Bad Blood: 15 Years On

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What used to be a major controversy between psychoanalysis and empiricism has become tempered, the battle is over and the argument has been won. By both sides. Or perhaps it would be more realistic to say it has become more polarized. On the one hand, a non-empirical approach has developed into a more extreme philosophical position, as expressed by Irwin Hoffman

> 'the privileged status that this movement [empiricism] accords systematic research and neuroscience as compared with in-depth case studies and strictly psychological accounts of the psychoanalytic process is unwarranted epistemologically and potentially damaging both to the development of our understanding of the analytic process itself and to the quality of our clinical work.'(Hoffman, 2009/' p.1044)

Meanwhile, mainstream psychoanalysis has learnt to live with empiricism and long-term psychotherapy as opposed to four times weekly psychoanalysis; long-term treatment is now often no more than two years. Psychoanalysis often takes place once or twice a week. But epistemologically, there is no conflict anymore. Theoretically, psychoanalysis has won: attachment theorists have conceded that attachment is but one of a number of drives (not that Bowlby ever thought it was the only one) and there are other routes to reward other than from attachment (Fonagy, Luyten, & Allison, 2015).

Thus peace has not altogether broken out. A new battle now lies in convincing neuroscientists and CBT therapists that relationships matter. To take one example, those working in the field of BPD require no convincing that emotion dysregulation is a key part of the clinical problem that individuals with this diagnosis present. Both behavioural (Linehan, 1993) and neuroscientific (Silk, 2010) (Siever & Weinstein, 2009) theorists can construct compelling stories that explain other clinical features of the disorder in terms of such person-based deficit. Perhaps unintentionally, but nevertheless pervasively, these models obscure the importance of interpersonal relationships as drivers of clinical phenomenology. Again, clinicians will need no persuading that relationship problems are ubiquitous in BPD. However, there is a critical step that is consistently overlooked: these relationship problems are reduced to the difficulty an individual (implicitly assumed to be the innocent party) might have in dealing with someone who is prone to unpredictable mood fluctuations. The relational problem is placed squarely at the foot of the patient with the diagnosis. The therapy is also individually focussed on assisting the patient in gaining control over their emotional states, whether by increasing their cognitive competences or with the aid of psychopharmacology (less likely). What is missing from these approaches is a perspective that speaks to patient within their social system and their capacity to learn from, adapt to and benefit from their environment. The persistent *social* dysfunction of an individual with BPD,

or indeed other forms of personality disorder, emerges from difficulties in social communication that reverberate through, echo and often become exaggerated through the patient's social environment. A model for treatment is needed that considers the individual as the communicator and recipient of distorted social communication.

Any psychodynamic formulation, be that a Kleinian model of projective identification, a Sullivanian interpersonalist model, or even more strikingly, a relational model, or even a self psychology model would see the emotional outburst in the context of transference or countertransference processes where the patient's problems are seen as deeply nested in introjection and projection, just like the proverbial Winnicottian baby, never alone. Attachment theory occupies the same space. Bowlby's internal working model is inherently interpersonal, not just historically but cross-sectionally, with the individual seeking to rediscover familiar patterns of interaction in the current interpersonal exchange. The emphasis in dynamic theories nowadays and probably for the last two or three decades has been on the creation of the intrapsychic in the theatre of the interpersonal and to this end there is no distinction between attachment and the psychoanalytic approach but a deep chasm between those who see a sequential rather than a parallel process between the intrapsychic and interpersonal. To state it in a somewhat abstract form, the opposition is between a model where individual characteristics impact on social interaction (sequential) versus one where the intrapsychic becomes manifest within the interpersonal (parallel). Psychoanalysis and attachment theorists stand shoulder to shoulder in opposing the reductionism that is implied in the serial model of at least severe psychopathology.

Conflict between psychoanalysis and attachment, however, does remain in the arena of the model for clinical intervention. Classical psychoanalysis proposed an insight-oriented therapeutic approach which brooked no compromise. The experience of insight, placing ego where id had been, was the royal road to cure. Of course this model could have no theoretical

or empirical validity, as became obvious when psychoanalytic theories multiplied and the content of insight, supposedly curative, became diverse to the point of irreducibility. Further, as Grünbaum classically pointed out, cure could and mostly did happen without insight (Grünbaum, 1984). Attachment theory, meanwhile, had no theory of change: to this extent, at least, it was not embarrassed by psychoanalysis' evident epistemological failure. To the extent that Bowlby had suggested a model, this was in the sphere of Alexander and French's idealised notions of restorative emotional experiences in the context of therapy (Alexander & French, 1946).

Neither model is tenable, and most now agree that change occurs in the context of a relationship. Within our own model, which is based on a combination of psychoanalytic and attachment theory ideas, it is absorbing information from those around one that may be critical to modifying one's own actions, and this is what changes as a consequence of therapy (Fonagy et al., 2015). The advantage of a generalised theory of psychotherapy such as the epistemic trust model is that it can incorporate cognitive behavioural as well as psychodynamic understandings. There has never been good evidence to support the hypothesised links between changes in specific cognitive structures assumed to underpin progress in CBT and behavioural change. If we assume that change occurs in the extent of openness to information from the patient's relational network, the precise combination of mechanisms that may set such changes going is irrelevant. Looking in psychotherapy transcripts for predictors of change may simply be the wrong data source. It is the nature of the relationship that the patient has with people outside the consulting room, in his or her relationships, that propels forward the therapeutic process. This insight is perhaps more closely linked to attachment theory than to classical psychoanalysis, but probably sits uncomfortably with either orientation as both regard the person of the therapist as the key agent of change.

The issue now is no longer about the role of empiricism, it is about thinking about psychopathology in a way that truly accommodates the fundamental social nature of the human psyche – in health or ill-health. Modern western culture in general, and the professions of academia and psychoanalysis in particular, are highly individualistic; our approach to mental health treatment has been commensurately so. But considering the mind in isolation, or in seclusion with another, fails to capture the social imperatives that underpin the complexity – and the vulnerability – of the human psyche. Understanding the fundamentally social and cultural processes that surround a mind in distress will, I suggest, be vital in going forward to think meaningfully about how we conceptualise psychopathology, and what makes treatment effective.

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