



Jonathan Shedler was interviewed in conjunction with the British Psychoanalytic Council (BPC) conference “[Psychoanalytic Therapy Now 2018](#).” It’s a wide-ranging interview about the state of our profession today. It’s been published in the British Psychoanalytic Council magazine, *New Associations*, and also in the International Psychoanalytical Association newsletter, *IPA News*.

In addition to his many roles and responsibilities, Jonathan is an Advisor to PsiAN.

Ten Questions: An Interview with Jonathan Shedler

Interviewed by Jessica Yakeley, MD for the British Psychoanalytic Council

1. Your 2010 paper in the journal *American Psychologist*, *The Efficacy of Psychodynamic Psychotherapy*, received international acclaim and continues to be much cited. How did you become interested in this area?

I was fed up with the false narrative that we hear over and over, that psychoanalytic therapy has been discredited and so-called evidence-based therapy is scientifically proven and superior. I knew the research and I knew that the public, policy makers, and mental health professionals were being sold a bill of goods. I also knew from first-hand experience that “evidence-based” therapy—which is typically a code word for brief, manualized CBT—fails enormous numbers of patients. I was supervising in a university-based psychiatry clinic and saw them every day. Someone needed to set the record straight.

There is also a personal backstory. I was disillusioned with the academic world and done writing academic journal articles. It is thankless work, for reasons I could go on about. Bob Wallerstein, with whom I worked on the first edition of the *Psychodynamic Diagnostic Manual* (PDM), asked me to write an article on psychoanalytic outcome research, supposedly for a special issue of *American Psychologist* on psychoanalytic therapy. I told him I was done writing journal articles and declined.

Bob called me every week, for months. In the end, I relented. I took on the project, more out of a sense of obligation to the profession than anything else. I gave the project an acronym, T-LAP, which stands for The Last Academic Paper. That’s still what I call it with friends.

Another irony is that *American Psychologist* never intended to publish a special issue on psychoanalytic therapy. It was all a misunderstanding. The other papers submitted with mine were shot down immediately. There is such prejudice against anything psychoanalytic that the journal could not even find an editor willing to handle my manuscript. Psychoanalysis is so marginalized that mainstream journals don't publish papers on psychoanalytic topics. T-LAP was a unicorn.

2. How would you describe the current state of research in psychoanalytic and psychodynamic psychotherapy?

There are psychoanalytic researchers doing excellent work. But we still don't have a culture in psychoanalysis that is supportive of research. Few psychoanalysts bother to read the research—even those who speak of its importance. Some say research is important, not because they see any intrinsic value in contributing to psychoanalytic knowledge, but only for PR purposes. Psychoanalytic researchers sometimes walk a lonely road. They are marginalized in the academic world where “everyone knows” psychoanalysis has been debunked, and they are viewed as outsiders by some in the psychoanalytic community: not really “one of us.”

3. In the UK, health services are required by commissioners to carry out on-going outcome monitoring to demonstrate safety, quality, and effectiveness of treatments. It is difficult to make this a meaningful exercise rather than just something carried out to satisfy commissioners. As you know, at the Portman Clinic, with your guidance, we have been using the [SWAP](#) instrument and have found it highly informative as a diagnostic and outcome measure. We are able to show changes in personality structure in long-term treatment, which has helped ensure the on-going commissioning of our psychoanalytic psychotherapy service. We see this as an example of practice-based evidence as opposed to evidence-based practice. How would you encourage psychoanalytic and psychodynamic practitioners to become more involved in modest pieces of research like this?

You've put your finger on it. Many psychoanalytic clinicians approach outcome research holding their noses, and with good reason. One problem is that there is usually a profound mismatch between the aims of psychoanalytic therapy and the outcome measures used in research. Outcome measures tend to focus on acute symptoms—for example, DSM diagnostic criteria—and little else.

Psychoanalytic therapy has other goals. We are trying to change underlying psychological processes—what psychoanalysts have historically called

“structural change.” When psychoanalytic treatment is successful, it is not just symptoms that change, the *person* changes. The person becomes a different and better version of himself—someone more comfortable in his own skin, someone who is able to live life more freely and more richly. Psychoanalytic therapists will start to see outcome research as meaningful when, and only when, we assess outcome in ways that are relevant to what we do.

Your research at the Portman clinic is a wonderful example of psychoanalytically-relevant research. You are using the *Shedler-Westen Assessment Procedure* (SWAP), which Drew Westen and I developed to assess personality in psychoanalytically-meaningful ways. The SWAP is not a questionnaire completed by patients. It is an assessment instrument completed by the clinician, based on the clinician’s in-depth understanding of a patient. The SWAP assesses unconscious mental life reliably and validly. For example, it assesses intrapsychic conflict, defences, fantasy life, compromise formations, unconscious motives, internal and external object relations, transference propensities, self-experience, and ego strengths and deficits (visit www.SWAPassessment.org for information).

When we study the outcome of psychoanalytic therapy with the SWAP, we see things like reduction in intrapsychic conflict, a shift from relatively rigid and costly defences to more mature and flexible defences, more integrated self- and object-representations, development of healthy psychological resources and capacities, and so on. These intrapsychic changes dovetail with symptom improvement.

Ultimately, research must help us to understand our patients more deeply and work more effectively. If not, what is the point?

4. Coming to your clinical work as a therapist yourself, how would you describe your theoretical orientation? In the UK, although there has been much emphasis on the plurality of psychoanalytic theoretical schools, arguably Kleinian and post-Kleinian ideas continue to exert the most influence within psychoanalytic training, at the expense of other approaches such as the British Contemporary Freudian or Independent traditions. Moreover, in my experience, although the work of Otto Kernberg is well known, many psychotherapy trainees here have little exposure to other psychoanalytic schools that have been prominent in the US such as ego psychology and self psychology, let alone developments in more recent years such as the relational or intersubjective movements. Do such theoretical distinctions

sound to you like the narcissism of small differences or have they been relevant to your own training and practice?

It is hard to think of anything more destructive to our profession than this idea that we should choose a theoretical orientation. Critical thinking comes to an end when ideas are no longer considered on their own merits but instead become litmus tests of group loyalty or signifiers of ingroup/outgroup status. That is not scholarship, that is tribalism.

New theories arise to address limitations of existing theories. As analysts encountered new clinical phenomena, they developed new theories to explain them. We can and should ask, which theoretical concepts fit this particular patient at this particular juncture and why? Are we dealing primarily with intrapsychic conflict? With unintegrated or malevolent self- and object representations? With difficulty maintaining a coherent or positively valued sense of self? The more versatile we are with respect to theory, the more effective we can be with a wider range of patients.

Unfortunately, theoretical concepts that were originally developed to address specific kinds of patients and issues morphed into all-encompassing schools and movements. These movements arose in reaction against existing orthodoxies but then they became new orthodoxies. This pattern has been strikingly cyclical.

When our own identities are too closely tied to a theoretical orientation, we risk forcing patients into the Procrustean bed of our preferred theory, whether it fits or not.

5. You describe yourself on your website as a psychodynamic psychotherapist rather than a psychoanalytic psychotherapist. Why is this, and how would you explain the difference between psychoanalytic psychotherapy and psychodynamic psychotherapy, which may be confusing for the general public?

I use the terms *psychodynamic* and *psychoanalytic* interchangeably. Most people don't know the history of the term *psychodynamic*. It became widespread in the U.S. after a conference on medical education after World War II, where it was used as a synonym for *psychoanalytic*. I am told that the intent of those who introduced the term was to secure a place for psychoanalytic education in psychiatry without unduly alarming American training directors who may have regarded "psychoanalysis" with some apprehension. In short, the term *psychodynamic* was something of a ruse.

Unfortunately, the term *psychoanalytic* has taken on negative connotations for large segments of the public. It does not mean to them what it means to us. It conjures up negative stereotypes and pejorative preconceptions. When I

communicate with the public, I tend to use the term *psychodynamic*. When I communicate with colleagues, I am more likely to say *psychoanalytic*.

6. Linked to this, there are many different therapeutic modalities, often identified by three letter acronyms or “brand names,” that may be classified under the broad umbrella of psychodynamic psychotherapy, particularly for research purposes. However, this may also leave patients as well as many psychotherapists, including myself, confused as to the merits of one psychodynamic psychotherapy over another. Do you think this is a helpful situation?

We have an alphabet soup of non-analytic therapies that are known by three- and four-letter acronyms. Frankly, it’s an embarrassment. Surely, there are not so many completely distinct approaches to treatment. I would feel better if students mastered foundational principles and built on that foundation.

As for psychodynamic “brands,” it is possible to group them under broad themes or currents of psychoanalytic thought. A solid background in the major currents of psychoanalytic theory—drive theory, ego psychology, object relations, self-psychology, relational psychoanalysis—provides a framework to understand how the treatments fit in the bigger picture. Each brand offers its own vantage point, but there is value in thinking about them integratively, as parts of a whole. Instead of thinking of competing voices, we might think of elements of a symphony.

Here’s an example of what I mean by integrative thinking. The concept of splitting is central to Kernberg’s object relations approach to severe personality pathology (which they now call Transference Focused Psychotherapy or TFP). Some relational psychoanalysts detest the concept of splitting but embrace the concept of “dissociated self-states.” Now there’s something to think about. Are they describing the same phenomena or something fundamentally different? What do we gain or lose by adopting the language of one tradition versus another? Different people may come to different answers, but I think there is value in wrestling with the questions.

But I realize I haven’t answered your question. You asked if the emergence of psychodynamic “brands” is helpful. I’m of two minds. It contributes to a certain amount of confusion. On the other hand, much of our psychoanalytic terminology is so off-putting to students and trainees that they turn off as soon as they hear it. Our language is the opposite of user-friendly. We end up alienating people who would otherwise be interested in psychoanalytic therapy. To reach a new generation, we may have to find new ways to communicate. One reason trainees gravitate to CBT is that it is simple to grasp. Beginning therapists are anxious and often desperate for structure of any kind.

7. Do you think that we as psychoanalytic and psychodynamic psychotherapists can be too dismissive of CBT without acknowledging its benefits, as well as emerging areas of overlap with psychodynamic psychotherapy?

We should be open to learning wherever there is something to learn. That said, I would draw a distinction between CBT practitioners and CBT researchers. Practitioners are colleagues who struggle with the same clinical challenges we do. We may not use the same terminology, but there is a shared grounding in clinical experience and we can have a dialogue. Many academic researchers, on the other hand, have little meaningful practice experience. They are the ones pushing for brief, one-size-fits-all manualized therapies. Some are openly disdainful of the notion of clinical expertise. Their vision for the future of psychotherapy is one where treatment is delivered by minimally-trained technicians following instruction manuals.

I take the “10,000 hour rule” seriously—the finding that it takes 10,000 hours of practice experience to develop mastery. This is true for musical performance, athletic performance, writing, computer programming, and pretty much every other skilled activity. The idea was popularized in the book *Outliers* by Malcolm Gladwell. Ten thousand hours of experience does not guarantee mastery but it is a prerequisite.

A real clinician with 10,000 hours of practice experience is a colleague who probably knows something I can learn. An academic researcher with no meaningful practice experience? I’m not so sure.

8. A controversial issue that has gained prominence over the past 20 years or so is the use of therapist’s self-disclosure in relation to their countertransference. In your 2015 article in *Psychology Today*, [The therapy relationship in psychodynamic therapy versus CBT](#), you give a vignette of a woman who is elegant and successful but who has not been able to achieve an intimate relationship. She has attempted therapy several times but reports it never helped, and that the therapists always end up seeking *her* approval. You state that colleagues trained in CBT and other “evidence-based” therapies rarely attach much significance to her feelings about her past therapy relationships.

If I may quote you, you state, “Some venture that Caroline may need a ‘secure’ therapist who won’t be intimidated by her looks or status. From a psychodynamic perspective, it is irrelevant whether Caroline’s therapist is personally secure or insecure... She needs a therapist with the self-awareness and courage to notice that twinge of insecurity in Caroline’s presence, treat it as information, and use it in the service of understanding.

Such a therapist might say: ‘You know, you have come here for my help and yet in many of our interactions, I am aware of a vague feeling of wanting to impress you or gain your approval, which of course doesn’t help you at all. I’m

trying to figure out what it means, and whether it could be a window into understanding something about what happens in your relationships more generally. Perhaps this is something that feels familiar to you.”

In this vignette, you directly reveal to the patient the feeling she evokes in you, i.e. a feeling arising from your countertransference. I think many British Psychoanalytic Council therapists would hesitate to speak openly of their countertransference feelings, but instead use these feelings to inform an interpretation such as “I wonder whether you worry that I might want to impress you or seek your approval like you feel your previous therapists did,” which doesn't expose the therapist's own feelings. These differences in technique may sound subtle but I think they are important and may be a source of confusion, particularly for therapists in training, and so I would be very interested in your thoughts on this, and the rationale as to why the therapist's self-disclosure here might be more effective as a therapeutic intervention than a transference interpretation in which there is no self-disclosure.

There was a time when I would not have disclosed what I did and would likely have said something along the lines you suggested. But my thinking has changed.

Before I comment on the specific intervention, let's acknowledge the elephant in the room: our field's problematic relation to change. All disciplines grow, evolve, and change. What is not growing is dying. But in the culture of psychoanalysis, some view change not as evolution but betrayal.

I felt it myself. I had a very classical analysis. When I began treating patients, I practiced as my own analyst practiced because that was “real” psychoanalysis and I wanted to be a real psychoanalyst. I soon discovered that this way of working was often unhelpful to my patients and sometimes harmful. To help them, I had to learn to do things differently. But somehow, doing things differently did not feel like learning. It felt like betrayal of my own analyst, supervisors, and teachers—people I respected and even loved. But let's face it—“my teacher did it this way” is not an intellectually sound basis for clinical decisions.

Now, let's return to “Caroline.” To be clear, I do not advocate indiscriminate self-disclosure. We are discussing disciplined, considered disclosure in the service of the analytic work. I do not disclose just anything. What I disclose is my reaction to what is happening in the room, in the here-and-now of our interaction.

The patient and I are enacting something. It is not purely intrapsychic, it is in the interaction between us. It takes two. In other words, the therapist is already a

participant in the enactments, wittingly or unwittingly. Some would use the term *intersubjective* to describe this aspect of the encounter.

Suppose I said what you suggested: “I wonder whether you worry that I too will want to impress you or seek your approval.” This would not have brought the specific enactment into focus. The patient might have said, “No, I wasn’t worrying about that with you,” or perhaps, “You’re a famous doctor, I don’t think you would need to impress me.” The patient is *not* in fact worried that I will react this way. It is ego-syntonic for her. It is just how she experiences the world, as natural and invisible to her as water to a fish.

When I say “I am aware of a feeling of wanting to impress you or gain your approval,” I am stating a fact that must be reckoned with. It is not a speculation about *her* experience. It is a fact that this is how I am experiencing the interaction. I am also mindful of why the patient has come to treatment: something gets in the way of intimate relationships. Here is an example of that “something,” right here, right now.

The comment is both clarification and confrontation. It clarifies something that would otherwise escape notice and directs the patient’s attention to it with the expectation that she will reflect on it. It is also an invitation to think *together* about its meaning. There is a meta-message that the work is a collaboration and we are in it together. I am not going to interpret her experience to her. When we arrive at an interpretation, and we will, it will be *our* understanding, not just my understanding.

9. You say you take pride in helping people who have not found the help they need from other professionals. How do you think you are able to do this?

It’s an accidental specialty. I realized that virtually all my patients had had previous treatments that had not helped, or helped only minimally. Many had multiple prior treatments, psychotherapy and pharmacotherapy both.

Let’s face it, there is a lot of bad treatment out there. A therapist who works psychodynamically, who develops a strong case formulation, who involves the patient as a collaborator, and keeps their eye on the ball of what the patient wants from treatment, is likely to be successful.

10. Finally, what would you wish for the future of psychoanalysis and psychoanalytic therapy and how might this be achieved?

We are not good communicating to the public, or policy makers, or other mental health professionals about what we do. We have been far too insular and too preoccupied with internecine disputes. Psychoanalysis has historically turned inward. Proponents of other therapies have filled the void with their own (often false) narratives, using psychoanalysis as a foil or strawman.

We have to learn how to engage with students and colleagues outside our own closed circles. We also have to learn how to communicate in English, not jargon. All of this means changing the culture of our profession. That's not an easy thing.