

Clinical wisdom, science and evidence: The neglected gifts of psychodynamic thinking

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Abstract

We review five key areas of contemporary psychodynamic practice and research to highlight the contributions psychodynamic concepts can make to clinical psychiatry. These areas are as follows: (1) Contributions to understanding the development of subjectivity. (2) The psychodynamic understanding of the effects of early childhood trauma and their consequences in adult life. (3) The vital importance of the psychodynamic notion of the ‘holding environment’ based on an understanding of the dynamics of the development of subjectivity and trauma which, if applied, might improve the quality of psychiatric care in the public mental health system and enhance both the clinical competence and morale of clinicians in the system. (4) The emerging scientific disciplines of Neuropsychoanalysis and Affective Neuroscience, which illustrate the importance of seriously studying the mind as well as the brain. (5) A brief summary of some research into the clinical effectiveness and efficacy of psychoanalysis and its related psychodynamic therapies.

Keywords

Psychoanalysis, trauma, neuropsychoanalysis, Friston, evidence, holding environment

In the first half of the twentieth century the whole intellectual and artistic effort was to see behind things, and that is no longer of interest. To explore consciousness was the great mission of the first half of the century- it doesn't matter whether we're talking about Freud or Joyce, or about the Surrealists or Kafka or Marx or Frazer or Proust ... the whole effort was to expand our sense of what consciousness is and what lies behind it. It's no longer of interest. I think we're seeing a narrowing of consciousness. I read in a newspaper ... that Freud was some sort of charlatan or something worse. This great tragic poet, our Sophocles.

Philip Roth (quoted in David Remnick,
The New Yorker, 15 May 2000).

First, we want to clarify the relationship between psychoanalysis and psychodynamic theories. Psychoanalysis is a noun that refers to a theory of the mind and a form of clinical practice, initiated by Freud and developed by his students and successors. Psychodynamic is an adjective that describes the fluidity of mental development and structure that results from the conflict between opposing mental forces. Psychoanalytic theories are psychodynamic theories. The concept that the mind exists in a psychodynamic state has become central to the practice of psychodynamic psychotherapists as well as psychoanalysts. The application of psychodynamic theories outside of formal psychoanalysis used to be called applied psychoanalysis as opposed to what used to be called pure psychoanalysis. Given the elitist connotation of ‘pure’ the terms are no longer used and we

now speak of formal psychoanalysis and psychoanalytic psychotherapies. In addition to these methods of treatment, psychodynamic theories can assist in understanding the mental states of all patients. Application of that understanding can often be the means of improving their day-to-day *management*, regardless of the treatment modality being used.

In a recent paper endorsing the conclusions of the Victorian Government Royal Commission into Mental Health to which he was a principal advisor, Professor Patrick McGorry (2021) characterised psychoanalysis as ‘reductionistic’. The Royal Australian and New Zealand College of Psychiatrist’s recently released clinical practice guidelines (CPG) for the treatment of depression, ignore psychoanalysis and the psychodynamic therapies based on it (Malhi et al., 2021). Such attacks on or dismissiveness of

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psychodynamic concepts are not evidence based. We wish to summarise some important psychodynamic clinical formulations and some of the recent evidence that supports the value of psychodynamic ways of thinking and practice in clinical psychiatry.

We will study this from five interrelated perspectives:

1. Contributions to understanding the development of subjectivity. Understanding our patient's mental states can improve management decisions.
2. The psychodynamic understanding of the effects of early childhood trauma and its consequences in adult life is an area of particular importance for planning optimal management.
3. The importance of the 'holding environment' in psychiatric care. The 'holding environment' can be viewed as the clinical application of an understanding of our patient's mental states and their resultant vulnerabilities.
4. Neuropsychanalysis and Affective Neuroscience are fields of study that are integrating mind studies and brain studies. Although still in their infancy, these fields point to some new ways of understanding how the mind and the brain work together.
5. The evidence-based research on the efficacy and effectiveness of psychoanalysis and psychodynamic therapies based on it. These studies indicate that the application of psychodynamic treatment and management principles should not be ignored if psychiatry is to achieve best practice status.

Subjectivity

Psychoanalysis still represents the most coherent and intellectually satisfying view of the mind. (Kandel, 1999: 524)

The study of subjectivity in relationships is often cited as the weakness of psychoanalysis and its associated psychodynamic therapies, but it is also its strength. Psychodynamic concepts derived from clinical experiences have enhanced our understanding of what it actually *feels like* for a person to have an abnormal state of mind. The re-introduction of the mind into psychiatry, integrated with brain and behavioural studies, is perhaps the greatest gift that psychoanalysis and the psychodynamic therapies derived from it have to offer.

A good example is Melanie Klein's (1946) description of the paranoid-schizoid position as a recurring experience in a person's life, in the context of particular relationships in which both oneself and the other are viewed in polarised idealised or denigrated ways. At times such a person relies on defensive self-idealisation and cannot tolerate fair-minded criticism without responding with vindictive anger and scorn towards the critic, and at other times experiences hostility-laden depression about themselves. The failure to

recognise these dynamics may cause the depressed patient to be diagnosed as suffering from 'treatment-resistant' depression, for which increasingly heroic combinations of psychotropic medication or other forms of treatment are prescribed. Similar feelings may also influence the patient's perception of the doctor-patient relationship, which in turn adversely influences the patient's attitude towards psychiatric treatment, including their compliance with psychotropic medication. If the treating clinician understands this psychodynamic, a less confronting and more cooperative interaction can often be fostered.

Psychodynamically informed research on the subjective development of children highlights the importance of secure attachment to caregivers. Secure attachment is not an end in itself, but is the foundation of mastering developmental tasks throughout life. These include separation-individuation, the development of gender identity, the capacity to give genuine care to and receive genuine care from others when vulnerable, the capacity to feel secure in intimacy, to differentiate between tenderness and sexual satisfaction, to grieve appropriately, to manage one's aggression appropriately and to accept moral responsibility for one's betrayals and hurt of others (Kernberg, 1995). All of these may be relevant to understanding a patient's state of mind and planning management, regardless of the psychiatric diagnoses they are given.

From Thomas Ogden's (2012) creative summary of the fecund originality of several key psychoanalytic thinkers, we have selected his overview of the ideas of Donald Winnicott about developing subjectivity, in order to highlight his important contribution to our understanding of pathological psychodynamics. Ogden (2012) describes Winnicott's formulation of four dialectic movements between a mother and her baby which have implications for the child's personality development throughout life and for psychotherapy (pp. 76–96). These are the primary maternal preoccupation, the I-me dialectic of the mirroring relationship, the child's discovery and creation of the transitional object and the child's capacity to be alone in the presence of the mother. The failure of one or more of these processes can lead to a failure to develop a sense of basic integration of the self, a feeling of subjective formlessness. A person afflicted in this way is prone to 'basic' anxieties such as the fear of going to pieces or of having no relation to one's body. Desperate somatic, behavioural and psychological defences are mobilised against such experiences.

Subsequent psychodynamic researchers have highlighted specific psychopathological disturbances that may ensue (Stein, 2005; Tuch, 2010). For some patients this may include living in a state of chronic suicidality, though the patient may not be clinically depressed (Maltsberger et al., 2010). For such patients the possibility of suicide might be a perverse survival mechanism and might be part of an array of perverse ways of relating to oneself, one's body and to others, whereby vulnerability and helplessness

in oneself are denied and mocked in others who are seen as clinging pathetically to safety and security (though overtly the patient may appear altruistic and caring). Truth and falsehood, integrity and hypocrisy, care and exploitation, sex in the name of love and sex as a form of aggression are 'confused' or rationalised away (Kernberg, 1992). Such a person may go through life feeling emotionally empty, lifeless and chronically bored; they may experience somatic complaints; they may be driven to seek relief in alcohol and illegal substances or appear fated to create and then destroy recurrently disappointing, loveless relationships. One particular subgroup of such patients, the so-called malignant narcissists (Kernberg, 1992), display a combination of narcissistic, paranoid and antisocial personality characteristics. While sometimes outwardly successful in life, they are at risk of suicide as a way of asserting their ego-syntonic, aggressive superiority and 'strength' over those whom they scornfully perceive as clinging fearfully to life. Clinically, they do not usually present to a psychiatrist as depressed. Suicide may occur when the aforementioned attempted solutions fail and helplessness increasingly gives way to hopelessness. Not only suicide but homicide or even mass murder may follow (Stein, 2005; Tuch, 2010).

Understanding such subjective dynamics leads us to the conclusion that persons with the same psychiatric diagnosis, but different subjective developmental experiences, can have different responses to a biological or behavioural psychiatric treatment. Understanding the patient psychodynamically should form part of a comprehensive bio-psycho-social psychiatric assessment, regardless of the diagnosis and treatment modality finally chosen. Even when psychodynamic psychotherapy (PDT) is not the indicated treatment, psychodynamic understanding can help clinicians to provide optimal day-to-day *management* while the patient is in treatment. Yet psychiatrists often lack the skills to do this.

Trauma

Freud used the term trauma (from the Greek word for wound) to describe that the mind could be wounded by events which breached what he described as the mind's 'protective shield', its 'special envelope or membrane' so that it could no longer process incoming stimuli appropriately. He noted that 'the mind's protection against stimuli is an almost more important function for the organism than its ability to receive stimuli' (Freud, 1920: 18).

Generations of psychoanalysts and psychodynamic psychotherapists have offered thoughtful, reflective listening, careful observation, empathy and disciplined interpretation of the states of mind of traumatised children in long-term psychodynamic therapies, including children's drawings and play in therapy. This has led to a profound understanding of the complex, often-turbulent, contradictory and sometimes apparently self-defeating ways of subjectively experiencing themselves, that traumatised children have

towards themselves and others including the therapist. Such pathological self-experiences often become manifest as pathological behaviours. It is unlikely that such an understanding could be arrived at by any other method of inquiry.

A synthesis of psychodynamic views of the enduring effects of childhood trauma is offered by Shengold (1979, 1989, 1992, 1999). The abused child must live with the 'delusion' that the parent is good; therefore, the abused child must be 'bad' and causes the 'good' parent to be 'bad'. The 'bad' child may experience themselves as an all-encompassing, embodied, somatic experience of 'badness', expressed in a variety of somatic or behavioural symptoms. These include chronically painful conditions such as functional bowel disorders (Ringel et al., 2008), eating disorders (Ross, 2009), pseudo-seizures (Bowman and Markland, 1996), attention and learning difficulties, difficulties in symbolically representing the trauma and other states of mind (Coates, 2016), destructive relationships (Gelinas, 1983; Weldon, 1988) and impaired self-representation so that the person can neither bear to be alone with themselves nor to be close to another in a relationship (Kogan, 2007: 63–66). The latter dilemma may also be accentuated during adolescence where the youngster's second separation-individuation process may trigger panic attacks (Milrod et al., 2004).

But belief and pleasure in one's badness can become an antidote to the helplessness caused by the abuse (Rosenfeld, 1987). This and the ensuing 'bad' action, often impulsive, is the defence Freud described of turning passive into active, i.e., this is not being done to me, I am doing it. The associated feelings of omnipotence or narcissistic self-inflation, accompanied by ideas of disowning, dissociating from or killing the 'bad', vulnerable or dependent body, may encourage a state of 'driven' suicidality (Maltsberger, 1997).

Furthermore, the perpetrator may rationalise and justify the abuse and convince the child that she is bad or deserves it or is bad for not being grateful. So, if the parent is 'good' and the child is 'bad', all the child has to do is to become 'good' and both parent and child will then be happy. The child thus feels responsible to make self and parent 'good', whereupon the complex mental states of neglect, loneliness, unworthiness, shame and guilt will all be resolved. Freud called this magical or omnipotent thinking. While typical of children, it may recur in adult life in states of regression and overwhelming anxiety or fear, often accompanied by the blurring of the self-other boundary and a loss of the capacity to form a representational world (Orgel, 1974). Treatment should address the developmental and traumatic dynamics which have undermined the patient's self-other boundaries (Diamond, 2020).

In adult life, the traumatised child can often come to form a deep attachment to a person who constantly criticises, humiliates, devalues, betrays and shames them. Physical abuse is often a recurring feature of such relationships. It can lead to disturbed power and nurturing relationships,

such as parentification of the child (Gillman, 1980), across the generations in a family. Alternatively, the abused child sometimes appears to have learned that submitting to a persecutory caregiver or provoking a neglectful one is the only reliable way of being acknowledged by the abusive or neglectful parent. In adult life this leads to the use of provocative, self-defeating or sado-masochistic tactics in a relationship whose goal is to maintain a relationship with a caregiver and avoid abandonment (Rosenfeld, 1978). The ending of such a relationship may have tragic consequences (Berman, 1996; Howell, 1996). Another possible consequence is that the person may live a life characterised by what has been termed ‘psychogenic death’ (Tarantelli, 2003) or develop an addictive relationship with alcohol and drugs, both prescription and illicit, that offers them a precarious sense of identity (Read, 2002).

Such dynamics are also repeated in the patient’s relationship with their clinicians (Akhtar, 2014; Lowenstein, 1993), which is why psychoanalysts and psychodynamic psychotherapists pay close attention to a patient’s feelings about breaks or interruptions in therapy.

A second dimension of the psychodynamic contribution to understanding trauma is how it (and other family secrets) may be silently transmitted across the generations in a family. Psychoanalysts and psychodynamic psychotherapists have described several possible ways in which this can happen.

- (a) Originally described in survivors of the Holocaust, a traumatised, grieving parent might have been unable to grieve the death of a child at the time of its death and now remains in a perpetual state of hypervigilant, ‘frozen-in-time’ grief. Psychodynamic studies have shown that a new child born into this family might experience herself in the parent’s mind as if she was the dead child. This experience has been graphically described as the new child’s mind being like the family crypt (Yassa, 2002). The child may identify with the role assigned by the family dynamics. If so, the child may not be recognised for who she actually is and her sense of secure attachment is jeopardised. In order to survive that experience, the child may develop a variety of narcissistic survival strategies which render her omnipotent, defiant and prone to enactments which render her relationships brittle, typically avoiding genuine intimacy or seeking to control or dominate others, which in its extreme form may lead to the dehumanisation of others (Tuch, 2010). Or the child’s identity may be totally subsumed in protecting the traumatised parent from despair and keeping the traumatised parent alive, in which case somatic symptoms and impulsive behaviours may be understood as reflecting the child’s inability to form a stable, integrated sense of herself (Henningsen, 2018: 130).

- (b) In families where the parents survived the Holocaust and other life-threatening catastrophes, their child’s age-appropriate anger, defiance or rebellion are sometimes experienced by the parent as a form of re-traumatisation, a threat to the parent’s own survival or integrity inflicted by their own child who is then viewed as a persecutor or threat. The child’s anxious avoidance of being perceived in this way leads to excessive conformity, solicitude, achievement and self-idealisation by the child. When these defences break down, typically in adolescence or adult life, paranoid states and obsessive-compulsive disorders may occur (Fonagy, 1999). The treatment of these disorders requires attention to the developmental dynamics of family trauma and the child’s identity formation in such a family.
- (c) Via projective identification, the traumatised parent splits off aggressive or other feelings towards their abuser/ persecutors and endows the child with such feelings, who may then enact those feelings on behalf of the family. Schore (2012: 169–172) has proposed a model of this phenomenon in terms of right brain to right brain communication in an intersubjective field.

These mental processes need to be understood if such patients are to be treated and managed optimally.

The ‘holding environment’

There is considerable empirical and clinical evidence reported by experienced psychodynamically trained clinicians that the application of psychodynamic principles can reduce violent enactments, conflicts, psychotic relapses, exploitative antisocial behaviours and suicide attempts among patients suffering psychiatric illness, including patients in in-patient and high-security units (Adshead, 1998, 2021; Gordon and Kirtchuk, 2008; Kernberg, 2016; Vasse, 2017). These principles include management plans based on recognising and addressing the fundamental importance of the transference–counter-transference between the patient and the treating team and the ability to recognise and address other individual and group defences such as dissociation, projective identification, regression, splitting, omnipotent negation, denial, idealisation and denigration, angry exhibitionism and other enactments. Interventions based on this psychodynamic understanding can also protect and improve staff morale and help clinicians develop more clinically useful treatment and management plans.

Even in the psychodynamically informed management of psychoses, modifications to the therapeutic milieu have evolved over the past century (Lotterman, 1996). Psychodynamic understanding of the ways a patient suffering from psychosis experiences themselves and others has