians for the value of quantification. They were followed by research off site, evaluating a consultative intervention by members of the clinic (Blumenthal, under review), and a study of mental health professionals' perceptions of risk (Blumenthal, in press). Subsequent studies involved qualitative interviews with patients (Yakeley and Wood, under review) and a small, naturalistic outcome study evaluating a specialist treatment group (Wood and Von der Tann, in progress).

These studies have highlighted the fact that, on the whole, clinicians seem significantly more sensitive to intrusions into the therapy than their patients. Not a single patient involved in research has protested about the research, although one or two have availed themselves of the possibility of opting-out of the research, with no consequences for their treatment. Indeed, many patients seem to enjoy participation in the research and value the attention and engagement with the researchers. Many have agreed to hours of questionnaire-completion and interviews without any objection, and those in therapeutic groups usually encourage others to participate.

Moving through audit, research off-site, research with clinicians rather than patients, qualitative research with patients, and research with a circumscribed group of patients treated by a research-sympathetic clinician, it has been possible to arrive at the point of being able to undertake larger scale studies, surveying wider groups of patients, and linking with others in multi-site treatment evaluations. When new proposals are discussed within the clinic they now evoke pertinent questions rather than blanket hostility or resistance. Regular research meetings provide a think tank and peer support, and involve a committed group of psychiatrists and psychologists who see research as integral to their role. Change does not require that everyone should do research themselves; managers have a crucial role both at a practical level of allocating appropriate resources, but also in effecting cultural change and ensuring that research is valued and not seen as a defection from or a threat to the psychoanalytic work.

I have focussed here on outcome research and have not addressed more pure research, testing psychoanalytic concepts; I also have not addressed the potential inspiration that can be derived from findings within the empirical literature which mesh with psychoanalytic propositions. These are subjects for another occasion. With respect to outcome research on psychoanalytic psychotherapy, despite the difficulties of conducting such research, there are grounds for cautious optimism: Shedler's (2010) excellent review draws on a range of studies and meta-analyses which repeatedly demonstrate that "psychodynamic psychotherapy sets in motion psychological processes that lead to ongoing change, even after therapy has ended" (p. 101). He reviews studies which suggest that it is the psychodynamic processes operating in both cognitive and

psychodynamic therapies that are associated with positive outcomes, and studies which demonstrate the range of benefits gained from psychodynamic treatments, beyond symptom improvement. In his view there is increasing evidence that effect sizes for psychodynamic therapies are as large as those for other treatments which are considered to be well-supported by the empirical evidence.

Since the compilation of the NICE guidelines referred to above there are some examples of published studies which support the superior effects of longer term psychotherapy with anxiety and mood disorders and complex presentations. The Helsinki Psychotherapy Study (Knekt et al, 2008) warrants mention because of the ambition and scale of the study, despite some methodological limitations. This group compared short-term psychodynamic therapy, long-term psychodynamic therapy and solution-focussed therapy with outpatients with mood or anxiety disorders in a randomized clinical trial. Knekt et al claim that, although short-term psychodynamic therapy and solution-focussed therapy were more effective than long-term psychodynamic therapy in the first year, the long-term therapy group continued to improve throughout the three years and, after three years, long-term psychodynamic therapy was more effective with 14-37% lower scores on the outcome variables. The study is methodologically flawed in that duration of treatment and frequency of sessions were confounded: short-term therapy entailed 20 once-weekly sessions, whereas solution focussed therapy entailed up to 12 sessions at 2-3 weekly intervals, and long-term therapy was 2-3 times per week for up to 3 years. In addition, though the final ratings are denoted “3 year follow-up”, it appears that some of the long-term treatment cases would still have been in treatment or have only just

finished treatment at this point, while patients receiving the shorter therapies might have finished therapy more than two years earlier, and some patients received further "auxiliary treatment" during this post-treatment phase. While recovery from anxiety disorders was significantly higher in the long-term treatment group than either of the brief therapy groups, there was no significant difference between the therapies in recovery from depression, despite 84.7% of participants identified as having mood disorders at the outset. Despite these methodological limitations, the authors have demonstrated the possibility of conducting a randomized clinical trial with a significant sample (326 participants) which draws attention to the possible gains from longer-term and more intensive treatments.

Leichsenring and Rabung's (2008) meta-analysis of long-term psychodynamic therapy for complex mental disorders has also attracted critics. They defined long-term psychodynamic psychotherapy as of at least a year or 50 sessions' duration, involving careful attention to therapist-patient interaction and interpretation of the transference. "Complex mental disorders" included personality disorders, chronic mental disorders, multiple mental disorders and complex depressive and anxiety disorders with a chronic course or co-morbidity. In an analysis of 23 studies they found that LTPP showed significantly better outcomes than shorter forms of psychotherapy in terms of overall effectiveness, target problems and personality functioning. The Leichsenring meta-analysis is encouraging because they included results from good naturalistic studies as well as RCT's and found that this was justified statistically. It is useful to have this confirmation that rigorous naturalistic studies can contribute to the body of evidence and

are worth undertaking if a research team lacks the resources, infrastructure or service context to conduct an RCT. Fonagy (2010) summarises the criticisms that have been levelled at this meta- analysis but refers to as yet unpublished results from a further meta-analysis which provide “the first set of strong signals which suggest that long-term psychoanalytic psychotherapy is superior to less intensive treatments when directed towards complex mental disorders” (p.27).

Leuzinger-Bohleber et al’s (2003) retrospective evaluation of psychoanalytic treatments in Germany terminating between 1990 and 1993, provides an impressive model of the use of a range of measures designed to tap “psychoanalytically-relevant” and “objectively-relevant” change. They compared data from interviews conducted by independent psychoanalysts with former patients, with patient self-report on standardised questionnaires, data from insurance records, interviews with the participants’ former analysts, and the written reports submitted to insurance companies by the analysts. This qualitative and quantitative data, while only retrospective and not conforming to a pre- and post- test research design, provides a convincing account of the power of psychoanalytic treatments at a range of levels – both conscious and unconscious, and in terms of subjective, behavioural, interpersonal, and occupational functioning .

It is not easy to conduct empirical studies which are both methodologically sound and which do justice to the complexity of patients’ difficulties and the treatment provided. Nevertheless, if we can provide sound empirical evidence for what we do, we will increasingly have a place at the table of policy-makers and funders. The values of

psychoanalytic psychotherapy may not chime with the contemporary emphasis on short-term interventions, “quick cures”, de-professionalisation and self-help, but there is no evident political conspiracy to exclude psychoanalytic psychotherapy. Shedler (2010) suggests that the dissemination of psychoanalysis was hindered in the US by the dominance within psychoanalytic institutions of a medical hierarchy who denied access to training to non-medics and were dismissive of research; in his view this apparently arrogant stance provoked antipathy, particularly amongst academics, who may have given disproportionate attention to the empirical evidence supporting non-psychoanalytic methods of treatment. In the UK there has been a tradition of training “lay” analysts so there is not the same history, but it may indeed be the case that the perceived exclusivity of psychoanalysis in the past has provoked retaliatory attempts to exclude psychoanalytic treatments in turn.

Nevertheless this culture is changing. Psychoanalytic ideas increasingly provide the foundation for a wide range of applied interventions, particularly with more disturbed patient populations (see for example, Lemma and Patrick, 2010). Service providers and commissioners cannot ignore the significant proportion of people with mental health problems with complex and longstanding disorders who have exhausted available short-term treatments and require specialist help. If we deliver the research which demonstrates the effectiveness of psychoanalytic psychotherapy in such situations, we will surely be entitled to participate and contribute.

There is inevitable tribalism and rivalry between groups who have devoted themselves to learning and practicing different therapeutic techniques. These affiliations inevitably influence the interpretation of research results, and even the conclusions drawn from studies (see Fonagy, 2010). If there is a popular misconception of psychoanalytic psychotherapy it is surely that the therapist will be inert and inactive, that it is a treatment for the worried well, and that it constitutes "naval-gazing" but does not address symptoms and distress. (There is probably an equivalent misconception of CBT within the psychoanalytic community that CBT is inevitably mechanistic, superficial, fails to address the therapeutic relationship and is always short-term). The only prospect of dismantling such misconceptions and prejudices is if we learn to communicate in a common language, and the language of science is one that traverses different domains.

Perhaps we are not helped by the mystique which continues to shroud our methods and trainings; even if the perception of psychoanalytic treatments as exclusive is dissolving, the perception of opacity may remain. How often do we hear that people learn by the "apprenticeship" model, or even "by osmosis". Systematic research will require manualisation of our methods, and however uneasy psychoanalytic psychotherapists may feel about any rigid prescriptions for technique, sensitively-constructed manuals may be very important in making what we do accessible and teachable. In the search for a secure base for the delivery of psychoanalytic psychotherapy in the NHS, the development of treatment manuals which demystify what we do and when, can potentially enhance training, facilitate research, and may be as influential in winning allies and recognition as the demonstration of effectiveness in RCTs.

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