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A new deal for dynamic psychotherapies: the psychoanalyst as street-level bureaucrat

In the UK in 2007 a national experiment was initiated with the aim of tackling 'Britain's Biggest Social Problem' – Depression. Improving Access to Psychological Therapies (IAPT) was devised as the solution. A universal free-to-access talking therapies programme would make available evidence-based treatment to all adults with depression. NICE (National Institute for Health and Care Excellence), the body that decides on what is cost-effective, said CBT, not antidepressants, should be its first-line offer. The starting gun was fired.

The promise from IAPT was 3-fold: to scale up access to CBT rapidly; to achieve recovery targets that would reduce the prevalence of depression over time; and – most ambitious of all – to ensure the Treasury would see a return on its investment by reducing the economic burden from depression. People who were on invalidity benefits due to depression would be supported back into employment. It was a New Deal for depression. As well as for CBT.

But did it work? A decade and a half on with IAPT, are we in a position to offer an answer?

This paper will seek to draw lessons about 'What Worked', and what didn't, to ask *ourselves* a question: are *we* – those of us in the applied psychoanalytic community – willing to garner what can be learned from IAPT to advocate a new deal for evidence-based psychoanalysis?

Faced with challenges from unemployment and widening inequalities, against a backdrop where global economic recovery must heed the existential threats from climate change and ongoing warfare, to say nothing of the scale of loss and grief for those already impacted by bereavement due to the pandemic, the need for some such deal could not be more urgent.

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To: Larry Rosenberg & Ghislaine Boulanger

A new deal for dynamic psychotherapies:

the psychoanalyst as street-level bureaucrat

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Two roads diverged in a wood, and I —
I took the one less travelled by …
Robert Frost (1916) **The Road Not Taken**

In the room where it happened

"… and tell the officials we won't be needing them", said Lord Freud to his Principal Private Secretary, as he welcomed me into his office at the top of Caxton House, HQ for the UK's Department for Work and Pensions. "Carol Black tells me we're wasting our money giving everyone CBT," he said. I was there to talk to the Minister for Welfare Reform about mental health. The reason he wanted to talk to me was not because he was Sigmund Freud's great-grandson, but I decided to mention him anyway. "With all respect to Dame Carol", I replied, "your great-grandfather would not have agreed. The problem is not that CBT doesn't work. NICE recommends it because it does. As does our evidence-based version of psychoanalysis, by the way. But in IAPT, we know from the data, CBT, brief dynamic, person centred – we're setting them all up to fail." I knew what was coming next. Lord Freud had been briefed by the Department of Health. Their flagship IAPT programme was more than meeting its access targets, said the official briefing – and soon enough would offer NICE-approved talking therapies to over a million people each year. Already, within three years, IAPT was closing in on its recovery target: 50% below clinical threshold for anxiety and depression at discharge. Initially, on its 'quick wins' IAPT was faring well (Gyani et al., 2013). That was the party line.

Lord Freud had not only read his brief, however, he had spoken to IAPT's key architects, Professors Lord Layard and David Clark. "So you don't agree with Carol. But you don't agree with Richard or David either. They're now pushing us for more money – and, as I'm sure you know, no Government that has invested £300M into something is going to say that it failed." "Yes", I replied, "but nor will the Government publish the full data. For people who you are worried about, people with depression on incapacity benefits, IAPT isn't working. What was it Sigmund Freud said – 'like distributing menus in a famine'…" "Then we must do better, Jeremy, only … ", the Minister for Welfare Reform hesitated, aware that public spending on welfare benefits was just about to be cut in any case, "no one knows how …" (Freud, 2021).

Across the developed world this conundrum of depression, and its social and economic cost burden, had been looming ever larger since the turn of the 21st C. Why? World Health Organisation surveys had been predicting depression would become the single greatest burden of disease worldwide by 2020 (Murray & Lopez, 1996). The global financial crash in 2008 undoubtedly exacerbated these trends (Kessler & Bromet, 2013). In the USA, as economists Ann Case and Angus Deaton, winner of the Nobel Prize, have shown in their compelling analysis of rising mortality rates amongst white, middle-aged Americans, there are some clear, albeit complex, causal patterns for what they aptly term 'deaths of despair':

> *"So you get a situation which would certainly drive me to consider whether my life was worth it or not, which is you're a 50-year old man, you've had two or three sets*

> *of children, you don't know any of them because they're living with other men or with your ex, and you've never been married, and you reach this time in middle-age and you say 'what have I done?' …* (Deaton, 2021).

To give due credit to Richard Layard, a UK-based economist, he had spotted a key causal factor earlier on. In his report describing depression as a neglected social problem, what Layard managed, which no-one had before, was to capture the Treasury's attention (Layard, 2006). It was costing government's more, year on year, as larger numbers of otherwise productive members of the labour market succumbed to chronic depression, and were then left to languish on incapacity benefits. Layard argued that if you treated their depression you could get these people back to work. The alternative advice, put by Dame Carol Black, was that getting back to work would be the cure for most peoples' depression. In theory and, according to the principle of equifinality, both could be right: a Department of Health led CBT-first programme, IAPT, may well produce as a side-effect, as it were, the added benefit that Layard was predicting. The initial IAPT pilots had demonstrated this as a proof of concept (Layard & Clark, 2014). Equally, a Department for Work and Pensions led work-first policy, the Work Programme, could generate beneficial side-effects by preventing a person's depression from becoming more chronic and more disabling (Waddell et al., 2006).

So why, in practice, has this mutually desirable goal proven elusive whichever road is taken?

More by accident than design with Lord Layard, 2007, I was in the room where it happened.

> *"What will happen is this",* explained Layard to me, on the steps outside the Cabinet Office in Whitehall. *"We'll present our business case, and they'll ask us a few easy questions. And then one of them will point out it sounds good but we don't have the data* ***they need*** *to prove it works. Of course not, because it hasn't been tried before."*

The business case for IAPT @ £300M rested on a simple logical argument. The single biggest reason given by people for being on incapacity benefits, we knew, was chronic depression. We have treatments that work, namely CBT (NICE, 2004). But none of these people were getting access to CBT. A national programme to improve such access 'will pay for itself'. But the real winner will be the Treasury: as its welfare benefits bill will then start to come down.

> *"This is when they will all nod their heads and smile",* continued Richard, *"and say 'Well, then, Richard – if you're right, obviously we must do more pilots'. Your job is to say 'Absolutely not. Out of the question'".* I felt alarmed. *"Don't worry", said Richard, noticing my look and pointing to his plastic carrier bag, "I've got some proper shoes in here. I'll change out of these trainers when we're inside."* And that, pretty much, is what happened. Half an hour later, Jeremy Heywood, the most senior civil servant, announced to the Treasury boffins in the room, and Lord Layard, and myself: *"Thank you gentlemen. I think I've heard enough."* Outside in Whitehall we went for a drink to celebrate. *"I'm buying",* said Richard. *"What happened?",* I asked. *"What happened, Jeremy, is that they didn't say no. £300M! Not bad for a morning's work".*

With Lord Freud, three years later, I felt responsible to tell the truth. The road to IAPT for depressed people on social welfare was the wrong one to take. I knew that. But not why.

The war against neurasthenia, and the long road to finding a cure for depression

There was a moment at the end of the 1st and 2nd World Wars when psychoanalysis made an offer to Government: 'Support us, and we will provide your public a cure for neurosis'.

We have an impressive historiography available, when we reappraise the earlier psychoanalytic movements (Aron & Starr, 2013; Burnham, 2012; Danto, 1999, 2005, 2009, 2009a, 2016; Ffytche & Pick, 2016; Herzog, 2017; Makari, 2008; Stepansky, 2009; Zaretsky, 2004, 2015). These studies eschew the sterile polemics of 'the Freud wars', whilst engaging critically with the contribution psychoanalysis has made to our contemporary understanding of identity (Henry & Fong, 2018). For Aron & Starr (2013), for example, "it is at the margins where psychoanalysis thrives and where it is best ethically located" (p. 8). Danto's vital project, returning to the European period between the world wars, is to revive our more progressive, activist tradition: "to reclaim Freud's urban, clinical and social justice legacy" (2016, p. 6). Herzog, Stepansky and Zaretsky show how this was lost when the centre of gravity shifted towards conservative climates in America and Britain after the 2nd World War. Ffytche and Pick's contributors examine the shattering impact of totalitarian regimes.

Today, we are placed at the margins within evidence based medicine, whether we like it or not (Clarke, 2020, 2020a, 2021). The story Danto (2005) tells ends, we know, in catastrophe: "By 1940, the psychoanalytic community in continental Europe had been wiped out" (Makari, 2008, p. 462). From then on our unfinished story is told against a gloomy American backdrop of decline and fall (Hale, 1995). If we continue further down that road what is to stop us slipping right off the edge? Engaging with IAPT was about reclaiming our place *at the centre* of the UK's mental health and welfare system. What could we learn from our history?

Freud's speech to the Budapest Congress in 1918, subsequently published as *Lines of Advance in Psychoanalysis,* set us a bold challenge to this end: to pursue expansion along *new* treatment pathways (Freud, 1918). It was a newcomer, the German Psychiatrist Ernst Simmel, to whom Freud turned primarily for his thinking about how the crisis of war might also be an opportunity. Simmel worked in the field during the war, directly with soldiers incapacitated by shell shock. Adapting techniques described in Freud's earlier work with Breuer (Freud & Breuer, 1895), Simmel had attracted attention of officials in charge of the war effort for the Central Powers. His reports helped persuade military authorities that shell shock could best be understood psychologically, rather than as a physical injury to the brain or nerves, and brief cathartic analysis might be its most effective treatment (Simmel, 1918, 1921; Brunner, 1991). The most widely used 'cure' was Kaufmann's electro-shock therapy; otherwise, work-therapy – giving men work to do to make up labour shortages at home. Most of the physical and behavioural treatment approaches were deliberately punitive, in the belief this would have an added benefit that if the cure was worse, or at least as bad as the illness, those tempted to malinger, or fake illness, would be deterred (Shephard, 2000).

The success rates claimed for these rehabilitation programmes were quite impressive (Linden & Jones, 2012). But from the perspective of the military, four years in, it was clear that most men treated, even if recovered, did not return to fighting (Lerner, 2003). It was not sustainable. In Vienna, 120,000 soldiers were suffering with shell shock (Hofer, et al., 2011). And, as reports of deaths from the more brutal treatments began to cause disquiet, continued use of 'Kaufmann's cure' was restricted. After the war, Freud was called upon for

his expert testimony in complaints of malpractice brought against Julius Wagner-Jauregg, Professor of Psychiatry at Vienna University, and Director of the Psychiatry Department at Vienna Hospital; Vienna's most powerful psychiatrist. His electric shock 'cures', said Freud, whether effective or not temporarily, were "too cruel". Nor in his opinion was it justified to assume that soldiers with shell shock were faking, as the primary cause of their 'illness' was a very real danger of being killed; denying this, if anything, was even more 'ill' (Danto, 2016).

The stakes in this court-room drama were high for all concerned. The Commission inquiry found that the treatment regime overseen by Wagner-Jauregg was overly brutal, misguided, and ultimately ineffective. But apart from denting his *amour-propre* there was no further sanction or prosecution. And when positions were reversed, when Wagner-Jauregg got to decide if a licence to open a free psychoanalytic clinic, the Ambulatorium, should be allowed in Vienna, he did not forget Freud's criticisms – it was rejected. Professional rivalries and reputations aside, however, the authorities' main concern was potential crippling costs from war pensions (Jones et al., 2002). Here was a problem of utmost political and professional urgency, then, for which psychoanalysis may be seen by the authorities as a 'clean' solution.

The psychoanalytic social worker and historian, Elizabeth Danto (2005), has traced the fruits of Freud's most progressive moment at Budapest in her brilliant study of the Free Polyclinic movement that sprang up around Europe during the period between the two world wars. It was not a blip or aberration. Freud's vision was for *universal* improvement in public health. Psychoanalytic practice should have a central role in *universal* public services. The potential for achieving this vision was nowhere better situated than in Red Vienna following the war (Gruber, 1991). There were many sympathetic and like-minded social democratic reformers, such as Julius Tandler, who was in charge of welfare reform as Under-Secretary of State for Public Health (and had been Freud's classmate in school). Experience in planning and logistics that would be needed for rebuilding had been gained during mass mobilisation for the war effort, led by Otto Neurath at the Department of War Economy in the War Ministry. Working with Tandler and others, Neurath led initiatives to improve housing, city planning, green spaces and small garden plots, where local self-help groups could provide community support. He also brought together the intellectuals, philosophers and social scientists who formed around the Vienna Circle Manifesto, spearheading logical positivism (Cartwright et al., 1996). On the face of it Freud was surrounded by ideal allies to promote psychoanalysis.

There were catches. However willing to entertain it as a potentially helpful therapy few, if any, psychiatrists or neurologists believed the story that Freud and Breuer told about female hysteria, namely, that repressed sexuality was the underlying pathogenic factor. What did this have to do with soldiers suffering from war neuroses (Lerner, 2003)? More intractable still was the ethical dilemma: if, for psychoanalysis proper, the aim is to liberate autonomy of the individual ego, how can that be reconciled with the State's need for a treatment that would return invalid soldiers to fighting, whether they wanted to fight or not (Henry, 2019)?

The end of the war came before any new policy was implemented. But it is worth looking briefly at how Freud engaged with these issues. At Budapest his title, as given, translates as *The Paths of Psychoanalytic Therapy*, viz: more than one way forward. In 1918, in search of a universal intervention to improve public mental health, which roads did he advocate us taking? In 1920, giving court testimony after defeat, how had his thinking further evolved?

The best known gobbet is Freud's analogy of analytic techniques with precious metals: *"It is very probable, too, that the large scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion; and hypnotic influence, too, might find a place in it again, as it has in the treatment of war neuroses".* Here, Freud espouses pragmatic adaptation. Yet, in his closing remark that follows, he pulls back from its implications immediately: *"But, whatever form this psychotherapy for the people may take, whatever the elements out of which it is compounded, its most effective and most important ingredients will assuredly remain those borrowed from strict and un-tendentious psycho-analysis"* (Freud, 1918). True, his main thrust is towards new adaptations of existing ideas. Nor, grappling with the prospect of mass psychotherapy for the people - 'if that's where you want to get to, I wouldn't start from here' – would we expect the movement's founder to go AWOL. But by framing 'applied' psychoanalysis as a 2nd-class enterprise, the road less 'pure' has tended to be less travelled, demoted in status (Blass, 2010). Instead, a 'strict' hierarchy has endured as a limiting factor that closes off any new pathways (Cooper & Lousada, 2010).

This 'pure versus applied' split obscures the spirit of Freud's call for genuine innovations:

> *to admit the imperfections of our understanding, to learn new things and to alter our methods in any way that can improve them.* (Freud, 1918).

His extended analogy is a comparison of the work of the analyst with that of the laboratory chemist, separating substances into their constituent elements; seeing their properties, and what the nature of these basic elements is; understanding how they combine and interact with each other, and finding out what happens when they mix with other substances. Psychoanalysis, insists Freud, is an experimental science at heart, open to new discoveries:

> *we have thrown light on the sexual impulsions in man by separating them into their component elements; and when we interpret a dream we proceed by ignoring the dream as a whole and starting associations from its single elements.* (Freud, op cit.).

Following a passage in which he contradicts himself about creating a new synthesis in which elements of the self are better integrated, Freud turns to Ferenczi to consider the scope for active intervention by analysts to help a patient's predicament in life (Gaztambide, 2012):

> *After all, what he can achieve depends, too, on a combination of external circumstances. Should we hesitate to alter this combination by intervening in a suitable manner? I think activity of such a kind on the part of the analysing physician is unobjectionable and entirely justified.* (Freud, op cit.).

He then clarifies this is not for relief of suffering but to support genuine change, otherwise we risk '*never achieving any improvements except quite insignificant and transitory ones'.* The analyst's primary task, says Freud, is to maintain focus on working through the conflict. But the treatment goal, with reference to the split from Jung, is primarily for the patient to decide: *to liberate and fulfil his own nature, not to resemble ourselves.* He gives two brief instances of an active stance to treat phobias and obsessions - to introduce gradual exposure for the former; and set time limits to treatment in the latter '*as only samples of the new developments'* (op cit.). All these practical, concrete tasks fall within his purview.

Finally, he confronts the scale of the challenge and workforce needed to staff outpatient or child guidance clinics *'so that men who would otherwise give way to drink, women who have nearly succumbed under their burden of privations, children for whom there is no choice but*

between running wild or neurosis, may be made capable, by analysis, of resistance and of efficient work. Such treatments will be free.' He adds: *'Often, perhaps, we may only be able to achieve anything by combining mental assistance with some material support'* (op cit.).

For Danto (2016) it is our fundamental right to good mental health, and the State's duty to support this, that unite Freud's purpose in his Budapest speech in 1918, and testimony to the Commission for Investigation of Derelictions of Military Duty, in Vienna two years later. By speaking on behalf of soldiers who suffered the double injustice of being wrongly made to feel ashamed and mistreated for suffering shell shock, and couching it in terms of parity of esteem for a person's mental as well as their physical health, Freud was able to make a powerful argument for psychoanalytic treatment as a force for social justice, as opposed to electric shock and other punitive treatment approaches. Although he had no direct clinical experience, he could cite the work Abraham, Ferenczi and Simmel undertook treating shell shock psycho-dynamically in Germany and Hungary. Against the usual charge that analysis was impractical for scaling up because it took too long to achieve results, Simmel's method – with over 2,000 soldiers – had achieved remission in only 2-3 sessions (Kaufmann, 1999).

Wagner-Jauregg had overseen a regime of treatment that mainstream medical opinion had endorsed. He was judged subsequently to have been corrupted by patriotism, losing sight of his over-riding duty of care. "Military psychiatrists", said Freud, had "acted like machine guns behind the front lines, forcing back the fleeing soldiers" (Danto, 2016). It should be remembered, however, speaking to military authorities in 1918, this was precisely Simmel's boast for the success of psychoanalysis that Freud eagerly promoted (Linden & Jones, 2012).

The inherent tension is captured by Julius Tandler's tribute, quoted by Danto to underline Freud's integrity. Describing him as a friend and colleague he said that Freud: *"is a person who is only accountable to his own law... He is without a doubt a person who influences his time... If he were not a Jew he might be Bismarck"* (Danto, 2016, p. 6). The reference to Bismarck relates back to welfare benefits: if shell shock were to be a qualifying entitlement under something like Bismarck's social insurance provisions – a 'malingerer's charter', as seen by medical practitioners, who remained sceptical - it would risk a crippling financial burden in pension payments, as became the case in Weimar Germany (Jones et al., 2006). Freud's expert opinion ("if (only) he were not a Jew"?!), about the indeterminate aetiology of disability from war trauma – a complex interaction triggered by overwhelming fear, together with maintaining factors that utilised unconscious psychopathological defences – however scientifically circumspect, let Social Democratic authorities in Vienna off the hook.

In *Thoughts for the Times on War and Death* (Freud, 1915), Freud tells of when an English friend (Ernest Jones) spoke in America about what psychoanalysis has uncovered from our dream-lives, where we are amoral and selfish. "A lady" in the audience, says Freud, objects: that may be true for Austrians but she and her friends "were altruistic even in their dreams" (p. 74). What would a "lady" know, after all? Yet the question of war: what is one's duty?, was beyond Freud too: "It is, to be sure, a mystery why the collective individuals should … despise, hate and detest one another – every nation against every other ... even in times of peace" (p. 76). Across in England, in 1912, Robert Frost and his great friend, Edward Thomas, were recovering from depression. Frost set up home in a small community of poets in Dymock, on the border of England and Wales between the Malvern Hills, the River Wye

valley, and the Cotswolds. Here, Frost drew inspiration for *The Road Not Taken.* He shared it with Thomas. He recalled a scene from their walks when Thomas would doubt the way. Its most memorable image is a choice, and consequences of that choice, for what then follows.

Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveller, long I stood
And looked down one as far as I could
To where it bent in the undergrowth

Then took the other, as just as fair,
And having perhaps the better claim,
Because it was grassy and wanted wear;
Though as for that the passing there
Had worn them really about the same,

And both that morning equally lay
In leaves no step had trodden black.
Oh, I kept the first for another day!
Yet knowing how way leads on to way,
I doubted if I should ever come back.

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I—
I took the one less travelled by,
And that has made all the difference.

Robert Frost (1916) **The Road Not Taken**

The two friends had talked about leaving with their families for New Hampshire to live close by each other there. Early 1915, Frost left England, taking Thomas' son, Mervyn, expecting Thomas and the others to follow. But after reading the poem that Frost had sent him, as a fond remembrance of their walks together, *The Road Not Taken,* Thomas changed his mind and decided he must enlist to fight in the war. He never saw Frost again. On Easter Monday, April 1917, shortly after arrival at the front line of fighting in France, he was killed within the first hour of an Allied offensive launched at Arras. The moral dilemma to join up to fight that Thomas wrestled with – a cause of his tormenting depression – alters the whole poignancy of what the poem portrays as a simple decision made on a walk in the woods (Hollis, 2011).

We cannot turn back the clock for Edward Thomas, or Wilfred Owen, or countless others. For Owen, the call to war was based on a lie, an "old lie": *Dulce et decorum est pro patria mori*. Frost's greatest fear was losing Thomas. But he respects that it is his decision to make.

> *Not mine to say you shall not think of peace. Not mine, not mine. I almost know your pain.*
> *But I will not believe that you will cease, I will not bid you cease, from being slain.*
> *Till everything that might have been distorted Is made secure for us and Hell is thwarted.*
> (Frost, Dec. 7th 1916, letter to E. Thomas, later titled: *On Talk of Peace At This Time*)

Born in the USA – inventing the cure for depression: a cautionary tale

When the moment arrived for psychoanalysis in America, Freud was dead. 'Good', he may have thought, given his opinion of everything American. And, if the feeling was not mutual, at least for its leading light after the 2nd World War, William Menninger, it was no great loss (Aron & Starr, 2013). American dynamic psychiatrists were not lacking commitment. Their leadership during wartime positioned psychoanalysis as the "War Hero" (Shephard, 2000).

Here was the deal. If psychoanalytic psychiatrists were confident they could identify those soldiers that were vulnerable to breaking down under the stress of combat, then they must be put in charge of a mass screening programme. The rationale for this was compelling: a more efficient military fighting unit and, from the perspective of the State as seen from the 1st World War, huge cost-savings in future war pensions if numbers of psychiatric casualties could be reduced (Salmon, 1917). 'Yes, we can', replied the military's top medics, promising that 75% of those at risk could be screened out using a psychodynamic psychiatric interview (Kiene et al., 1942; Menninger, 1941). For medical analysts this was a golden ticket. They got to train more military psychiatrists in the war, estimated Menninger, than all the medical schools in America could have trained in a whole decade. How right to restrict this training to psychiatrists! (Makari, 2008). The influence and prestige this conferred meant that by the 1960s, USA psychiatry was a monopoly preserve for psychoanalysis alone (Stepansky, 2009).

But there were some serious cracks in these foundations. Firstly, the screening didn't work. Not because it was psychoanalytic. Most mental health screening tools don't work, notably, those designed to predict suicide and, for that matter, depression (Carter et al., 2017; Kessler et al., 2020; Gilbody et al., 2006). There were just two problems: 1. False negatives – failure to identify those soldiers who did break down, at a rate four times higher than in the 1st World War (Jones et al., 2003). 2. False positives - in huge numbers: healthy men were rejected for military service on spurious psychiatric criteria who would, in all likelihood, have made as good a soldier as any other man (Strecker & Appel, 1945; Shephard, 2000).

The lessons learned from the 1st World War, supposedly, had resulted in a double whammy during the 2nd: more men were being rejected as unfit beforehand; but more soldiers, who had been deemed fit, were then breaking down in conflict. It is difficult to know which was the more damaging. For those who didn't see fighting, rejected at recruitment as unfit on 'psychiatric' grounds, estimated at over one and a half million (Ginzberg et al., 1959), they then had to get on with their lives carrying the stigma and shame of their rejection. Especially if the reason then reported on to their employer by the army was their suspected homosexuality, [one of the tests for failure (psychiatric disorder; learning difficulties; sexual perversion)], future prospects for their civilian lives were blighted by the discrimination they faced back home. Some lost jobs, some probably more. But others came out (Bérubé, 2010). Gore Vidal (1948) explored these war-time experiences, and their disruptive, paradoxically liberating effects on sexuality and freed-up *gay* identities in his novel *The City and the Pillar.*

But the most puzzling legacy from World War 2 is how psychoanalysis emerged as winner? Screening using brief dynamic interviewing techniques was impossible to implement. Harry Stack Sullivan, remembered as one of the giants of interpersonal psychoanalysis, led training in a standard 15-minute interview, thought to be more revealing if men were made to strip naked. But 15 million recruits meant psychiatrists were interviewing 200 men per day, two

minutes each (Grob, 1994). Decisions on mental fitness could be nothing but arbitrary, biased by institutionalised racism and homophobia (Aron & Starr, 2013). Rates of rejection (around 1 in 10) varied wildly between interviewers (@ 35 times). The military lost faith and re-inducted most of those rejected, who mostly turned out to be fine (Ginzberg et al., 1959).

The case for an heroic contribution of psychoanalysis to the war effort has more plausibility, perhaps, when it comes to treating American psychiatric casualties in the 2nd World War. 'Forward psychiatry', based on experience from the 1st World War, deployed the treatment principles of 'pitiless psychology' (Shephard, 1999). In this model, soldiers were treated as near to the front line as possible, in uniform, and under military discipline; they were told that their mental breakdown was a physiological response – a transient episode of battle fatigue; and that swift return to combat was good for their morale (Jones & Wessely, 2003).

Two psychoanalytic psychiatrists, Roy Grinker and John Spiegel, developed a brief therapy not dissimilar to Simmel's cathartic dream interpretation under hypnosis in the 1st World War. The added ingredient for their *narcosynthesis* treatment was sodium pentothal, which induced an altered state of consciousness. Traumatic images could then be accessed safely. They also elaborated a psychoanalytic theory of identification, which remains the standard view today in the military for re-activating a soldier's motivation to fight via loyalty to one's fellow soldiers and immediate unit leader *['primary group']* (Grinker & Spiegel, 1943, 1945). In Britain this was applied to group treatments and the idea of a *therapeutic community* at Northfield Military Hospital by pioneer analysts: Bion, Rickman, and Main (Harrison, 2000).

Here, then, is a well-trodden path that follows a linear narrative from shell shock through to PTSD, co-morbid with depression. In this story, injustice done to those shot for cowardice, or made to feel ashamed for moral weakness, was rejected by compassionate figures using Freud's ideas about trauma and the unconscious, viz. in Britain, W.H.R. Rivers (1918, 1919).

In Pat Barker's *Regeneration* trilogy, Rivers is portrayed wrestling with his inner conflicts, whilst dutifully challenging the conscientious objections to continuation of war that landed his patient, Siegfried Sassoon, in Craiglockhart War Hospital. Rivers' treatment methods – patient, compassionate talking therapy, listening out for what has been repressed or dissociated due to overwhelming trauma – are contrasted with those of Dr. Lewis Yealland, who used electrotherapy to shock mute patients into speaking. In Terence Davies' (2021) film *Benediction* it is also clearly the love that Rivers feels for Sassoon that effects the cure.

This same trope is deployed in representations influenced by experience of treating war trauma in the 2nd World War. The theme of unconscious mental conflict as proximal cause of debilitating symptoms is the pretext for promoting psychoanalytic methods over physical and dangerous treatments then in increasing vogue namely, surgical lobotomies (Raz, 2013).

The respective real-life ethical duel here is between Lawrence Kubie and Walter Freeman. Kubie was a leading American psychoanalyst, who had undertaken analysis with Edward Glover in the UK, and worked with Menninger on combat fatigue during the war. He was the author of the section on sexual perversions in the military screening manual (Kubie, 1943). He was Leonard Bernstein's and Tennessee Williams' analyst. Freeman was President of the American Board of Psychiatry and Neurology, and the main pioneer in lobotomy operations

for curing mental illness. He carried out 3,500 lobotomies, including on Rosemary Kennedy, sister of President John F. Kennedy. She was left permanently brain damaged (El-Hai, 2005).

In *Suddenly Last Summer* (1959), the film of William's play, Elizabeth Taylor's character has been placed in a mental asylum after being traumatised during a trip to Europe with her cousin, Sebastian, who was killed. She is "babbling" about Sebastian's relationship with his mother, played by Katharine Hepburn. The psychiatrist Dr. Sugar, Montgomery Clift, is offered $1M for a neurosurgery clinic if he will perform a lobotomy on the disturbed niece. Hepburn says the niece is driven by envy to want to destroy her son Sebastian's reputation:

> *"Doctor, you've got to cut that hideous story out of her brain" …* referring to Taylor's allegation that mother and son together had seduced and corrupted young men - *"I can't guarantee that a lobotomy would stop her – babbling",* replies Dr. Sugar. *"That may be, maybe not, but after the operation who would believe her, Doctor?".*

But Dr. Sugar(-Kubie!) does, in fact, believe the truth lies in his patient's repressed memory; her unconscious. His intervention is to administer the drug sodium pentothal and, under hypnosis, enable his patient to recall the traumatic scene of Sebastian's death. In revealing the terrible truth about Sebastian's repressed homosexuality, *her cure* is effected by talking. Sadly for Rose Williams, Tennessee's older sister, that was not to be. In 1943, with 60,000 other US citizens from 1936 to 1956, she underwent a lobotomy (Caruso & Sheehan, 2017).

The Freudian road, less travelled at the outset, had been borne out by world events to lead to truths which – given the right guidance – could set free troubled minds. In contrast, more invasive psychiatric methods that stuck to the path of biological aetiologies were associated with the dominant view of asylums by the mid-20th C. (Goffman, 1961). In the popular mind they were exposed as places of horrific cruelty in the film *One Flew Over the Cuckoo's Nest*.

Why, then, a cautionary tale? Firstly, within our own discipline we are still to come to terms with rise of evidence based medicine, and complete reversal of our position – biological psychiatry bossing it over psychoanalysis at the start of the 21st C. (Shorter, 2021). Big Pharma had sold the American public a wish-fulfilling dream it wanted to hear (Kramer, 1993). It was CBT that set out to prove itself equal (Clarke, 2020b). When Layard came along after NICE recommended CBT, those of us who joined on their coat-tails were frowned on.

Psychoanalysis chooses, mostly, to cling to 'pure' Freud. It is a strategy less likely to succeed in rehabilitating our reputation for scientific credibility with every passing year (Scriven, 1959; Luyten, 2015). And it misses the main point this review underscores: there will always be conflicting trade-offs, driven by urgent policy demands, whenever we engage in scaling up mass public health interventions at speed (Le Grand, 2007). Yet 'applied' means just that.

Secondly, though, as David Freud lamented, the American dream evaporated in the face of the economic burden of depression (OECD, 2014). If USA-led standardisation of psychiatric practice did more good than harm in post-war decades by facilitating deinstitutionalisation, it is unclear that its benefits outweighed its costs of over-reliance on psychopharmacology later (Healy, 2021). As the costs of USA mental healthcare have risen, so 'deaths of despair' have also escalated (Case & Deaton, 2020). Does IAPT offer the USA a better path to tread?

Reasons to be cheerful: one, two, three

> *Health service glasses, gigolos and brasses*
> *Round or skinny bottoms* (Ian Dury & the Blockheads, Reasons to be Cheerful, 1979).

In the remainder of this paper, I will focus on three distinctive contributions we made to the evolving IAPT project from a dynamic perspective around access; treatment; and outcome.

The idea of a national health service (NHS), offering universal access at point of need for all citizens to treatments provided free, is held to be an alien concept to the American mindset (Klein, 1997). The core fear is one of moral hazard (Arrow, 1963). Namely, if *my taxes* are paying for someone else's treatment, but neither the person who is ill, nor the person who provides the treatment, is worried about its costs, how do *I know* its benefits are worth it? At the start of the NHS in 1948 this hazard manifested itself in a rush on free spectacles (Ian Dury's reason to be cheerful), allegedly amongst those whose eyesight was perfectly fine; 'best get them now they're free, just in case'; viz, the perverse incentive of a moral hazard.

Against this, Aneurin Bevan's vision, in founding our national health service, and continuing in the radical tradition of his Welsh predecessor, Lloyd George, set a different moral tone:

> *"On July 5th [the start of the NHS] there is no reason why the whole of the doctor-patient relationship should not be freed from what most of us feel should be irrelevant to it, the money factor, the collection of fees or the thinking how to pay fees … the picture I have always visualised … for the less well-off [is] not of anything charitable or demeaning, but rather of a nation deciding to make health-care easier and more effective by pooling its resources."* (Bevan, 1948).

The British and American health systems diverged from this point onwards. In 1950, medical care expenditure as a percentage of gross national product was roughly comparable: 4.1% in the UK and 4.6% in the USA (Hollingsworth, 1986). Over decades these expenditures grew. Today, the UK spends almost 10%. The USA spends near to 20%; 3 times as much as on education; 4 times as much as defence (Case & Deaton, 2020). At the heart of relationships between 'the doctor, his patient and the illness' in America, a tradition of a fee for a service remained central (Callahan & Berrios, 2004). Access to care depended on ability to pay. No one stopped to ask in the case of depression: can money alone buy its cure? (Sandel, 2013).

Why not? If the market is left to determine how healthcare is rationed, a different ethos prevails. When Gordon Gekko, the New York banker in *Wall Street* (1987, 2010), played by Michael Douglas, is asked to explain moral hazard, he says: "it means they can steal your money and no one is responsible". Greed is good, then, in *that* world, for the *rich*, not the poor. A philosophy, ironically, that produces a health system in which vastly higher sums are spent on health in return for dying, on average, sooner than everywhere else (OECD, 2019).

The unique coalition that came together in support of IAPT's original vision, the *New Savoy Partnership,* was able to challenge this negative view of universal public services, including for Bevan's less well-off, by pointing to a different kind of moral hazard. Critics of IAPT, subsequently, have tended to focus too narrowly on its primary treatment intervention, CBT or, too broadly, on IAPT's allegedly neo-liberal ideology (Dalal, 2018; Jackson & Rizq, 2019).

This misses the mark (Clarke, 2020b). Depression is an illness that sooner or later will affect all our families; why such disparity in the way resources are rationed? Across mental illness the proportion of NHS spending on its treatment is 13%, yet it represents 23% of the total burden of disease (Layard et al., 2012). Spending on research into a cure for cancer equated to £1,571 per patient. Comparable spending on a cure for depression was £9.75 (MQ, 2018).

At the heart of the argument for IAPT was the fact that NICE guidelines apply the same cost effectiveness criteria to treatments, irrespective of the type of illness (Rawlins, 2009). The real moral hazard was stigma. Institutionalised discrimination in healthcare denied access to cost-effective psychological therapies. *Entitlement* to therapy just didn't exist (Lamb, 2014).

The original principles of social insurance that Beveridge had deployed for the Welfare State were put to use in arguing that IAPT would benefit us all. Not only Keynes' original dictum: 'look after the unemployment, and the budget will look after itself' (Keynes, 1993) but, first and foremost, invest in interventions that will improve population resilience and national happiness, to cite the index Layard advocates (Layard & Clark, 2014; Layard & Ward, 2020).

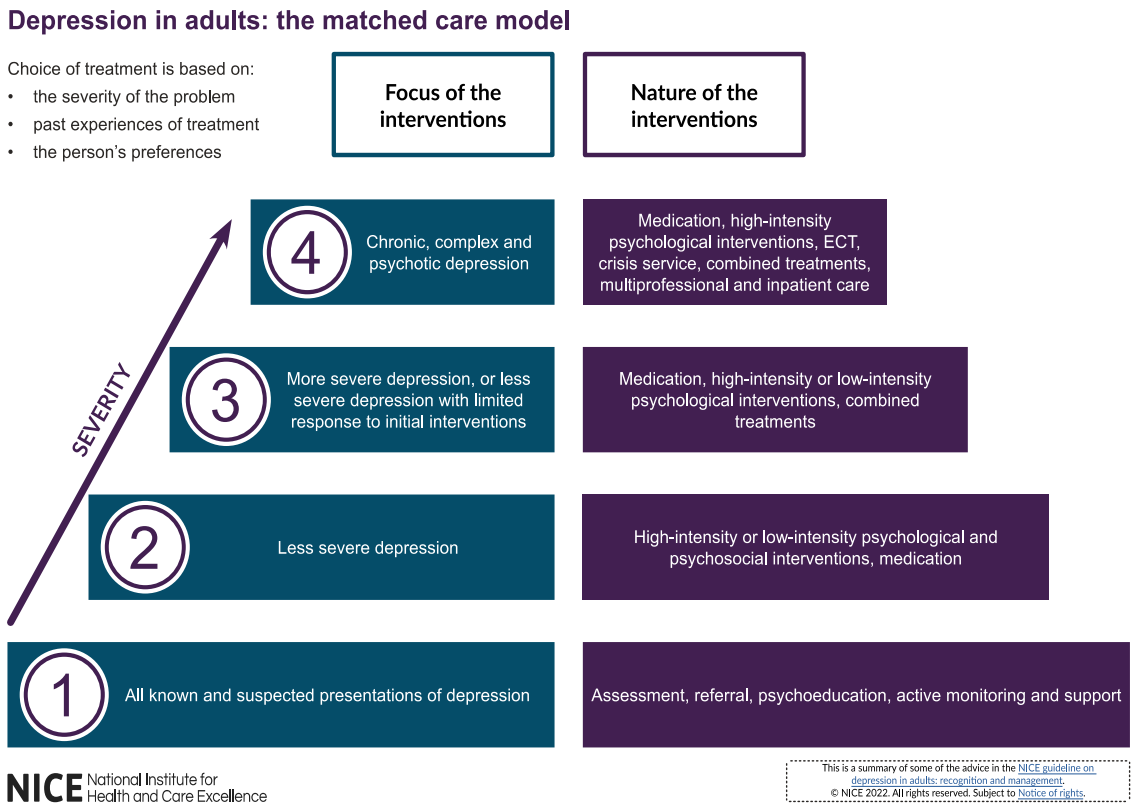
Not only critics, but also its cheerleaders, have failed fully to appreciate the significance of Layard's intervention. Fully occupied, understandably, in its initial phase, IAPT's leadership focused on overseeing compliance with our command-and-control style, top-down access targets (Clark, 2018). IAPT, said *Nature,* the British popular science journal: *'represents a world-beating standard thanks to the scale of its implementation and the validation of its treatments'* (Nature, 2012). The *New York Times* wrote that IAPT was: *'the world's most ambitious effort to treat depression, anxiety and other common mental illnesses'* (Carey, 2017). On the issue of access alone, the bold targets IAPT has set – to offer treatment to 1.9 million people by 2024; 75% of whom are to be seen within 6 weeks from referral (NHS England, 2019) – are unmatched by anything attempted in mental health during peacetime.

''The conscience of society will awake and remind it that the poorest man should have just as much ***right*** *to assistance for his mind as he now has to life-saving help offered by surgery",* predicted Freud (1918) amidst carnage in World War One. That moment arrived with IAPT.

The protocol for IAPT borrowed from insurance-based USA 'managed care' models (Reed & Eisman, 2006). But with an important difference. The principle: *iff* the 'least burdensome, most effective' treatments are offered first (stepped care), this *reduces* moral hazard relies on decisions being made by trusted gatekeepers. Bower and Gilbody's (2005) review of the evidence for stepped care was cautious: "Although psychological services might benefit from the adoption of the stepped care model, a substantial research agenda needs to be fulfilled before a judgement can be made as to whether stepped care might be an efficient method of delivering psychological services." IAPT sought to test these relative benefits of efficiency, effectiveness and/or acceptability in its two 'demonstration' pilots (Clark et al., 2009). But real world confounding factors got in the way of reaching a definitive answer. As the independent evaluation put it: "fast, cheap, good: choose any two" (Parry et al., 2011).

Nevertheless, NICE recommended stepped care (NICE, 2009), and IAPT implemented this into its design. This has now evolved into a matched care model [Fig. 1 below] (NICE, 2022). Arguably, the in-built tendency for matched care is more towards good, than fast or cheap.

Figure 1: Matched Care for Depression (NICE, 2022)



What was the psychoanalytic contribution to improving *access* to psychological therapies?

At the outset of the NHS, Michael Balint, recently moved from a child guidance clinic in Manchester to the Tavistock Clinic in London, observed: *The original idea clearly delineated by Freud: psychotherapy for the masses, became completely lost … It is a justified charge against us analysts that we are so little concerned about it, and only a fair consequence that the therapy of the masses is passing more and more into other hands and will eventually be solved -- rightly or wrongly -- without us.* (Balint, 1948). Predictably, when the lion's share of investment in IAPT went towards training a new CBT workforce, psychoanalysts responded with condescension: "[they] run the risk of appearing to turn treatments into marketable products, to be offered to all patients … into recipes or boxes to be ticked" (Brearley, 2010).

As the only psychoanalytically oriented person amongst IAPT's national experts at that time, my role, I was told, was as a 'scout': "Get close enough to know what's going on, but not so close you get shot – or converted!", (Lousada, 2008, personal communication). But if there had been any *strategic* psychoanalytic leadership in IAPT what would this have looked like?

Depression can be mild and self-limiting at one end, but a marker for high suicide risk at the other (Goldberg, 2011). The task of identifying *which* depression is presenting, traditionally, has been given to GPs. Within a Balint group, the expert Doctor listens to the emotional undercurrent with his Patient, which helps characterise the Illness (Balint, 1957; Schoenberg & Yakeley, 2014). This is not how evidence based medicine (EBM) works. EBM is the other way round. The Illness and Patient are assumed as standard. Expertise consists in balancing

fidelity and flexibility to deliver interventions at scale (Fonagy & Luyten, 2019). We saw how badly this went wrong for Sullivan et al. (Wessely, 2006). Knowing which depression it might be is complex, far less than an exact science (Mitchell, et al., 2016). Over-treatment; long-term dependency on medication; inequity for disadvantaged groups, all can result, if the sole gate-keepers are time pressed GPs (Brown et al., 2010; Mojtabai & Olfson, 2014; Kendrick et al., 2015; Olfson et al., 2016). IAPT did something different. It gave responsibility to a *non-medical, non-professionally affiliated* role: 'low-intensity' Psychological Wellbeing Practitioners [PWPs] (Turpin et al., 2009). What about *their feelings?* (Clarke & Hyatt, 2009).

If the tradition of applied psychoanalysis has generated useful knowledge for delivering care *at scale,* its core idea is to do with tracking the emotional availability of frontline staff (Menzies-Lyth, 1960). The burden of meeting access targets, at the same time as performing highly complex tasks of personalised assessment, falls heaviest in IAPT services on PWP staff (NCCMH, 2021). At the front door a person seeking help is met, usually online or over the telephone, by a PWP with a sheaf of psychometric forms. These enable PWPs to: *accurately identify the presenting problem(s), make an informed clinical decision about the person's suitability for the service, determine the appropriate NICE-recommended treatment and step in collaboration with the person, and identify the correct outcome measure to assess change in the problem(s).* (NCCMH, 2021). The IAPT manual (op cit.) instructs: *Clinicians should ensure that assessments are completed in full.* This involves 7 elements: 1. Screening / Triage 2. Risk assessment 3. Diagnosis 4. Clustering into a payment package 5. Selection from a menu of psychometric instruments for use to track recovery 6. Problem formulation 7. Treatment planning to include collaborative agreement on personalised outcome goals. From early on, high staff turnover rates in PWP roles told us we had got something wrong. Making an emotional contact with the person seeking help is not mentioned in the above.

Building on the idea of institutional defences, and further work consulting to organisations, a tradition of applied psychoanalysis in the UK has elaborated a sustained critique of the way empathy in mental healthcare has increasingly become sacrificed to other imperatives (Cooper & Lousada, 2005; Hoggett, 2010; Krantz, 2010; Armstrong & Rustin, 2015). But even where based on empirical research, these analyses rarely do more than problematise or pathologize increased access (Pickersgill, 2019, 2019a; Rizq, 2014). Policy makers faced with an urgent need to scale up delivery understand this complexity, but still need solutions. In truth, serious plans came only from cognitive-behavioural experts (Richards et al., 2012). As one of the pioneers of applied psychoanalysis in organisations noted, our discipline has yet to apply itself critically to the problem of supporting organisational *change* (Jacques, 1995). In IAPT, if our psychoanalytic expertise contributed added value, it was by recognising the genuine challenge of implementing universal access: by *trying-to-fail-better* (Beckett, 1983).

As PWP casualties began to increase, it became clear we had created an impossible situation (Zacka, 2017). IAPT's relentless access targets were causing high PWP attrition rates; which were causing workforce expansion targets to be missed; then a vicious spiral of increasing caseloads for PWP team members that remained in the services (Walklet & Percy, 2014; Steel et al., 2015; NHS England and Health Education England, 2016; Delgadillo et al., 2018). Someone needed to blow the whistle and, as National Professional Adviser (2008-2013) that responsibility fell to me. We consulted on a Charter to re-set the balance between targets and workforce capacity, and provided managers with a psychometric tool to monitor team

morale and support staff wellbeing at the frontline (Hacker Hughes et al., 2016). With the British Psychological Society we conducted a staff survey to highlight what matters beyond national productivity targets ie: for sustainability (Summers et al., 2020; Harper et al., 2020).

Across a series of annual surveys our findings showed a consistent picture of the negative impact of productivity targets on staff wellbeing: 48% felt depressed, almost 50% felt like a failure, and 92% found their job stressful at least some of the time. In the most recent survey prior to the pandemic (n= 1,678 practitioners), these findings were again replicated (Summers et al., 2020). We had presented these results to the Minister at our conference:

> *'I can't be standing on platforms day in, day out, talking about a world-leading service if I'm standing on something that's rusting away beneath me . . . It can't be done unless [staff] feel valued and unless [staff] feel [that their] wellbeing is taken seriously'.* (Rt. Hon. Alistair Burt MP, Minister for Mental Health, 2016).

This was guaranteed to get me shot. But it also led to substantial changes in IAPT's manual:

> *Staff wellbeing is paramount ... A highly challenging professional context should be matched with high levels of support. Productivity aspirations should be based on workloads that are consistent with professional and ethical guidelines for sustainable quality of care.* (NCCMH, 2021).

We had failed to solve the problem of universal access in IAPT. But by opening a space for PWPs to function as 'street-level bureaucrats' (Zacka, 2017), we succeeded in failing better. And we now had a clue to the impasse facing David Freud. How could we put it to the test?

Dream team: the invention of DIT, and the revival of applied psychoanalysis in the UK

"Walk my path, wear my shoes
Talk like that, I'll be an angel" (D:Ream, Things Can Only Get Better, 1993)

Sometimes the stars are aligned for a genuine eureka moment. We knew that what was needed was a brief dynamic intervention, suitable for use in universal free-to-access NHS services, and distinctive enough to add value to the work being done by hard-pressed CBT, PWP and Counsellor team members. Dynamic Interpersonal Therapy [DIT] (Lemma, Target & Fonagy, 2011) was the result. This was the genius invention of three psychoanalytic colleagues, whose combined talents came together at the right time, and in the right place, to produce the right outcome: Alessandra Lemma, Mary Hepworth (nee Target), and Peter Fonagy (Fonagy et al., 2020). We are seeing a revival from the ground up – a new generation of practitioners in publicly funded services, using applied psychoanalysis to treat depression, and making a lasting difference to ordinary peoples' lives (Clarke, Cundy & Yakeley, 2020).

During IAPT's first phase (2008-2013), I was the National Professional Adviser, which enabled me to oversee specification and commissioning of new therapy modalities that had been recommended by NICE for depression (NICE, 2009). In relation to NICE (2009, 2022), I was an expert adviser for its clinical guideline for Depression in adults. Additionally, as Chair of the New Savoy Partnership, I brought mental health charities and professional disciplines together to endorse a Joint New Savoy Declaration (Fig. 2 below); then, to get politicians to

deliver on its promises. In return for reform of mental health services to deliver evidence based interventions, approved as cost-effective by NICE, the Declaration crucially specified that patients should be guaranteed a choice. IAPT would not be able to offer them CBT only.

Alongside Malcolm Allen (2010) and Matthew Patrick (2010), who both held key leadership positions in UK psychoanalytic institutions, what follows is my own perspective; sometimes brought onto the pitch of a pragmatic randomised controlled trial to try to score; generally, as a roving midfield clinician. Day-to-day, I support – defend – NHS therapy teams delivering Dynamic Interpersonal Therapy to patients within constrained resources *as street-level bureaucrats*: psychiatrists, psychologists, psychotherapists and counsellors. Occasionally, I step up to wear the captain's armband, to speak to our managers about the team's morale.

Figure 2: The New Savoy Declaration

In 2009, a century after Freud's lecture visit to the USA, psychoanalysis had gained its first recognition as an evidence based treatment in the UK's NICE guideline for depression (NICE, 2009). Michael Scriven, one of the world's leading evaluation methodologists, had stated our problem succinctly at the half-century mark, at an important Symposium in New York:

> *As a set of hypotheses it was a great achievement fifty years ago; as no more than a set of hypotheses it is a great disgrace today.* (Scriven, 1959, p. 226)

Fifty years on, the opportunity arose, albeit the threat was real: we provided evidence for efficacy of applied psychoanalysis as a treatment for depression, and gained a place at the table within the NICE/IAPT axis; or we retreated further into private practice (Allen, 2010).

The blend of active ingredients in the alloy for DIT had been established by the empirical research efforts of several generations of psychodynamic practitioner scientists. Two broad paths had been charted. One, led by Malan's work at the Tavistock, as a member of Michael Balint's early group (Malan, 1975). This tradition is being carried forward ably today, under the rubric of Intensive Short-Term Dynamic Psychotherapy (ISTDP) by Alan Abbass and Joel Town and others (Abbass et al., 2006; Town et al., 2020). Conceptually, ISTDP applies a *Drive / Structural* psychopathology model (Messer & Warren, 1998; Abrahams & Rohleder, 2021). This alloy added a thread of silver for conducting more active techniques that ISTDP relies upon, where the therapist generates some *heat and electricity* into the treatment at speed.

The second broad tradition can be seen as a family of more *Relational* brief psychoanalytic models. As well as building on the work of Bowlby, and the British Object Relations schools, including Klein's important differentiation of a *Depressive position* (Lubbe, 2011), and Blatt's (1974) empirical demonstrations of distinctive patterns of treatment-resistance, this branch of work has produced some key treatment manuals (Luborsky, 1984; Strupp & Binder, 1984; Barkham et al., 2017). It has helped us refine subtle competences (Stiles et al., 1998; Blatt & Luyten, 2009). It adds elements of bronze or brass, as well as gold, silver and copper. Using mentalisation, it increases *capacity for resilience* as its therapeutic goal (Luyten et al., 2020).

Dynamic Interpersonal Therapy borrowed from all these in its protocol (Lemma et al., 2010).

Significantly, for the first time, NICE's evidence based guideline has recognised both *choice* of treatment, and a need to establish a person's *preference* for this (Williams et al., 2016); plus specific *mechanisms of change* within different treatment modalities, which mean they are better or less well indicated for different presenting issues (NICE, 2022). This reflects an evolution in evidence based practice from its initial articulation to a broader definition today (Howick, 2011). Originally, proponents of evidence based medicine (EBM) asserted that:

> *Evidence based medicine de-emphasises intuition, unsystematic clinical experience, and pathophysiological rationale as sufficient grounds for clinical decision making and stresses the examination of evidence from clinical research* (EBM Working Group, 1992).

Over the past couple of decades, however, there has been a slow, unmistakable paradigm shift in evidence based mental health practice (Clarke, 2020, 2020a, 2021). Current EBM definitions have had to acknowledge complexity in the science that underpins evaluation e.g. when matching best available treatment to an individual patient, or making forecasts for prognosis (Cartwright 2022; Deaton 2020). The revised EBM definition now concedes:

> *Evidence based medicine requires integration of the best research evidence with our clinical expertise and patient's unique values and circumstances* (Strauss et al., 2018).

In this vein, NICE's (2022) guideline for Depression sets out different features of treatments. [From NICE (2022)]

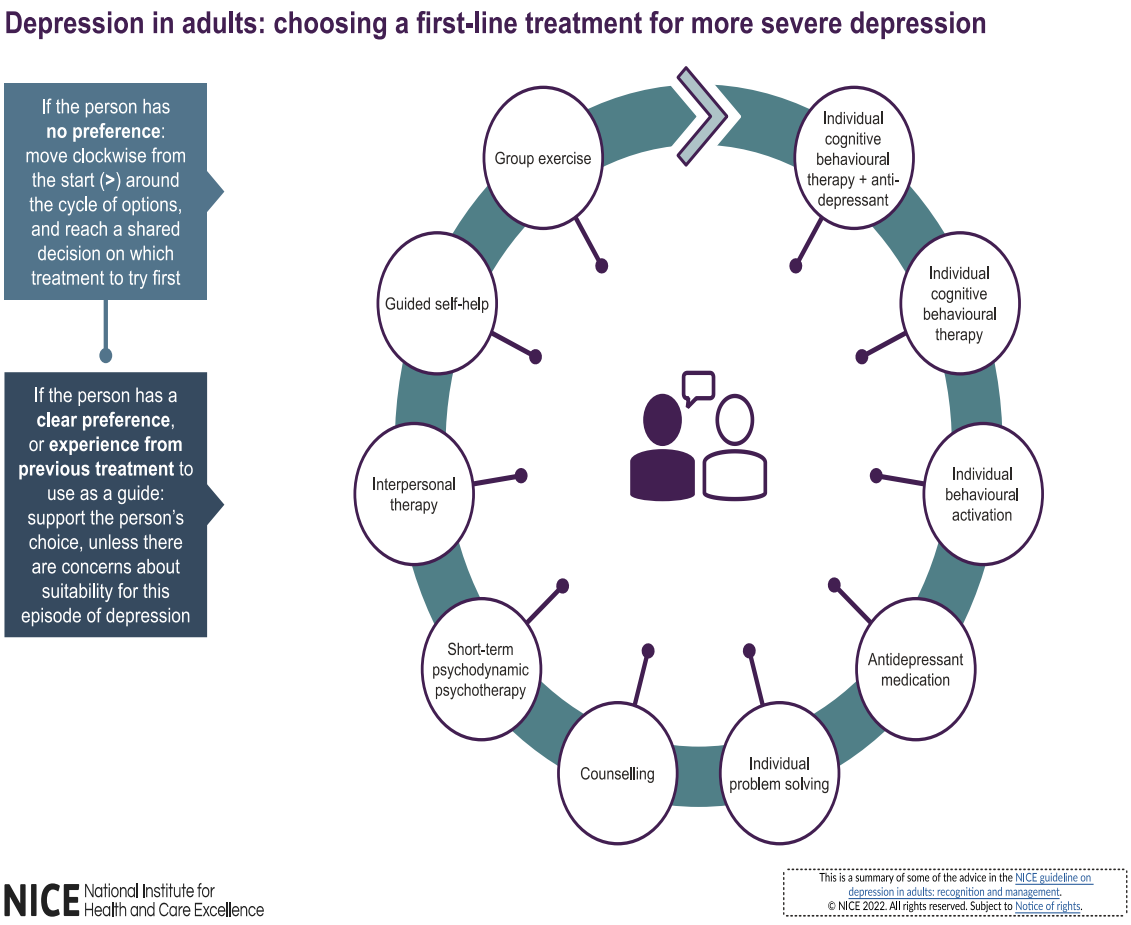
Short-term psychodynamic psychotherapy (STPP)

- *Individual sessions delivered by a practitioner with therapy-specific training and competence.*

- *Usually consists of 8 to 16 regular sessions, although additional sessions may be needed for people with comorbid mental or physical health problems or complex social needs, or to address residual symptoms.*
- *Uses an empirically validated protocol developed specifically for depression.*
- *Focus is on recognising difficult feelings in significant relationships and stressful situations, and identifying how patterns can be repeated.*
- *Both insight-oriented and affect focused.*
- *Relationship between therapist and person with depression is included as a focus to help support working through key current conflicts.*
- *May be useful for people with emotional and developmental difficulties in relationships contributing to their depression.*
- *May be less suitable for people who do not want to focus on their own feelings, or who do not wish or feel ready to discuss any close and/or family relationships.*
- *May suit people who do not like talking about their depression in a group.*
- *Focusing on painful experiences in close and/or family relationships could initially be distressing.*
- *Avoids potential side effects of medication.* (NICE, 2022).

Thus, NICE promotes a more iterative process of therapist-guided treatment selection. At present, this is the only way to achieve the personalised integration that EBM now requires.

Figure 3: Choice of Interventions for Depression



Across all levels of severity of depression, short-term psychodynamic psychotherapy can now be offered within the NHS as a first-line treatment option, recommended by NICE, if this is the treatment that is indicated and preferred by the patient. Likewise, for patients

with depression co-morbid with personality disorder, with chronic or psychotic depression, or for relapse prevention, extending the protocol length for psychodynamic therapy is endorsed in guidance (NICE, 2022). It is a breakthrough. We are back on the starting grid.

The "psychopharmacological revolution … that began in the early 1950s", according to a recent historical account "undermined the supports of psychoanalysis and eventually led to its startlingly rapid collapse" (Scull, 2022, p. xvi). What also became clear, since its increasing hegemony from the 1990s on, was that evidence based practice could be the final nail in our coffin, unless …. unless what? If society's conscience had now awoken – via NICE / IAPT – we needed to act. We could not continue sleepwalking as if nothing had changed. What we started with Dynamic Interpersonal Therapy, engaging with NICE / IAPT, others are pursuing elsewhere (Yakeley, 2020, 2021). Is this the sign at long last that things can only get better?

Revisiting the origins of the Welfare State and the costs of Depression

> *"The object of government in peace and in war is not the glory of rulers or of races, but the happiness of the common man."* Beveridge Report (1942)

In the autumn of 1933, J.B. Priestley travelled through the industrial North of Britain. He recorded his observations in *English Journey* (1933). Priestley grew up in Bradford. He knew its proud heritage from when he worked in the Yorkshire wool-trade. He was also a survivor from the 1st World War. He contrasts his own idea of social justice, informed by these experiences, with that of the great Irish playwright and social critic, George Bernard Shaw:

> *"Bernard Shaw once declared that all he wanted to do was to abolish the working class and put in its place some sensible people … I would as soon see England filled with [them] – and, mark you, it is not … otherwise it would be a different England – as I would see it populated by average members of the Fabian Society … such men (working class), like Mr Shaw himself, stand on their own feet, do their jobs with a will, stoutly resist stupid opposition but give way to affection, and, like him, are grand lumps of character … What more can you want?"* (Priestley, 1934/97, p. 167).

The impact of *English Journey* was anything but sentimental and nostalgic, however. It was a call to the conscience of society. Priestley's influence is credited with shaping the post-war Welfare State. His war-time radio broadcasts in the 1940s, *Postscripts,* galvanised people in the fight against Hitler's evil. More than this, he spoke for the nation and a vision of what we were fighting *for*: in Beveridge's historic formulation, the happiness of the common man.

Priestley's *Postscripts* helped win support for Attlee's Labour government at the end of the war. Huge popular support for social justice reforms, and for investment in a wide-ranging programme of re-building Britain, swept Labour to its landslide majority victory in 1945. Priestley's call to action opened up a space for Beveridge and Keynes to dream up a *New Jerusalem* of the Welfare State, a National Health Service, and free universal Education, all underpinned by full employment. Here is Priestley, in the 1930s, observing the effects of the collapse of the cotton trade on the people of Manchester, and its surrounding townships:

> *With her trade leaving her, her businesses going bankrupt, her mills silent and vacant, her workpeople by the thousand losing their employment, Lancashire needed*

> *a plan. Lancashire must have a plan. What is the use of England – and England in this connection, of course, means the City, Fleet Street, and the West End Clubs – congratulating herself upon having pulled through yet once again, when there is no plan for Lancashire? Since when did Lancashire cease to be a part of England? …*
>
> *No man can walk about these towns, the Cinderellas in the baronial household of Victorian England, towns meant to work in and not to live in and now even robbed of their work, without feeling that there is a terrible lack of direction and leadership in our affairs. It does not matter now whether Manchester does the thinking today and the rest of England thinks it tomorrow … but somebody somewhere will have to do some hard thinking soon … And on this most unsatisfactory conclusion, asking myself, over and over again, what must be done with these good workless folk, I took leave … and made for the bleak and streaming Pennines … with the weather, like my journey, going from bad to worse.* (Priestley, 1934/97, pp. 235-6).

Here is Beveridge, a decade on, articulating the plan for the country, including Lancashire:

> *Freedom from want cannot be forced on a democracy or given to a democracy. It must be won by them. Winning it needs courage and faith and a sense of national unity: courage to face facts and difficulties and overcome them; faith in our culture and in the ideals of fair-play and freedom for which century after century our forefathers were prepared to die; a sense of national unity overriding the interests of any class or section … in this supreme crisis the British people will not be found wanting.* (Beveridge, 1942, quoted in Timmins, 2001, p. 42).

Beveridge's great social evils – Giant Want, Giant Disease, Giant Ignorance, Giant Squalor and the insidious Giant Idleness – were lifted from the pages of Priestley's *English Journey.* Here, in starkest terms, was how Depression had robbed ordinary people of their lives. And, if we were to abolish its evil effects, crucially, it was everyone's business to understand how.

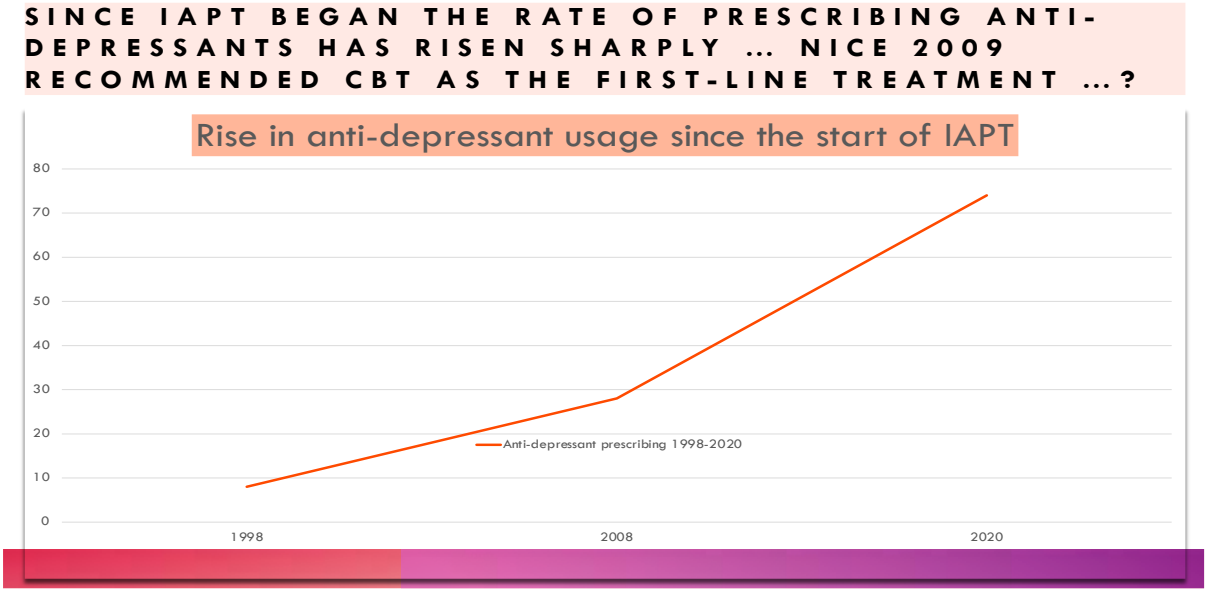
IAPT after the Financial Crash in 2008

When the Coalition Government came to power in 2010 it was offered two simple plans for reducing the burden of depression. Lord Layard wanted to put all his eggs into CBT – if NICE had said it was a cost-effective treatment to cure depression, why not a national CBT service (Layard & Clark, 2014)? The obvious flaw, as even some CBT researchers pointed out, was that taking away someone's symptoms during brief treatment, does not prevent recurrence, if their underlying reason for being stays the same (Delgadillo et al., 2016). This important caveat applies to antidepressant treatment all the more, as depression memoirs can testify (Clarke, 2020). And, more fundamentally, it presents us with a paradox: what some are now calling "the treatment-prevalence paradox" (Ormel et al., 2022). Namely, however much we spend on 'evidence based' treatments, depression prevalence stays the same, or increases.

In the USA, there has been a striking trend towards increased treatment using anti-depressant medication, and a corresponding decline in psychotherapy treatment in recent decades. In 1987, around one third of Americans who were diagnosed, were then prescribed medication; compared to over two thirds who were offered psychotherapy. By 2007, however, over four fifths were being prescribed medication; twice the numbers who

were then being offered psychotherapy (Marcus & Olfson, 2010; Marcus & Olfson, 2010a; Olfson & Marcus, 2010; Mojtabai & Olfosn, 2014; Mojtabai et al., 2016). That picture was part of the argument used for IAPT. But if some were hoping to buck that trend, the rise in unplanned medication rates in the UK, post-2007, easily outstripped the rise of CBT (Fig. 4).

Figure 4: Rise in antidepressant prescribing since advent of IAPT



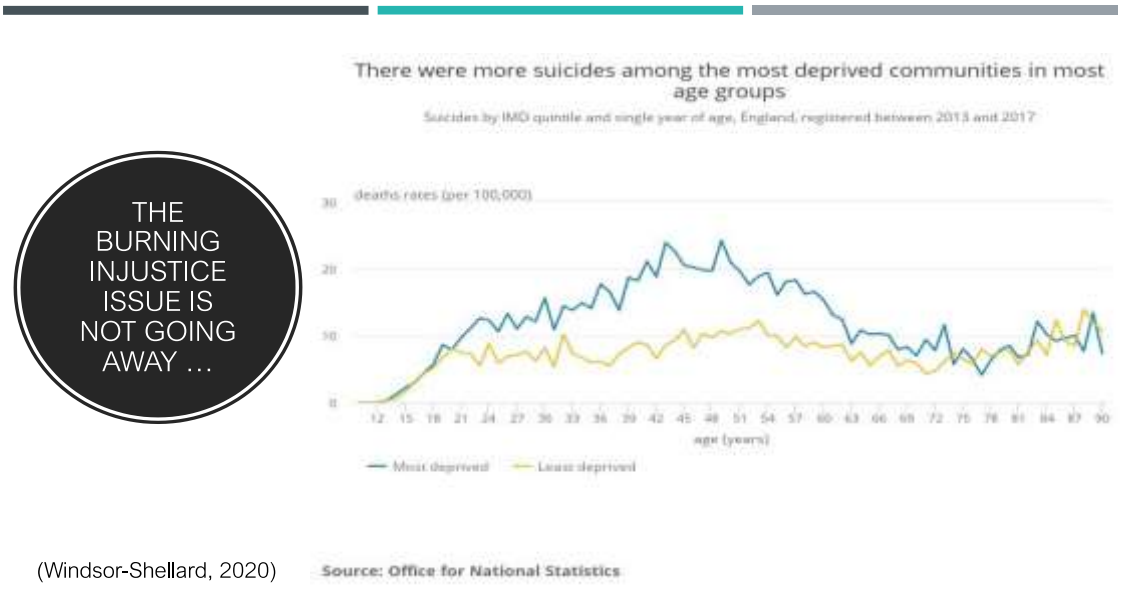
Lord Freud's plan was even simpler: pay by results. If NICE is right, he said to Layard and Clark, once IAPT is up and running, you shouldn't need any money from government. If a proportion of the NHS depression caseload includes people claiming unemployment and / or invalidity benefits (JSA & ESA benefits – job seeker and employment support allowance, respectively), and providing government gets its incentives right, argued Freud, it should be able to set payments for successful return-to-work outcomes at a rate lower than the cost of treatment or support. Freud wanted to create a market, and a reward system so the most efficient providers would work alongside IAPT and, together, become its financial winners:

> "We'll get the money from the private sector. They'll invest their money to get people into work and the state can reimburse them from the actual savings when it doesn't have to pay out the benefits". (Freud, 2021, p. 10).

If demand for access to CBT still exceeds IAPT's supply, he reasoned, the private sector will procure its own supply of therapists in order to achieve rapid results. The appeal of Freud's plan to policy makers was that it 'contracted out' the risks of moral hazard from the State.

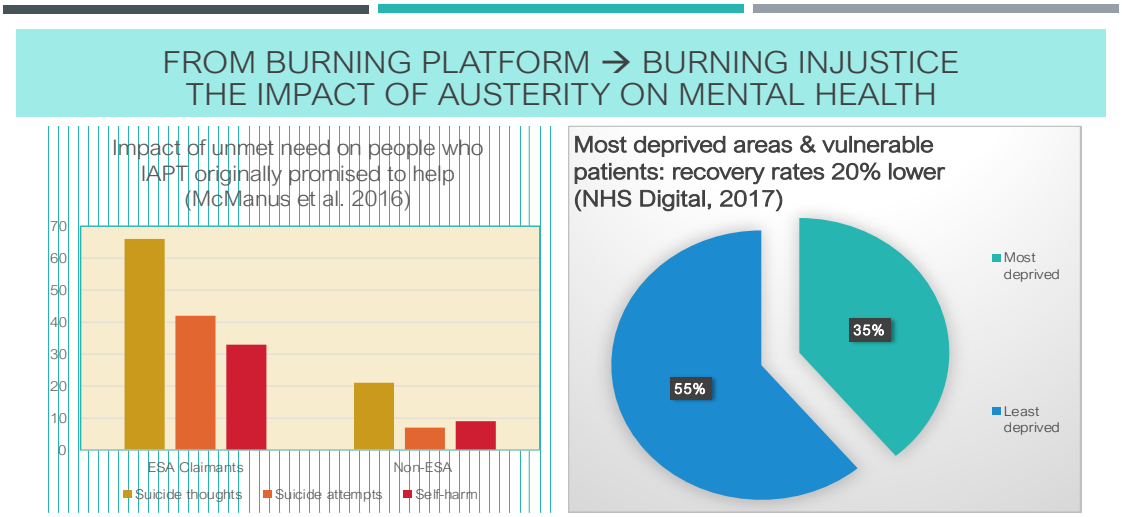
Neither plan worked. With hindsight it is clear why. The period of austerity since 2008, the *Great Recession,* is comparable to previous periods during the *Great Depression* of the 1930s, as well as the recession and unemployment crises in the early 1980s. Although the relationship is complex, we can see that *economic* depression causes widespread *misery,* leading to an increased prevalence of chronic depression, and higher suicide rates [Fig. 5] (Blakeley et al., 2003; Milner et al., 2013; Gunnell et al., 2015; Norstrom & Gronkvist, 2015).

Figure 5: From Burning Platform to Burning Injustice – our failure to reduce the burden during austerity



A valid criticism of Layard's CBT-first plan is that people were depressed for good reasons. Even more telling, against Freud's simple Work-first plan, was the fact that the conditions of insecure, precarious work were *causing* chronic depression (Harvey et al., 2017); and, if this didn't push them under, the mechanism relied on to encourage them back into work again was the more than visible whip-hand of welfare benefit sanctions (Dwyer et al., 2020; Wright et al., 2020; Williams, 2021). This insult-to-injury misery, courtesy of neo-liberalism, produced even higher spiralling costs of depressive invalidity (OECD, 2014; Scambler, 2021). The same burning platform that convinced Treasury officials of an urgent need to invest in evidence-based therapies was now being recognised as a 'burning injustice'. But Brexit (and then a pandemic) entrenched those inequalities that had underpinned rising illness [Fig. 6].

Figure 6. Invalidity benefit claimants (ESA) = increased suicidality. Depression + Deprivation > Recovery.



The 'invisible hand' of misery is what feeds Beveridge's twin Giants of Want and Idleness.

What Manchester thinks today … the USA can learn from?

During the *Great Recession* I had a privileged and somewhat unique position to see what was happening. Within IAPT my role was National Professional Adviser to the Department of Health, with a particular brief for overseeing the development of brief, manualised versions of counselling, couple therapy and dynamic interpersonal therapy for depression. In 2007, the NHS was organised into regions called Strategic Health Authorities, and I had also opted to sponsor the roll-out of the programme in the North West region, my own place of origin.

When it was clear fairly early on that we were not reaching those people with incapacitating depression, on whom our business case was focused, I accepted the invitation to work with Lord Freud at the Department for Work and Pensions, in 2010, to implement a more joined-up approach to welfare reform and mental health support. During the Coalition (2010-15), I was a member of a Ministerial Advisory Group working with Paul Burstow, then Norman Lamb and, eventually, Alistair Burt, as the successive Ministers with the mental health brief. What had I learned about IAPT and its three principal aims: to improve access; to reduce the burden of depression; and to achieve savings from helping people on benefits back to work?

We failed to achieve anything near to universal access. It is a fair criticism of IAPT in its existing form that it cannot engage sufficient numbers from those who need its help to be a sustainable solution to the problem of depression. In its latest annual report (NHS Digital, 2022), just under two thirds of patients neither engage in, nor complete their treatment. IAPT's "treatment prevalence paradox" (Ormel et al, 2022), then, shows a recovery rate of less than 15% of its total cohort. This is unimpressive for what should be its over-riding aim.

Yet, on these counts, IAPT still failed better than anything we have yet to try (Clarke, 2020b). In New York, for example, *ThriveNYC* invested $1 billion into mental health with very little to show (Editorial, Lancet Psychiatry, 2022). These failures may not matter if the biggest prize of all could be won: welfare savings. That may yet go to the Mayor of Greater Manchester. Andy Burnham, a former Health Secretary in Prime Minister Gordon Brown's administration, and an early sponsor for IAPT, argued that *local* leadership best understood the needs of those with depression on benefits across Greater Manchester's ten local authorities. I was invited to help design him a programme, *Working Well* (SQW, 2020), which stands to date as our most effective intervention to reduce the social and economic burden of depression:

> [Working Well] 'changed the weather in this area of public policy and brought in some much- needed new thinking' (Andy Burnham, GMCA, 2018, p. 3).

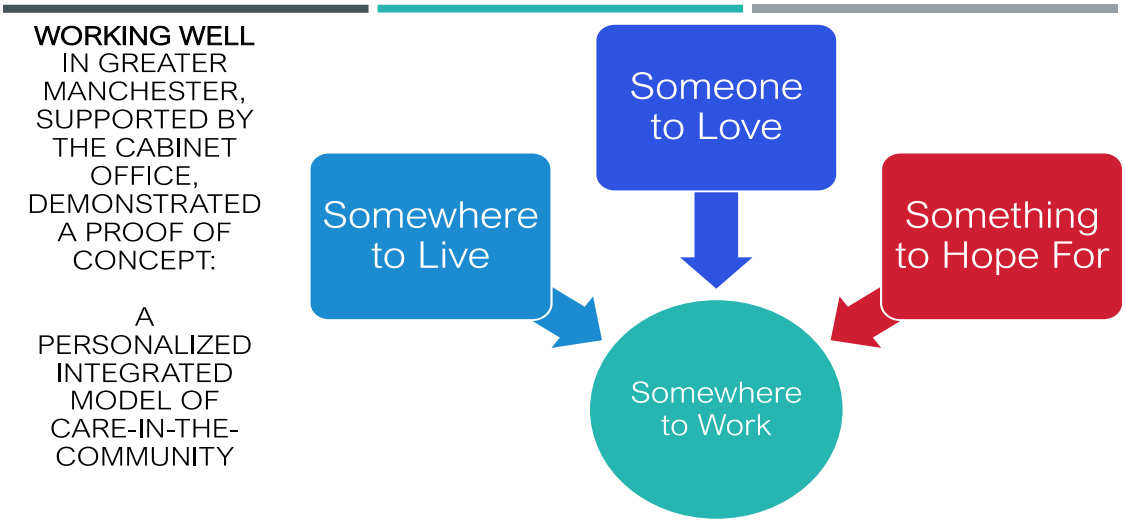
IAPT's plans to get people with chronic, disabling depression back to work had set a target success-rate of less than 5%, measured by numbers coming off benefits. *Working Well* gave itself a target of 20% off benefits, into employment, sustained over a year. An independent evaluation showed *Working Well* more than met its target (GMCA, 2018). How did it do it?

Layard and Freud's insights converged on behavioural change, nudging us, subtly, towards self-efficacy (Bandura, 1977, 1995), enabling us all, in theory, to thrive (Halpern, 2019):

> *"economic growth is a means to an end … prosperity alone can't deliver a better life … you've got to take practical steps to make sure government is properly focused on quality of life as well as economic growth"* (Prime Minister David Cameron, quoted in Halpern, 2019, p. 228; see Fig. 7 below).

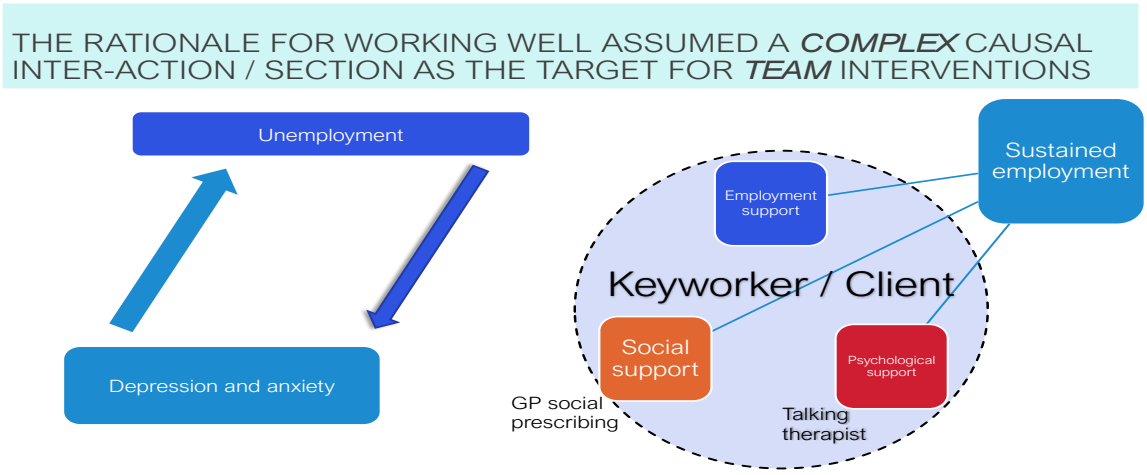
If your starting point is a better quality of life, you can engage far more people successfully.

Figure 7. Using real-world outcome targets to drive better engagement and uptake of interventions.



Secondly, the radical implications of the business case Layard and myself had made were never fully appreciated, even by IAPT's most ardent supporters (Clark, 2018). If anxiety and depression sit at the *intersection* of gaps in welfare provision, like an invisible helping hand for Beveridge's Giant Social Evils, how do you know what to target? It is difficult enough just to stratify depression into NICE's four steps (NICE, 2022). But severity of depression is not a good predictor for which level of intervention is the most likely to work (Bower et al, 2013). Once you add maintenance factors such as poor housing, financial debts, domestic abuse – and so on, the causal chain becomes more complex, and the sequence, and timing, more contingent. Evidence based practice is criticised for reducing individual patient needs to a 'cookie-cutter'-style formulation (Sidhu, 2019). IAPT's over-reliance on CBT made it vulnerable to being seen as a 'one-size-fits-all' intervention, which was only half-true (NHS Digital, 2022). Yet in *Working Well,* almost all the therapists were IAPT CBT practitioners.

Figure 8. The balance between fidelity and flexibility within a complex intervention.



The difference was the freedom we gave for them to work as a more flexible team (Fig. 8). This was important during setbacks, when team morale suffered as a consequence, partly, of injurious intra-group dynamics (Fletcher & Clarke, 2020; Williamson et al., 2018, 2021).

Conclusion: can psychoanalysts in the 21st C. step up to leading from the front?
Viewed in the long run, Lord Layard, Lord Freud, and IAPT can be seen as a continuation of Lloyd George's *Peoples' Budget* and Beveridge's *Welfare State*. At the societal intersection of poverty, illness, unemployment, homelessness, and lack of any qualifications or skills to provide prospects and some hope for improving someone's quality of life, sits the invisible hand of depression. IAPT is not the last word. But it has shifted the dial on common misery.

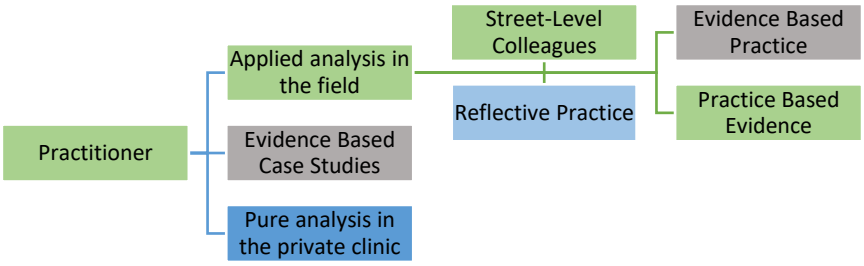
What are the lessons for us? There are two big shifts in our own culture that must follow.

The method of generating psychoanalytic knowledge and evidence that we have clung to as a discipline is one that economists would describe as a trickle-down model (Galbraith, 1982). It means we look backwards and upwards, instead of outwards and forwards. But a credible evidence base demands proof of cost-effectiveness (Fonagy, 2002; Kernberg, 2006).

Figure 9: the trickle down model for generating psychoanalytic knowledge

The drawback of our existing culture is not just what comes out the other end: 'if you feed the horse enough oats, some will pass through to the road for the sparrows' (Galbraith, 1982). We are simply not open enough to inter-disciplinary studies using empirical methods, including randomised controlled trials, to secure our place in clinical guidelines. Nor do we use case studies to help build scientific knowledge (McLeod & Elliot, 2011; Clarke, 2021a; Morgan, 2019); scientific models, or scientific theories (Morgan and Morrison, 1999); or even usable scientific data (Barkham et al., 2010), by putting these together (Cartwright et al., 2022). We badly need to update our ways to generate useful psychoanalytic knowledge.

Figure 10: realist evaluation = applied psychoanalysts (street-level bureaucrats) leading from the front



The damage from our 'splendid isolation' still reverberates amongst influential voices today:

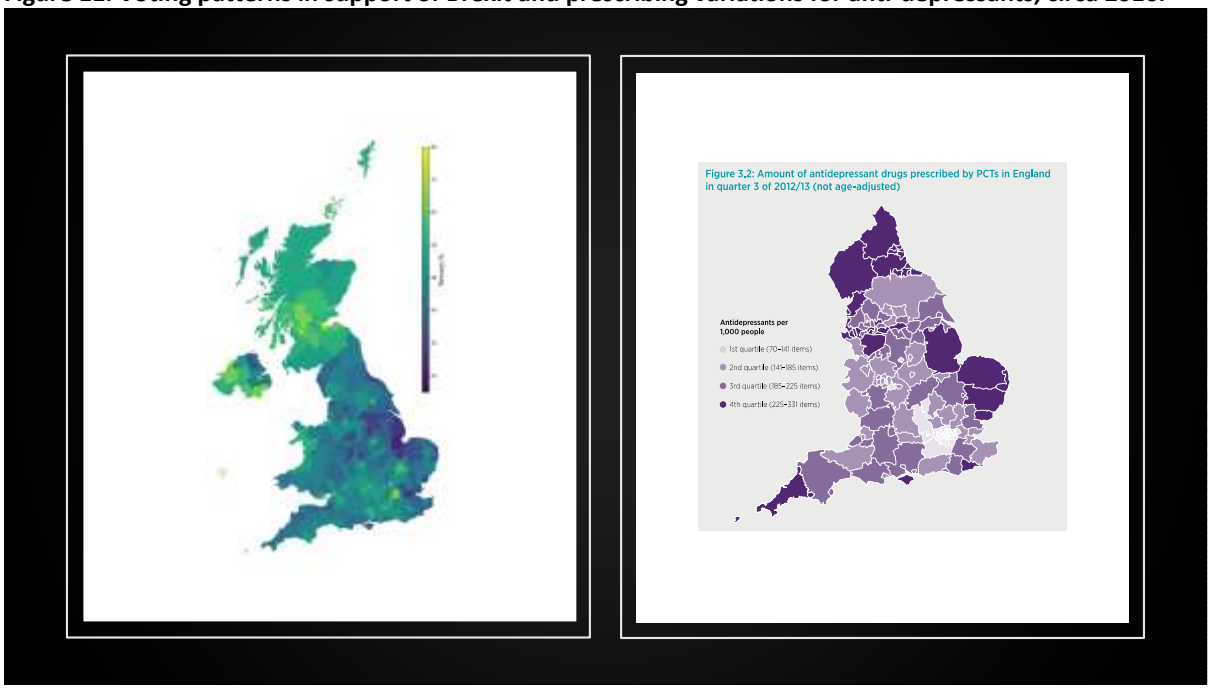
> *"Brian Haynes started worrying about the relationship between evidence and clinical practice during his second year of medical school when a psychiatrist gave a lecture on Freud's theories. When asked "What's the evidence that Freud's theories were correct?" the psychiatrist admitted that there wasn't any …* (Strauss et al., 2018, p.x).

What is “the conscience of society”? And – to return to the question that neither Jones nor Freud considered seriously, raised by an American lady - does it vary between nations? This paper has argued not only it does, but that it varies due to war; structural factors or, *within* different regions in relation, for example, to unemployment. So, when we see rising rates of depression during the pandemic (ONS, 2020), how does this affect *our* society’s conscience?

One of the most dispiriting things for practitioners in *Working Well* was when one of their clients had been making progress with improvement in their mental health, and confidence in returning to work, only for this to be unravelled if the client received a benefits sanction. Sometimes, due to lack of communication in the system, the client missed an appointment with staff at the job centre, because they were attending their session with their therapist. In the film by Ken Loach (2016), *I, Daniel Blake,* the tragic consequence of this cruel policy is shown, including a reinforced feeling of being to blame for being depressed (Byrne, 2021). If applied psychoanalysis is to remain relevant to contemporary mental health needs, and have something of value to offer, it follows that the focus for our clinical work and training experiences that we provide must shift outwards into our communities, onto the frontline.

The wider consequence otherwise, the true costs of failure, are deeply unforgiving (Fig. 11).

Figure 11. Voting patterns in support of Brexit and prescribing variations for anti-depressants, circa 2016.



J.B. Priestley’s best known work is his play *An Inspector Calls* (1947). It is set just before the 1st World War, when Lloyd George pushed through his Peoples’ Budget and, finally asserted pre-eminence of our House of Commons, over their Lordships, in Parliament. It is a searing critique of how the British class system treated the less fortunate prior to the Welfare State.

The moral of Priestley’s play, first performed in 1945, using the license open to a dramatist, asks us if we could see the consequence of our actions for others, would we change how we had behaved? The eponymous Inspector Goole calls on the Birling family home one evening, as they are celebrating their daughter’s engagement to be married. Goole is investigating a

young woman's suicide. Eva Smith was pregnant and, with nowhere else to turn, faced being destitute with a new baby. So, she chose in despair to take her own life by poisoning.

Each member of the family, including the daughter's fiancé, is shown how his or her actions have led on, step by step, whether knowingly or not, to Eva's eventual ruin and final suicide. Through the Inspector's intervention, Eva's suicide impacts not only on the Birling family and their immediate circle, it also ripples across the whole of the community. But for all his 'pitiless' devotion to his duty, Goole is still not able to prevent the young woman's suicide. In Goole's parting speech, Priestley underlines the stark significance of his ultimate failure:

> *"But just remember this. One Eva Smith has gone – but there are millions and millions and millions of Eva Smiths and John Smiths left with us, with their lives, their hopes and fears, their suffering and a chance of happiness, all intertwined with our lives and what we think and say and do. We don't live alone. We are members of one body. We are responsible for each other. And I tell you that the time will soon come when, if men will not learn that lesson, then they will be taught in fire and blood and anguish. Good night."* (Priestley, 1947).[1]

Today, there are millions and millions more Eva and John Smiths, who may end their lives in despair. We may fail. But we should fail trying to give them back their chance of happiness.

[1] The best recent film production of *An Inspector Calls* is an adaptation for BBC television in 2015, with Sophie Randall as Eva, and David Thewlis as Inspector Goole; Ken Stott and Miranda Richardson are the Birling parents; Chloe Pirrie and Finn Cole are their daughter and son; and the American actor Kyle Soller is the fiancé.

Stephen Daldry's 1992 acclaimed production of Priestley's play, and its revival again recently, have had successful runs in the West End in London, on Broadway in New York, as well as on tour to audiences widely.

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