Applied Psychoanalytic Thinking

THE TALKING THERAPIES UK PRACTITIONER SERIES



Applied Psychoanalytic Thinking

Using psychoanalytic ideas in contemporary practice

Advanced level · 14 hours of continuing professional development

TALKING THERAPIES UK

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First edition, 2026.

This manual accompanies the Applied Psychoanalytic Thinking course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

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A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

This advanced Continuing Professional Development course is designed for experienced clinicians seeking to deepen their professional practice through the rigorous application of psychoanalytic theory. It moves beyond foundational knowledge to explore how complex concepts such as transference, countertransference, and enactment manifest in real-world clinical encounters, offering a sophisticated toolkit for navigating the nuances of the therapeutic relationship. Learners will engage deeply with the clinical use of containment, examining how this fundamental concept stabilises the therapeutic process and supports the patient's capacity to manage affect. The curriculum specifically addresses the management of enactment, guiding practitioners in identifying and working through moments where internal conflicts are played out between analyst and patient, thereby transforming potential ruptures into opportunities for insight and repair.

Beyond the one-to-one dyad, this course extends psychoanalytic thinking to the broader organisational context, exploring its application within institutions, teams, and reflective practice groups. Participants will study how unconscious processes influence group dynamics and institutional culture, equipping them with the skills to foster a more attuned and psychologically informed working environment. A critical component of the syllabus involves a rigorous examination of the evidence base for psychoanalytic and psychodynamic therapies, encouraging a balanced and honest appraisal of their efficacy alongside other modalities. Furthermore, the course addresses the stringent ethical and boundary considerations inherent in the tradition, ensuring that practitioners maintain the highest standards of professional conduct while integrating these advanced concepts into their daily work.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 14 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each

chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Apply analytic concepts in once-weekly and time-limited settings honestly
- Use brief dynamic models, including Malan's and Davanloo-informed focus, with selection care
- Work analytically in organisations: consultation, groups and institutional dynamics
- Apply analytic understanding to supervision and reflective practice
- Relate analytic ideas to neighbouring evidence, from attachment research to mentalizing
- Judge which clients need intensity you cannot offer, and refer well

PART 1

Transference, Enactment, and the Analytic Frame

This module explores core psychoanalytic concepts including transference, countertransference, containment, and the technical management of enactments.

CHAPTER 1

Transference, countertransference and enactment

Transference, countertransference and enactment

The foundations pathway defined transference and countertransference; applied work begins where the definitions end, in the hour-by-hour discipline of clinical use. The applied stance treats the transference not as an occasional event to be detected but as the constant medium of the treatment: everything the patient says and does in the room is, among its other truths, a communication about the state of the relationship and the internal figures currently governing it. The clinician therefore maintains a continuous background question, who am I now, in this material, at this moment, tracking the answer through the session's weather: the shift from easy speech to caution, the story whose villain has the therapist's habits, the compliment that arrives just after a boundary held, the lateness that begins the week after a break is announced. Countertransference is tracked with the same constancy and the discipline already established, contain, examine, translate, with one applied refinement: the clinician learns their own signature, the specific feelings they are prone to import, so that the instrument's baseline error is known and what remains can be more confidently read as reception.

Enactment is the concept that makes this monitoring urgent. An enactment is a lived-out episode in which the patient's internal drama and the clinician's responsive participation mesh, so that for a period, minutes or months, the two are not discussing the pattern but performing it. The relational tradition's hard-won consensus is that enactment is not an occasional technical failure but a structural inevitability: projective identification recruits, the clinician is human, and the deepest material, precisely because it is unworded, can often reach the treatment in no other way. The patient organised around exploitation will, sooner or later, find the therapy subtly exploitative, or manoeuvre it into becoming so; the patient who was endlessly accommodated into falseness will secure a therapist who cannot bear to disappoint them; the abandoned patient will produce, in an ordinarily reliable

clinician, an uncharacteristic cancellation. It is characteristic of enactment that it is recognised late, from inside, usually through a disturbance in the clinician: a practice with this patient that quietly differs from practice with every other, sessions that overrun, notes left unwritten, a topic jointly and wordlessly avoided, a dread or eagerness before the hour.

Recognising an enactment therefore depends on cultivated self-suspicion, and the applied craft supplies its instruments. The deviation audit: any sustained departure from one's ordinary frame with one patient, however benign its rationale, is treated as a possible symptom of the treatment rather than a policy. The affect audit: feelings about a patient that are unusual in kind or intensity for this clinician are logged as data. The supervision test: the case one somehow never brings, or brings only in polished form, is the case in enactment, and the parallel process, the supervisee becoming evasive about an evasive patient, helpless about a helpless one, is often the supervisor's first sight of it. Repair then proceeds in a definite order. The clinician first does their private work, recovering their own mind, understanding what role they have been playing in whose script, before any disclosure, because processing the enactment with the patient prematurely re-enacts it with better vocabulary. Then the pattern is opened in the room, with the clinician owning their actual participation in plain terms, I have noticed that I have been ending our sessions late, and I have come to think I was joining something rather than helping with it, without either confessional flooding or the retreat into blaming the patient's pathology for the clinician's behaviour.

An extended example fixes the arc. A therapist notices, in month eight of a treatment, that she has begun preparing for this patient's sessions with unusual care, reading notes she would not reread for others, choosing her words in advance, and that the patient, a man whose barrister mother had cross-examined his childhood, has been praising her precision. The sessions are fluent and curiously dead. In supervision, describing the case with documented thoroughness, she hears herself and stops: the parallel process has surfaced the enactment, she has become the examined child performing for the exacting parent, or the exacting parent for whom the patient performs, the roles circulate, and the therapy has become a viva. Her private work identifies the hook in herself, an old academic anxiety happy to be recruited. In the room she says, in due course, that she has noticed how prepared they both are with each other, and wonders when it became unsafe

to think aloud here. The patient is silent, then says his mother never once asked him a question she did not know the answer to. The deadness lifts; the treatment's subject has walked into the light. Nothing in the sequence is exotic; it is the applied craft working as designed, deviation noticed, hook owned, participation named, pattern returned to the patient as usable knowledge. The craft, once acquired, also travels: the clinician who can catch herself being recruited in a consulting room will catch it in a ward round, a safeguarding meeting or a management dispute, which is why this lesson sits at the gateway to the institutional material that follows.

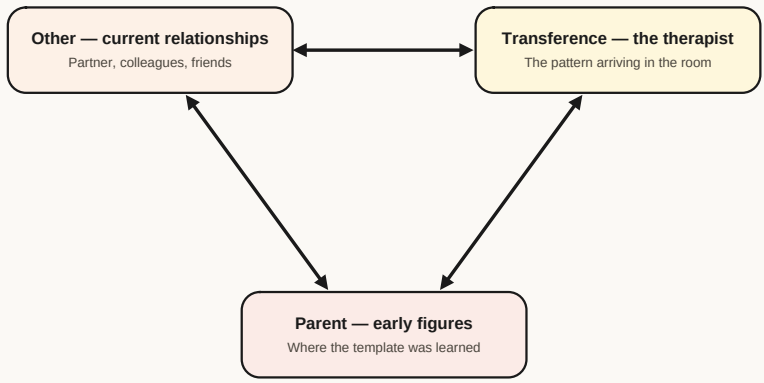
What makes the sequence therapeutic rather than merely reparative is the final movement, learning from the enactment. Handled through, an enactment yields knowledge obtainable no other way: the pattern has been run live, with both parties inside it, and its interior, the pressures, the payoffs, the exact feel of the roles, is now shared experience rather than hypothesis. The repair itself is frequently the treatment's turning point, since for many patients it is the first time a figure in the powerful position has noticed the drama, named their own part, and neither collapsed nor retaliated; the old script has been run and, for once, rewritten in front of them. Applied technique therefore neither courts enactment nor pretends immunity; it assumes participation, builds the instruments that shorten the distance between enactment and recognition, and trusts the repair to do work that interpretation alone cannot. The next lessons widen the same logic beyond the dyad, to the containing function itself and to the institutions in which most clinical work actually happens.

Going deeper: the early-warning system, and the repair done well.

Enactments are recognised late by definition; the applied skill is making 'late' as early as possible, and the detection instrument is deviation from one's own norms. Every practitioner has a professional baseline: how long their sessions run, how much they disclose, how they schedule, the temperature of their concern between sessions. Enactment announces itself as unexamined exceptions accumulating around one patient: the sessions that keep running over for her, the sudden flexibility about cancellations for him, the case you think about in the supermarket, the one you realise you have stopped charging properly, the referral you did not make because nobody else would understand her. None of these is damning alone; the signal is the pattern plus the exemption from curiosity, since the defining property of an

enactment is that it feels, from inside, like ordinary clinical judgement or ordinary irritation. Hence the two external instruments: supervision that hears the logistics as well as the material (the drift is usually visible in the diary before it is audible in the sessions), and the private audit question, asked of one's caseload monthly, 'with whom am I not quite myself, and in which direction?'

The repair sequence, once recognition lands, has a describable grammar. First, internal work: the clinician sorts what belongs to whom, their own contribution owned to themselves without either self-flagellation or exculpation. Second, restoration of the frame in action, quietly, before or alongside any words, because a repair announced while the deviation continues is theatre. Third, judicious naming with the patient, dosed to what the treatment can use: sometimes full collaborative examination ('I think we have both been treating you as too fragile for endings; I extended our sessions three times, and I want us to understand what we were doing'), sometimes a simpler resumption of reliability that is itself the interpretation. Fourth, harvesting: the enactment is mined for what it reveals, since the roles the dyad fell into are a live map of the patient's object world, obtained at some cost and wasted if unread. Done fully, the sequence delivers what this lesson's close promises: the old drama run, caught, and for once revised, which is the applied tradition's distinctive cure.



The most mutative links are usually those that include the transference.

FIGURE 1.1 Malan's triangle of person

The same relational pattern tends to appear in three places: with current others, with the therapist in the transference, and in its origins with early caregivers. Linking any two corners is an interpretation; the triangle keeps the therapist oriented to where the pattern is alive right now.

Points worth keeping

- Clinical transference and countertransference
- Enactment
- Recognising and repairing enactments
- Learning from them

PRACTICE TASK

Describe an enactment and how you would think about it.

CHAPTER 2

Containment across settings

Containment is a cornerstone of applied psychoanalytic thinking, first articulated with systematic rigour by Wilfred Bion in the mid-twentieth century. Bion described containment as the process by which a mind — whether that of an individual therapist, a supervisory pair, or a multidisciplinary team — receives raw, unmetabolised emotional experience, termed beta elements, and through the operation of the alpha function transforms them into thinkable alpha elements. The metaphor of the container and the contained captures this dynamic: the container offers a bounded psychic space capable of holding, tolerating, and processing the chaotic affect that the contained — patient, supervisee, or team member — cannot yet bear alone. In this formulation the container does not merely absorb; it actively works upon the projected material, rendering it available for symbolisation, verbalisation, and integration.

The mechanism of projective identification is the vehicle through which the contained deposits beta elements into the container. The patient, overwhelmed by terror, grief, or rage, unconsciously evacuates these fragments into the analyst, who must survive the onslaught without retaliating or collapsing. The analyst's capacity to remain receptive, to think under pressure, and to return a metabolised version of the experience constitutes the alpha function. When this function operates, the patient can gradually internalise a representation of a mind that can survive and think about unbearable affect, thereby expanding their own psychic container. If the analyst's alpha function falters, the beta elements remain untransformed, and the patient is left in a state of psychotic anxiety or regression, unable to develop a symbolic order.

In the consulting room the container-contained relationship is enacted in the moment-to-moment interplay of transference and counter-transference. The therapist's reverie, informed by Bion's notion of "negative capability", allows the analyst to tolerate uncertainty and to wait for the emergence of meaning. The analytic third, as described by Thomas Ogden, emerges from this intersubjective field, providing a shared symbolic space that neither participant could generate alone. The therapist's own containment needs

are, in turn, addressed through clinical supervision, where the supervisor functions as a secondary container for the therapist's projected anxieties, preserving the therapist's capacity to think.

The container-contained model extends naturally into team and organisational settings. A multidisciplinary team — comprising psychiatrists, psychologists, nurses, social workers, and occupational therapists — can be conceptualised as a collective container for the anxieties generated by complex clinical presentations and by the institution itself. The team's task is to metabolise the projective identifications that arise during case discussions, formulation meetings, and crisis reviews. Bion's basic assumption groups — dependency, fight/flight, and pairing — describe the regressive configurations that threaten the team's thinking function when containment fails. A well-functioning team maintains a "work group" mentality, characterised by reflective dialogue, mutual respect, and the capacity to hold contradictory perspectives without premature closure.

The consultant or team leader often occupies the pivotal role of the primary container within the group. By naming the affective climate, by tolerating silence, and by offering interpretations that link the team's emotional reactions to the patient's unconscious communications, the consultant enables the group to transform beta elements into shared alpha elements. This process is analogous to the analyst's reverie but occurs at a systemic level: the team's collective alpha function produces a coherent formulation, a safe care plan, and a narrative that can be communicated to the patient and to the wider organisation. The team's capacity to contain is further supported by institutional structures — clear governance, protected reflective spaces, and regular supervision — that act as an outer container for the team's own anxieties.

Organisational containment, a concept elaborated by Isabel Menzies Lyth and later by David Armstrong, recognises that institutions themselves generate powerful anxieties — about risk, litigation, resource scarcity, and moral injury — that can infiltrate clinical teams. When the organisation fails to provide a containing framework, teams may enact defensive structures such as excessive bureaucracy, scapegoating, or the splitting of "good" and "bad" patients. The result is a parallel process in which the institution's uncontained anxiety is projected into the team, and the team's uncontained anxiety is projected into the patient, perpetuating a cycle of regression.

When containment fails, the boundary between container and contained dissolves. The team may become the patient, experiencing the patient's dissociative episodes, self-harm urges, or paranoid fears as their own somatic and affective states. This phenomenon, described by Meltzer as "the aesthetic conflict", manifests as a loss of reflective capacity: the group either fragments into hostile factions — one demanding immediate discharge, the other insisting on indefinite admission — or descends into paralysis, unable to formulate any plan. The projective identification that once served a communicative function becomes a toxic contagion, and the basic assumption of fight/flight dominates, eroding the work group's integrity.

Clinical supervision is the designated arena for repairing a ruptured container. The supervisor, occupying a meta-container position, helps the supervisee or team to recognise the regressive enactment, to name the projected material, and to restore the alpha function. Through a process of "containment of the container", the supervisor models the capacity to think under pressure, offering a holding environment reminiscent of Winnicott's facilitating environment. The repair involves re-establishing boundaries, re-introducing reflective space, and re-authorising the team's authority to think rather than react.

A concrete illustration can be drawn from a multidisciplinary team meeting concerning Mr A, a thirty-four-year-old man who has recently disclosed a history of severe physical abuse and now presents with frequent dissociative episodes and self-injurious behaviour. The team gathers to devise a crisis plan; the room is thick with dread. The consultant psychiatrist notices that the nursing staff are unusually silent, the psychologist is arguing forcefully for an immediate transfer to a specialist unit, and the social worker is advocating for community-based safeguarding. The consultant names the affective field: "We are all feeling the terror that Mr A carries, and we are each trying to evacuate it in our own way." By articulating the shared projective identification, the consultant enables the team to recognise that the urgency to discharge and the urge to protect are complementary fragments of Mr A's unmetabolised beta elements. The team then moves into a reflective stance, integrating the psychologist's risk assessment, the nurse's knowledge of Mr A's daily triggers, and the social worker's understanding of his housing instability. Together they formulate a phased safety plan that includes a brief inpatient stabilisation, a tailored grounding

protocol, and a coordinated community follow-up. The container has held, the alpha function has operated, and the team emerges with a coherent, containable plan.

Had the consultant not intervened, the team would likely have split along the lines of fight/flight: one subgroup pushing for immediate discharge to relieve their own anxiety about risk, the other insisting on prolonged admission to soothe their guilt about possible abandonment. The meeting would have ended in deadlock, the care plan would remain unwritten, and Mr A would be left without a coherent holding structure. The failure would be evident in the team's subsequent interactions — increased irritability, avoidance of the case, and a rise in sickness absence — signalling that the container had collapsed and the team had become a vessel for the patient's uncontained trauma.

The implications for practice are profound. Clinicians must cultivate their own alpha function through regular personal therapy, reflective supervision, and engagement with peer consultation groups. Teams require protected time for reflective practice — such as Balint groups, case-based discussion forums, or structured debriefs — that function as institutional containers. Organisations must recognise that containment is not a luxury but a clinical necessity; policies that erode reflective space, impose unrealistic throughput targets, or punish emotional expression undermine the very capacity that keeps patients and staff safe. Training programmes in applied psychoanalytic thinking should therefore embed experiential learning about containment, using role-play, live supervision, and organisational case studies to make the abstract concepts tangible.

In summary, containment across settings operates as a recursive, multi-layered process: the individual therapist contains the patient; the supervisor contains the therapist; the team contains the clinical complexity; the organisation contains the team. Each layer depends on the integrity of the one beneath it. When any layer fails, the reverberations travel upward and downward, manifesting as regression, splitting, or paralysis. Mastery of containment — recognising beta elements, sustaining alpha function, and repairing ruptured containers — is therefore the central competence for any practitioner working within the psychodynamic tradition, and it remains the most reliable safeguard against the enactment of uncontained trauma in both consulting rooms and corridors of care.

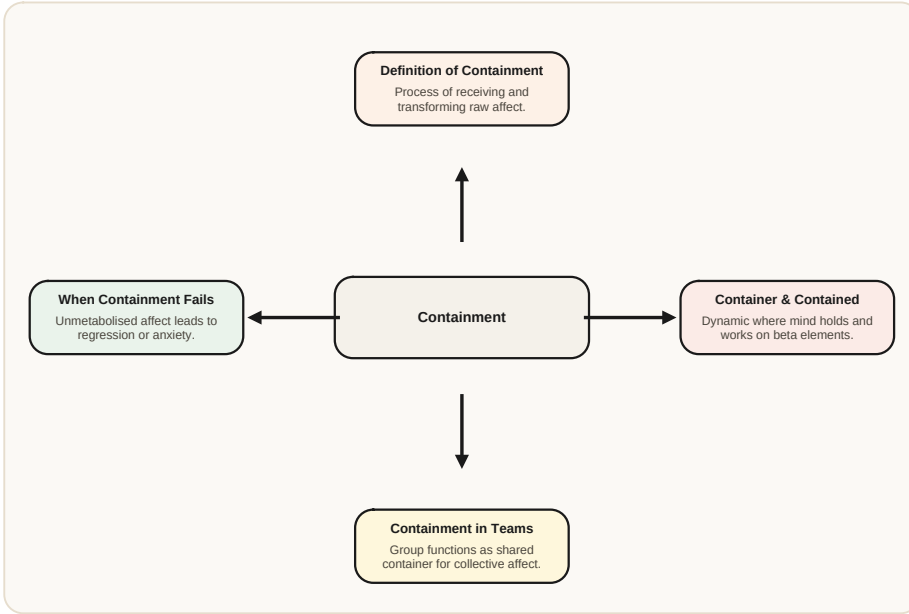


FIGURE 2.1 Containment Across Settings

This hub diagram illustrates the core aspects of containment across individual and team settings. It highlights definition, dynamics, application, and failure points.

Points worth keeping

- Containment defined
- The container and the contained
- Containment in teams
- When containment fails

PRACTICE TASK

Give an example of containment in a team under strain.