The four basic components of psychoanalytic technique and derived psychoanalytic psychotherapies

Four aspects jointly determine the very essence of psychoanalytic technique: interpretation, transference analysis, technical neutrality, and countertransference analysis.

Interpretation is the verbal communication by the analyst of the hypothesis of an unconscious conflict that seems to have dominantly emerged now in the patient's communication in the therapeutic encounter. In general, interpretation of a defense or a defensive relationship initiates the interpretative process, followed by the interpretation of the context, or the impulsive relationship against which the defense was erected, and the analysis of the motivation for this defensive process.

Interpretative interventions may be classified into: a) clarification, by which the analyst attempts to clarify what is consciously going on in the patient's mind; b) confrontation, that is, tactful bringing into awareness nonverbal aspects of the patient's behavior; and c) interpretation proper, the analyst's proposed hypothesis of the unconscious meaning that relates all these aspects of the patient's communication to each other.

This condensing hypothesis is interpretation "in the here and now", to be followed or completed with interpretation "in the there and then", that is, the genetic aspects of interpretation that refer to the patient's past, and link the unconscious aspects of the present with the unconscious aspects of the past.

Transference may be defined as the unconscious repetition in the here and now of pathogenic conflicts from the past, and the analysis of transference is the main source of specific change brought about by psychoanalytic treatment.

The classical concept of transference analysis has been expanded significantly by the concept of the analysis of the "total transference" proposed by the Kleinian approach[1]. This involves a systematic analysis of the transference implications of the patient's total verbal and nonverbal manifestations in the hours as well as the patient's direct and implicit communicative efforts to influence the analyst in a certain direction, and the consistent exploration of the transference implications of material from the patient's external life that, at any point, he/she brings into the session.

The inclusion of a systematic consideration of the patient's total functioning at the point of the activation of a predominant transference points to an important implicit consequence of transference interpretation, i.e., the analysis of character. Defensive characterological patterns tend to become dominant transference resistances and lend themselves to systematic analysis leading to characterological modification. This is a significant effect of psychoanalytic treatment, surprisingly underemphasized in the literature.

Technical neutrality tends to be misinterpreted as a recommendation for an analyst's distant, uninvolved attitude, "a mirror to the patient's presentations". In essence, it simply refers to the analyst's not taking sides in the patient's activated internal conflicts, remaining equidistant, as A. Freud[2] put it, from the patient's id, ego, and super ego, and from his/her external reality. Technical neutrality, in addition, implies the analyst's not attempting to influence the patient with his/her own value systems. S. Freud's early metaphor of the analyst as a "mirror" clearly was questioned by himself, and he protested against a view of analytic objectivity as "disgruntled indifference"[3].

Technical neutrality also implies the concept of "abstinence", in the sense that the analytic relationship should not be utilized for the gratification of libidinal or aggressive impulses of the patient or the analyst. In contrast, technical neutrality does not imply the concept of "anonymity", a questionable development in psychoanalytic thinking in the 1950s, importantly related, in my view, to authoritarian pressures within psychoanalytic education, and the related institutionally fostered idealization of the training analyst, who should not show any usual personal human characteristic to the patient. This idealization of the analyst has been sharply criticized in recent years, particularly by the relational school.

Technical neutrality implies a natural and sincere approach to the patient within general socially appropriate behavior, as part of which the analyst avoids all references or focus upon his/her own life interests or problems. The analyst cannot avoid that personal features emerge in the treatment situation, and do become the source of transference reactions. The patient's realistic reaction to realistic aspects of the analyst's behavior should not be considered a transference reaction: not everything is transference! Maintaining the definition of transference as an inappropriate reaction to the reality presented by the analyst, that reflects the activation of the patient's unconscious conflicts, should differentiate transference from other patient's realistic reactions to natural, as well as idiosyncratic, aspects of the treatment situation.

Countertransference is the analyst's total, moment-to-moment emotional reaction to the patient and to the particular material that the patient presents. The contemporary view of countertransference is that of a complex formation co-determined by the analyst's reaction to the patient's transference, to the reality of the patient's life, to the reality of the analyst's life, and to specific transference dispositions activated in the analyst as a reaction to the patient and his/her material.

Under ordinary circumstances, countertransference mostly is determined by the vicissitudes of the transference, and as such, the analyst's emotional reactions may fluctuate significantly within each session. In contrast to acute fluctuations of the countertransference, chronic distortions of the analyst's internal attitude toward the patient usually indicate significant difficulties in the analyst's understanding of the transference. They often point to a stalemate in the analytic situation that the analyst may need to resolve outside the actual times of analytic sessions

with the patient, through self-exploration or consultation. Serious characterological difficulties of the analyst may contribute to such chronic countertransference distortions, but most frequently they relate to more limited difficulties in his/her understanding and interpretations and are related to particular developments in the transference[4].

Full internal tolerance of countertransference reactions, including regressive fantasies about specific relations with the patient, may be followed by the analyst's internal exploration of the meanings of his/her reaction in terms of the present transference situation, and thus prepare the road for transference analysis.

This is an overall outline of the basic aspects that, I suggest, essentially define psychoanalytic technique, and that may be applied to the analysis of various developments in the analytic situation, such as the analysis of dreams, character, acting out, and repetition compulsion, all of which, in the end, will culminate in transference analysis.

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Functional remediation: the pathway from remission to recovery in bipolar disorder

Bipolar disorder is not just a mood disorder. Patients nowadays do not just want *to feel well*, they want *to do well* because they want *to be well*. This is equivalent to say that the critical endpoint is not anymore mere *improvement*, nor even *remission*, but *recovery*. The current therapeutic armamentarium, consisting of traditional drugs such as lithium, plus anticonvulsants, antipsychotics and, in some cases, antidepressants, has made remission an achievable goal for many patients with bipolar disorder. Illness-focused psychological interventions, such as psychoeducation, have helped many to stay well for longer periods of time, and in some cases, indefinitely. But many patients with bipolar disorder stay there, more or less *feeling well*, but not *doing well* at all. Many take their medicines, after having learnt that stopping them leads to relapse and misery and, in addition, more medication, but are unable to get their jobs back or to finish their studies. Many live on the ashes of what used to be their social life before everything was gone with the fire of the illness.

For a long time, the assumption was that recovery was difficult due to social factors, stigma and discrimination. And those are indeed powerful reasons for many to feel socially disabled. But we also learnt that the illness itself carries an increased vulnerability to stress and cognitive difficulties, which were historically neglected, and that those problems persist over time beyond clinical remission.

Functional remediation is an intervention that aims to fill the gap between remission and recovery. Obviously inspired by traditional neurocognitive remediation techniques, such as those that have worked well in brain damage and other neuropsychiatric conditions, its major feature is that it focuses on functioning rather than cognition[1].

The intervention has, therefore, a neurocognitive and psychosocial background including modeling techniques, role playing, self-instructions, verbal instructions, and positive reinforcement, together with metacognition, with objective functioning as the main target. It includes education on cognitive deficits and their impact on daily life, and provides strategies to manage deficiencies across several cognitive domains, such as attention, memory and executive functions. The family and caregivers can also be involved in the process to facilitate the practice of these strategies at home and for reinforcement[2].

Functional remediation is not a mere sensible proposal. It is manualized and evidence-based. The first randomized, controlled trial to test it has been published[3] and is now being replicated. The primary outcome was the improvement in global, clinician-rated measure of psychosocial functioning. A total of 268 outpatients were enrolled across 10 academic sites in Spain. After 21 weekly group sessions, functional remediation improved aspects related to work functioning and interpersonal abilities, increasing personal autonomy and reducing financial dependence.

The intervention works for patients with bipolar I and bipolar II disorder as well, and the positive effects last at least 6 months beyond the final session of the program[4]. In its current format, it is intended for late-stage bipolar disorder, but with some modifications it could be tailored to enhance cognitive reserve[5] and prevent further progression of cognitive and functional impairment in patients at early stages. Hence, there is great potential in designing an intervention combining psychoeducation and functional remediation with focus on early stages and prevention of further morbidity and mortality.

As Insel[6] has questioned, is it realistic to expect conditions as complex as psychotic, mood or anxiety disorders to respond to a singular intervention? Bipolar disorder, perhaps the most polymorphic and complex of all psychiatric conditions, clearly