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## **Psychoanalysts' understanding of therapeutic success : interviews with 5 experienced psychoanalysts.**

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PSYCHOANALYSTS' UNDERSTANDING OF THERAPEUTIC SUCCESS:  
INTERVIEWS WITH 5 EXPERIENCED PSYCHOANALYSTS

A Thesis Presented  
by  
CANDICE FISCHER

Submitted to the Graduate School of the  
University of Massachusetts in partial fulfillment  
of the requirements for the degree of

MASTER OF SCIENCE

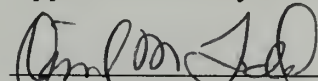
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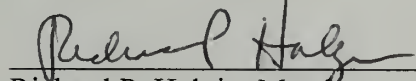
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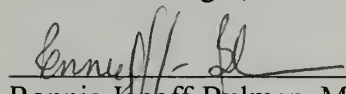
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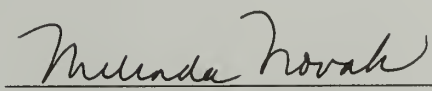
A Thesis Presented  
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## ABSTRACT

### PSYCHOANALYSTS' UNDERSTANDING OF THERAPEUTIC SUCCESS

FEBRUARY 2005

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Despite a relatively long-standing focus on studying treatment outcome, psychotherapy theorists as well as researchers continue to differ on definitions of therapeutic success. This lack of consensus is reflected in the difficulty in establishing a standard psychotherapy outcome battery. Following from this difficulty, differential outcomes may not be so much a function of the techniques or the therapists delivering the treatments, but rather from the application of different definitions of success (Hill & Lambert, 2004).

The present study explored the way in which five psychoanalysts (each with more than 30 years of clinical experience) understand and conceptualize therapeutic success, as well as "un-success" within their own clinical practice. Qualitative analyses suggested that psychoanalysts' understanding of therapeutic success centered on five main themes: symptom reduction, interpersonal abilities, social or work performance, intrapsychic change, and the therapeutic relationship. Of these dimensions, symptom reduction was not a good predictor of therapeutic success, as it was emphasized as a characteristic for both successful and unsuccessful cases. The last two categories were the most frequently and the most strongly addressed by the participants. Intrapsychic change included, among others, issues such as the development of an integrated sense of self and others, the

capacity to reflect, and the ability to enjoy life. The therapeutic relationship reflected a working alliance through which transference issues could be effectively addressed.

The fact that therapists alluded mostly to a revealing moment during the *process* of therapy as an illustration of success suggests that these analysts may experience some difficulty distinguishing process from outcome. To them, the term success may involve a series of turning points in the process of therapy, which are negotiated through the therapeutic relationship. Furthermore, the impact of key therapeutic events may not be revealed until after therapy has been completed. In this vein, the analysts considered follow-up to be essential for the evaluation of therapeutic success (follow-up assessments in successful cases ranged from 1 to 15 years).

The present findings highlight the importance of domains of therapeutic success that may often go untapped by traditional measures of treatment outcome.

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*Well... success is a one-sided term. There is always the shadowed side. Always, to everything... and success, it feels like a thin idea. You see a successful musician; well what does that mean? Does that mean that his compositions are played? That he's a good product? That he's been a good commodity? Success is very tricky in this culture, economically and politically. And a measure of failure, so called failure, might be very necessary in life. We are very afraid of failure. And yet there are some people who think dying is a failure.*

Dr. D.

## CHAPTER I

### LITERATURE REVIEW

In the past half century of psychotherapy research, there has been an increasing number of studies seeking to prove the effectiveness of psychotherapy treatment. As noted by Lambert & Ogles (2004), the finding that psychotherapy is beneficial has been supported across thousands of studies and hundreds of meta-analyses. However, in spite of this “seemingly undebatable” result, there has been a striking lack of consensus among scholars and researchers on the criteria used to define success (Hill & Lambert, 2004).

#### Theoretical Definitions of Success

Different organizations and theoretical perspectives define therapeutic success in unique ways. The American Psychological Association (APA) refers to the goal of psychological intervention as an attempt to “promote satisfaction, adaptation, social order, and health”. In broader terms, APA describes interventions in Clinical Psychology as “directed at preventing, treating, and correcting emotional conflicts, personality disturbances, psychopathology, and the skill deficits underlying human distress or dysfunction”.

From a psychoanalytic theoretical standpoint, Freud’s notion of success involved symptomatic relief and the possibility that the process of analysis provided prophylaxis in terms of future difficulties for the patient. In other words, success was related to how well patients could continue to analyze themselves after treatment had been discontinued in order to gain “certain immunity to past conflicts overwhelming them and causing a repetition in their present life” (Ellman, 1991, p. 334).



According to Aaron (1990), “Freud discusses therapeutic progress in terms of ‘whether the subject is left with a sufficient capacity for enjoyment and efficiency’” (vol. 16, p. 457). “Thus, the patient’s abilities to love and work are important criteria for many psychodynamic practitioners” (Aaron, 1990, p.48).

Other goals of psychotherapy from a Freudian viewpoint are the conscious awareness of previously unavailable attitudes, feelings, and memories; resolution of conflicts; flexibility of adjustment mechanisms; suitable ego defenses; and effective handling of anxiety (Miller, 1954, as cited in Gleser, 1975).

Ego psychologists would tend to look for “improved autonomous ego functioning; improved interpersonal, social, or object relations (increased ability to love); and an increased sense of self or identity” (Aaron, 1990, p.48).

From a general psychoanalytic point of view, therapeutic success occurs to the extent to which the patient achieves insight, or the extent to which there is a change in the personality organization (Galatzer-Levy, Bachrach, Skolnikoff, & Waldron, 2000). Galatzer-Levy et al. (2000) make reference to the “quality of life” approach, which is highly consistent with many psychoanalytic visions of health in that it emphasizes peoples’ overall psychological functioning rather than particular, isolated areas of function.

McWilliams (1999) describes nine goals of traditional psychoanalytic therapy: symptom relief; insight; agency; identity; self-esteem; recognizing and handling feelings; ego strength and self-cohesion; love, work and mature dependency; and pleasure and serenity.

In spite of a rich existing theoretical psychoanalytic literature, it is hard to find much written on psychoanalytic theorists' specific conceptualizations of therapeutic success or effectiveness. The focus of theory seems to be placed with a stronger emphasis on the process and technique of treatment.

Even within a psychoanalytic framework, there is such a diversity of approaches that it is hard to imagine a unique consensus or agreement on the criteria that define success. Dahlstrom (1975) refers to the prevalence of "fundamental divergencies in conceptualization of the goals and accomplishments of psychotherapy that make it difficult for some to accept without question criteria that others employ or endorse" (p. 14).

One of these fundamental differences appears to be the view of psychotherapy as a growth-enhancing process versus the view of it as a means of rendering relief from particular miseries and discomforts. "The one view opts for great generality, the other, for exquisite specificity and precision" (Dahlstrom, 1975, p. 14). Aaron (1990) alludes to this when he describes psychodynamic therapists as "more comfortable with abstract phenomena such as intrapsychic change than with symptom alleviation and the reduction of presenting problems or complaints" (Aaron, 1990, p. 51).

The general discrepancies in the conceptualization of success among different theoretical frameworks, and the lack of writing found in the literature about therapeutic success or effectiveness from a psychoanalytic framework, have profoundly impacted the development of psychotherapy research.

## Outcome Criteria in Psychotherapy Research

Since the beginning of the past century, research in psychotherapy has become an increasingly important field in the area of psychology (Wallerstein, 2001). Initially, the emphasis in psychotherapy research was placed on demonstrating the general effectiveness of psychotherapy, while later efforts were made to demonstrate the success of one treatment over another and disprove "*the Dodo Bird Effect*." Since 1936, when Rosenzweig used this Alice in Wonderland metaphor to refer to the equivalence in outcome of different theoretical approaches of psychotherapy ("At last the Dodo said, 'Everybody has won, and all must have prizes'"), generations of researchers have focused on measuring and comparing psychotherapy outcome (Wampold, 2001; Lambert & Ogles, 2004).

Hill & Lambert (2004) describe outcome as the immediate or long-term changes that occur in clients as a result of their participation in therapy; the way to measure these changes would be the central issue in outcome research. In other words, for psychotherapy research, treatment success is a direct result of the dimensions of change being measured and the instruments being used to measure these changes. In order to standardize treatment measures to evaluate these changes, common treatment goals should be implied (Schulte, 1997). However, it is doubtful that a generally applicable definition of such ultimate goals could be achieved, as demonstrated by the lack of agreement among researchers on the dimensions of change that predict therapeutic success (Mintz, 1980; Schulte-Bahrenberg, 1990 as cited in Schulte 1997).

Goldfried (1997) commented on the extent to which therapeutic success can be determined through generic measures or whether the measure of success should be

individually tailored to the particular client. He mentioned how this issue may have been minimized as psychotherapy outcome research has moved away from studying personality change in general to change within the context of specific target populations.

In 1975 the National Institute of Mental Health (NIMH) sponsored the first Outcome Measure Project in order to select "a core battery of outcome measures that could be used by a broad range of psychotherapy researchers" (Waskow & Parloff, 1975, p.1). This project involved a series of discussions among a group of consultants that later was published in a book format. The reasons that motivated this project are succinctly stated in the introduction of the book, Psychotherapy Change Measures:

The psychotherapy research literature abounds with instruments that have been used to measure change and/or improvement. Researchers in the area often have not accepted each others' criteria and related measures as reflecting meaningful aspects of therapeutic change, and thus have tended to develop and use their own untested instruments to assess a particular construct- sometimes even when there were more established and often better instruments already available. Numerous new measures in this field have been used only once or twice and have never been picked up again.

Others [researchers] have used only those measures that are specifically relevant to a single theoretical orientation. As a result of these trends, it has been extremely difficult to compare research findings from studies using completely different outcome measures. It has been all but impossible to make any general statements about the effects of particular treatment approaches for particular types of patients; that is statements that would encompass the results from more than one treatment and research setting (Waskow & Parloff, 1975, p. 2).

The researchers participating in the discussion of this project raised various domains as possible targets of change, namely, self-actualization, personal maturity, adaptability to new problems, personal comfort, self-acceptance, freedom from incapacitating fears, resentments, sexual inhibitions, and dependency; social responsibility, effectiveness, sensitivity to others, self-insight, impulse control, and



stability (Dahlstrom, 1975, p.16). Other areas of change considered in this project were the ability to function autonomously, seriousness of symptoms, degree of discomfort, effect upon the environment, utilization of abilities, quality of interpersonal relationships, breadth and depth of interests, and ability to handle stress (Strupp & Bloxom, 1975, p.173).

Strupp and Bloxom (1975) also acknowledged the importance of working “toward the achievement of a better consensus among therapists subscribing to divergent theories” (p.173). However, in another more recent attempt to develop a core battery to measure patient’s improvement after treatment, the 1975 Outcome Measure Project was criticized for lacking an overall conceptual framework for the battery (Lambert, Strupp & Horowitz, 1997).

This recent project was a conference held in 1994 (also later published in book format), which gathered a group of psychotherapy experts in a collaborative effort to address the need to develop a consensus about which measures most accurately reflected patient improvement. After more than 20 years since the Outcome Measure Project (1975) took place, a new attempt was made to answer analogous inquiries concerning the lack of consensus about appropriate methods and measures for evaluating patient improvement after treatment (Lambert, et. al., 1997).

For the purpose of this conference, treatment success was defined as “attainment of the goal of healing or improvement of (mental) diseases or as improvement of (psycho) pathological states” (Shulte, 1997, p. 62), and it was agreed that the measure should be “theory-free”, therefore, it should not be tied to a particular theory of

psychopathology or treatment, but should be viable for use across a spectrum of theories (Horowitz, Strupp, Lambert & Elkin, 1997).

Discussants decided on the following domains of change to be measured: a) the severity of the patient's subjective distress; b) the degree of impairment in the patient's life functioning (for example, in work, self-care, interpersonal relationships, and family functioning); and c) the salient symptoms and their frequency of occurrence (Horowitz et al., 1997). It was concluded that the following content domains were essential for a universal battery: the assessment of symptomatic states, social role functioning and interpersonal functioning (Lambert, Horowitz & Strupp, 1997, p.492).

Hill & Lambert (2004) mentioned other conceptual schemes that have been proposed to bring order to outcome assessment, namely, reduction of symptoms; improvement in health, personal and social functioning; cost of care; and reduction in public health and safety threats (McLellan and Durell as cited in Lambert, 2004).

From a psychodynamic research perspective, Galatzer-Levy et. al. (2002) reviewed studies conducted by Firestein (1978), Pfeffer (1959), and Wallerstein (1986) and concluded that the conceptual constructs these studies explored were in terms of multiple aspects of psychological functioning, such as the ability to love, work, and play, and the development of self-analytic capacities. However, he also concluded that the interrelations among the various measures of outcome were unclear.

A psychoanalytic approach seems to be strongly underrepresented in the outcome literature; it is difficult to find published attempts to provide a battery of measures that convey this approach. Fonagy (2003) attributed the absence of psychoanalytic outcome

research to “the fundamental incompatibilities in the world view espoused by psychoanalysts and most of current science” (p. 130).

At a more impressionistic level we might say that the world-view that is normally created by working intensively and long-term with disturbed individuals is incompatible with the ethos of tightly controlled studies (Fonagy, 2003, p.30).

The lack of agreement on the dimensions of change being measured has been a problem for decades. Hill & Lambert commented on the fact that a great deal of effort has been expended on understanding the effects of psychotherapy, “yet the lack of agreement in what constitutes adequate outcome measurement can create many problems when interpreting study results” (Hill & Lambert, 2004, p.105). Already in the 1950’s, Eysenck and Bergin drew different conclusions regarding the effectiveness of psychoanalysis using the same data set. “Eysenck came to very negative conclusions based on a selective use of change criteria, whereas Bergin found the same clients to be substantially improved and psychoanalysis to be far more effective than spontaneous remission” (Hill & Lambert, 2004, p.105).

Hill & Lambert (2004) concluded that this lack of consensus is apparent when scholars attempt to reconcile conclusions drawn from psychotherapy research literature based on different and ambiguous criteria of success. This lack of a unanimous criterion of success is mirrored in the lack of agreement on measures used to evaluate client’s change after treatment.

The following was part of a review by Hill and Lambert (2004) about measures used in assessing outcome:

A seemingly endless number of measures have been used to access outcome. Froyd, Lambert, and Froyd (1996) reviewed 348 outcome studies published in 20 selected journals from 1983 through 1988. These

journals were selected to represent therapy as practiced and reported in contemporary professional literature. A total of 1,430 outcome measures were identified for a wide variety of client diagnosis, treatment modalities, and therapy types. Of this rather large number, 840 different measures were used just once and many were unstandardized measures! In another review, which included a much more homogeneous set of studies (all clients were diagnosed with agoraphobia), published during the 1980's, 106 studies were located and found to have used 98 different outcome measures (Ogles, Lambert, Weight & Payne, 1990). This multitude of measures occurred in studies of a well defined, limited disorder, treated with an equally narrow range of interventions, mainly behavioral and cognitive behavioral therapies. The proliferation of outcome measures is overwhelming, if not disheartening.

It is rare to find consensus about using a specific measure within a limited disorder, even when a particular measure has been recommended at professional meetings (Ogles et al., 1990; Strupp, Horowitz, & Lambert, 1997).

Farnsworth, Hess, and Lambert (2001) reviewed articles measuring outcome that appeared in the *Journal of Consulting and Clinical Psychology* from 1995 through June 2000. In this review, they found that the Beck Depression Inventory (BDI) was the most preferred self-report measure, followed by the State Trait Anxiety Inventory (STAI), the Symptom Checklist 90-Revised (SCL-90-R), and Inventory of Interpersonal Problems (IIP).

The substantial difference in the measures used to assess treatment success is not trivial, but large enough to raise questions about the interpretation of the results observed in these studies (Hill & Lambert, 2004). Since the birth of outcome research, researchers have called for better operational definitions of success that can work towards a consensus on the measures used and the dimensions of change being measured. In the first attempt to create a core battery to measure therapeutic change, several conceptual constructs were mentioned, but no agreement was made as to which of these should be the key dimensions to be measured by outcome research in general. Twenty years later, in



1994, some progress was made in defining dimensions of change and a new core battery was proposed. Still ten years later, Hill and Lambert (2004) comment on the substantial differences between individual studies and their reported outcomes, and how “the differences between rates of successful outcome appear to be not so much a function of the techniques or therapists who offer the treatments, but result from applying different definitions of success” (Hill & Lambert, 2004, p.106).

#### Sources of Information about Effectiveness

The *source*, or the person or institution who delivers the information as to whether the treatment has been successful, seems to be another long-standing area of discord in the field of outcome research (Schulte, 1997). Therapists were initially considered the main source of information in evaluating client’s changes in the process of therapy. However, they were soon disregarded as the sole source of information and considered biased about their perceptions of their patient’s changes (Galatzer-Levy et. al., 2000; Strupp & Bloxom, 1975).

In the 1975 Outcome Measure Project, participants discussed the fact that self-report techniques remained the most common outcome measures in research at the time. On the other hand, they also argued about the “paradoxical reliance on a reporter (the patient) who, by definition, is under high emotional stress and hence open to criticism as a judge of the quality and extent of his own feelings and behavior” (Imber, 1975, p.40). Several sources of error in patient self-reports were mentioned. Among these was the difficulty for the patient to accurately describe his feelings and attitudes when he has never been trained to be objective, and therefore, his report might be influenced by the context in which it is made. Imber (1975) argued that if a patient is feeling fearful or if he

mistrusts those who have access to his report, he may conceal symptoms and difficulties or, on the other hand, may exaggerate them to lend conviction to his need for help.

Moreover, someone who has been in therapy is “well aware that the procedures used are intended to reduce his distress and therefore may be inclined (e.g., out of gratitude to his therapist) to report positive change” (Imber, 1975, p.40). Therefore, he argued that self-report measures should seldom be relied upon as sole indices of outcome.

In regard to the source of information, Kantrowitz (1997) emphasized that given that psychoanalysis is an interactive process, “assessment of only one of the participants would not be sufficient to predict an outcome” (p.88).

Indeed, in the last three decades, the ideal for outcome research has become to include and represent all parties involved who have information about change, including the client, therapist, relevant (significant) others, trained judges (or observers), and societal agents that store information such as employment and educational records (Strupp & Hadley, 1977 in Hill & Lambert, 2004). However, at the beginning of a new century, evidence demonstrates that the progress made to achieve this “ideal” (to include different sources to measure change) has been modest, as shown in the following paragraph extracted from a review done by Hill & Lambert (2004):

In a study examining recent trends in outcome assessment, Farnsworth, Hess, and Lambert (2001) reviewed 133 outcome studies from 1996 through June 2000 published in the *Journal of Consulting and Clinical Psychology*. Specific outcome measures were classified into one of five “source” categories: self-report, trained observer, significant other, therapist, or instrumental (a category that included societal records or instruments such as physiological recording devices). As might be expected, the most popular source of outcome data was client self-report. In fact, 41% of the studies used client self-report data as the sole source of evaluation (Hill & Lambert, 2004, p.113).

The patient, as a *source* or reporter on the effects of change, seems to have an increasingly primary role in research. However, the reality of the clinical setting is that a psychotherapy process refers to an evolving relationship between two people: a client and a therapist. Strupp & Blosom (1975) argued in favor of the therapist as an essential reporter on therapeutic effects:

There is no doubt that the therapist is in an exceedingly favorable position to make thorough observations about the patient. Indeed, there are virtually no parallels to the richness of the psychotherapeutic situation as a source of data. As a trained clinician, he is able to weigh and integrate information from diverse areas and levels; his experience permits him to compare one patient with a sizable sample of others; and his training permits differentiation between socially acceptable verbalizations by the patient and “real” changes. In sum, the demands for openness and honesty prevailing in the therapeutic situation, the clinical necessity for objectivity, and the opportunity for observing a patient over extended periods of time place the therapist in a most unusual situation for evaluating change. Given these remarkable assets, one might expect the therapists’ evaluations of treatment outcomes would by now have become a fine art. Instead, progress has at best been modest (Strupp & Blosom, 1975, p.171).

In their clinical practices, therapists work together with their clients to achieve a “successful treatment”. It is most probable that therapists, in contrast to researchers, do not generally apply formal measures and questionnaires to their clients to determine when a therapy is effective and when it might be time for termination. Clinicians must have a pre-conceived idea of what effectiveness is; whether it is a notion that extends across different clinicians, or it varies from one to another, it has yet to be investigated.

### Statement of the Problem

The present study proposes to re-consider psychoanalysts as an essential source of information in the process of understanding psychotherapy effectiveness. For this purpose, a group of psychoanalysts was interviewed utilizing a qualitative approach

through which this study sought to gain insight into therapists' understanding of therapeutic success or effectiveness within a psychoanalytic framework.

Research questions included the following:

1. How do these therapists think about effectiveness or therapeutic success in their own clinical practice?
2. How does their general understanding of therapeutic effectiveness relate to the way in which they think about a specific treated case, which they considered to be successful?
3. Does the therapists' understanding of therapeutic success differ from case to case? And if it does, in what ways?
4. How do these therapists understand a treated case that, in their opinion, was an "unsuccessful therapy", and how is this understanding related to their more abstract statements about the nature of effectiveness?
5. In what ways is their understanding of effectiveness being drawn from, or reflecting, research and the dimensions of change considered by outcome measures?



## CHAPTER II

### METHOD

#### Participants

Participants were five experienced psychoanalysts selected from Western Massachusetts, and from the Boston and New York areas. For the purpose of this study, “experienced” was defined as having practiced psychotherapy for a period of at least 30 years.

The sampling was implemented by contacting experienced psychoanalysts by phone or by email. This included analysts known to the Chair of the committee and other professional associates, as well as acquaintances of the researcher. Other names were identified in different psychoanalytic publications.

Given that many of the clinicians contacted were extremely well known and busy, the researcher was turned down by several of them. Of the nine analysts that were initially contacted, only five expressed interest in being interviewed about their thoughts on therapeutic effectiveness. In order to protect their confidentiality, these participants are referred to in this report as Dr.’s A, B, C, D, and E.

Given the small size of the sample and the intention of the writer to analyze these therapists’ understanding of therapeutic success in depth, diversity among therapists was limited. All participants ascribed to a psychoanalytic perspective; however, there were differences with respect to the specific theoretical approach within psychoanalysis to which they ascribed. These included a variety of perspectives that ranged from Freudian, Interpersonal, and Object-Relations to an Integrated approach. This information is presented in Table 1, which also summarizes the characteristics of each participant in



terms of their degree, orientation, years of clinical experience, the type of population they predominantly work with, and their experience conducting research.

Aside from the identification with a specific theoretical orientation within psychoanalysis, it was intended that the sample also provide diversity in regard to gender and degree. There were two women psychoanalysts (Dr. A and E), three MD's (Dr.'s A, B and C), and two Psychologists (Dr.'s D and E) among participants (See Table 1). All analysts worked primarily with an adult population (with the exception of Dr. A, who also saw children and adolescents as part of her caseload) and most of them saw patients with a severe range of psychopathology in their practices.

Participants' years of clinical experience ranged from 32 to 58, and all of them had been authors, at some point in their careers, of books and/or papers that largely influenced different realms of psychoanalytic theory, thought, and/or practice.

The degree to which participants were involved in research also varied. Two of the five analysts were currently researchers themselves, while two others just participated "informally" in research. Only one of the participants (Dr. C) expressed a truly "skeptical" stance towards research and denied any current involvement in any research project.

### Procedure

There were several stages in the procedure. The first stage involved an initial contact with the selected therapists (by phone or email), in which they were asked about their willingness to participate in the present study.

The second stage, once the analyst agreed to be interviewed, required that he/she sign a written consent form about the conditions and confidentiality of the content of the interview (See Appendix A).

The third stage of this study covered an exploratory 60-90 minute interview with each of the therapists. The interview included a series of open-ended questions designed to closely capture how each of the psychoanalysts understood therapeutic “success” or effectiveness (See Appendix B). The questions served as a guide, but were modified during the interviews in order to get a more detailed and rich understanding of each participant’s response. Therefore, the interview was adjusted to the responses obtained so as to take into consideration individual differences among interviewees.

Given the aim of this study, therapists were asked during the interview to talk about terminated cases from their own clinical practice, selecting two cases, which they considered to have been “effective” or “successful” treatments, and two cases, which they deemed to have been “unsuccessful” treatments. Each participant was allowed to spontaneously address any case that came into his or her mind that met the specified conditions, and was encouraged by the interviewer to elaborate on his or her thoughts about the selected cases.

### Data Analysis

As stated above, the aim of this study was to describe, explore, and understand the way in which a small group of therapists thought about effectiveness in their own clinical practices, in order to gain insight on how these analysts understood therapeutic success.

The intention here was to come closer to the intimate and personal way each of these therapists experienced therapeutic success. In other words, the goal was to see

through each therapist's eyes the constructs he/she considered to be most relevant for an effective treatment, and gain a different perspective and understanding on the issue. For this purpose, all interviews were tape recorded and verbatim transcripts of those recordings were prepared by the principal investigator in collaboration with a research assistant.

The approach to the data focused on three areas: 1) descriptions and illustrations of themes within each therapist's account of therapeutic success and description of common issues raised by therapists across the interviews; 2) depiction of cases selected by therapists to exemplify successful or unsuccessful treatments; and 3) analysis of the manifest and latent content of the interviews, with particular attention to the types of cases selected in relation to the therapeutic constructs addressed by the therapist.

Common themes that emerged from the interviews were described and illustrated through case vignettes. An emphasis was placed on addressing common issues as well as unusual or infrequent ones raised in the conceptualization of therapeutic success through these psychoanalysts' own clinical case examples.

In addition to the participants' definitions of effectiveness in psychotherapy, the type of cases selected by each therapist to address this issue were described and examined.

Dr. C was reluctant to go into detail about any of his cases, and addressed therapeutic effectiveness or success merely from a general, abstract stance. Therefore, he was not included in the section that explained and analyzed case examples; his understanding of therapeutic success or effectiveness is only provided in the section that illustrated participant's responses about this theme in general abstract terms.

### Pilot Interview

A pilot interview was conducted in July 2003. The purpose of this interview was to explore the degree to which the preliminary questions were relevant, and the present study was possible and useful. The therapist interviewed was an advanced PsyD candidate with approximately eight years of clinical experience.

Some interesting themes that came up in this interview were the following: the diagnoses of the two cases selected by the participant (one to represent therapeutic success, the other to represent unsuccessful treatment); length of treatment, in relation to these cases; the therapist's understanding of therapeutic success, and how this conceptualization differed when she was referring specifically to a treated case as compared to her abstract conceptualization of treatment success.

### Confidentiality

In order to protect the confidentiality of participants and of the case material presented by them, it was necessary at times to limit the detail of case information. This process sometimes involved the exclusion or modification of specific aspects of the case that could otherwise be identifying information. Despite these limitations, care was taken to preserve the essence of the case discussed.

It should also be noted that all participants were asked to protect confidential or identifying information of their patients when addressing case material, and were asked to only disclose the amount of detail they felt comfortable sharing with the researcher who would consequently share this with committee members.

## CHAPTER III

### RESULTS AND DISCUSSION

#### Therapists' Understanding of Therapeutic Success or Therapeutic Effectiveness in General, Abstract Terms

After inquiring about practical details (like degree, theoretical orientation, and years of clinical experience, among others), the interview approached therapists' understanding of therapeutic success or effectiveness in general, broad terms. Their answers were diverse; they would sometimes address this question with hesitation and even come back to it further along in the interview.

The following section will first attempt to characterize each participant's thoughts about therapeutic success or effectiveness, and will then be followed by a brief discussion on similarities and divergences in these therapists' responses. Specifically, this section will address each therapist's response to the following question: "How can you tell if a psychotherapy treatment was effective or successful in general, broad terms?" With this question I intended to capture these participants' abstract understanding of therapeutic success.

According to Dr. A, a clinician can tell whether a treatment was successful or effective "from various perspectives: a symptomatic perspective, an adjustment perspective (to family, to work, to friends), and an individual perspective". She defined the latter by "the change from maladaptive coping mechanisms to the capacity to reflect on oneself", "what is currently called 'the reflective capacity'". She also addressed the ability to "modulate affect" as an important indicator of therapeutic success; when the "transition from one affect to the next one goes on smoothly and predictably, and affect is



appropriate to content". She also referred to the patient's internalization of the therapist, in terms of her or his "function of talking, thinking and reflecting", as another index of success.

For Dr. A, success can also be measured in "relative terms" when one "looks at where one particular patient started off and where he/she ends at".

Similarly, Dr. B considered that change should be evaluated on an "ongoing basis" with his patients, and that it is important to look at "the specific issues in the life of an individual" and look at "how that person changes".

Dr. B offered a detailed and elaborate description of therapeutic success that addressed symptom reduction as well as in-depth personality change:

First of all, by symptom reduction and by positive changes in major areas of inhibition, blockage, or malfunctioning of the patient's personality; so you look at symptoms: anxiety, depression, conversion symptoms, etc, and they should decrease, and in fact they decrease with many treatments, not only in psychoanalysis or psychoanalytic psychotherapy. Then you look at more complex areas of functioning, the patient's capacity to become more effective, more creative, more satisfied in work, in a profession, more able to develop relations, satisfactory relationships and intimacy, particularly integrating tender and erotic feelings in a relationship in depth; in other words, develop depth stability, satisfaction in love relationships, in marriage, and more effective and gratifying ways of social relations; and through activity in any area in which the individual develops interest, hobbies, commitments. So you look at a broad spectrum of both, on the negative side, symptoms that disappear, on the positive side, capabilities or functioning that increase in all areas.

From Dr. B's perspective, psychoanalytic psychotherapy implies certain goals to be achieved by a successful treatment that differ substantially from other types of psychotherapy treatments:

...Psychoanalysis and psychoanalytic psychotherapy are interested really in profound changes in the personality (...what is called structural intrapsychic change...) and in the capacity for development of autonomy and adaptation beyond symptom resolution ... being able to change a person's personality and to improve their happiness and their well-being and effectiveness, and that has always seemed to me as the most fascinating usefulness of psychoanalytic psychotherapies. This runs against the classical assumption that personality is something given that can't be changed.

Furthermore, he outlined a "structural approach" postulated by psychoanalysis that considers the "ego, superego, and id as overall psychic structures organizing behavior". According to Dr. B, this approach understands a successful treatment as one in which "there should be an increase in ego functioning and decrease in unconscious superego and id pressures". However, he indicated that this "hasn't worked clinically", that "it is much too general", and explained that structural intrapsychic change is now being understood as a "change in the organization of internalized object relations", thus, the "integration of the concept of self, and the integration of the concept of significant others that jointly constitute integration of the subjective orientation of the individual regarding his psychosocial environment".

Dr. C hesitated before answering the question about therapeutic success: "That's a very broad question..." He believed that success or therapeutic effectiveness can be understood in the broadest way as "what Freud said a long time ago: the capacity to love and work", even though he was convinced that the notion of therapeutic success is "highly individualized"; what can be successful for one patient may not be so for someone else. He also explained that "one hopes there will be symptom reduction", but that "that is a very superficial way of looking at it", and described therapeutic success as "enabling the individual to free his/her potentials, without being held back by neurotic

inhibitions”. According to Dr. C, the way to tell if a treatment has been successful is to look at “whether the person is now able to make use of their inner capacities and potentials”.

With a puzzled expression, Dr. D answered my question in a straightforward way: “Well, partly from what people tell you and what they say. Partly I’ve always maintained the practice of arranging a session from six months to a year after termination so that we can talk together about what the effect has been, good and bad”. Like Dr. C., he explained he believes the understanding of therapeutic success is something that varies from person to person, and even though “there are certain signs of inner well-being, (somebody who looks better, or eats better, or sleeps better)”, he is “a little leery of that”, and prefers to “keep an individual focus”:

There are many different ways, but each person is very different. I never develop criteria for improvement that I think are across the board. With some people you can’t tell. For example, in the field we sometimes think that somebody has improved if they go back to school, or if they get a good job, or if they get married, or have children. I’m not sure about those criteria, I mean, those are general criteria for adjustment within our culture, but I don’t know whether they necessarily reflect a freer, inner person; a person who is living with himself or herself in a more free way. So, sometimes somebody who quits school, or changes a job into a job that’s less affluent, or less successful seemingly; somebody who moves inward and becomes more reclusive, that might represent a very important positive therapeutic outcome. So you can’t always tell by social measures, although those are the easiest; and family members, and social society in general is happier when somebody seems to be adjusting to the needs of society, but for some people, that absolutely means, it could mean a defeat, a deep defeat in the relation of their own inner cycle of life, so it’s a very good, but very difficult question.

Dr. E also suggested a cultural bias in the definition of success, where the “problem of trying to get common definitions is that they tend to be ‘culturally specific’”.

Different cultures have different norms about what is mental health, and those norms tend to be the kind of psychologies that are adaptive in that culture. For example we put a lot of emphasis on autonomy in this culture, because to survive in this culture you better be pretty autonomous, but if you were in India or China, the emphasis would be much more on your capacity to carry out your prescribed social role without friction.

According to Dr. E, however, among psychoanalytic communities within the United States there seems to be a “pretty high degree of agreement about what effectiveness is” which, she recalled, “would probably come down to the capacity to love and work and play”, which, with the exception of “play” (that was later included), is “what Freud originally postulated”.

Dr. E would tell a successful treatment by “[asking] her patients”. She considered that therapeutic success translates into helping her patients achieve the “kinds of goals they want to pursue”. Furthermore, she expressed feeling that she was “the employee of her patients”, and found that in most cases her patients knew well the kinds of goals they hoped to pursue. On the other hand, Dr. E explained that sometimes there are goals that surprise her patients, “as they find themselves getting more in touch with authentic parts of themselves in the treatment”.

...They may come to me to reduce a depression but they find all kinds of other side effects: like increased capacity to negotiate for themselves, and to feel honest in their intimate relationships, and to enjoy sexuality, and to enjoy their work, and to find some creativity... those things may open up for them, so it's very common that as we work towards their relief of their depression all kinds of other things happen too.

According to Dr. E “individual clients have individual notions of what they are going for”, therefore, one person may want to be able to be “more socially involved” while another person may want to be able to “tolerate aloneness”. In Dr. E's words,



“effective therapies would involve them meeting those goals, even though they are opposite goals”.

Dr. E also believed that therapeutic success could be understood as an individual process, as well as a general concept that cuts “across the board”.

...What is therapeutic to one patient might not be to another. Some patients need to become more affectively demonstrative, and some need to rein in their acting out of their affects all the time; and you could say that about all kinds of things, but in general, I think you can make generalizations about what psychotherapy ought to do.

She mentioned several general goals a psychotherapy treatment should achieve in order for it to be successful:

... It should reduce the symptoms that the patient comes complaining of. It should increase their sense of agency. It should increase their capacity to be intimate with other people, so their ability to love. It should increase their sense of creativity. It should increase their capacity to work in some kind of productive way, hold a job. It should increase their self-esteem. It should challenge and slowly deconstruct their pathogenic unconscious beliefs. It should allow them to have more pleasure in life in general, and a kind of serenity rather than a hyped up, chemically altered or manic form of pleasure; more self-acceptance and comfort. Those things, I think I would say across the board.

For Dr. E, therapeutic effectiveness is linked in a higher degree to an “affective dimension” rather than to “the explicit behavior-change dimension”. According to her, someone can change a behavior, but that modification will not necessarily bring a change in the person’s affect, self-esteem or “drive-ness about life”. She explained that for her, improvement was associated to seeing her patients’ “spirit expanding”.

Opposite to Dr. B’s approach to deep personality changes, Dr. E explained she did not think people’s personalities change:

I don’t think people’s personality does change, either in terms of what level they are on, in terms of whether they are more neurotic, borderline, or psychotic, or in terms of what type of personality they have. But I think



that they become just much better at managing what type of person they are, and I think that's universal, that we all have character and that our growth involves our being respectful of our own character and getting better and better at managing and having more flexibility and having more aspects of other kinds of character. But I don't think that people with hysterical characteristics turn into obsessional people or visa versa. Or that borderline people become neurotic; they become much better regulated people with a borderline kind of psychology. I just haven't ever seen evidence for that kind of transformation; I think we get hardwired for that pretty young.

## Discussion

Looking at the five responses we can see that even though there was a tendency among therapists to name symptomatic reduction as an important dimension to be considered in the understanding of therapeutic success, it was not addressed as the most important one.

Being the most concrete of all categories or conceptualizations of change mentioned by participants, symptom change tended to be addressed in an early stage of their responses. However, participants elaborated with much more freedom and passion later on in the interview about other more abstract and unique dimensions of therapeutic success. Some examples of these were "the capacity to reflect on oneself", to "modulate affect", the "patient's capacity to become more creative" and "autonomous"; the "capacity to love", and to have "satisfactory relationships and intimacy"; the ability to "make use of their inner capacities and potentials"; the capacity to "get in touch with authentic parts of themselves"; to "be creative" and be able to help the "patient's spirits expand". In other words, participants tended to understand therapeutic success as the development of capabilities or improvement of functioning beyond symptom resolution.

The ability to enjoy life was another idea conveyed by these analysts' understanding of therapeutic success. Dr. B referred to an improvement in the patient's "happiness and well-being", Dr. D emphasized the importance for a person to "live with himself/herself in a more free way" and Dr. E addressed the relevance for a patient to "have more pleasure in life".

Only two therapists (Dr. B and Dr. E) explicitly addressed deep personality changes as a parameter of therapeutic success. Even though at first sight they seemed to have antagonistic views on the matter –Dr. B advocating for "profound changes in the personality" and Dr. E stating that "people's personalities do not change"- the subtleties of their thoughts allowed for further interpretations towards possibly similar points of view.

While Dr. B seemed to believe in personality change as the "change in the organization of internalized objects", Dr. E explained that even though she did not think a person's personality could change, she believed that people could "get better at managing what type of person they are"; growth involves becoming "respectful of our own characters" and flexible enough to allow for other types of personality characters to simultaneously co-exist with our predominant one.

One can wonder whether Dr. E's thoughts are not so dissimilar to Dr. B. Dr. B explained that a change of internalized objects involves the "integration of the concept of self, and the integration of the concept of significant others that jointly constitute integration of the subjective orientation of the individual regarding his psychosocial environment." This could be consequently understood as becoming more "respectful" and "flexible" towards our own character of personality, as understood by Dr. E.

Another aspect of therapeutic success that was mentioned spontaneously by three of the five participants was the involvement of the patient in the therapist's determination of success or therapeutic effectiveness. Dr. B expressed that change should be evaluated "on an ongoing basis with the patient". Dr. D described that he could tell whether a treatment had been successful from what the patient told him. And Dr. E claimed she would tell a successful treatment by "asking [her] patients". This leads to the question as to how much weight patients' understanding of success have in the therapists' view of therapeutic effectiveness.

Is the therapist's notion of therapeutic success mostly determined by helping the patient achieve the goals initially stipulated by her/him? Or does the therapist understand success as something given that is not dependant on the patient's initial expectations of treatment? It seems that for most participants, therapeutic success is a construct achieved and elaborated by both therapist and patient, who work together to reach certain goals of treatment established in mutual agreement.

Dr. E emphasized the importance of this "collaborative process" in which the patient would come with certain goals in mind and the therapist would have the "responsibility to expand these goals" if she or he considered this to be more helpful to the patient. For Dr. E, it is the patient who best knows if the treatment has been successful and it is for the therapist to listen to "whether the patient feels like [he/she] is progressing".

## Therapists' Understanding of Therapeutic Success Within their Own Clinical Practices

### Dr. A: Successful Case 1: Silvia

Dr. A saw Silvia in the “late 80’s”, when Silvia was in her “middle thirties”. At the time, she had “been treated as a schizophrenic patient for ten years”. When Dr. A first saw her, she realized that Silvia had been misdiagnosed; “she was not schizophrenic”, and it was very probable that her “thought disorder” was due to “the amount of medication she was getting”. Dr. A explained that she then “took all the medications out and started to treat her”.

Dr. A treated Silvia twice-a-week for four years, and then “less regularly” for “a couple of years”. She diagnosed her with a “borderline personality disorder” and referred to this case as her “Pygmalion”, since, as stated by Dr. A, “it turned out that [Silvia] was extremely gifted in art and design and she became a person in her own right”.

To the question as to what made Dr. A think of this case as a successful one, she responded without any hesitation:

Well because I have had a follow up with her, so I know that she became very well known in her field and she was very successful financially; she was able to raise her two daughters, and work with her husband, and her symptoms disappeared; she could hardly talk coherently, and became very thoughtful. She developed more assurance in herself, although her relationship with her husband remained conflictual. But she could handle it, and get the marriage going in these times when there’s such a high incidence of divorce. She was able to keep the family together.

Dr. A explained that Silvia came from a “rich, immigrant family”, and that as a child, she had been “physically and emotionally abused”. As indicated by Dr. A, this was a successful case in that Silvia was able to “extricate herself from the impact of those traumatic experiences” and “come to terms” with her parents and establish an “emotional contact with them”. This was a major change from Dr. A’s perspective, which also was



seen in the way Silvia treated her children, who had been “traumatized in turn by her being totally unable to take care of them”. As a consequence of treatment with Dr. A, Silvia was able to put a stop to the “trans-generation transmission of trauma”.

According to Dr. A, if we asked Silvia to share her thoughts about treatment, she would certainly remember it as a “helpful” experience: “Because in moments of crisis in her life, she has come to see me, so I think she has a feeling that she can trust me and that I can help her view things in a more objective way”.

Dr. A proudly expressed that in her treatment of Silvia, she had “kept on being a very traditional therapist”. She added, “I have not offered her a supportive approach or anything of that nature”.

#### Dr. A: Successful Case 2: Bill

Bill was seen by Dr. A “almost 20 years ago”. He was seen in “traditional analysis”, “four times-a-week”, for “almost five years”. As described by Dr. A, Bill was a “patient with narcissistic personality disorder”, who also “suffered from depression”. He was a “professional man”, but his “professional achievements were very modest in comparison to how great he felt he was”.

...This was a person that in one occasion when he started treatment he realized that he couldn't see other people as other people. He said “I live in a world of people populated by people like me”; as if people around him were like *clones* and everybody was like him....

According to Dr. A, this was a “very impressive case”:

There was a change in the way he related to his children, the way he related to his wife; he progressed in his professional field, he became the chief person of his institution, in his specialty, and he was getting more creative, was contributing to his field, and he felt that he didn't need to envy others; he felt he was living a life!



Dr. A thought that Bill would remember treatment “with a certain fondness”. She explained that she has heard from Bill “from time to time”, and believes he would think of the treatment he had with her as “something helpful”.

When Dr. A was asked if she always believed that these two patients would get better, she responded without hesitation that she “never [knows] how the patients are going to turn out”.

I think what seems important is that I establish a certain type of contact in which the transference can unfold. So I am tactically always thinking that this can improve or that can be improved, but I don’t have an idea until the treatment is over of how things go.

#### Dr. B: Successful Case 1: Elizabeth

Dr. B began seeing Elizabeth 40 years ago and ended psychotherapy with her 33 years ago. He saw her for a total of seven years, with a twice-a-week frequency. Elizabeth was “said to have the diagnosis of schizophrenia”, she had “been hospitalized, sometimes been treated with electro-shock, and neuroleptics”. Once Dr. B started treating her, he found that Elizabeth had “schizotypal personality, with strong masochistic features”, but that she “was not a schizophrenic”.

So I changed the diagnosis. I took her off all medication and started doing psychoanalytic-psychotherapy. She was hospitalized and after three months she was ready to leave the hospital. She used to cut herself all over her body with the fantasy that she had little vaginas that were bleeding, obsessive ideas about sexual organs, complete passivity; she was sitting in a corner, not doing anything, and withdrawn from all social life. She talked in vague ways that could barely be understood. I mean there were good reasons why people thought she might be schizophrenic, but in confronting her with the vagueness of speech and with the fact that this would increase whenever she was angry or annoyed, and disappear when she seemed relaxed, its defensive use could be demonstrated, normalized. It was clear that all these fantasies were realistically evaluated by her; were not delusional; they were pseudo hallucinations, but no true hallucinations.

According to Dr. B, this was a successful case in that Elizabeth was able to go back to school, “graduate from school”, get into “postgraduate training in the field of mental health in a broad sense”, and become a “successful professional”. She had a “severe sexual inhibition that she was able to overcome”, she got “involved with a man”, married, had children; “normalized her life completely”.

And that was a patient who for years had been just going from one mental hospital to another. I think that in the course of the treatment the kind of things that evolved... primitive fantasies about savage kinds of aggression condensed with primitive sexual conflicts, developed in the transference, almost psychotic-like, experiences in the relationship with me that we could gradually sort out, and analyze, and trace back to her past.

Dr. B followed-up this case for 15 years after completion, at first, having once-a-year contacts with Elizabeth, and then “once every three or four years”.

Dr. B: Successful Case 2: Andrew

The next case described by Dr. B was a case of analysis. Andrew was “a professional, a very effective businessman”, but “with a terrible history of relationships with women”.

He had a chronic sexual promiscuity with intense sadism and mistreatment of women. Went through several marriages, and the marriages were chaotic. I came in his third one. ...those were the years of sexual liberation and group sex, and he forced his wife into going into group sex. And she was submissive and subservient, and so he finally practically forced her to become a slave of sexual orgies that he watched with great satisfaction; this is the kind of person I’m trying to describe. But then the result was a complete devaluation of her; he would get rid of her and then go on to the next.

Andrew came to treatment because he “developed hypochondriacal fears, and thought he had all kinds of illness and problems”. He was seeing an internist at the time, who referred him to Dr. B. Dr. B’s diagnosis was that of a “severe narcissistic personality”, with “hypochondriatic and paranoid features”.

He treated Andrew in analysis, four sessions a week, over a period of approximately 6 years.

And in the course of which we were able to analyze his deep hatred of women, envy of women, unconscious, strong homosexual leanings and linked with the envy of women, the wish to be a woman, admired by men. So women were extremely attractive to him, but the fact that they were physically attractive already made him feel resentful, feeling that they were teasing him, so he had to really destroy them in his mind, and was dealing with primitive sadistic fantasies; he was obsessed with women’s breasts, so he wondered what can you do so you are not teased by them, so well, you can cut them off, but if you can cut them off, it’s not the same. This was the kind of level of fantasy, a very primitive sexually infiltrated with aggression.

As indicated by Dr. B, Andrew had a “horrible past” with various traumatic experiences with both parents. Dr. B thought of this case as successful in that “working through” these issues permitted Andrew to “resolve these problems”, and “change his very deepest attitudes toward women and towards himself”.

Eventually he was able to really appreciate women, and one woman, and fall in love, and develop a normal relationship, and get married, but not only formally, but in an emotional sense, get out of that nightmare which he had lived in. With that, his entire life changed. He didn’t have to use business to escape from relationships. And didn’t have to spend every moment of his free time picking up bizarre kind of women who would be willing to go along with the perverse scenarios he had to invent for himself and include them. ... It looked like such an impossible case in the beginning, it was really gratifying.

Dr. B also followed-up Andrew “up to fifteen years after termination”. He believed that by the end of treatment Andrew’s personality disorder “was resolved”: “he still would have narcissistic features, but would not fulfill the criteria for narcissistic personality disorder”.

When asked whether he believed from the start that Elizabeth and Andrew’s treatments would turn out to be effective or successful ones, Dr. B responded that he “never knows”. He explained that he had come to “accept that [he] will do the best, knowing that [he] may be limited”.

I think it is important for a therapist to really want to help the patient, to have an investment in that; there has to be something in your contratransference that you like about the patient. Even if it is something potentially that you see... if you have a patient whom you really dislike profoundly even before your treatment starts, then just send them to somebody else... (laughs). But then within that you have to accept that you’ll do the best. Patients ask me, “am I going to get rid of all of it, am I going to get better?” I tell the patient: “well that’s the objective of the treatment. Hopefully yes, because I believe that you have a good chance I am treating you; if I thought it would be impossible I wouldn’t be offering treatment. On the other hand, I am not certain, some patients don’t improve; I can’t give you any guarantee”. “Do I have to have faith in the treatment, doctor?” I say: “No, you don’t have to have any faith, just benevolent skepticism, that’s all it takes”, and with that, you can start.

#### Dr. D: Successful Case 1: Monica

Dr. D saw Monica “way back” in the late 1960’s and early 1970’s for a period of two years and a half. Dr. D remembered this case in particular because of Monica’s “early disturbance”. While he described this case, Dr. D leaned down towards a small table in front of him and held in his hand a bunch of small rubber animals. He explained that Monica “probably had a schizophrenic breakdown in her late teens” in which she kept in her mouth these rubber animals for about a year. During this time she could not



speak and had a hard time eating –“she only had juices and nearly died as part of this breakdown”.

By the time Dr. D saw her, Monica was in her early 30's and was “yearning for some way of reconnecting with her spirit in that breakdown”. Dr. D described Monica as a “very interesting” and “very bright”, but also as a “very constricted person” as, he explained, are many people who go through a breakdown. According to Dr. D, those who come out of a breakdown can be “more cautious”, “a little bit narrower”, and “careful about opening themselves because they know what's underneath that”.

As indicated by Dr. D, “the work with [Monica] included gaining some readmission to that earlier period and learning together what was in the heart of that breakdown, and what was precious about it, as well as what was terrible about it”.

To the question “what is it of this case that made you think of it as an effective one”, Dr. D responded without any hesitation:

From the really increasing relaxation in her entire psychology; so she was then open to her intellectual and her sexual life, which had been quite constricted as an outcome of the psychosis. She was very constricted in order not to be nuts, in order to survive; so her openness to intellectual life and her sexual life were signs that she was now able to resume the life that she was probably meant for before the break-down. ...She was able to relax considerably when she was able to reunite with the psychotic person she was... I was very moved by that...and she at the end of the treatment brought in these animals to let me have them, to keep them. She may show up some day and ask for them back, but I loaned them from her, she's quite a wonderful person who's in the [mental health] field actually.

Dr. D began treating Monica “three times a week, for about 6 months”, but then went “down to twice a week, once a week, once every two weeks, and finally once a month”. Occasionally they would meet “more frequently when [Monica] felt shaky as she was getting reacquainted with some of the earlier psychotic material”. They only met



“twice more” after termination, but Dr. D recalled seeing Monica “occasionally and professionally from afar”.

Dr. D: Successful Case 2: Thomas

The second case Dr. D chose to discuss was someone he treated in the “middle seventies”, “three times a week”, for “over three years”. Thomas was a “young man”, in his late 20’s, who was at the time a musician, in college, but “he couldn’t earn any money and he was tied to a family that hated him”. “He was very angry”, Dr. D explained. “He was sort of homosexual; if that had taken place now his life would have been a lot easier, but at that time he was truly tormented by it”.

According to Dr. D, Thomas had “also been a mess”. “Somewhere between nuts and just a behavior disorder; a troubled psychopathic, he caused a lot of trouble to his family, and the hospital they sent him to. He used drugs a lot, LSD at the time”.

Dr. D felt Thomas’s use of LSD and marijuana “really contributed to the disintegration of his personality” and made it harder for him “to have any kind of a life”. He thought that “each time [Thomas] took LSD, his mind was blown for weeks and [they] (Dr. D and Thomas) couldn’t make any headway”. Dr. D discussed with Thomas his feelings about him “testing the limits” and told Thomas “that if he took acid again, he (Dr. D) would be unable to work with him (Thomas) again”.

After about a year into treatment Thomas showed up in Dr. D’s office one morning, “pale, sweaty”, and “he confessed that he had just taken acid”. For Dr. D the question was to whether “keep [his] word” and “maintain the frame and the structure” or whether “to talk”. They “ended up talking”.

...And the reason I mention this, was the decision to not practice principle, but to do the right thing. There’s a saying that one of my teachers used to

say “every once in a while one must rise above principles to do the right thing”. With him, it turned out that the right thing was not to kick him out according to my word, to my principle, but to talk to him.

Thomas had taken acid at “about 4 o’clock in the morning” that day, and “at about 7 o’clock”, he went over to his Grandmother’s tomb and “thought he heard voices from the tomb”. He then “went home, looked in the mirror, and thought he saw a baby’s face, his face”. He had “a number of hallucinatory experiences and was very shaken by them”. According to Dr. D, “it turned out that what [Thomas] found out in that acid experience brought him to the center of his problem in life”.

And he would have not have gotten it without this. That is, there was a baby who was born and died, when he was about 3 and-a-half years old. And that had been suppressed, repressed and never mentioned, but his experience of that baby’s death, which was recovered at his grandmother’s tomb and in the face of the baby and his face in the mirror, opened up an enormous amount of material that we worked on for the next year. And he was able to bring his life together because he was finally able to face... an enormous guilt for what he felt was the murder of the baby; unconscious, and that kind of activity led him to be able to resume some kind of meaningful life.

In spite of the fact that Thomas “lived a difficult life”; he was “still flaky”, and “left therapy without all of it being resolved”, but for Dr. D, there was a major issue resolved: “[Thomas] was able to live a life”.

Most of life has to take place in life, not in therapy. Therapy is only a substitute in a way, but we’ve turned that around. Many people today think therapy is life, and it’s not, so I was very glad to work with him briefly, and then for him to have real life, to have the rest of his therapy go on in life, with people, and so on. I think that was very successful...

#### Dr. D: Successful Case 3: Sara

This case was spontaneously mentioned by Dr. D. as an example of a successful “dream therapy” with a person “who considered herself to have become invisible”.

Sara was the daughter of two Holocaust survivors, both of whom had lost their previous children in the Holocaust. Sara's parents came together in a displacement prisoner's camp, where her mother became pregnant with her. She was her mother's second child and her father's third, and "each time they looked at her she felt that what they saw was their dead children"; "their eyes filled with tears and grief".

Every time they looked at her, in her experience, she felt that she could only be loved if she was dead, and little by little she became dead. She still dressed and lived, and went to school, but inside, the Neshama, the soul, was dead.

Dr. D saw Sara "three times a week" for approximately "four years", a time period in which they developed a "very warm relationship". It was in the frame of this relationship where, according to Dr. D, Sara "developed a series of dreams that healed her".

By that I mean that the dreams brought her parents together. It was only in the last two dreams when she realized that she had been dreaming this for ten years. One parent was in China, the other parent was in Austria. Then one parent was in the North Pole, the other in the South Pole. Then little by little they got closer, and finally there was this dream where they both appear at her bedroom door. She is making love with her husband, and as she is making love, and he is about to come, she looks over to the door and sees her parents and indicates to them: "this is how you do it". And the hope is that they would then be able to make love, finally. They were both dead actually, but they would make love in imagination, and at the moment of conception her soul would join the self, which is a folk myth about how life begins. At conception, the soul is sent down...and then she could live, she could then be a live child and not a dead child. And that dream clarified that for her. It was at the end of a prolonged difficult therapy, but she was able to blossom.

Dr. D explained that even though Sara was "still a loner"; "occasionally invisible", "occasionally depressed", "therapy" and "her dream" enabled her to "resume to be in the living" and become a "fine artist and mother".

To the question regarding what each of these patients might say about treatment if we were to bring them to this interview, Dr. D responded openly and very thoughtfully. He explained that Monica would probably say that he was “patient” and “interested in her”, since he was “very careful with her”, but “very interested”.

According to Dr. D Thomas would say he (Dr. D) was “a pain in the ass”

He thought I was just one of these shrinks, that I had some conventional ideas, that I was too caught up in my own image and being, doing well, and then too caught up in capitalism, he hated it. He had big fights with me about money, and really attacked me enormously. I think to help me understand something about what his life was like, devastating for him, or guilty, he made me very guilty about my materialism, so...But he would remember that I was a jerk, but that I also liked music and jazz. We talked a lot about jazz.

Sara would probably remember that Dr. D encouraged her artistic skills. She “might also be angry”, Dr. D recalled, at the thought that she “wanted [him] to probably save her”, “to run away with her”, and “she might feel angry about that or hurt”. Dr. D thought Sara would also remember him “as a fellow Jew”, and as somebody who helped save her “psychological life” with his “interest in dreams” and his “interest in art”

Dr. D hesitated for a moment after he responded to my question and expressed feeling aware that this was something he had “never thought about before”:

I just think that I am not very coherent about what I think is in their head after, because I guess I leave that up to them. I don't do interpretations very much, either with dreams or with peoples' symptoms. I think people have a need to find who they are, on their own terms, when they get around to it. So I would ask them what they think, and then I would know, but I don't know that I imagine or think that I might know what's in their mind. So it's an area that I haven't really thought about. I've noticed that I am a little shy in that area because it presumes too much, and it's my fantasy.



Something that struck me after Dr. D shared his thoughts on this matter, was the fact that in his immediate response about how he imagined his patients would remember him and the treatment he conducted, he mentioned many negative thoughts. Considering that he specifically chose the cases he discussed because he thought of them as “successful” cases, one can wonder what could have pushed Dr. D in such a direction. Being intrigued by this at the moment of the interview, I decided to go ahead and ask him. The following was the dialogue at the time:

Interviewer: I think it is interesting that you mentioned these three cases as very successful, but when I asked you to imagine what they would say, you mentioned a lot of negative things, like anger...

Interviewee: Oh yeah. Disappointment... Well I think that it is a person's freedom to not idolize the therapist... that the person has to free themselves from the therapist, and sometimes that's done with ambivalent feelings, and the life of ambivalent feelings is holy. I am a little nervous when somebody has entirely positive feelings. I feel something's not real about it. Because I know in my own experience with my therapist I have plenty of mixed feelings, so why should people I work with not have the same?

#### Dr. E: Successful Case 1: Caroline

Dr. E began seeing Caroline in 1972 and treated her for about 15 years. Caroline was in her early twenties and had already “been through a slew of therapists” at the time she started treatment with Dr. E. According to Dr. E, Caroline had “a symphony of pathology”:

She was homicidal, she was suicidal, she had tried to attempt suicide and she had also attacked people. She was a self-cutter; she was paranoid. She was addicted to a number of street drugs and she was also addicted to, I think it was Valium at the time, and she'd been put on a lot of drugs that she was prescribed that she was abusing in one way or another. She was having sex with, sort of indiscriminately with men and women, she'd gotten pregnant twice and had two abortions by the time that I saw her, and I discovered later that she had been bulimic although I didn't discover

that until 5 years into treatment when she said to me: "oh by the way I'm not puking anymore." She had a powerful phobia about dying, and she had some compulsions including hand washing and a few others.

Dr. E explained that "everybody but [her] had diagnosed this patient as schizophrenic", and that with the help of her supervisors at the time she had been able to make the adequate diagnosis of "borderline towards the psychotic end of the continuum". In other words, Caroline "was disorganized enough when she was under stress that she looked psychotic".

Dr. E started seeing Caroline once a week, but as she "became more attached she was able to tolerate twice and then three times a week". Dr. E saw her three times a week for "a number of years" until the twelfth year of treatment she began to cut down the number of sessions, to twice a week, then once a week and finally to "whenever [Caroline] needed it".

Dr. E considered this case a successful one mainly because of the changes in Caroline's life:

She's quite a transformed person... and she had been in and out of mental hospitals again and again when I first saw her and now that's a thing of the past. I wouldn't say she's a poster child for mental health at this point, she still can become paranoid, she's having a bit of a hard time with her own daughter's separation from her. But she feels that her life was saved by the therapy. She's lost most of the major symptoms, she was able to marry and raise a daughter who is much healthier than she was. She enjoys her life. She doesn't cut her self, she doesn't smoke, and she doesn't overeat. But, you know, if you asked her she'd probably emphasize the internal things; that she feels that she has a self now, that she values herself. That she's able to stand up for herself and be protective toward her family. She's never really gotten good at holding a job but she's been able to be a pretty decent homemaker and spouse and mother. She used to torture animals as a kid and she got a dog and was able to be very loving to the dog.

Caroline is still “occasionally” in touch with Dr. E. Dr. E will hear from her “four or five times a year”, either because “something is bothering her and she wants to run it by [Dr. E] or because she is feeling particularly good and wants to express her gratitude”. According to Dr. E, Caroline is “very touching in her sense of appreciation for the psychotherapy”.

Dr. E believes her treatment with Caroline was “highly cost-effective”:

I think even though I worked with her many, many years and at a high frequency for most of the time, I’ve saved the state an awful lot of money that would have otherwise went to her bouncing in and out of mental hospitals, abusing drugs, possibly being involved in criminal activity, hurting other people, or herself. So I think it has been highly cost effective despite peoples’ feeling that psychoanalysts keep their patients forever and see them too frequently.

An important issue emphasized by Dr. E is that with the help of treatment Caroline was able to “break the re-traumatization of each generation by families that have been damaged”, and do “a lot less damage to her daughter than was done to her”.

When asked about her thoughts on what Caroline might say about treatment if we brought her to the interview, Dr. E responded promptly that “she would probably say she has hope now”; “she has a capacity to love” and “she feels a sense of continuity of who she is and she’s not ashamed of it”.

To illustrate Caroline’s feelings towards treatment, Dr. E told about a “wonderful dream” Caroline brought to a session towards the end of the therapy together. In the dream, Caroline found herself in a mental hospital but then realized she “was on the other side of the partition”; she realized “she was not a mental patient”, but a “visitor”.

And then she realized she was hungry and she went down to the hospital cafeteria to get something to eat and she went through the cafeteria line and the cashier at the end told her “oh you know you can’t get that, because only the patients are allowed to eat”. And she thought about this

and she thought, “that’s not right, I should be able to eat even if I’m not a patient”; and she argued to that effect and persuaded the cashier and took her food and left with it.

According to Dr. E, this dream showed “the switch from [Caroline’s] thinking of herself as a mental patient”, as well as the “internalization of the idea that you are allowed to take care of yourself even if you are not a mental patient”. In other words, Dr. E explained that Caroline would appreciate “that internal change”: the feeling that “she has the right to take care of herself” and the “right to live a good life”. Moreover, as mentioned by Dr. E, Caroline “would also probably emphasize understanding herself”; she would now be able to understand why her history had inclined her in what seemed “crazy directions” and would be able to “do something about it”.

#### Dr. E: Successful Case 2: Andrea

Dr. E treated Andrea about 25 years ago. She saw her approximately three years, three times a week. She presented with “a lot of anxiety symptoms” and “some worries connected with a life-threatening allergy that she had”. She also had a “somewhat difficult marriage” and some problems with her job — “she herself was a therapist who had a difficult job as a therapist, dealing with patients who had been extremely abused or neglected”. Her work induced many feelings in her and “she needed a place to talk about them”. She also had “difficult parents” and was “stuck” in some “oppositionality patterns,” that were related to her father and mother.

For Dr. E this represented a successful case because of important changes in Andrea’s life:

She became more self-protective about the life-threatening allergy. And she wore a medical bracelet that she had been too proud to wear before; those very concrete things mattered a lot to me because I worried with her about her dying. But she would say that her self-esteem improved a lot,



that she became less automatically oppositional, that she felt some support for her very difficult work and that it became easier for her over time, psychologically, easier emotionally, that she made progress in terms of being able to deal with authorities. I think she understood herself very well and didn't enact her stuff in that setting (her work) and was able to make a great contribution within that setting. Her marriage improved and her relationships deepened. She did well with her kids and she became highly successful, both in her work and a couple of things sort of on the side, artistic things that she did.

It is interesting to note the disparity between the two cases presented by Dr. E in terms of the degree of depth that she chose to go into. In the first case, Dr. E offered a very detailed and extended description of Caroline's symptoms, treatment and improvements, while in the case of Andrea, Dr. E limited herself to a brief portrayal of this patient's difficulties and specific changes.

One can wonder whether the discrepancy in the degree of elaboration on the two cases could stem from the difference in length of treatment. In the case of Caroline, the treatment lasted for 15 years at a "high frequency" and Dr. E followed her up for a long time after termination. In the case of Andrea, the treatment lasted for three years only, and we lack the information as to whether Dr. E followed-up this case after that period. It could be speculated that after spending so much time with Caroline, Dr. E might have felt more invested with this case as compared to how she might have felt with Andrea's, offering therefore a much more detailed description of Caroline.

### Discussion

This section will address two themes that emerged in therapists' understanding of success through their own clinical case examples: general characteristics of the cases and therapists' reasoning to explain why these cases were considered to be successful.

### Characteristics of the Cases Chosen to Illustrate Therapeutic Success

There were certain similarities in the type of cases (initial diagnosis), and in the specific characteristics of treatment (c.g. length and frequency) described by therapists participating in this study. The initial severity of the patients' disorders is something that stands out. Drs. A, B and E specifically mentioned cases of people whose psychopathology was so severe, that professionals before them had misdiagnosed them with schizophrenia. The first case that came to these therapists' minds when asked about therapeutic success seemed to be the case of someone who was "misdiagnosed" and properly diagnosed by each of these participants as someone in the "borderline spectrum" of functioning. This sheds light on the meaning of making the right diagnosis and the importance for these therapists of properly diagnosing their patients as an essential step towards therapeutic effectiveness.

Even though Dr. D did not explicitly mention a categorical diagnosis for any of his cases, he did talk about Monica, who "probably had a schizophrenic breakdown in her late teens" and about Thomas, who was described as a "troubled psychopathic", "somewhere between nuts and a behavior disorder", both patients presenting severe symptomatology.

The choice to address cases of patients presenting severe psychopathology to illustrate therapeutic success could be understood from different perspectives. On the one hand, there is the possibility that helping a patient who is initially severely mentally ill could have made a bigger impact in the professional lives of these therapists. This can be because there is more room for improvement for someone who starts treatment with a severe mental disorder than for someone who is healthier, or because the professional

gratification of being able to help someone who is so mentally ill is enormous, especially if we consider that most of these cases were treated in an earlier stage of these therapists' professional careers.

On the other hand, this may be a group of therapists that might be particularly interested in severe psychopathology since several of them have even written about these types of patients. Therefore, and taking into account that perhaps a big part of their case loads include these type of patients (patients diagnosed in the borderline functioning spectrum), their tendency to address these cases when referring to therapeutic success would be understandable.

Another common characteristic observed in three of the nine cases described by all participants is the involvement of these patients in the mental health field. The cases of Elizabeth (described by Dr. B), Monica (described by Dr. D) and Andrea (described by Dr. E) allude to three patients that were in this field, either before or after treatment. One can wonder if there is a natural inclination for people who are involved in mental health to seek therapy, being themselves more aware of their difficulties and more knowledgeable about treatment. On the other hand, there could be an identification with the role of the therapist that might foster in the patients an interest or motivation to pursue further studies in the area of mental health and to become themselves providers of treatment.

In order to better understand any existing preference or bias in the cases chosen to be described, it would be interesting to learn the percentage of patients in these therapists' caseloads that are in one way or the other related to the mental health field. Unfortunately we lack that information.

Another characteristic shared by most cases is the length of treatment. One would presume that participants, being all psychoanalysts, would tend to address cases that were seen for a long period of time. Therefore, it is not surprising that cases described by therapists to illustrate therapeutic success range from 2-and-a-half to 15 years of treatment, and from a frequency of two to four sessions per week (see Table 2).

What might be unexpected is the importance that most participants attribute to follow-up. When asked what was it about the case that made them think of it as a successful one, most therapists mentioned the fact that they followed-up those cases as something crucial in helping them realize that the treatment had been successful; following up their patients as long as 15 years (e.g. Dr. B) or even longer (like Dr. E, who is still in touch with Caroline).

These therapists might believe (like Dr. A), that an important trait of psychoanalytic treatment is the thought that the patient “continues to improve” once the treatment is over. Therefore, follow-up acquires a predominant role in order to evaluate therapeutic success according to this concept.

A different way to understand the importance of follow-up was illustrated by Dr. E, who viewed follow-up as a natural step after termination given the “intensity” the therapeutic relationship reaches during treatment:

Well I think psychotherapy is a chance to go through developmental things that somehow didn't go right in your own family. And normal development doesn't involve the parents dropping off the face of the earth once the child is launched so it seems to me that the attitude that my door is always open is just a basic attitude for a person in a therapeutic role. And I like it when I hear from my patients about how they are doing. I don't systematically follow up on them, I don't have a general policy that I call them up and interview them at one year and 5 years and ten years but I do encourage them to get back in touch with me periodically and let me



know how they are doing. It just seems like a more natural way to process the slow emergence from the intensity of the psychotherapy relationship.

Another striking characteristic of the cases selected by these analysts is the time frame when treatment took place. Overall, the starting point of therapies offered by participants ranged from 15 years ago to 40 years ago, with a surprising average of almost 25 years ago. In other words, therapists chose to illustrate therapeutic success mostly through cases that they began seeing more than twenty years ago.

Given the importance that these analysts attribute to follow-up, and also given that some therapists, like Dr. B for example, followed-up their cases for up to 15 years, it might not be surprising that they chose to discuss cases seen a long time ago so they could observe the evolution of the patient over time.

One might wonder about the way in which follow-up is integrated in the process of treatment. From this therapist's perspective, when does treatment really end? Is termination something conceptualized to occur before the initiation of follow-up, or is follow-up simply another crucial piece in the process of therapy that eventually leads to a new and revealing type of termination in which change and improvement can be truly observed?

### Therapist's Understanding of the Reasons These Cases are Successful

Several common themes emerged regarding therapists' understanding of success in their own clinical cases. A dominant theme conveyed by all therapists was symptom reduction. Specific examples in this area included issues such as: "stopped cutting herself", "stopped overeating", "became less depressed", "her anxiety decreased"; which in broad terms included a wide spectrum of symptoms typically addressed in the Axis I of the Diagnostic and Statistical Manual of Mental Disorders.

Another salient theme in therapists' responses was professional success. Many of the patients not only succeeded in their professions but also were able to excel in their work and make important contributions in their field (for example, the cases of Andrea described by Dr. E, Elizabeth described by Dr. B and Bill described by Dr. A).

In regard to professional accomplishments, several therapists mentioned the capacity to become more creative as well as the ability to develop artistic skills as two significant dimensions in their understanding of therapeutic success. Dr. A addressed the case of Silvia, who with the help of treatment became surprisingly "gifted in art and design"; Dr. D mentioned that with treatment Sara "became a fine artist", and Dr. E illustrated as an example of improvement the fact that Andrea became highly successful in doing some "artistic things" on the side of her job.

A third theme that emerged regarding therapists' illustration of therapeutic success through their own clinical case examples was relationships with significant others; specifically the relationship with a romantic partner. The fact that the patient was able to establish a long-term intimate relationship and get married was something commonly mentioned by these therapists as a signal of major improvement.

Similarly, the capability to "fall in love" and be "emotionally close" to someone else was particularly emphasized by Dr. B, for example, when he described Andrew's improvements, as well as by Dr. E who also addressed the way in which her patient's "relationships deepened" as a result of treatment. In the same line, the ability to "overcome a sexual inhibition" (as mentioned by Dr. B) and to "be open to a sexual life" (as explained by Dr. D) was regarded as something crucial.

Other than romantic relationships, therapists often addressed improvement in the relation between patient and his/her parents as well as with his/her children as an indicator of therapeutic effectiveness. Dr. D, for example, described Sara's treatment as successful in that Sara was able to reconcile with her own parents.

Similarly, Dr. A referred to Silvia's case as someone whom, with the help of treatment, was also able to "come to terms" with her own parents, and was able to properly "raise her daughters". The capacity to parent and properly relate to their children was a concept particularly emphasized by Dr. A, as well as by Dr. E.

Dr A elaborated on the concept of "trans-generational transmission of trauma", and explained that one of the achievements of treatment was that Silvia was able to put a stop to the "transmission of trauma across generations". Dr. E addressed this idea as well when she explained that with the help of treatment Caroline was able to "break the re-traumatization of each generation" and "do a lot less damage to her daughter than was done to her".

Up to this point there is an interesting coincidence between these salient themes and what Dr. C pointed out to be Freud's notion of therapeutic effectiveness: the "capacity to love and work". However there seems to be a third category, addressed by all therapists, that alludes to internal changes or achievements made by their patients. Dr. B briefly touched on this dimension when he described Andrew's case and the change in his "deepest attitude towards himself".

Dr. E elaborated this further when she stated that "Caroline would probably emphasize the *internal* things", and by this she meant that with the help of treatment Caroline was able to have a "self" and feel a "sense of continuity of who she is", and was

also able to “take care of herself”. Caroline, as explained by Dr. E, “has hope” and is “now able to enjoy life”.

This idea of a specific ability that can be fostered through treatment to “enjoy life”, to “have a life” or to “live the life [the patient] was meant for”, was a common theme throughout most cases. Dr. D elaborated on this thought when he talked about Monica and her “increasing relaxation in her entire psychology” that allowed for her to “resume the life she was probably meant for”, and when he talked about Sara, who was able to let her “soul join the self” and become alive and “blossom”.

Another theme that emerged among the cases in regard to the understanding of therapeutic success was the idea of gaining “understanding” through treatment. Drs. A, D, and E mentioned this as part of an effective change in the patient throughout treatment. In the case of Andrea, for example, Dr. E explained that she “understood herself better and did not enact her stuff”, attributing a central meaning to the idea that treatment helped this patient to understand, and that the “understanding” of her issues fostered at the same time a decrease in the enactment of these same issues.

Dr. D emphasized the importance of “rising above principles to do the right thing”, the right thing being at that point to discuss with Thomas his state of abusing drugs, which consequently allowed for Dr. D and Thomas to reach an “understanding” of Thomas’ situation; a crucial understanding that perhaps would not have been reached otherwise. What Dr. D was really touching on was the idea that therapeutic success has to do with particular turning points in the process of treatment in which a new understanding of the patient’s life is gained by the patient and by the therapist.



Dr. B also addressed the process of therapy in order to answer the question about outcome exclusively focusing on the idea of understanding. In the case of Andrew, for example, Dr. B explained that its success stemmed from the fact that they were able to “work through” Andrew’s issues and that allowed him to “resolve these problems” and “change his deepest attitudes”. Once again the conceptualization of a process in which understanding is essential and leads to ‘resolution’ and improvement is conveyed.

Linked to this idea of understanding is the concept of “thoughtfulness”, raised by Dr. A when she described the case of Silvia. Dr. A mentioned as an indicator of therapeutic success the fact that Silvia had become “thoughtful”, which is concordant with her thoughts about therapeutic effectiveness in general abstract terms (raised in a previous section) where she alluded to the “capacity to reflect” as an essential indicator of therapeutic success.

Similarly, Dr. E emphasized that if questioned, Caroline would probably allude to the “understanding of herself” as a crucial gain of treatment. Most therapists described their impression of what their patients might say if brought to the interview in very positive terms, with one interesting exception: Dr. D.

Dr. D addressed the “life of ambivalent feelings” towards the therapist as something “holy” and explained that “the person has to free himself/herself from the therapist” and that this is sometimes done with “ambivalent feelings”. He introduces an understanding of therapeutic success in which the idea of “realness” is conveyed, in that treatment can help someone view the other person in a genuine and real way. It is this wholeness or realistic view of the other (including the person of the therapist), as opposed to an “idealized” or “purely positive” position, that is illustrated in the ambivalence, an

ambivalence which manifests itself in the recognition of positive as well as negative qualities in the other person.

Developing realistic (or “integrated”) views of others that contain both positive and negative aspects is a significant achievement of healthy development. Even though this understanding is firmly based on theory and has been elaborated and postulated by different schools of thought in psychoanalysis, it may represent a controversial stance for outcome research. Usually, a successful treatment would be associated with the expectation that the patient would report mainly or uniquely positive impressions about the past treatment. However, Dr. D uses himself as a clear example to illustrate that this might not always be the case. He explained that in his own experience he had “plenty of mixed feelings” with his therapist, so “why should [his patients] not have the same?”

#### Therapists’ Understanding of ‘Un-success’ within their Own Clinical Practices

Therapists were more hesitant to discuss what they considered to be “unsuccessful” cases in their own careers as therapists. One of the participants worried about confidentiality when asked to describe an unsuccessful case, and it was harder for therapists in general to think about and even remember examples of these types of cases.

##### Dr. A: Unsuccessful Case 1: Marian

When asked to discuss a terminated case in her whole career as a clinician, Dr. A chose to talk about Marian. She described Marian as a “young woman”, who was an “as if” personality”, a “borderline, schizoid” personality. Dr. A saw Marian twice a week, for a period of “two years and a half”, after which Marian moved abroad.

Dr. A described Marian as “one of the cases with the highest degree of identity diffusion”, and thought of her as an example in which symptom reduction did not necessarily imply recovery. She explained that Marian had been “severely depressed” for “more than ten years” and was even hospitalized for a “whole year” prior to treatment with Dr. A.

...I think this is an example of a case where symptoms are not... she overcame her depression, she graduated from a challenging college, she engaged to be married, but her sense of her self, her dependence on her parents and the degree of somatization she had, that surprised me... surprised me because they didn't do as well.

When asked to explain the reason she considered this case to be unsuccessful, Dr. A's response was as follows:

I think that this is the kind of case where one could imagine constitution and “givens” as very important. She came from a family with psychotic members, so I think there was something there... she was very intelligent... and it could have been also, you know there is always a possibility that you will not be the best therapist for that particular patient. She came and she came religiously, but there may have been some limitation of my own, in terms of the effort that I put into that patient, I really gave it all of my best, but she didn't go where I would have liked her to go, her relationship with other people really was very tenuous, conventional and formal, and unsuccessful because she was like an echo of whom she related. So when people discovered that, they withdrew systematically... I think there's something that I didn't understand...I think I was therapist number 8. So it was possible that this patient had something with her psychic functioning that made her... like a stone.... A very interesting case.

Dr. A explained that Marian “wrote a letter” to her, where she apparently “realized that she could not use what [Dr. A] had to give her”. According to Dr. A, Marian had “some perception that what [Dr. A] had to say was useful, but she could not use it”. Dr. A indicated that if she were to describe Marian, she would call her “my impenetrable patient”.

Dr. A clarified that this was a “terminated” case, and recalled recommending Marian to continue treatment, since “therapy can last 6 years for this kind of severity”.

When asked to describe another case that she thought of as “unsuccessful”, or “ineffective”, Dr. A responded as follows:

I haven’t had unsuccessful treatments. I have had partially successful in the context of things. I remember one of my teachers saying: “you cannot help everybody all the time, but you can always help somebody some of the time”. This is very true. So I haven’t had any case get worse, for example.

Dr. B: Unsuccessful Case 1: Sandra

Dr. B chose to talk about Sandra as an example of an “unsuccessful” case in his clinical career. According to Dr. B, at the time Sandra came to see him she “had already been in psychoanalysis before, which was unsuccessful”.

She had a very typical combination of narcissistic-masochistic personality disorder... Patients who combine the narcissistic grandiosity, yet with terrible suffering, and an attitude: “I am the greatest sufferer in the world”, so the greatness comes from the greatness of their suffering. In the course of that analysis, the need to demonstrate that she knew everything better than I, and the gratification with my being unable to overcome that, was more important than her wish to get better, which was suffering from depression...from any impossibility of establishing a relationship with a man.

Dr. B described Sandra as a “beautiful”, “highly intelligent”, “successful lawyer”. She had “men around her all the time”, but on the one hand she managed to “devalue” all men who were “really giving and warm”, and on the other hand to get “fixated” on those “more narcissistic and frustrating men”, who treated her terribly. According to Dr. B, Sandra was “grandiose, arrogant, and sadistic” with nice men, and “totally in the hands of



people who mistreated her”. Dr. B explained that this pattern replicated in the therapeutic relationship with him:

And you can see how in the treatment she tried to put me even in the position of a nice, warm man who was totally incompetent, and whom she had to depreciate, or a “sadistic son-of-bitch” who was making her suffer, and efforts to interpret that pattern really didn’t lead anywhere, and it was as if she got so much pleasure out of the sense that she could defeat all my efforts, that at the end, I raised the question with her: “It looks more that you are here to show me that I can’t do anything to help you, than because you are concerned about yourself”, and she triumphantly said, “Ah, ha, you’re giving up, you see, I knew it, you’re giving up on me”. This was the atmosphere.

Dr. B explained he “tried for about 4 years and a half”, until he decided to tell Sandra that he “could not help any further” and that he “wanted to refer her to someone else”. To this, Sandra responded by saying that she “had had enough of treatment” and that she was going to “deal with her life on her own”.

By the time treatment ended, Sandra was “living alone”, and was “having affairs with men that were unsatisfactory”. According to Dr. B, she had the fantasy of having children, but then “gave it up” because she felt they were going to be “kind of a bother”, being, as worded by Dr. B, “too narcissistic for that”.

Dr. B saw Sandra 25 years ago, 4 times-a-week. He thought Sandra was an example of an “almost untreatable patient”:

And there were times when she went into relationships that threatened her professional stature, and I was able to help her on various occasions from avoiding that she get herself into a terrible mess. ... But as a reaction to that, there was such intense aggression toward me, a sense of humiliation, because I’d helped her, and that I must be gloating for the fact that I’d helped her, that it spoiled it, it never left anything positive. Andre Green would say that the death drive was so strong in her, the need to destroy any helpful objects. That’s an illustration of a case where I think I did as much as I could. ...It was a very intense treatment. I learned a lot from that case.

Dr. B explained that he “often had the fantasy” that he was able to “resolve” the therapeutic relationship with Sandra: “there was something teasing about her, she invited one to not give up, to then be triumphantly rejecting”.

When asked to describe what he thought Sandra might say about the treatment if we were to bring her to this interview, he responded thoughtfully that he believed Sandra would say that she had had two psychoanalytic treatments, and that they “did not help her”. According to Dr. B, Sandra would also say that the psychoanalysts were “terribly stubborn”, “rigid” and that they would have to “have it their way”; they were “arbitrary”, “inattentive”, “argumentative”, and “unreliable”.

Dr. B: Unsuccessful Case 2: Mary

The second case spontaneously mentioned by Dr. B to illustrate an “unsuccessful” treatment was the case of Mary, an 18-year-old girl Dr. B treated 20 years ago. Dr. B described Mary as a “beautiful”, “attractive” girl; with a “symbiotic relationship with her mother”, “multiple drug abuse”, “shoplifting” and “chronic lying”. He referred to her as a “typical borderline patient”; Mary would risk her life going into dangerous neighborhoods at night to pick-up men to have “sexual experiences”. She would expose herself to “life-threatening dangers” that, as indicated by Dr. B, he would “try to stop” unsuccessfully, by “setting clear limits”.

She was unable to really stick with the contract that we had, and used drugs again and again to small extents, not enough to say that “this was it”, but that, combined with chronic deceptiveness... I could never find out what was really going on. She was not an antisocial personality, but she was really unable to establish a relationship with me that permitted to explore that fully in the transference. I had a sense that I was never really able to establish a fully honest relationship with her.

Dr. B explained that there were “things going on outside the session” that he would only learn about “after the fact”. Mary’s parents would call Dr. B “in despair” every once in a while, occasions in which Dr. B would learn about instances that Mary was not reporting in the sessions.

There was not enough control; she was supposedly studying in a college setting, where she attended enough so it was not a major crisis ever, but she failed her courses; everything was chaos, and I was unable to go through that. It was like a big cloud of half-truth, chronic dishonesty that made it impossible, so that the antisocial features reflected in chronic mendacity in the relationship, which made treatment impossible. ...I tried to for a long time, for a year and a half, in which I didn’t notice any change, and it was clear treatment failure.

Dr. B believed that the most important prognostic feature for failure is the “degree of antisocial behavior”, and that patients with such “implicit lack of honesty” would tend to fail with “all kinds of treatments”. He did note though, that in the hypothetical case that Mary came back to treatment, he would “accept her” and “try again”:

If she came back to treatment, I would accept her; I would try. If this young girl, well she is not so young any more, if she came back, or if somebody like that came back, I would make it very clear that absolute honesty is a precondition in the light of our past experience, and if I discovered that was not so, I would end the treatment. So it would start out with a big bang.

When asked what he thought Mary would say about treatment if we now brought her to the interview, Dr. B answered without any hesitation that she would probably say that he was “a very nice man”, but he “didn’t understand anything about life”. Dr. B thought Mary’s words would be the following: “I don’t know what he wanted; it never made sense to me, I don’t know what it was all about”.

Dr. D: Unsuccessful Case 1: Martha

Dr. D described without any uncertainty the case of Martha as an illustration of an “unsuccessful” case. Martha was a psychiatric nurse he treated in the seventies, 2 to 3 times-a-week for a period of a year and a half. Dr. D thought that nowadays her diagnosis would be of a “borderline”, and he explained that he felt he just “did not get it with her”.

I mean... I thought we had a good relationship going, she seemed to be getting better; she was less depressed. She just became enraged at me, and I never understood why that happened. And it ended up with phone calls late at night, screaming. It was awful... She had had this kind of experience twice before, but again you assume you'll be able to, especially with this faith, you assume you'll be able to help. And I wasn't mindful enough of the small signs of hatred, disappointment, need that wasn't gratified and so on. And that was terrible. It was terrible because she was in a great deal of pain, and I felt responsible for it, didn't know what to do about it, because it frightened me, I was very frightened.

Looking back at this case, Dr. D explained he thought he had been “naive” and too “open” with Martha, and he probably “shared too much with her”. He learned from this case that that kind of openness is “very important for some people”, but for others it may be “dangerous”.

When asked about the specifics of the case that made him think of it as “unsuccessful”, Dr. D explained that Martha was “in terror and rage”, and that she spent her nights “wanting to destroy”.

I was terrified she was going to kill herself, or me, or my child at the time. She was wild, raging over. She had a breakdown, and I was unable to help her, or to direct her to some place where she could get some help. What she needed was to be hospitalized at the time. She'd been a nurse in a psychiatric hospital for a long time, and needed to be one of the patients. I don't even know what happened to her. Just ended one time. I was so frightened by what was happening, I wasn't able to stay on top of it enough to learn about what happened in her life.



Dr. D thought that if we brought Martha to this interview “she would not want to be here”, “She would just scream and yell, and jump up and down, try to kill me, I don’t know”. Dr. D explained that in treatment with Martha, they “opened up the realm of hatred that’s extreme”, and that for him it is hard to work with that amount of hatred.

Some people work well with hatred. There are people who are tougher than I am, and who are willing to be criticized, and have an easier time being hated. I have a difficult time... and so when I began to feel that hatred coming, or hatred developing in me, I must have done things with her, in an effort to overcome that, rather than to go into it. I thought I was going into it with her actually, but it made it worse. Even though I was relatively less experienced I wasn’t inexperienced with psychosis and with hatred, but I have a hard time... some people do better with suicide, threats and with hatred, than I do, I have a hard time with it.

Dr. D: Unsuccessful Case 2: Toni

According to Dr. D, he has been “very fortunate”, since “people respond well to what [he] does”. However, as mentioned by him, there are some cases in which he “does not get to follow-up” his patients in order to learn what might have gone wrong. It was in this context that Dr. D mentioned the case of Toni. He had “three consultations” with Toni, slowly getting “further and further” into them, and then all of a sudden “[Toni] disappeared”. Dr. D explained that he called Toni, he even talked to his wife and she reassured him that Toni would get back to him, but he did not. Dr. D sent a letter in which he wondered if there was “any way in which [Toni] would let [him] know what went wrong”, but never heard back from him.

Dr. D expressed that until this day he feels “puzzled”:

I’m puzzled, I am thinking about what went wrong. And what was there about the interaction that enabled me to think that it was going well, when in fact it wasn’t. Why didn’t I see that? What was I insensitive to? What is there about this guy? You know, I have had a lot of thoughts about that, but I really don’t know. I think I identified him probably too much with my son. I think I probably missed a number of things, but mostly I don’t

know. It's puzzling. That's the most recent failure. But maybe it's not a failure. It's a failure and it isn't. Maybe he found that we were not a good match, and he just didn't want to waste his time, or money, helping *me* think about it. I just hope he found himself someone he could talk to, because he was in real trouble.

From Dr. D's point of view, the "people [he] has worked with over long periods of time" would not be considered by him as "failures", but he would consider them "mixtures"--"complex mixtures".

Dr. E: Unsuccessful Case 1: Nicole

When asked to describe a case treated at some point in her entire career that could illustrate an "unsuccessful" treatment, Dr. E hesitated for a moment and then talked about Nicole:

There's one woman I feel bad about. I think I failed as a therapist and I'm not sure I could have helped her anyway because I think there was considerable sexual abuse in her history and she was very reluctant to talk about that. Now when people decide they are not going to talk about some important area of their history, I think Freud was right about that, it's like cornering off a city and saying "the police aren't going to go there", so all the riff raff ends up there.

According to Dr. E, Nicole began treatment with "a lot of anxiety" that Dr. E might be "one of these seductive kinds of women that suck up to men". Nicole happened to see Dr. E in a different context, twice, accompanied by a man. As explained by Dr. E, Nicole interpreted Dr. E's attitude toward the man as "seductive", which was not the "internal attitude" perceived by Dr. E. at the time. After the second time Nicole saw Dr. E in a different context, she felt, according to Dr. E, that Dr. E was "too dangerous to work with".

I still feel bad about that treatment. I couldn't find a way to... when people see you out of role they tend to think they are seeing the real you even though their transference is still really active, and I just couldn't keep her and I think she gave up on therapy after that.

Dr. E saw Nicole “once or twice a week”, for “as long as a year”. For Dr. E, this was “long enough that [she] felt it was really a shame for that to have happened”. Dr. E “liked [Nicole] a lot”. She described Nicole as “talented” and “passionate”, and as someone whom “you could see so much possibility for her life” if she “could have slowly let herself be completely known by another person”. But, as indicated by Dr. E, “[Nicole] was so conflicted about that”.

I think that the treatment is not going to be successful if the patient doesn't trust the therapist, and her experience of me was that I wasn't trustable. So I just don't think it's possible to open yourself up to somebody you don't trust. Everything else is secondary.

Dr. E thought that if we brought Nicole to this interview she would say “she got very disappointed at [Dr. E]”, because Nicole “did not feel [Dr. E] was trustable”, or the “type of person she would like to identify with”. According to Dr. E, Nicole saw her (Dr. E), as a “feminine woman”. This, understood within the context of Nicole's history of abuse, made her feel it was “terribly dangerous” to identify with the kind of women who would “invite any sexual response from men”.

To the question as to whether a natural percentage of the cases seen by a therapist end up being “unsuccessful”, Dr. E answered affirmatively.

Yes, it's hard to help people and just as educators can't assume that every kid that they teach is going to learn everything that they have to teach, or doctors can't assume that they are going to cure everybody, I don't think therapists can assume they are going to help everybody. But I think most of us start with a hope that we can and we approach every client with that hope. But no, I think sometimes the chemistry is wrong between any two people, sometimes the patients' motivation isn't really very strong, sometimes the therapist misunderstands the patient, sometimes the patient withholds information that's critical for the therapist to be able to help the

patient. Some people are determined to enact something that defeats the therapist. There are a lot of reasons why you can't help everybody.

### Discussion

This last paragraph alludes to several themes that stand out in the understanding of therapeutic “un-success”, which range from patient’s characteristics (like a weak motivation for treatment on the patient’s behalf), to therapist’s attributes (such as “misunderstanding” of the patient on the therapist’s behalf). However, a crucial theme that emerged regarding therapist’s understanding of “un-success” or ineffective treatments was the *relationship* between therapist and patient.

Several other themes can be understood in light of a problematic or difficult therapeutic relationship. In this way, lack of honesty on the patient’s behalf seems to be a salient theme regarding therapeutic “un-success”. Dr. B specifically emphasized this topic when he addressed the case of Mary, and the fact that “chronic mendacity in the relationship”, expressed through “chronic deception” and “dishonesty”, made the treatment “impossible”. Dr. E also raised the difficulty implied in helping someone who is “reluctant to talk” about certain issues, when she referred to the case of Nicole. According to Dr. E, she thought there was “considerable sexual abuse” in Nicole’s history that she (Nicole) did not want to address in treatment.

At the same time, Dr. E alluded to what she considered to be an essential topic, the fact that a treatment will not be successful if the “patient does not trust the therapist”. Dr. E thought Nicole “did not trust” her, and therefore would not “open” herself to Dr. E.

The theme of trust might be relevant in understanding what Dr. E described as the possibility for a patient to “let herself be completely known by another person”. For Dr. E this was personified in the case of Nicole; for Dr. A, on the other hand, this was



illustrated in the case of Marian. Referred as her “impenetrable patient”, Dr. A explained that Marian had “something in her psychic functioning that made her like a stone”, and therapeutic “un-success” probably stemmed from the fact that Dr. A could not get to know Marian in enough depth for the treatment to progress.

One can wonder if patients’ degree of deception, dishonesty and mistrust might be directly related to the severity of the psychopathology presented by the patient. This seems likely considering that most cases discussed by this group of therapists as examples of therapeutic “un-success” were diagnosed with acute personality disorders. On the other hand, there seems to be a big difficulty among these patients to establish a relationship with the therapist.

For Dr. A, Marian’s treatment was unsuccessful in that she “could not use what [Dr. A] had to give her”. For Dr. B, the “pleasure” Sandra got out of “defeating all [his] efforts” and the “need to destroy any helpful objects” was stronger than the “wish to get better”. For Dr. D, Martha’s “hatred” and “rage” frightened him to the point that Dr. D seemed to struggle to “stay on top” of this case. For Dr. E, Nicole was “withholding crucial information” and at the same time perceived Dr. E as someone “terribly dangerous” to identify with.

All these cases have in common an acute difficulty on the patient’s behalf to, on the one hand, be able to receive the help the therapist is offering through treatment, and on the other hand, to allow the therapist to really get to know them. One can wonder whether these patients shared a wish for treatment that was somehow sabotaged by the inability to establish a kind of relationship with the therapist that could foster change and improvement.

Drs. A, D and E addressed the possibility of a “miss-match” between patient and therapist that could translate into therapeutic failure. Dr. A, referring to the case of Marian, explained that “there is always the possibility that you will not be the best therapist for that particular patient”. Similarly, Dr. D wondered whether Toni perhaps felt that they “were not a good match” thus providing a possible reason for his dropout, and Dr. E alluded to the fact that at times “the chemistry is wrong between two people”.

This “miss-match” between therapist and patient could be understood in light of another theme that emerged in regard to therapists’ view of “unsuccess”: the lack of understanding about the patient or the case. Drs. A, D, and E specifically alluded to this feeling of “missing” something important about the patient, or not being able to “understand” or “get” the patient and his/her dynamics.

Dr. D elaborated some more on this feeling when he discussed the case of Martha. He explained that Martha “became enraged at [him]”, and that he “never understood why that happened”. However, he did point out that he felt he “was not mindful enough” of the “small signs of hatred” coming from the patient, and acknowledged that for him it was especially “hard” to work with “that amount of hatred”.

A relationship between those areas of the patient that the therapist has a hard time understanding and something about the therapist’s own traits might make it specifically hard for the therapist to see, acknowledge and understand certain characteristics of their patients. Dr. D, for example, felt he could not understand his patient’s rage, but also acknowledged the difficulty he had in dealing with such levels of anger, which could eventually explain his lack of understanding.

It should be noted that while Dr. D openly referred to his difficulty to work with “hatred” as something that could interfere with his role as a therapist, Dr. B described as one of his strengths the fact that he considered himself able to deal with aggression in treatment:

I think that I am able to absorb aggression without going under, without either reacting with counter aggression or becoming paranoid, or getting depressed, or narcissistically wounded and abandoning the patient. I think that’s important when you treat very ill patients.

Dr. D brought-up two other themes that were not mentioned by other therapists regarding the understanding of “un-success” or therapeutic failure: the feeling of “fear” towards a patient, and the ‘disclosing’ of personal information.

The former was emphasized several times when Dr. D addressed Martha’s case, and how “terrified” and “frightened” he felt at the possibility that Martha might harm him; the latter was also raised in the course of this case when Dr. D introspectively pointed out that he had been “naive” and “too open” with Martha and that he had “shared too much” with her.

#### General Characteristics of the Cases Selected by Therapists to Illustrate Un-success

It seemed like a much harder task for participants to discuss their unsuccessful cases than their successful cases given that for the latter they addressed a total of 9 cases while for the former they only mentioned 6 cases and were much more hesitant to do so.

Certain common characteristics among the cases addressed by this group of therapists to illustrate lack of success or therapeutic ineffectiveness can be observed. All therapists seemed to have chosen patients with severe mental pathologies and most of them specified a diagnosis in the borderline personality spectrum. This pattern was

consistent with the type of cases selected to illustrate therapeutic success, where therapists also mentioned examples of patients diagnosed with personality disorders.

It is also interesting to note that five of the six cases ranged from one year to 4 ½ years of treatment (see Table 3) with a frequency of 2 to 4 times-a-week. The one exception was the case of Toni mentioned by Dr. D who only attended 3 sessions. This implies that these therapists spent a considerable amount of time interacting with these patients throughout the period of treatment. It may be argued that what these therapists considered to be treatments, even though they were a “failure” or unsuccessful, was a process that lasted at least for a period of a year and implied a certain amount of investment in the therapeutic relationship. This is contrary to the expectation that therapists might consider dropout cases as the most unsuccessful.

Another aspect of the cases that stands out is that half of them already had experienced previous treatments that were not successful (See Table 3). Marian had had seven previous treatments when she saw Dr. A, Sandra had had one unsuccessful previous treatment when she saw Dr. B and Martha had had two before seeing Dr. D.

Dr. A alluded to an interesting topic when she explained that she had not had “unsuccessful treatments”, but “partially successful” treatments. In the one case she mentioned as an example of an unsuccessful treatment she talked about the fact that it was not about “symptoms”. Marian had significantly decreased her symptomatology, graduated from college, even gotten engaged –all characteristics that would lead one to think of this case as successful. But it was something else, something crucial for Dr. A that made her choose this case as unsuccessful: the patient’s “sense of herself”, the degree of somatization and the type of relationships this patient established with others.



Dr. D also touched on this issue when he explained that he would not consider “failures” those treatments of patients that he had seen for a long time, but that he would consider them “complex mixtures”. He also addressed the fact that Martha “seemed to be getting better” and “seemed less depressed”, which could point to symptom reduction.

Not surprisingly, it seems that treatment un-success or failure for these therapists might be associated with something beyond symptom reduction; a dimension that in fact was raised by most therapists in their illustrations of therapeutic success: the achievement of a therapeutic relationship that allowed for the transference to be “worked through”.

## CHAPTER IV

### CONCLUSIONS

As stated in the introduction, the purpose of this study was to explore the way in which a group of psychoanalysts understood therapeutic “success” or effectiveness and therapeutic “un-success” within their own clinical practice. The concept of “success” or “effectiveness” generated in these interviews is somewhat different from the definition of therapeutic success and un-success that is found in research literature. In particular the concept of success, which in general alludes to an outcome, a final or terminated product, was presented as a more complex construct of the term. As so adequately articulated by Dr. D, effectiveness can be a “one-sided” term, in that it misrepresents the depth of these analysts’ comprehension of a psychotherapy treatment and leaves out a crucial piece in the understanding of the beneficial effects of therapy.

This group of analysts seemed to struggle with the idea of “success”; either they verbalized this explicitly like Dr. D, or referred to it implicitly by describing a specific instance of the treatment process to identify and signify success. All participants seemed to go back to a meaningful moment in the treatment where either something crucial about the patient would come to light, thus increasing understanding about the case, or where something in the relationship between therapist and patient would be resolved, “worked through” or simply verbalized and understood by both characters. These moments were not real ending cues, but rather could be interpreted as revealing moments of treatment that signified some turning point of change worth addressing as success.

The typical interpretation of success seems to center on one final outcome that crowns off the therapeutic process. Instead, success in the context of the interviews was perceived as a series of partial outcomes, each marking a further advance in the treatment process and leading to a higher step of healing and understanding. Success in these terms is viewed as a continuous chain of small achievements or breakthroughs, the sum of which add up to a conception of the patients' state of mental well being, and may result in "process-outcomes" that might even keep on taking place after the treatment is over.

Two points should be discussed in regard to this difficulty of separating outcome from process in a psychoanalytic perspective of treatment: one concerns the criteria used by therapists to determine when a case is "un-successful"; and the other is the emphasis placed by therapists on the importance of follow-up.

The interviewees were hesitant to consider cases as un-successful. The idea that the process of psychotherapy should involve a considerable number of "mini-outcomes" sheds light on the fact that participants had difficulty thinking of case examples that represented total failures, and alluded to the concept of "partly unsuccessful" treatments, or "complex mixtures".

Since most cases chosen as examples of un-success had been treated for more than one year, and more often than not with a high frequency of sessions, we can understand that an intense therapeutic process had already taken place. As part of this process, several "process-outcome" moments might have also taken place, thus explaining the difficulty analysts had in considering these cases fully "unsuccessful". Evidence of this could be the tendency for participants to address case examples to

illustrate un-success that, at the same time, would show a significant amount of symptom reduction.

Given that symptom reduction is typically thought of as a crucial sign of an effective or successful treatment, it is ironical that therapists in both successful and unsuccessful cases mentioned symptom reduction or symptom resolution. Therefore, from a psychoanalytic understanding, we should perhaps question this dimension as a good predictor of change or improvement. I will get back to this issue when I discuss the relevance this study could have in terms of outcome research.

In regard to follow-up, this was a salient theme that emerged in most participants' conceptualization of therapeutic success. The relevance of follow-up could be understood in terms of these analysts's tendencies to explicate success as different turning points throughout the therapeutic process, (what has been addressed as "process-outcome" moments). If these moments continue to happen after the treatment is over, follow-up acquires a crucial role in assessing improvement.

Fonagy (2003) refers to this idea in what he describes to be the "sleeping effect", in other words, the fact that "many of the benefits of psychoanalytic psychotherapy seem to emerge after the termination of treatment" (p. 132). This entails a special challenge for outcome research, in which measures are typically applied at the actual termination of treatment and for which follow-up is still very limited.

In sum, therapeutic success or therapeutic effectiveness might represent a somewhat limited concept that may not really reflect the depth captured by these psychoanalysts' understanding, where outcome seems to be the result of the combination of a therapeutic process, a treatment technique and a therapeutic relationship. Perhaps this



could explain the difficulty experienced in finding research literature in regard to therapeutic success from a psychoanalytic framework, while, on the contrary, writings about the process of therapy are seemingly abundant in psychoanalytic publications.

### Dimensions of Change Suggested by these Psychoanalysts' Understanding of Therapeutic Success

There is ample consistency between the therapists' understanding of therapeutic success or effectiveness and the interpretation of psychoanalytic theory on the subject. Both views coincide in the inclusion of aspects such as symptom relief, the ability for patients to "continue to analyze themselves", the ability to love and to work, achievement of insight and understanding, the capacity for enjoyment, the development of ego strength and self cohesion, and others.

A striking similarity prevails between participants' responses and the types of criteria that, according to Aaron (1990), are primarily taken into account by therapists for ending a treatment. These dimensions include intuition, symptom relief, improved intrapsychic and interpersonal functioning, resolution of transference and dreams. The three last concepts of this list are of major relevance to the present study since they capture salient themes prevalent in these analysts' understanding of therapeutic success.

"Dreams" was the least salient of the three criteria but was still mentioned by two participants in their illustration of therapeutic success. Drs. D and E discussed the effectiveness of treatment by describing their patients' dreams.

Improved intrapsychic and interpersonal functioning refer to dimensions such as the ability to love, to develop an integrated identity, to have better functioning of the ego,

to generate an increased sense of self, to improve object relationships, and other dimensions (Aaron, 1990).

When describing their patients' improvement or change, the therapists strongly emphasized the importance of these same concepts defined by Aaron. Moreover, according to the therapists their patients would remember as the most valuable contribution of their treatment these internal changes (represented by the Aaron concepts) reflected in improved psychic functioning. The case of Caroline, depicted by Dr. E, is an example of this.

The resolution of transference criterion, according to Aaron (1990), would involve the resolving or "working through" of the transference as well as the patient's ability to see the therapist as a real person. Aaron (1990) explains Ferenczi's point of view on the matter: "By the time of termination, the client should be able to see the therapist as a real person, relate in a less subordinate manner, and be as free as possible from idealizing or deprecating the therapist" (Aaron, 1990, p. 49).

Especially Dr. B, who considers this to be a defining moment in the process of treatment, emphasizes the resolution of transference with his patients. It is the impediment to achieve this "working through" of the transference (e.g. the case of Sandra) that mainly determines whether a case will be "unsuccessful" or not.

It is Dr. D, on the other hand, who captures precisely the point made by Ferenczi. He describes the importance that his patients remember him as someone "real" and elaborates on the fact that his patients (examples of the most successful cases of his entire career) would probably remember him in negative as well as positive terms. From this

standpoint the ability for a patient to be realistically analytic or critical of his/her own therapist is therefore seen as a major sign of improvement.

Given that the figure of the therapist represents much of the meaning that the “treatment” as a whole acquires in the eyes of the patient, this ability to be critical of the therapist might extend to the therapeutic relationship and to a global sense of the treatment as a whole. Thus, it would not be surprising that from a psychoanalytic stance, “working through the transference” would involve an ability for the patient to evaluate in a realistic matter not only the therapist, but the therapeutic relationship and the treatment; looking at both in positive as well as in negative ways. The fact that this is not considered a failure but a major achievement of therapy opens up a new way of conceptualizing outcome in terms of the patient’s view of the therapist and the therapy.

Considering Hill and Lambert’s (2004) review about recent trends in outcome assessment, the most popular source of outcome data is still client self-report. A positive self-evaluation in terms of changes (particularly in regard to symptom resolution) is highly praised and translates into a successful outcome. From this point of view, if a patient evaluates the treatment and/ or the therapist in a way that is not exclusively positive, the extent to which this denotes successful therapeutic outcome might be questioned.

The understanding of success in terms of the patient’s gain of a more realistic and integrated way of perceiving the other (particularly the therapist) opens up a new realm for examining improvement that should be captured by outcome measures.

## Outcome Research and Psychoanalysts' Understanding of Therapeutic Success

The analysts who were interviewed mentioned a series of dimensions when they elaborated on therapeutic success and “un-success” (see previous discussion sections). These could be categorized into five relevant themes: symptom reduction, interpersonal abilities, social or work performance, intrapsychic change<sup>1</sup> and therapeutic relationship. This last category (therapeutic relationship) was particularly relevant when psychoanalysts discussed examples of unsuccessful cases and what seemed to strongly contribute to the therapy’s failure.

In contrast to the most salient themes in therapists’ understanding of therapeutic success, Farnsworth, Hess, and Lambert (2001) found in their review about therapeutic outcome that the measures most often used were four self-report measures, three of them targeting essentially symptomatology, and the fourth, (the Inventory for Interpersonal Problems) targeting an interpersonal realm. This finding is also concordant with two of the three domains of change suggested as part of the 1994 outcome measures’ conference: the degree of impairment in the patient’s life functioning (e.g. work and interpersonal relationships) and salient symptoms and their frequency of occurrence (Lambert, Horowitz & Strupp, 1997).

Participants’ understanding of therapeutic success coincides with the outcome criteria mostly accepted in research in that symptomatology, interpersonal skills and ability to work should be three areas of change to be measured as part of therapeutic success or effectiveness. However, intrapsychic change and the therapeutic relationship

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<sup>1</sup> Intrapsychic change would convey issues such as “sense of self”, “ego-strength”, “joy for life”, among others; themes described in previous section about Therapists’ understanding of therapeutic success through their own clinical case examples.



(the two themes mostly emphasized by participants) are left aside in this conceptualization.

When it comes to agreement on dimensions of change, particularly among different theoretical perspectives, it seems that there is a clear consensus on symptom reduction as the most widely accepted criteria for change. It is unfortunate, however, that, as previously mentioned, this is not a sufficient indicator of therapeutic outcome from these analysts' perspective.

One of the participants, Dr. E, elaborated on this matter when she referred to therapeutic effectiveness as an "affective" rather than a "behavior-change" dimension. In other words, changes in behavior will not necessarily bring about a change in the person's affect, self-esteem or joy in life. She was perhaps pointing to the "intrapsychic" dimension of change, which comprised such an essential piece of these analysts' understanding of therapeutic success or effectiveness, but which, on the other hand is the hardest dimension to define and perhaps as well to accurately measure.

This poses a special challenge to outcome research. It tends to be easier to measure behavior changes since these convey observable and tractable modifications that are easier to quantify, than abstract dimensions such as the ones depicted by participants through an "intrapsychic" dimension, which include things like "joy of life", the "relaxation of the patient's psychology", or the patient's "spirit expanding". Despite the fact that these dimensions might have a higher chance to be captured by projective measures, large-scale outcome studies require more cost-effective types of measures that could be applied and scored in less time, even though this might involve leaving out some

of these categories. The balance between utilizing cost-effective measures and the ability to capture intrapsychic and relational dimensions is still poor.

Therapeutic relationship is scarcely captured by outcome measures. This could be explained by the fact that the therapeutic relationship is often considered as a key concept in the process of therapy rather than part of the outcome. Attempts to study dimensions such as therapeutic alliance and transference resolution have often been a focus of psychotherapy process measures. Lester Luborsky's (1988)'s conceptualization of the core conflictual relationship theme (CCRT) is an example of a clear attempt to delineate the changes that take place in the process of treatment. As part of Luborsky's project, he and his colleagues operationalized eight curative factors: the patient's experience of a helping relationship, the therapist's ability to understand and to respond, the patient's gains in self understanding, the patient's decrease in pervasiveness of relationship conflicts, the patient's capacity to internalize the treatment benefits, the patient's learning of greater tolerance for her thoughts and feelings, the patient's motivation to change and the therapist's ability to offer technique that is reasonable, clear and likely to be effective (Luborsky,1988). These factors are mentioned as means to achieve the desired therapeutic outcome.

All analysts interviewed mentioned most of these factors in their conceptualization of therapeutic success. However, they emphasized these dimensions, particularly in their case examples, as a way to illustrate success or outcome and not purposely to address process.

In this line, the conceptualization of the therapeutic relationship as an outcome could be somewhat controversial, in that it alludes to a type of outcome that does not

occur uniquely at the time of termination, but that may take place in different ways, perhaps even gradually, throughout the entire treatment (consistent with the concept of “process-outcomes” previously discussed).

For these analysts, the therapeutic relation seems to be a crucial element in order to evaluate therapeutic success. The ability of the patient to generate a therapeutic alliance is perceived as a major improvement and is considered the basis for other changes to occur, like those discussed in the category of “intrapsychic change”.

### Limitations, Implications & Suggestions for Future Research

Given that the data of this study represents the understanding of therapeutic success or effectiveness of a small sample of psychoanalysts, conclusions about other analysts, and especially therapists of different orientations, should be drawn cautiously.

Furthermore, this sample involved a group of therapists with a high amount of clinical experience and knowledge about psychoanalytic theory, and who were trained a number of years ago. It would be interesting to look at more recently trained analysts in terms of obtaining a contemporary view of health care delivery and of therapeutic success.

It should also be noted that this study only focused on the therapist’s perspective, and therefore was limited to the one-sided stance of these analysts regarding therapeutic success. An attempt to incorporate the view of the patient involved asking participants about their patient’s probable thoughts about the treatment. However, future studies should optimally include and perhaps contrast the therapist and the patient’s understanding of therapeutic effectiveness.

In spite of these limitations, participants' understanding of therapeutic success offered a rich and in depth conceptualization of the term, that went beyond symptom resolution to include domains such as intrapsychic change, therapeutic alliance and transference resolution.

The present findings highlighted the importance of criteria of therapeutic success that may often go untapped by traditional measures of treatment outcome. Thus, the refinement of outcome assessment would most likely benefit from integrating the perspectives of expert analysts.

A possible limitation of this study was that therapeutic success and therapeutic effectiveness were considered as equal concepts, and analysts were asked about their understanding of either one indiscriminately. Future research looking at these two concepts separately might illuminate whether, and how, the understanding of each of these terms might differ from one another.

Future studies incorporating the understanding of expert clinicians of other orientations might allow for comparisons to be made, and consequently enrich the conceptualization of therapeutic success; eventually a wider consensus on the definition of this term might be reached. This may strongly benefit state-of-the-art outcome research.

In an era in which empirically based treatments, that have been "proved" to be successful, slowly gain importance and become the treatment of choice for many, psychoanalytic psychotherapy, and particularly psychoanalysis, struggle to be adequately represented in outcome research. The difficulty in finding measures that satisfactorily



capture and evaluate the dimensions of change emphasized by psychoanalysts, together with the length of treatment and long follow-ups, can be strongly discouraging.

However, cases presented by this group of psychoanalysts make a strong argument in favor of challenging the existing outcome measurement model, given that at least some of their cases were believed to have been highly cost-effective. The case of Elizabeth treated by Dr. B and Caroline treated by Dr. E are two examples of this, in which, as explained by Dr. E, they “have saved the state an awful lot of money” that would otherwise have gone to the patient “bouncing in and out of mental hospitals, possibly being involved in criminal activities, hurting other people or herself”.

Outcome measures should be expanded to evaluate the effects of treatment over long periods of time. Moreover, if the effects of treatment could be measured in the implication these may have in the patients’ children, we would perhaps come to the realization that treatments like those mentioned by these analysts, may not only affect the patient himself or herself, but have a major impact in future generations (like breaking the re-traumatization patterns from one generation to the next).

Table 1

General Information about the Therapists

	<b>Therapist A</b>	<b>Therapist B</b>	<b>Therapist C</b>	<b>Therapist D</b>	<b>Therapist E</b>
<b>Degree</b>	MD	MD	MD	PhD	PhD
<b>Orientation</b>	Object-relations theory; psychoanalytically inspired	Focus on the unconscious determinations of behavior; Object-relations theory, influenced by British schools, American Ego Psychology and French Psychoanalysis	Freudian psychoanalyses	Interpersonal, Freudian, Jungian, and Ecological psychologist	Integrated rather than aligned with a particular psychoanalytic orientation. Influenced by British Object-relations, American Ego, and Freud.
<b>Years of Clinical Experience</b>	42 years	53 years	58 years	48 years	32 years
<b>Types of Population they work with</b>	Children, adolescents, and adults	Adults	Adults	Mostly adults, and mostly severe neurotics	Very diverse population (from high functioning to psychotic and borderline)
<b>Research Experience</b>	Clinical Research in psychotherapy: interventions and development. 25 years doing research.	Personality disorders: psychopathology, etiology, diagnoses, and psychotherapeutic treatment. More than 30 years involved in research.	Very skeptical about research. Only research experience, years ago, project with hallucinations in schizophrenics.	Previously subliminal perception and hypnosis. Recently, dreams (informal research)	Only experience as research subject, but enthusiastic consumer of research in psychotherapy

Table 2

Illustration of Successful Cases

	Gender	Age	Diagnosis prior to treatment	Diagnosis made by therapist	Year when treatment began	Length of treatment	Frequency	Follow-up information
<b>Dr. A</b>	Silvia	30's	Schizophrenia	Borderline with a histrionic personality	Approximately 15 years ago	4 years (2 more years less frequency)	Twice x week	Followed –up with client
	Bill	Adult		Narcissistic personality disorder	20 years ago	5 years	4 x week	Followed up
<b>Dr. B</b>	Elizabeth	Adult	Schizophrenia	Schizotypal Personality	40 years ago	7 years	2 x week	Followed up for 15 years after termination (contact 1x yr, then every 3 years)
	Andrew	Adult		Narcissistic personality disorder	-----	6 years	4 x week	Followed up 15 years after termination
<b>Dr. D</b>	Monica	30's	History of schizophrenic break down		Approximately 35 years ago	2.5 years	3 x week initially, then 2 x week, then down to 1 x week and finally 1 x month	Two visits and twice on the phone
	Thomas	Young adult ~ 20		"Somewhere between nuts and behavior problem", "troubled psychopathic"	Approximately 30 years ago (middle 70's)	+ 3 years	3 x week	No evidence of follow up
	Sara	Adult			-----	Approximately 4 years	3 x week	No evidence of follow up
<b>Dr. E</b>	Caroline	Early 20's	Schizophrenia	Borderline towards the Psychotic spectrum	32 years ago	15 years	3 x week, then in the 12 <sup>th</sup> year of treatment down to 2 x week, then 1 x week	Follow up until now (hears from her 4 to 5 x year)
	Andrea	Adult		Anxiety, stress	25 years ago	3 years	3 x week	No evidence of follow up.

Table 3

Illustrations of Unsuccessful Cases

	Gender	Age	Diagnosis	Time frame of treatment	Mention of previous un-successful treatment	Length of treatment	Frequency of treatment	
<b>Dr. A</b>	Marian	~22	Borderline - schizoid personality	-----	Yes (7 previous treatments)	2 ½ years	2 x week	
<b>Dr. B</b>	Sandra	--	Narcissistic-Masochistic personality	25 years ago	Yes (1 previous treatment)	4 ½ years	4 x week	
	Mary	18	Borderline	20 years ago	-----	1 ½ years	-----	
<b>Dr. D</b>	Martha	---	Borderline	~ 30 years ago	Yes (2 previous treatments)	1 ½ years	2-3 x week	
	Toni	---	-----	Recently	-----	3 sessions	-----	
<b>Dr. E</b>	Nicole	---	Sexual abuse history	-----	-----	1 year	1-2 x week	



APPENDIX A  
INFORMED CONSENT FORM

Thesis Advisor: David Todd  
Principal Investigator: Candice Fischer  
Research Assistant: Nerissa Hall

The purpose of the present study is to gain an understanding of the way therapists think about therapeutic success or therapeutic effectiveness, as part of a Master's thesis project.

Your participation entails an interview that will be tape recorded. This interview will be later transcribed by the principal investigator or her research assistant, and the information will be kept as strictly confidential. Access to the tapes and transcripts will be limited to myself, David Todd Ph.D., and Nerissa Hall, and unless otherwise specified, the tape will be kept indefinitely by the principal investigator as a basis for continued research. All identifying information will be removed from any public presentation of the data, and you will have the option (if requested) of reviewing the parts of the thesis that are based on your interview for accuracy and confidentiality.

If there are any questions/concerns regarding the study, you can contact David Todd Ph.D. at 413-5450158 or email [david.todd@psych.umass.edu](mailto:david.todd@psych.umass.edu), or contact Margaret Burggren at 413-5453428 or email [burggren@ora.umass.edu](mailto:burggren@ora.umass.edu).

I, \_\_\_\_\_, agree to participate in this study and I understand it is my responsibility to protect the confidentiality of the case material I will be describing and I should discuss any concerns I may have with the interviewer. I am aware that my participation in this study is voluntary; I can decline to answer any questions being asked and I can end the interview at any time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Thank you for your participation!

Candice Fischer  
413-5453905  
E-mail: [cfischer@psych.umass.edu](mailto:cfischer@psych.umass.edu)

## APENDIX B

### INTERVIEW GUIDE

1. Gender of Therapist
2. Degree
3. Years of Experience
4. Theoretical orientation
5. Research experience
6. Type of patients seen
7. In your opinion, in what ways could you tell that a psychotherapy treatment was a successful or effective one?
8. Now I want you to think of a couple of cases you have treated in your whole professional career... they have to be terminated cases, which you think were successful treatments. Why do you think they were effective? What happened with this patient that leads you to believe it was a successful treatment?
  - a- How long ago did you treat this patient?
  - b- What was the length of the treatment and how often?
  - c- What was the diagnosis of this patient?
  - d- Did the patient's diagnosis change after treatment?
  - e- Gender of the patient.
  - f- If we brought this patient to the interview, what would she/he think of the treatment? Would he/she agree with you that it was successful?
  - g- Did you always believe this patient would get better or this treatment would be successful?
  - h- Did you follow up this patient?
  - i- Was your treatment guided at all by a manualized treatment?
9. Now I want you to think of a couple of cases you treated... they have to be terminated cases, which you think were unsuccessful treatments or ineffective... Why do you think it was ineffective? What makes you think of this case as being "unsuccessful"? (Repeat same questions mentioned above, but now in relation to this case).
10. In your opinion, what are the crucial ingredients for psychotherapy to be effective?
11. What are some of your strengths as a therapist?
12. If you saw another therapist present a case material, what would make you think that it is a successful treatment?
13. General Issues
  - a- How do the case examples you have given relate to your more general or abstract definitions of success
  - b- Do you think that effectiveness can usefully be defined in general terms, or to what extent does it need to be addressed individually?
  - c- What have been the most important influences on the formation of your ideas of effectiveness? Formal Theory? Personal values? Research?

- d- Do you think it is important for the field to agree on a definition of success?
  - e- Do you think the formal measurement of effectiveness can be a useful part of conducting therapy?
14. What “pearls of wisdom” could you give me, a training clinician who is just starting her clinical career?

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