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### BOOK CHAPTER

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## **Psychoanalysis in context**

Psychoanalysis touches a raw nerve: you either feel passionate about it or suspicious of it, but it is rarer to feel neutral. Psychoanalytic ideas arouse curiosity and interest, but they also reliably attract fierce opposition. In spite of this, psychoanalysis has remained one of the most enduring and influential approaches to understanding and treating psychological and emotional disorders in current use.

Over the majority of the 20<sup>th</sup> century, within applied psychoanalytic practice the interface of greatest tension and conflict was that with general psychiatry. As psychiatry struggled to distance itself from its reputation as more crude and controlling than scientific, it pursued initially phenomenological and then increasingly biochemical, molecular and genetic approaches to research and treatment. In so doing it lay claim to being the only evidence based approach to serious mental illness. Over the past twenty years in particular these approaches have yielded significant advances with the rapid development of the neurosciences, community based psychiatry and the establishment of a much more substantial evidence base. One might have expected, therefore, that this conflict would have intensified. Instead, the point of greatest difficulty and hostility has shifted: as opposed to psychiatry, it is perhaps the cognitive based sciences and psychological therapies that are now most in conflict with dynamic and psychoanalytic approaches.

In particular the development of Cognitive Behaviour Therapies (CBT) has presented a strong challenge. In part developed out of the behavioural sciences and psychology, in part developed in direct reaction to some of the perceived difficulties of the

psychoanalytic approach, these therapies and their advocates have been effective in developing treatments that are of help to many patients, and in gathering evidence to support their effectiveness. They have also been impressive in their commitment to refining their models in the light of both evidence and of the findings in related fields such as the developments in cognitive neuroscience.

The manifest criticisms of psychoanalytic approaches remain largely the same: that they are out of touch with contemporary society; that they are applicable only to an elite intellectual minority; that they prioritise the individual above population need; and that as treatments they are long, intense, expensive and without an evidence base for their effectiveness.

Some of the criticism is hard to refute. Psychoanalysis and empirical research have been uncomfortable bedfellows. Consequently psychoanalysis and its applications have been slow to develop an evidence base that meets the requirements of the dominant scientific paradigms, preferring instead to challenge the validity of those paradigms and their applicability. Although such research in psychoanalysis is now ongoing, and several chapters in this book provide good examples of the systematic evaluation of applied analytic work, this kind of integration is by no means yet routine.

As analytic practitioners, we have not helped our cause by being so resistant to engaging in outcome research and such routine evaluation of our applied work in public sector settings. In this respect our CBT colleagues perhaps have much to teach us.

Psychoanalysis has fallen behind in this regard, not only in the development of a recognised evidence base for its effectiveness, but also in generating new therapeutic models within a rigorous scientific paradigm in order to then evaluate their effectiveness. There are, of course, some notable exceptions to this such as the development of Mentalisation Based Therapy (Bateman and Fonagy, 2006), Psychodynamic-Interpersonal Therapy (Guthrie et al., in preparation), Panic Focused Psychoanalytic Psychotherapy (Milrod et al., 2006 and Chapter 10 in this book) and Transference Focused Psychotherapy (Clarkin et al., 2006) – all of these therapeutic models lay claim to being psychoanalytic, have been manualised, and all now have a reliable evidence base supporting their effectiveness. Although these developments are exciting, they do not yet form a substantial enough body of evidence to allow analytic work to be strongly represented, for example, as one of the treatments of choice within NICE (the UK's National Institute for Clinical Excellence) guidelines.

It is interesting to wonder why psychoanalysis has predominantly shied away from engaging with such scientific investigation and elaboration of its applications. Are we, within the psychoanalytic community, in some way doubtful of our method's ability to withstand scrutiny, or are there genuine scientific concerns? Empirical research is all too often idealised as the only respectable path to knowledge, yet, scientific endeavour is anything but neutral; behind the statistics proving one theory and disproving another lie researchers fuelled by deep passions.

Perhaps part of the problem is that the analytic model is so linked to the work of Freud and his corpus (almost literally) that as practitioners we are unwilling to challenge, discard, develop and change elements of practice that are not found to work. As such, development and change can be experienced as patricidal crimes. One professional expression of this is the way in which, within our own working groups, it can at times feel as if kudos is most associated with refinement of, and fidelity to, an illusive pure version of our model, as opposed to improving patient outcomes.

Perhaps psychoanalysis' difficult origins and experiences over the past century can also shed some light on its current predicament. From the outset Freud provoked dissent and criticism. His views were indeed challenging and provocative. They were considered to be all the more so because Freud was Jewish. Freud himself was acutely aware of the effect of his Jewish roots on the reception of his ideas, and whilst he may well have wanted to play down the Jewish connection, this fact was at the forefront of other people's minds. In the 1930s, with the rise of the Nazis, psychoanalysis was attacked: Freud's writings, together with those of Einstein, H.G. Wells, Thomas Mann and Proust, were burnt in public bonfires for their "soul disintegrating exaggeration of the instinctual life" (Ferris, 1997). Along with Darwin, Freud was vilified for subverting the high values of fair-skinned races.

The very real persecution suffered by the psychoanalytic movement in its infancy left deep scars. From the outset, Freud saw psychoanalysis as a cause to be defended against attack and the analytic institutes that emerged could be seen to be the "bastions" of this

defence (Kirsner, 1990). We would propose that this had the unfortunate effect of also keeping at bay other perspectives and related fields of enquiry, fearing their evaluation, criticism and attack. Consequently, for far too long, psychoanalytic institutions remained more inaccessible, more inward looking than was perhaps desirable for the growth of the profession. Dialogue with other disciplines, such as biology and cognitive neuroscience, has only opened up relatively recently, but it is a noteworthy development.

Dialogue with our therapeutic neighbours is vitally important to the development not only of psychoanalytic practice, but more generally, we would argue, to the advancement of psychological therapies. It is only through constructive dialogues that we can begin to understand each others' positions, put aside prejudices and apply our energies to developing effective interventions.

This book is about contemporary psychoanalytic applications. One way of framing the aim of the psychoanalytic process is in making the unconscious conscious. The aim of psychoanalytic applications, while retaining the centrality of unconscious processes, is focused on helping those with mental health problems. In order to achieve this more positivistic goal to the best of our ability our services need to reflect therapeutic plurality so as to do justice to the diversity of the problems we are presented with, and to the diversity of the people who come seeking help. We have in mind here, for example, diversity of culture, of ways of approaching psychic distress, of values and personal goals - all of which will play a part in how congenial and helpful any therapeutic model will feel to a given individual.

In theory there is nothing too controversial about what we have just said. Yet, in practice, we do seem to find it very hard to live together amidst difference. When faced with theoretical differences we manage mostly in one of two ways: we either blur the differences into a kind of ‘we are all the same really’, or we take up polarised positions that often entail setting up different approaches as rivals.

We are not all the same and it is not desirable for us all to be the same. The articulation of difference offers up the possibility of real disagreement, which in turn can provide fertile soil for thinking outside one’s familiar frame of reference. But what is harder is to be different *and* work together whilst respecting these differences. Pluralism – that is, sharing space - can be profoundly disturbing. It unsettles us so much that we would rather avoid it, so we keep to ourselves in our respective therapeutic niches:

“In the realm of ideas and understanding, we do seem to behave as if we have a psychic immune system, fearful for the integrity of our existing belief systems whenever we encounter new and foreign mental protein” (Britton, 2003: 177).

Theoretically speaking we all suffer from a degree of “psychic allergy”, that is, an allergy to the products of other minds that do not share the same theoretical world view (Lemma, 2007). Insulating oneself in a space free from foreign ideas can cure a psychic allergy, but we all stand to lose if we do not challenge ourselves on this front and engage constructively with colleagues who do not share our point of view. This requires us to

consider what it means to really ‘understand’ each other so that differences can be not only tolerated, but also provide the foundations for creativity. Understanding is, of course, not at all the same as agreement. It is about being able to entertain another’s point of view *as if* it were our own, but not necessarily to make it our own or to force our understanding on another person. Such an act creates its own discomforts but also opens up new vistas – the gift of perspective that we all too readily trade in for the comforts of sameness.

Protectionism does not seem to be the best way of developing the psychoanalytic project in the 21<sup>st</sup> century, or indeed of making its benefits available to as wide a population as possible. We are arguing here for a much more open approach, making room for a variety of different ways of thinking and formulation. In the domain of applied work we thus believe in hybrid vigour and do not think that the psychoanalytic quality of this work need be damaged by this; rather we think it is strengthened, and that many of the chapters within this book speak to this strength.

### **Applied work for the twenty-first century**

Psychoanalysis is a very robust animal (it has certainly weathered many attacks since its birth). Within the public sector its primary contribution has to be, and indeed should be, in applied form. At its best, the core of this applied contribution comprises a quality of psychoanalytic ‘intelligence’, a quality of thoughtfulness that is portable and that has broad relevance and accessibility. This contribution need not be expressed primarily in the provision of certain forms of psychotherapy, although these have an essential place.



Instead this model of applied work brings with it real flexibility and the possibility of radically rethinking how psychoanalysis might take up its place within healthcare economies.

If our applied psychoanalytic work is to develop and evolve we will have to face the inevitability of loss – loss of what we were, and felt ourselves to be before in this time. Such loss also brings with it, however, an opportunity for developmental transformation. One of the keys to the kind of transformation we have in mind is a genuine intercourse with the outside, a willingness to take something in, whether it be ideas or expertise in a manner that is itself transforming.

It remains to be seen whether the twenty-first century's concern with evidence based mental health care will now be the battleground on which psychoanalysis is finally relegated to the pages of history, along with mesmerism, hypnosis, psycho-surgery and insulin coma therapy; or whether it will be a time through which applied psychoanalytic work will survive and grow as a broadly applicable and beneficial approach to mental ill health.

What can psychoanalysis offer at this point in history to the mental health of the general population? The idea of this book grew out of our respective reflections on these invariably uncomfortable, yet necessary challenges. It is also rooted in our experience of working in public mental health settings in which we have been privileged to observe, and on occasions to be actively involved with, the development of innovative

applications of analytic thinking with high risk populations and hard-to-reach patients. This experience has informed our selection of the chapters in this book in order to illustrate the way in which psychoanalytic ideas can be applied, for example, to reach mother and babies in prison (Chapter 4), to work with forensic patients (Chapter 9), traumatised adolescents (Chapter 6), very young children and their families (Chapter 5), medical patients seen in a hospital for gastrointestinal disorders (Chapter 8), and with young Black people who would normally not access psychotherapeutic help (chapter 7). Chapter 12, by contrast, provides an important perspective from a very experienced CBT clinician on a more reciprocal relationship between psychoanalysis and CBT.

Several of the chapters describe innovative work that is not carried out within the comforts of a specialist clinic. Indeed some of the work does not involve any form of interpretation (Chapter 1). Rather, the contributors describe work taking place in inhospitable settings such as a women's prison, in community based settings such as GP practices and hospitals, or around a negotiating table.

Although psychoanalysis has often been criticised (and perhaps caricatured) for not taking heed of patients' real life stresses, several of the interventions described in this book speak to the way in which, at its best, psychoanalytic work embraces the complex interplay between external and internal forces without privileging one over the other. In this way, the work attests to the importance of understanding how very real, often deeply traumatic events, are taken inside the mind and given meaning in light of the individual's developmental history.

As long as psychoanalysis is viewed as an expensive treatment for the worried well its place in public health care will be untenable. The chapters in this book illustrate our experience that applied psychoanalysis has a very significant contribution to make, not only to the treatment of a range of mental health problems and of complex cases – of disturbed and disturbing patients – but also in training and supporting the range of mental health professionals working with them. There are, after all, not many alternative models for how a disturbed individual or community may impact upon the mind(s) and functioning of those engaged with them, or for the manner in which teams and organisations can come to act in manners determined by their work and the relationships that constitute such work (systemic models being perhaps the main alternative).

It is widely recognised that working with people who are ill and in pain (physical and/or emotional), as well as attending to the needs of their families or other carers, is both demanding and stressful (Borrill, et al., 1998). Stressful working conditions can reduce the contribution of staff to the workplace, to higher levels of staff absenteeism and higher levels of turnover (Maier et al., 1994; Elkin and Rosch, 1990; Borrill et al., 1998; Lemma, 2000). Indeed staff burnout has been especially noted amongst those working with patients with mental health problems. Burnout occurs when coping mechanisms for dealing with stress break down, and more primitive ways of functioning dominate the response to difficult interpersonal exchanges between staff and patients, such as projective mechanisms, scapegoating, rigidity, cynicism and withdrawal. The seminal work of Menzies-Lyth (1959) highlighted the consequences of ignoring the

psychodynamics of caring. She described the development of social defences operating in a nursing service aimed at coping with the anxieties evoked by the demands of the primary task of looking after patients. The defence system resulted in a service dominated by formal and rigid procedures that minimised personal contact with patients.

The availability of thoughtful support and opportunities for reflective practice (where practitioners can discuss their work and its impact upon them and their teams, without fear of censure) can mediate the otherwise detrimental impact on staff's well-being of the work, and hence on the quality of the care they deliver to patients (Jackson, 2008). The opportunity to undertake further post qualification training is often mentioned by staff as one route for accessing such sources of support. But training in isolation is unlikely to sustain staff and so ensure high quality services. Other workplace structures, such as the forums mentioned above, are essential to ensure that there are consistent opportunities to discuss cases and practice issues more broadly,

Many of the patients referred for help in the public health sector present with complex needs. How we define complexity is an interesting question in its own right, but beyond the remit of this introduction. At this point it is nevertheless important to note that complexity is, at least in part, a way of naming a clinician's 'difficult' feelings about the patient that may be harder to acknowledge and understand. Thinking spaces within which staff can process the emotional impact on them of their work are vital to the emotional resilience of individual staff members, but also to the overall resilience of a team. Yet

these spaces can all too readily be dispensed with when faced with long waiting lists and financial pressures.

The articulation of the competences to safely and effectively practice a range of psychological therapies (Roth and Pilling, 2007; Lemma et al., 2008) is a development that may provide a benchmark for those who develop trainings for staff, allowing services to set out clearly their requirements for a competent workforce and to monitor the delivery of services that are effective in helping patients. A focus on individual competences, however, should not distract from the question of what supports and characterises the competency of a whole service, ensuring its effectiveness in ‘containing the containers’ (Lemma, 2000). In this respect understanding unconscious organisational processes represents a key contribution that analytic thinking can make to the development of mental health services and to the functioning of those groups and individual practitioners that work within them.

Perhaps one place where one can see a more unhelpful and systemic enactment of unconscious processes is within poorly applied models of stepped care, and the models of stepped expertise that often accompany them (stepped or indeed stratified care, at its best, may be very sophisticated). Within cruder models, the individual patient is first offered the simplest and cheapest intervention that may be of benefit. In relation to practitioners, this is often delivered by the most inexperienced and most briefly trained. In reality, however, much of the most difficult and indigestible disturbance within the mental health system is encountered in ‘front line’ settings, involving patients who will never

‘graduate’ to more expert care. Practitioner disturbance and feelings of incompetence are thus projected down the system into those perhaps least equipped to cope, protecting us from our own experience of incompetence and inadequacy. Locating experienced practitioners alongside more junior staff in front line settings is one feature of some of the applications described in the chapters that follow.

All of this does raise a question about the place of pure models of intervention within public healthcare systems. We hope it is clear that we are not arguing here for a wholesale homogenisation of psychological approaches to mental ill health. Rather, we are arguing for clarity of difference with respect for others’ frames of reference, in a manner that may allow for a more genuine and creative intercourse bringing with it the potential for new offspring. Does psychoanalysis itself as a distinct therapeutic model (e.g. frequent sessions, centred around transference interpretation) have a place within public healthcare systems? We would argue strongly that it should do, and that there is developing research evidence for its indications and benefits (e.g. Beutel and Rasting, 2002; de Maat et al., 2009; Taylor, 2008).

Within the United Kingdom, and across the world, the importance of Public Mental Health is also beginning to be recognised. Public Mental Health has been defined as “*the art and science of promoting well-being and preventing mental ill health and inequalities through the organised efforts of society...*”

(National Expert Group for Public Mental Health and Well Being, 2008)

When you look at the numbers, the reason for this rising concern is perhaps clear. Mental Health problems are common and have a significant impact upon physical health: around one in six of the adult population experiences mental ill health at any one time (Singleton, 2000). Half of all women and a quarter of men will be affected by depression at some time in their life and 15% experience a disabling depression (Mental Health NSF, 1999); nearly 10% of children experience emotional and conduct disorder at any point in time (Green et al., 2005). In the UK, each day two children or adolescents take their own lives, and each year 16,000 make an attempt at suicide. (Fonagy, 2008). Suicide is in the top five causes of lost years of life. When measured across all age groups, mental illnesses are the leading causes of disability worldwide. The World Health Organisation (WHO) estimates that mental health problems account for 13% of all lost years of healthy life globally (draft Department of Health Public Mental Health Strategy, 2009).

One of the strengths of the psychoanalytic model, and of its potential contribution, is that it is developmental in nature. As such it affords a model for understanding the relationship between early experience, genetic inheritance, and adult psychopathology. There is an increasingly strong evidence base to support the view that the majority of adult mental health problems are developmental in nature; three quarters can be traced back to mental health difficulties in childhood, 50% arising before the age of 14 (Kim-Cohen et al., 2003). Prospectively, mental health problems experienced in childhood or adolescence are similarly often associated with serious difficulties in adult life including enduring morbidity (Jenkins et al., 2008). Childhood conduct disorders in particular cause children, families and schools considerable distress; result in social and educational

impairment (Lahey et al., 1997); and predict risk for numerous problems in adulthood including serious difficulties and underachievement in education, relationships, work and finances, dependence on social welfare systems, homelessness, dependence on tobacco, alcohol and drugs, and poor physical health (draft Department of Health Public Mental health strategy, 2009).

The psychoanalytic model not only offers a model for continuity across the lifespan, but also of continuity across the dimension from health to ill health. In particular it may offer a means for conceptualising the relationship between illness and pre-existing character (see Chapter 11). The absence of such a model of continuity is a key element in the stigmatisation of those with mental health difficulties, identifying ‘them as opposed to us’. Obviously we may all have an investment in maintaining phantasies of discontinuity when mental illness is so frightening.

Moving ‘upstream’ in terms of public health interventions is critical if healthcare services are to reduce the burden on acute adult mental health service provision, and the enormous cost of social care. By moving upstream we mean developmentally upstream, with a focus on shaping or adjusting developmental pathways. The very idea of such interventions is, we would argue, absolutely in line with psychoanalytic theory and practice, even if the expressions are themselves not so immediately recognisable as such: supporting and educating parents; working with primary school teachers; introducing models of reflective practice into training programs for the children’s workforce. Examples of such creative models of applied intervention form the core of this book



Public mental health programs, with their focus on population health and statistical analysis, can run counter to a recognition of the complexity of human psychology and psychopathology. The development of evidence based medicine may result, for seemingly sound scientific reasons, in screening out overt complexity in research studies or patient groups. This can lead to a focus on simple interventions for ‘simple’ (or non-complex) conditions. And yet, within clinical practice in the public sector, one rarely sees such non-complex conditions. The idea that they exist, and are amenable to simple and cheap interventions, is immediately politically attractive. This is not only because of the possible economic gains to be offered by such an approach, but also because it may serve as a means of keeping the messy truth about mental health somehow at bay, and of course this is something that we all yearn for somewhere inside of ourselves. The messy truth is that mental illness is common and may affect any one of us at any point in our lives. In many cases cure or recovery is hard to achieve (although of course it should be worked for); rather, a significant proportion of these patients require ongoing psychological and social interventions across their lives.

The majority of cases seen within normal public sector clinical practice are characterised by significant complexity. Most patients with clinically significant depression, for example, meet the criteria for several different symptom-based diagnoses and have to cope with many additional suboptimal functions of the personality (Westen et al., 2004). Only a minority satisfy the criteria of only one diagnosis. Patients meeting criteria for major depressive disorder are nine times more likely than chance to meet the criteria for

other conditions (Angst & Dobler-Mikola, 1984); 50–90% of patients with a diagnosis of a significant (Axis I) condition such as bipolar affective disorder or schizophrenia, also meet the criteria for other Axis I or Axis II (personality) disorder (Westen et al., 2004).

In relation to this more messy picture (and it is interesting that the language most commonly speaks of ‘mental health’ as opposed to mental illness) psychoanalysis provides a means for thinking about and understanding why we may shy away from it as an idea, because it is personally threatening and because it challenges our individual and societal omnipotence. It also provides models of education, support (Rustin and Bradley, 2008), organisational consultation and clinical intervention. As such, while facing up to the nature of much mental illness, psychoanalysis is also well placed to make a very significant contribution to developmental approaches to mental wellbeing.

And what, then, of more direct social, political and policy contributions? We are all keenly aware of the increasing attention (and often blame) laid at the feet of ‘dysfunctional’ families and communities (not to mention professionals), and yet they are all a product of societal and economic structures that we have created. Indeed it has always been thus. The projection of responsibility down a system into those near the bottom, an economic and psychological underclass (at least treated as such), is discussed in Chapter 2. Similarly, Chapter 9 describes the difficulties around treating those in society who may be most subject to vilification and hatred, identified as most ‘bad’ and unlike ourselves.

Economically, the developed world is currently in uncharted waters, itself in the midst of a serious depression. Retreating into states of mind in which we become focused on rightness and wrongness, goodness and badness, and identify wrongdoing in others while focusing on the attribution of blame may be attractive for any individual facing real depression, but it can also be enacted by communities, societies and governments at times of great stress. A culture of spiralling regulation within public services (or of paradoxical under-regulation within the private sector), coupled with the language of failure, blame and public punishment are common forms of expression. Taking the moral high ground in this way rarely leads to significant improvements in the quality of services. The absence of the thoughtfulness or concern that characterise more mature, integrated and balanced states of mind can lead to crude compliance, fear or further withdrawal in those on the receiving end.

The dominance of more primitive states of mind has a tendency to increase risk rather than to reduce it. If social workers are attacked and blamed in relation to each new and terrible case of child abuse, we are unlikely to create an atmosphere within which a culture of high quality therapeutic social work can develop, attracting high quality and committed staff. Between communities such states of mind can also lead to violence and, over time, to entrenched conflict. Chapter 1 describes in a moving way the psychological work and commitment to peace between warring political factions that is necessary to move on from such entrenched states of mind. Perhaps in this chapter there is also a lesson for our own communities, of psychoanalysts, psychological therapists, mental health professionals and more broadly, members of a local and broader society.

Within this book the contributors all give examples of their applied psychoanalytic thinking and work, in a manner that we believe demonstrates the contemporary relevance of the psychoanalytic project. These contributions also give expression to the way in which psychoanalysis as a theory remains uniquely powerful in generating models for understanding complex psychological phenomena, whether they be within the individual or the group.

It could be argued that many of the key contributions of psychoanalysis have already been incorporated into other disciplines; into psychology, psychiatry, and social theory, often under pseudonyms or under the banner of common sense. What remains is often then subject to caricature, and any developments within the past one hundred years or so passed over. We hope that what follows within this text will go some way to challenging some of these beliefs and stereotypes, highlighting an impressive range of genuinely contemporary and relevant contributions.

### **About this book**

An edited collection is invariably subjective, but not random, in its choice of contents. From the outset our aim has not been to produce a comprehensive, ‘state of the art’ account of the place of applied psychoanalysis in the public health sector. Rather, we have wanted to illustrate the different sorts of applied psychoanalytic work that we consider to be vital at this particular point in time. The chapters offer examples of

interventions or ways of thinking; they are not intended to specify how their underlying principles can be generalized elsewhere.

The domains we have concentrated on include therapeutic applications with diverse patient populations and delivered in diverse settings. Several chapters describe the way clinicians have applied analytic ideas to reach patients who would not have otherwise accessed work or thinking of this sort. We do not, however, regard these interventions to be in any way a ‘dilution’ of psychoanalysis; instead they speak to the resilience of a model that can, and should, evolve to respond to the needs of diverse patients.

As we have emphasized above, research and psychoanalysis have not always been the most comfortable of bedfellows; in an age of evidence-based practice, however, they need each other. Some of our chapters have been selected on the basis that they illustrate the way in which innovation can be productively combined with rigorous evaluation of new, briefer interventions that can legitimately claim their place within contemporary healthcare economies. In addition to direct interventions with patients, we have also chosen to emphasise the ongoing relevance of analytic ideas to interventions at a political, social and policy level. Within these latter chapters, contributors have also attempted to address the political within the realm of psychoanalysis itself.

We believe that psychoanalysis can only survive, and evolve, if it less opaque to those who are not well versed in its language. Similarly, we believe that our work will only thrive if we are prepared to engage with the language and thinking of others. We have

chosen to end this book with a significant contribution from an experienced CBT practitioner, to both describe and comment on the relationship between psychoanalysis and CBT.

Inevitably we have had to leave out many other potential contributions and more besides so as to produce a manageable book. We hope that it will nevertheless, in its modest way, foster dialogue and debate in a manner that may contribute to the continued development of applied psychoanalytic work.

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