

Landman P. (2013) *Tristesse Business; le Scandale du DSM 5*. Editions Milo.

Lehembre O. (2004) Qui sommes-nous? Que faisons-nous? Une enquête du Syndicat des Psychiatres Français et de l'Association Française de Psychiatrie. *La Lettre de Psychiatrie Française*, 31, 15–19.

Ménéchal J. (2008) *Psychanalyse et Politique*. ERES.

Naccache L. (2006) *Le Nouvel Inconscient. Freud, Christophe Colomb des Neurosciences*. Odile Jacob.

Roudinesco E. (1982) *Histoire de la Psychanalyse en France*, vol. 1. Le Seuil (réédition Fayard 1994).

Roudinesco E. (1986) *Histoire de la Psychanalyse en France*, vol. 2. Le Seuil (réédition Fayard 1994).

THEMATIC
PAPER

The scientific standing of psychoanalysis

Mark Solms

University of Cape Town, South Africa;
email mark.solms@uct.ac.za

Conflicts of interest. None.

© The Author 2018. This is an Open Access article, distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives licence (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is unaltered and is properly cited. The written permission of Cambridge University Press must be obtained for commercial re-use or in order to create a derivative work.

This paper summarises the core scientific claims of psychoanalysis and rebuts the prejudice that it is not 'evidence-based'. I address the following questions. (A) How does the emotional mind work, in health and disease? (B) Therefore, what does psychoanalytic treatment aim to achieve? (C) How effective is it?

A.

As regards the workings of the emotional mind, our three core claims are the following.

- (1) *The human infant is not a blank slate; like all other species, we are born with innate needs.* These needs ('demands upon the mind to perform work', as Freud called them, his 'id') are felt and expressed as *emotions*. The basic emotions trigger instinctual behaviours, which are innate *action plans* that we perform in order to meet our needs (e.g. cry, search, freeze, flee, attack). Universal agreement about the number of innate needs in the human brain has not been achieved, but mainstream taxonomies (e.g. Panksepp, 1998) include the following.¹
 - We need to engage with the world – since all our biological appetites (including bodily needs) can only be met there. This is a *foraging* or seeking or 'wanting' instinct. It is felt as interest, curiosity and the like. (It coincides roughly but not completely with Freud's concept of 'libido'.)
 - We need to find sexual partners. This is felt as *lust*. This instinct is sexually dimorphic (on average) but male and female inclinations exist in both genders.
 - We need to escape dangerous situations. This is *fear*.

¹Here I am focusing on *emotional* needs – which are felt as separation distress, rage, etc. – not *bodily* drives – which are felt as hunger, thirst, etc. – or *sensory* affects – which are felt as pain, disgust, etc. (See Panksepp, 1998.) The way in which I use the term 'action plans' in this article is synonymous with the use of the term 'predictions' in contemporary computational neuroscience.

- We need to destroy frustrating objects (things that get between us and satisfaction of our needs). This is *rage*.
 - We need to attach to caregivers (those who look after us). Separation from attachment figures is felt not as fear but as *panic*, and loss of them is felt as *despair*. (The whole of 'attachment theory' relates to vicissitudes of this need.)
 - We need to care for and *nurture* others, especially our offspring. This is the so-called 'maternal instinct', but it exists (to varying degrees) in both genders.
 - We need to *play*. This is not as frivolous as it appears; play is the medium through which social hierarchies are formed ('pecking order') and in-group and out-group boundaries maintained. The (upper brain-stem and limbic) anatomy and chemistry of the basic emotions is well understood (see Panksepp, 1998 for a review).
- (2) *The main task of mental development is to learn how to meet our needs in the world.* We do not learn for its own sake; we do so in order to establish optimal *action plans to meet our needs* in a given environment. (This is what Freud called 'ego' development.) This is necessary because innate action programmes have to be reconciled with actual experiences. Evolution predicts how we should behave in, say, dangerous situations, but it cannot predict all possible dangers (e.g. electrical sockets); each individual has to learn *what* to fear. This typically happens during critical periods in early childhood, when we are not best equipped to deal with the fact that innate action plans often *conflict* with one another (e.g. attachment *v.* rage, curiosity *v.* fear). We therefore need to learn *compromises*, and we must find *indirect* ways of meeting our needs. This often involves *substitute-*

formation (e.g. kicking the cat). Humans also have a large (cortico-thalamic) capacity for satisfying their needs in *imaginary* and *symbolic* ways. It is crucial to recognise that *successful action programmes entail successful emotion regulation, and vice versa*. This is because our needs are *felt as emotions*; thus, successful avoidance of attack reduces fear, successful reunion after separation reduces panic, etc., whereas unsuccessful attempts result in *persistence* of fear and panic, etc.

- (3) *Most of our action plans (i.e. ways of meeting our needs) are executed unconsciously.*

Consciousness ('working memory') is an extremely limited resource, so there is enormous pressure to consolidate and automatise learned solutions to life's problems (for a review see Bargh & Chartrand, 1999, who conclude that only 5% of our goal-directed actions are conscious). Innate action programmes are effected automatically from the outset, as are the programmes acquired in the first years of life, before the cortical ('declarative') memory systems mature. Multiple unconscious ('non-declarative') memory systems exist, such as 'procedural' and 'emotional' memory (which are mainly encoded at the level of the basal ganglia). These operate according to different rules. *Not only successful action plans are automatised.* With this simple observation, we can do away with the unfortunate distinction between the 'cognitive' and 'dynamic' unconscious. Sometimes a child has to make the best of a bad job in order to focus on the problems which it *can* solve. Such illegitimately or prematurely automatised action programmes are called 'the repressed'. In order for automatised programmes to be revised and updated, they need to be 'reconsolidated' (Tronson & Taylor, 2007); that is, *they need to enter consciousness again*, in order for the long-term traces to become *labile* once more. This is difficult to achieve, not least because most procedural memories are 'hard to learn and hard to forget' and some emotional memories – which can be acquired through just a single exposure – appear to be indelible, but also because *the essential mechanism of repression entails resistance to reconsolidation of automatised solutions to our insoluble problems*. The theory of reconsolidation is very important for understanding the mechanism of psychoanalysis.

B.

The clinical methods that psychoanalysts use flow from the above claims.

- (1) Psychological patients suffer mainly from feelings. The essential difference between

psychoanalytic and psychopharmacological methods of treatment is that we believe feelings *mean* something. Specifically, *feelings represent unsatisfied needs*. (Thus, a patient suffering from panic is afraid of losing something, a patient suffering from rage is frustrated by something, etc.) This truism applies regardless of aetiological factors; even if one person is constitutionally more fearful, say, than the next, their fear is still meaningful. To be clear: *emotional disorders entail unsuccessful attempts to satisfy needs*.

- (2) The main purpose of psychological treatment, then, is to *help patients learn better (more effective) ways of meeting their needs*. This, in turn, leads to *better emotion regulation*. The psychopharmacological approach, by contrast, suppresses unwanted feelings. We do not believe that drugs which suppress feelings can *cure* emotional disorders. Drugs are symptomatic treatments. To cure an emotional disorder, the patient's failure to meet their underlying need(s) must be addressed, since this is what is *causing* their symptoms. However, symptom relief is sometimes necessary before patients become amenable to psychological treatment, since most forms of psychotherapy require collaborative work between patient and therapist. It is also true that some types of psychopathology never become accessible to collaborative psychotherapy.
- (3) *Psychoanalytical* therapy differs from other forms of psychotherapy in that it *aims to change deeply automatised action plans*. This is necessary for the reasons outlined above. Psychoanalytic technique therefore focuses on the following.

- Identifying the *dominant emotions* (which are consciously felt but not necessarily recognised as belonging to the self, etc.).
- These emotions reveal the *meaning* of the symptom. That is, they lead the way to the (ineffective) *automatised programmes* that gave rise to the feelings.
- The pathogenic action programmes *cannot be remembered directly* for the very reason that they are automatised (i.e. unconscious). Therefore, the analyst identifies them *indirectly*, by bringing to awareness the *repetitive patterns of behaviour* derived from them.
- Reconsolidation is thus achieved through reactivation of mainly subcortical long-term traces via their *derivatives* in the *present* situation (this is called 'transference' interpretation). Only cortical memories can be 'declared'.
- Such reconsolidation is nevertheless *difficult to achieve*, mainly owing to the ways in which non-declarative memory systems work, but also because repression entails *resistance* to the reactivation of

insoluble problems. For these reasons, psychoanalytic treatment takes time – i. e. numerous and frequent sessions – to facilitate ‘working through’.

Mental healthcare funders need to learn how learning works. For a more detailed account of the mechanism of psychoanalytic therapy, see Solms (2017).

C.

Psychoanalytic therapy achieves good outcomes – at least as good as, and in some respects better than, other evidence-based treatments in psychiatry today.

- (1) *Psychotherapy in general is a highly effective form of treatment.* Meta-analyses of psychotherapy outcome studies typically reveal effect sizes of between 0.73 and 0.85. An effect size of 0.8 is considered large in psychiatric research, 0.5 is considered moderate, and 0.2 is considered small. To put the efficacy of psychotherapy into perspective, recent antidepressant medications achieve effect sizes of between 0.24 and 0.31 (Kirsch *et al.*, 2008; Turner *et al.*, 2008). The changes brought about by psychotherapy, no less than drug therapy, are of course visualisable with brain imaging.
- (2) *Psychoanalytic psychotherapy is equally effective as other forms of evidence-based psychotherapy (e.g. cognitive-behavioural therapy (CBT)).* This is now unequivocally established (Steinert *et al.*, 2017). Moreover, there is evidence to suggest that the *effects of psychoanalytic therapy last longer* – and even increase – after the end of the treatment. Shedler’s (2010) authoritative review of all randomised controlled trials to date reported effect sizes of between 0.78 and 1.46, even for diluted and truncated forms of psychoanalytic therapy. An especially methodologically rigorous meta-analysis (Abbass *et al.*, 2006) yielded an overall effect of 0.97 for general symptom improvement with psychoanalytic therapy. The effect increased to 1.51 when the patients were assessed at follow-up. A more recent meta-analysis by Abbass *et al.* (2014) yielded an overall effect size of 0.71, and the finding of maintained and increased effects at follow-up was reconfirmed. This was for short-term psychoanalytic treatment. According to the meta-analysis of de Maat *et al.* (2009), which was less methodologically rigorous than the Abbass studies, longer-term psychoanalytic psychotherapy yields an effect size of 0.78 at termination and 0.94 at follow-up, and psychoanalysis proper achieves a mean effect of 0.87, and 1.18 at follow-up. This is the overall finding; the effect size for symptom improvement (as opposed to personality change) was 1.03 for long-term psychoanalytic therapy, and for

psychoanalysis it was 1.38. Leuzinger-Bohleber *et al.* (2018) will shortly report even greater effect sizes for psychoanalysis in depression. The consistent trend toward larger effect sizes at follow-up suggests that psychoanalytic therapy sets in motion processes of change that continue after therapy has ended (whereas the effects of other forms of psychotherapy, such as CBT, tend to decay).

- (3) The therapeutic techniques that predict the best treatment outcomes, regardless of the form of psychotherapy, *make good sense in relation to the psychodynamic mechanisms outlined above.* These techniques include (Blagys & Hilsenroth, 2000):

- *unstructured*, open-ended dialogue between patient and therapist
- identifying *recurring themes* in the patient’s experience
- linking the patient’s *feelings* and perceptions to *past experiences*
- drawing attention to *feelings* regarded by the patient as *unacceptable*
- pointing out ways in which the patient *avoids* such feelings
- focusing on the *here-and-now therapy relationship*
- drawing connections between the *therapy relationship and other relationships.*

It is highly instructive to note that these techniques lead to the best treatment outcomes regardless of the type of psychotherapy the clinician espouses. In other words, these same techniques (or at least a subset of them; see Hayes *et al.*, 1996) predict optimal treatment outcomes in CBT too, even if the therapist believes they are doing something else.

- (4) It is therefore perhaps not surprising that psychotherapists, irrespective of their stated orientation, tend to choose psychoanalytic psychotherapy for themselves! (Norcross, 2005)

I am aware that the claims I have summarised here do not do justice to the full complexity and variety of views in psychoanalysis, both as a theory and a therapy. I am saying only that these are our *core* claims, which underpin all the details, including those upon which we are yet to reach agreement. These claims are eminently defensible in the light of current scientific evidence, and they make simple good sense.

References

- Abbass A. A., Hancock J. T., Henderson J., *et al.* (2006) Short-term psychodynamic psychotherapies for common mental disorders. *Cochrane Database Syst Rev*, 4, CD004687.
- Abbass A. A., Kisely S. R., Town J. M., *et al.* (2014) Short-term psychodynamic psychotherapies for common mental disorders (update). *Cochrane Database Syst Rev*, 7, CD004687.
- Bargh J. & Chartrand T. (1999) The unbearable automaticity of being. *Am Psychol*, 54, 462–479.

Blagys M. D. & Hilsenroth M. J. (2000) Distinctive activities of short-term psychodynamic-interpersonal psychotherapy: a review of the comparative psychotherapy process literature. *Clin Psychol*, 7, 167–188.

de Maat S., de Jonghe F., Schoevers R., et al (2009) The effectiveness of long-term psychoanalytic therapy: a systematic review of empirical studies. *Harv Rev Psychiatry*, 17, 11–23.

Hayes A. M., Castonguay L. G. & Goldfried M. R. (1996) Effectiveness of targeting the vulnerability factors of depression in cognitive therapy. *J Consult Clin Psychol*, 64, 623–627.

Kirsch I., Deacon B. J., Huedo-Medina T. B., et al (2008) Initial severity and antidepressant benefits: a meta-analysis of data submitted to the food and drug administration. *PLoS Med*, 5, e45.

Leuzinger-Bohleber M., Hautzinger M., Fiedler G., Keller W., Bahrke U., Kallenbach L., Kaufhold J., Ernst M., Negele A., Schött M., Küchenhoff H., Günther F., Rüger B. & Beutel M. (2018) Outcome of psychoanalytic and cognitive-behavioral therapy with chronic depressed patients. A controlled trial with preferential and randomized allocation. *Br J Psychiatry*, submitted.

Norcross J. C. (2005) The psychotherapist's own psychotherapy: educating and developing psychologists. *Am Psychol*, 60, 840–850.

Panksepp J. (1998) *Affective Neuroscience*. Oxford University Press.

Shedler J. (2010) The efficacy of psychodynamic psychotherapy. *Am Psychol*, 65, 98–109.

Solms M. (2017) What is 'the unconscious' and where is it located in the brain? A neuropsychanalytic perspective. *Ann NY Acad Sci*, 1406: 90–97.

Steinert C., Munder T., Rabung S., Hoyer J. & Leichsenring F. (2017). Psychodynamic Therapy: As Efficacious as Other Empirically Supported Treatments? A Meta-Analysis Testing Equivalence of Outcomes. *Am J Psychiatr*, doi: 10.1176/appi.ajp.2017.17010057

Tronson N. C. & Taylor J. R. (2007) Molecular mechanisms of memory reconsolidation. *Nat Rev Neurosci*, 8, 262–275.

Turner E., Matthews A., Linardatos E., et al (2008) Selective publication of antidepressant trials and its influence on apparent efficacy. *N Engl J Med*, 358, 252–260.



Psychodynamic psychotherapy training in South East Asia: a distance learning pilot program

César A. Alfonso,¹ Limas Sutanto,² Hazli Zakaria,³ Rasmon Kalayasiri,⁴ Petrin Redayani Lukman,⁵ Sylvia Detri Elvira⁵ and Aida Syarinaz Ahmad Adlan⁶

¹Associate Professor of Psychiatry, Columbia University Medical Center, New York, USA; email caa2105@cumc.columbia.edu

²Universitas Brawijaya, Malang, East Java, Indonesia

³Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia

⁴Chulalongkorn University, Bangkok, Thailand

⁵Universitas Indonesia, Jakarta, Indonesia

⁶Universiti Malaya, Kuala Lumpur, Malaysia

Conflicts of interest. None.

© The Authors 2018. This is an Open Access article, distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives licence (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is unaltered and is properly cited. The written permission of Cambridge University Press must be obtained for commercial re-use or in order to create a derivative work.

Populous countries in the Asia–Pacific region have adequate psychiatric residency curricula but inadequate psychotherapy clinical supervision, and the paucity of training programs reflects how underserved psychiatry is in this zone (Ruiz & Bhugra, 2008; Tasman *et al*, 2009). Cognitive behavioural therapy is systematically taught in most of Asia but other modalities such as supportive, interpersonal, dialectic behavioural, group, marital, family and psychodynamic psychotherapies are not well supervised. It is challenging to bridge these gaps given the demands of high volume services and few formally trained supervisors. Initiatives have been implemented to improve psychotherapy training in Asia (Alfonso *et al*, 2018). The most widely recognised among these initiatives is the China American Psychoanalytic Alliance program, which is largely conducted through videoconferencing (Fishkin *et al*, 2011). This article describes an abridged program designed to provide advanced psychotherapy training in underserved areas with limited pedagogical resources. Although the program was piloted in Asia, our hope is that it could be adapted or replicated in other areas with similar needs.

The World Psychiatric Association (WPA) Psychotherapy, Education in Psychiatry, and Psychoanalysis in Psychiatry Sections identified that

Asian psychiatrists have a keen interest in improving psychodynamic psychotherapy education. Liaisons with the Royal College of Psychiatrists in Thailand, the Malaysian Psychiatric Association and the University of Indonesia gave rise to our multinational, collaborative, pedagogic endeavour (Alfonso *et al*, 2018). The WPA pilot program was designed to take place over 5 years, targeting three countries (see Table 1). It was designed to be self-sustaining – with the aim of improving the psychotherapy skills of those enrolled in study activities and teaching psychiatrists how to supervise – so that, after completion, psychiatrists could work effectively as psychotherapy supervisors.

Phase 1: full-day workshops to improve clinical skills

Full-day psychodynamic psychotherapy workshops took place at meetings sponsored by the national psychiatric societies in Jakarta, Surabaya, Kuala Lumpur and Bangkok between 2013 and 2014. The hosting psychiatric society selected local psychiatrists to run workshop modules according to the experts' areas of interest (see Table 2). Clinical correlations and applicability of psychodynamic thinking in a variety of settings were emphasised. Attendance ranged from 35 to 50 people; a manageable number for the maintenance of