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Negative outcomes and destructive processes in psychoanalytic therapy

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We first need some background in the state of outcome research in general. Based on thousands of controlled studies we are in a position to be very confidant that psychotherapy is more likely to improve patients than to harm then. The overall effect sizes that have been reported are quite substantial ranging between 0.50 to 1.50. These effects are as large or even larger as the effects reported f. e. for anti-depressive medication and they are larger than those produced by a variety of methods typically employed in medical and educational interventions.
However these findings represent mean change scores. Comparing these average amounts of change occurring in experimental and control groups, a significant increase in the variability of criterion scores appears at post-testing in the treatments groups. This fact implies that some treatments cases were improving while others were deteriorating, thus causing a spreading of criterion scores. The phenomenon of deterioration although familiar to all clinicians knowing about some cases from ones own office or by the patients he or she had consulted has remained a neglected topic in treatment research even if A E Bergin pointed it out fourty years ago (Bergin 1963).

So the issue we have to deal with is really dramatic; not only does psychotherapy demonstrates significant changes across groups, it also demonstrates that it is a potent intervention that has positive and negative effects much more than so-called spontaneous remission factors.
Since the original paper by Bergin was published in 1963 in number of factors have been identified that contribute to such negative results.

Reading a conventional clinical paper on general factors leading to failures in all forms of psychotherapy one is likely to find the following list (reproduced from Stein 1972):

1. Incorrect diagnoses and, therefore, selecting the wrong form of treatment

2. Untoward external conditions

a) where external conditions are so unfavourable that actual gain through remaining sick seems of greater value than the advantage of good health.

b) where the attitude of the family supports neurotic (or psychotic) manifestations in the patient

c) Reality factors - education, class, economic status, and the effect of trauma such as illness and loss

3.) Constitutional factors - strength of instincts and of conflicts centring around penis envy in women and passive attitude in men (f. e. Freud 1937c)

4.) Unfavourable modifications of the ego- severe characterological disturbance

5.) Transference and countertransference

Indeed some of these factors are well taken and I shall comment on them. What we do miss there - which however comes out from treatment research - is the significant contribution from therapist factors. Only the very last item in this list - countertransference - points to such often neglected factors.

I shall now discuss some of these the factors; later then my presentation will rather focus on therapists' contributions on constructive and destructive processes and their relation to outcomes.

ad 1 Incorrect diagnoses: The assumption of this first point is that correct diagnosis makes a difference in selecting a proper treatment and thus leads to better outcome. Already in the report of the Berlin Institute (Rado et al 1930) out of 604 cases that were started a sizeable portions of 241 cases (40%) were interrupted - mainly initiated by the analyst. Positively reading these figures we may speak of successful trial analysis finding out that the indication was wrong. One may add to this figure that 47 out of 604 cases were classified as uncured (8%). For example already in these figures we find impressive hints that

psychosis - whatever this means in the various treatment reports - does not positively select for psychodynamic or psychoanalytic treatment:

Berlin Fenichels Report 1920 – 1930: some findings

	trial analysis	early inter-ruption	uncured	improved	much improved	cured
Hysteria	105	31	6	22	21	25
Schizo	45	26	8	8	2	1
Obsession	106	35	6	18	26	21

As patient diagnosis and degree of disturbance are related we should not be surprised of this finding. However it is linked to destructive processes and therefore deterioration insofar as some therapeutic techniques that are aimed at breaking down, challenging, or undermining habitual defenses seem to clearly contribute to negative outcome. Studies with psychotic patients f.e. by Feighner et al (1973), studies with borderline patients by Horwitz (1974), Weber et al. (1965), Fonagy et al (1996) or studies on disturbed participants in encountergroups by Liebermann et al.(1973) are demonstrating that worsening of patients does happen and that technique factors are responsible for these deteriorations. This is not to minimize that patients' characteristics also have their share which will we learn more about when discussing factors three.

ad 2

a) Unfavourable external conditions may lead to what Freud had termed "secondary gain from illness“. Let me quote some passages from our discussion of this phenomenon in the Ulm textbook (Thomä & Kächele 1994a, chap. 4) One of Freud's five forms of resistance was ego resistance, which "proceeds from the 'gain from illness' and is based upon an assimilation of the symptoms into the ego" (Freud 1926d, p. 160). In evaluating the external forces which codetermine and sustain the psychic illness, it is useful to bear in mind the

distinction between primary and secondary gain from illness that Freud made in 1923 in a footnote to his account of the Dora case (1905e). Between 1905 and 1923 the ego was assigned a much greater significance in theory and technique with regard to the origin of symptoms, specifically relating to defense processes. According to the 1923 footnote: "The statement that the motives of illness are not present at the beginning of the illness, but only appear secondarily to it cannot be maintained" (Freud 1905e, p. 43).
Precisely a case exhibiting a stable structuring of symptoms is characterized by a course in which the primary conditions are so mixed with the secondary motives that they can hardly be distinguished.
There is very little systematic research on the embedding of this internal neurotic mechanism into the context of life circumstances. The various follow-up studies on untreated patients could illustrate to such considerations.

In my opinion the case of the Wolfsman probably would serve as a good example where dramatic worsening of the life circumstances did contribute to his positioning himself as a life long patient (Gardiner 1971; Obholzer 1980).

b) The attitude of the family sometimes supports failures. In treatment of children and in young adults we may observe the phenomenon. The Hamburg study on anorexia (Engel et al 1992) reported that long time recovery was significantly related to the developmental necessary separation from the family. Long-term mortality was high in those adolescent women that remained with the primary family environment.

c) Reality factors - education, class, economic status may contribute to failure. As it is true of all somatic diseases also in psychological disorders poor education, low social class involving poor economic status has anti-therapeutic effects. The main effects being that these people not even receive treatment. Even within the German insurance covered psychotherapy system the percentages of the population in psychotherapy is not at all representative of the social stratification (see Meyer et al. 1991).
The effect of trauma such as illness and loss has received considerable attention in the clinical literature. The empirical studies that systematically explore the impact of loss have been instigated by John Bowlby's seminal by-now classic on "attachment and loss" (Bowlby 1973).

As special case in question when physical disability played a crucial role in leading a psychoanalytic treatment into dismal comes to my mind. A female candidate took a female bachelor working well as teacher in analysis that was hampered by a shortening of one leg due to a birth complication. She came from a socially very disturbed background with the father being a heavy drinker and with a brother who had killed himself in a psychotic raptus. The more the analytic work progressed the more the patient realized her deficiencies in many walks of life. She deteriorated over the course of the analysis in such a way that the analysis had to be terminated with the patient weakened in her defensive structures. First she developed a hopeless intractable love affair to her school director, and then succumbed to alcohol excesses so that she finally lost her job.

ad 3

The role of constitutional factors like strength of instincts goes back to Freud's (1937c) review of the factors influencing the outcomes of psychoanalytic treatment. He considered three main factors whose total impact was dependent on their interactions: " the influence of traumas, the constitutional strength of the instincts and alterations of the ego"(p. 224). The richer get richer, also means the poor get poorer.

Whatever the expression „strength of instincts“ may mean, a modernized understanding has been summarized by the truely famous psychoanalytic researcher Lester Luborsky:

He summarized the findings on the global dimension "Psychological Health-Sickness" (PHS) as a predictor of outcome in dynamic and other psychotherapies" (Luborsky 1962, 1975). Psychological health-sickness (PHS) is "a concept conveniently covering an extensive continuum from rosy, robust psychological health to the nadir of psychological sickness. A host of similar-sounding terms have been used for this concept: adjustment, ego strength, personality integration, emotional stability, psychiatric severity, adequacy of personality functioning, and mental health" (Luborsky et al. 1993, p. 542). For this concept - which in a simplified version of the original measurement device has been integrated in the DSM as GAF - research has demonstrated across many studies the mean predictive power was 0.27 on the outcome of psychotherapy. Freud's idea, the sicker the patient the harder it will be to make therapeutic gains, has been corroborated well (p. 546).

ad 4

Examples for the impact of unfavorable modifications of the ego- severe characterological disturbance have been provided by Wallerstein (1986) in his report on the long-term fate of some of the patients treated within the famous Menninger Psychotherapy Study

ad 5
The last item of this list invokes the central psychoanalytic topic: transference and countertransference. Ever since Freud's cases we studied again and again we have learned that not all of these cases had a favorable outcome. Certainly Dora did not. For good reasons enraged she left the treatment (Appignanesi & Forrester 1992). In Dora´s case it remains still controversial whether it should be looked at as an example of a destructive interactive process or as a creative act of the adolescent person to step out of a situation she could not make good use of (Levine 2005).
Much too often clinicians´ view of these negative outcomes puts the burden on the patients´ shoulder but we should learn to face that destructive processes mainly derive from the therapist's part in such a drama.

What do we know about such "therapist factors"

Hans Strupp - one of the early prominent leaders of the field of psychotherapy research invited former "patients to view their psychotherapy" (Strupp et al. 1969). As a consequence of this pioneering study he was commisioned by the US National Institute of Mental Health to perform an empirical investigation on what constitutes a negative effect and what in the view of experts were the reasons for it (Strupp et al. 1977). One of the most often cited sources of negative effects in psychotherapy was the therapist himself. Many experts agreed that "poor clinical judgment" or a general "fallibility of the therapist" are producing negative effects.

The therapist variables fall into two broad categories, the first being deficiencies in training and skills, resulting in part from poor training facilities and second "the development of delivery systems which do not require the maximum background in the biomedical and psychological sciences" on the part of practitioners. Deficiencies in training and supervision, which result in the delivery of inadequate professional services may produce particularly severe negative effects in dealing with borderline patients due to the therapist's

stimulating the release of primitive aggression without quite knowing how to deal with it in psychotherapy. Such negative effects may be exacerbated by the therapist who masochistically participates in the patient's acting out.

A significant contribution to negative effects in psychotherapy resides in what may be termed a "complex of ignorance and inappropriate personality". This may or may not coincide by an poorly trained or incompetent person. Sachs (1983) conducted one of the most careful empirical investigation specifically aimed at illuminating the process that lead to negative effects. Most dramatic in identifying success and failure in psychotherapy was a measure named „Errors-in-Technique-Scale“. This scale indicated that therapist´s competence and skill in applying verbal techniques in short term psychotherapy led to positive or negative change. Strupp´s own Vanderbilt-Research Programm also has shown that interpersonal process is connected to a differential psychotherapeutic outcome: good versus poor outcome was differentiated by greater levels of "helping and protecting" and "offering and understanding" and lower levels of "blaming and belittling" (Henry et al 1986).

A therapist´s abuse of his position today is considered as an important factor which may contribute to negative effects. Typical deleterious personality attributes mentioned by expert respondents of Strupp et al (1977) investigation include:

- coldness, obsessionalism
- "anything goes“ as long as 'analyzing' is happening
- excessive need to make people change
- excessive unconscious hostility, often disguised by diagnosing the patient as "borderline" or schizophrenic
- seductiveness, lack of interest or warmth
- neglect, pessimism, sadism, absence of genuineness
- greed, narcissism, dearth of self-scrutiny

Information on negative consequences of therapist maladjustment, exploitiveness, and immaturity can be gathered with ease from client self-report. Striano (1987, 1988) documented in publications for the lay public - based on her dissertation - a variety of "horror stories of the type that are often privately shared among clients and professionals but are rarely published“. A

German psychoanalytic candidate - Dörte von Drigalski - published her analytic training experience with three analysts under the title "Flowers on Granite - An Odyssey through German Psychoanalysis"(1979).

I met her once as we both were candidates in the seventies. Undoubtedly she was a gifted, talented person. Her first female training analyst was able to resonate reasonably well with the somewhat whimsical patterns of behaviors of the still late adolescent person. Then she left for Paris, for personal reasons. And then von Drigalski was transferred to another male training analyst. From then on her analysis more and more slipped into a devastating negative course. She felt rejected by the devaluating interpretations especially on the very accomplishments that had helped her to master her young life. She broke off, moved to another town and after some trouble found a quite young male training analyst. There things developed even worse. The person I knew had turned into a borderline person with even psychotic breakdowns. All this is detailed with a painful repetitive quality in the book. To provide a literary perspective on this kind of publication Keitel (1986) analyzing text from psychiatric patients calls these texts „Verständigungsliteratur“ – „communicative literature“. These mostly lay authors seek understanding by other human beings that have been through the same negative experiences.
Dörte von Drigaliski´ book was very successful with the lay public. Less so with the professional world. There was never any official echo from the Psychoanalytic Institutes to the publication of the report; when an english translation[1] appeared it was the psychotherapy researcher Hans Strupp who praised the work as a prime example demonstrating destructive experiences instigated by poor quality work in psychoanalysis (Strupp 1982).
Meanwhile a market for such therapeutic adventure stories has developed (f.e. Hemminger & Becker 1985; Märtens & Petzold 2002). The most recent painful report (Akoluth 2004) tells the story of a 58 year old woman who sought help to cope with the disabling disease of her husband. For a number of years she got what she was looking for. After the death of her husband her therapist unilaterally initiated body-contact and the lonely woman fell prey to her wishes. The therapist however was not willing to give her want she then wanted – although he clearly had induce these wishfull states of desire. This course is very typical. Most often senior therapist transgress boundaries for many good a

[1] The capacity of D von Drigalski to fight for her cause have been and are still remarkable

or bad reasons (Reimer 1999). What followed were protracted encounters that have turned from blissful moments to chronic nightmares (Brentano 2006).

Rick (1974) presented the most striking example in the research literature available. He examined the positive and negative change conducted by two contrasting therapists. He studied the adult status of a group of disturbed adolescent boys who had been seen by either of two therapists in a major child guidance clinic. Although the long-term outcomes of these two therapists were not different for less disturbed clients, there were striking differences in their therapeutic styles and outcomes with the more disturbed boys. For all the cases in the sample, 55 percent were judged to have become schizophrenic in adulthood. Only 27 percent of therapist A´s cases, however , had such an outcome, whereas 88 percent of therapist´s B cases deteriorated to such a state. The caseloads of the two therapists were equal in degree of disturbance and other characteristics at the beginning of therapy.
In analyzing differences in therapist style, it was found that therapist A devoted more time to those who were most disturbed while the less successful therapist B did the opposite. Therapist A also made more use of resources outside the immediate therapy situation, was firm and direct with patients, supported movement toward autonomy, and facilitated problem solving in everyday life, all in the context of a strong therapeutic relationship.
Therapist B seemed to be frightened by severy pathology and emotionally withdrew from the more difficult cases. He frequently commented on the difficulties of cases and seemed to become depressed when confronted with a particularly unpromissing one. He became caught up in the boys´ depressed and hopeless feelings and thereby reinforced the client´s sense of self-rejection and futility[2].

Today this topic is discussed under the heading of optimal match. Incompatibility between the patient's and therapist's personality may contribute to negative effects in psychotherapy. Kantrowitz (1986) has provided some suggestive findings that these effects may well be contribute to outcome of psychoanalytic treatment as well.

[2] This report is based on Lambert & Bergin´sa descrition of the study, p.178

The variety of factors discussed here may adversely influence therapy in a number of ways, including deleterious effects on the relationship with the patient, and misuse of therapeutic techniques. It is also possible for a well-meaning therapist, with the unconscious motivation of enhancing his own personal and professional self-esteem, to inadvertently overemphasize his assets. I conclude this part with the general comment that psychopathology or deficient skills in the therapist may lead to inadequate recognition of transference manifestations, premature uncovering of unconscious conflicts without provision of concomitant support, or both. Therefore we face an open issue: Should we diagnose therapists in traning and how can we do it? (

I shall add some more clinical aspects.
Psychoanalytic clinicians rarely speak about their everyday personalities - they prefer to speak about work-ego or countertransference. Ever since countertransference was transformed from Cinderalla into a radiant beauty (Thomä & Kächele 1994a, p.81) we can observe true enthusiastic <the more the better> reception in the psychoanalytic community - all one needs is to study educational papers in the International Journal of Psychoanalysis (Hinshelwood 1999; Jacobs 1999).
Countertransference induced failure is one of the denied aspects of psychoanalytic therapy (Fäh 2002) although the substantial body of research findings that I have mentioned points to the overwhelming influence of this phenomenon.

Recently I learned from an candidate that suddenly her analyst decided to unilaterialy terminate her analysis which she had not anticipated as an impending possibility. Sure, there had be quarrels, misunderstandings, wrong words, or even a feeling on her part that the analyst had started to intervene too active, to directive, or that she even critized him directly. – The candidate rightfully wondered: hadn´t psychoanalysis especially been invented to provide „a secure base“ (Bowlby 1988) to further a critical discourse?

An early documentation of the enmenshment of transference and countertransference was provided by Elisabeth Zetzel (1968) discovery on the so-called good hysteric. A study on the issue of suitability by the Boston Psychoanalytic Institute demonstrated that "hysterical patients, partcularly in

analysis as first supervised patients, are, to put it simply, very good or very bad patients“ (Knapp et al. 1960, p.472)

Summarizing this strand of findings Thomä & Kächele (1994b) concluded that some factors are very likely to contribute to an development of destructive processes (Schrecken ohne Ende) when one is left to hope for an ending in terror (ein Ende mit Schrecken)

1. Attempts to master such crises situations solely by working with transference and resistance is insufficient if it is not linked to an improvement in the patient's real life situation.
For example an unmarried elderly female patient with an young candidate-analyst had to be reconciled to the possiblity, in fact the probability, that she would never marry; the fact that the analyst wakened unrealistic hopes therefore had to have antitherapeutic consequences. Unreflected rescue fantasies on the part of the therapist had an unfavorable influence in this case.
2. When a patient has no partner, focussing on unconscious transference wishes is likely to have an antitherapeutic effect because, once again, the forced reference to transference wishes aroused unrealistic hopes.
In the initial phase of the aforementioned analysis the candidate fell into the role of seducer, and this role had harmful effects on the rest of the analysis.
3. Often a patient´s employing the therapy as a weapon against her or his family members (mother/father) may be a consequence of the therapist´s taking sides. As a consequence, the patient's aggressive impulses, whose development was inevitable after her hopes had been disappointed, were directed onto someone outside therapy, which paved the way for the later, unfavorable collusion.
4. Threats of committing suicide, lead to the analyst´s giving more sympathy to the patient than can be maintained in an analytic setting. This obstructs then the interpretation of aggressive impulses, especially the patient´s using the threat to commit suicide to coerce the analyst. Then a patient's preexisting tendency to treat the analyst as a real partner will be strengthened precisely, without patient and analyst jointly reflecting on the role transference played in maintaining his or her self-esteem.
5. In cases a lonely female patient is somehow aware of the male analyst´s personal situation, being single or divorced, this is likely to increase illusory hopes. If an unmarried patient who cannot cope with being alone happens to

have a therapist who is the right age, alone, and possibly even unhappy, then the social reality of this constellation is so strong that it is probably extremely unusual for them to be able to focus on the neurotic components of a patient's hopes. Expectations and disappointments that have antitherapeutic consequences are almost inevitably the result.

6. Often a therapist, under the burden of the disappointments and complications that he at least in part caused, is not able to resist the pressure of his or her own feelings of guilt and lets himself get tied up in telephone conversations justifying his or her procedure. In trying to justify himself it is then almost natural that the therapist's arguments are dictated by his or her own interests and not by the patient's needs. This in turn promotes the patient's secret hopes of overcoming the limitations of the therapeutic setting.

7. Sometimes the therapeutic frame only regaines its importance the moment the therapist admitts his failure and announces that it means the termination of therapy.

To end let me repeat a message that runs through this presentation: negative outcomes are likely to happen; the experts for this topic estimate a percentage around 10-12%. However as Luborsky et al (1985) have demonstrated, therapists vary in their competence, so the early identification of destructive tendencies in therapists in training should be the concern of our professional responsability.

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