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Negative Outcomes And Destructive Processes In Psychoanalytic Therapies[1]

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Abstract:
Negative outcomes and destructive processes are fairly neglected topics in the clinical and research literature in the vast literature on psychoanalytic therapies. This paper discusses various point of views and zooms in on the contribution of therapists factors to these processes.

We first need to look at some background about 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 – a statistical measure that allows comparing the effects of various interventions in medicine, psychology and pedagogic - are quite substantial. These effects are as large or even larger as the effects reported for example 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 average scores. Change occurring in both experimental and control groups show a significant increase in the variability of criterion scores which become manifest at post-testing in the treatments groups. This implies that some treatment cases were improving while others were deteriorating, thus causing a spreading of these scores. The phenomenon of deterioration, although quite familiar to many clinicians, has remained a neglected topic in treatment research even though it was pointed it out forty years ago by Bergin (1963). So the issue is really quite dramatic; not

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only does psychotherapy generate significant change across groups, it also is a potent intervention that has significantly positive and negative effects beyond so-called 'spontaneous remission' factors.

Since Bergin's original paper a number of factors have been identified that contribute to some of the negative results. Reading a conventional clinical paper on general factors leading to failures in any form 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 the actual gain by remaining sick seems to be of greater value than the advantages of having good health.
   b) where the attitude of the family supports any neurotic (or psychotic) manifestations in the patient.
   c) other 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 centering around 'penis envy' in women and 'passive attitudes' in men (Freud, 1937c)
4. Unfavourable modifications of the person's ego leading to a severe characterological disturbance
5. Transference and countertransference

Indeed some of these factors are well-known and we shall comment on them. However, what one mises here are the factors relating to any significant contributions from the therapist. Only the very last item in this list - countertransference - points to such factors, which are neglected not only in psychoanalytic therapies.

We shall now discuss some of these factors; later we will focus on the therapists' contributions to constructive and destructive processes and their relation to treatment outcomes.

Category 1: Incorrect diagnoses leading to incorrect indication:

The assumption is that a correct diagnosis makes a difference in selecting the proper treatment and thus leads to a better outcome. In the report from the Berlin Institute (Rado et al., 1930), out of 604 cases that were started, a very sizeable portion of the 241 cases (40%) was interrupted: the interuption mainly being initiated by the analyst. Positively reading these figures, we may speak of a successful work in finding out that the indication was wrong. One may add to this figure that 47 out of the 604 cases were classified as uncured (8%). For example in these figures we already find impressive hints that psychosis ('schizophrenia') - 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 degrees of disturbance are related we should not be particularly surprised about this finding. However it is linked to destructive processes and therefore to patients´ deterioration insofar as some therapeutic techniques, aimed at breaking down, challenging, or undermining habitual defenses, clearly seem to contribute to a negative outcome. Studies with psychotic patients (Feighner et al., 1973), studies with borderline patients by Horwitz (1974), Weber et al. (1965), Fonagy et al. (1996), or studies with disturbed participants in encounter groups by Liebermann et al. (1973) are all demonstrating that a worsening of patients' conditions does happen and that factors of technique are probably responsible for these deteriorations. This is not to minimize the point that patients' characteristics also have a

contribution to this deterioration, which will we learn more about when discussing factors three.

Category 2: Unfavourable external conditions:

a) Unfavourable external conditions might lead to what Freud had categorised as a "secondary gain from illness“. In a discussion of this phenomenon in our Ulm textbook (Thomä & Kächele, 1994a, chap. 4.5), we explore this point:

> 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).
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> 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.
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> 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 (Thomä & Kächele 1994a, p. 133).

In our opinion the case of the Wolfsman probably would serve as a good example where a dramatic worsening of the patient’s life circumstances contributed to his identifying himself as a life-long patient (Gardiner 1971; Obholzer 1980).

b) The attitude of the family sometimes supports failures. We may observe this phenomenon in the treatment of children and in young adults. The Hamburg study on anorexia (Engel et al., 1992) reported that long recovery time was significantly related to the developmentally necessary separation from the family. Long-term mortality (!) was higher in those adolescent girls that remained with the primary family environment compared with anorextic girls leaving home may excert considerable negative impact without truly understanding why this should be so.

c) Reality factors - education, class, economic status may also contribute to failure in therapy, or in the therapeutic relationship. As it is true of all somatic diseases also in psychological disorders: poor education and low social class, especially involving a low economic status, have anti-therapeutic effects. One of the main effects is that these people are not even considered for treatment. Even within the German insurance-supported psychotherapy system, the percentage of the population in psychotherapy is not at all representative of the overall social stratification (see Meyer et al. 1991).

The effect of trauma, such as separation, loss and abuse has received considerable attention in the clinical literature. The empirical studies that systematically explored the impact of loss (especially in the hospitalisation of small children) have been instigated by John Bowlby's seminal by-now classic on "attachment and loss" (Bowlby, 1973). More recent studies have substantiated these findings Infants who are regularly and seriously abandonned or frightened by aspects of their caregiving environment are at risk to develop a “disorganized attachment behavior” (Solomon & George 1999). These infants show e.g. clear signs of fear torward the parent. Mostly this behavior was observed in high-risk samples (maltreatment, low-income etc) (Lyons-Ruth & Jacobvitz 1999). Child abuse is one of the most dramatic examples of frightening parental behavior. Such violence is terrifying because it creates an extreme conflict between the need to search for security and the impulse to flee at the same time. There is also much evidence for a connection between infant disorganization and parental unresolved loss or trauma in the parents’ history (van

IJzendoorn et al. 1999). This suggests when parents still struggle with own traumatic experiences the transgenerational transmission of frightening caregiving behavior is much more likely. At least 8 prospective studies to date have shown that infant and child disorganization is associated with the development of externalizing disorders, aggression, and dissciative disorders in adolescence (Lyons-Ruth & Jacobwitz 1999, Liotti 1999). Most of the research on trauma and psychopathology in adolescents and adults does not consist of longitudinal outcome studies of infant attachment, but rather has examined the degree of which attachment related trauma like loss or maltreatment is predictive of psychological problems as a function of current attachment classification. The states of mind with respect to attachment are assessed by interview assessments like the Adult Attachment Interview (George et al. 1985) and the Adult Attachment Projective (George et al. 1999). This approach classifies attachment through examination of the person's linguistic qualities of the narratives. Disorganized/unresolved individuals are flooded with painful affect, often evidenced through verbal descriptions of intense fear or linguistic disorientation (Main et al., 1996). When trauma or loss is not resolved there is an increased risk of psychopathology (Dozier et al. 1999). We have as yet no systematic information about the role of attachment environment and the mental organization of attachment experiences in our patients to use psychotherapy sucessfully. (e. g. Buchheim & Kächele 2003, Buchheim & Kächele in press) .

A special case might illustrate another point, where physical disability played a significant role in leading a psychoanalytic treatment towards a dismal outcome. A female psychoanalytical candidate took a female bachelor into analysis. The patient had been working well as a teacher but a shortening of one leg, due to a birth complication, hampered her a bit. 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 longer that the analytic work progressed, the more the patient realized that her disability had created deficiencies in many walks of her 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 she succumbed to the excesses of alcohol, so that she eventually lost her job.

Category 3: Constitutional factors:
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 rich get richer, also means that the poor get poorer.

Whatever the expression „strength of instincts“ may mean, the famous psychoanalytic researcher, Lester Luborsky, has summarized a modernized understanding with 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 displayed a correlation of 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 well corroborated (Ibid, p. 546).

Category 4: Modifications of the ego:
Examples of the impact of unfavorable modifications of the ego leading to severe characterological disturbances have been provided by Wallerstein (1986) in his report on the long-term

fate. Some of the patients treated within the famous Menninger Hospital in Topeka became so-called lifers, permanent users of psychotherapeutic support systems (p. 561).

Category 5: Transference and countertransference

The last item of this list invokes the central psychoanalytic topic: transference and countertransference. Ever since Freud's cases were studied in depth, we have learned that not all of these cases had a favorable outcome. Certainly the case of 'Dora' did not. For good reasons, she left the treatment with Freud enraged (Appignanesi & Forrester, 1992), and it still remains controversial whether this case should be looked at as an example of a destructive interactive process (Freud's initial view), or as a creative act of an adolescent person starting to step out of a situation that she could not make good use of (Levine, 2005). She later acknowledged to Freud that the analysis had been useful, in that he had believed her, and this gave her the courage to confont her tormenting parental figures, after which the hysterical symptoms stopped. However, much too often, the (countertransferential) clinicians´ view of these negative outcomes puts the burden of responsibility on to the shoulder of the patients (i.e. they failed to respond to the therapy), but we should learn to face that destructive (or unconstructive) processes derive mainly from mishandling of the therapist's role in such a drama.

What do we know about such "therapist factors"?

Hans H. Strupp, one of the early prominent leaders of the field of psychotherapy research, invited former "patients" to review 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 frequent sources cited in this research into negative effects in psychotherapy was the therapist himself. Many experts agree that "poor clinical judgment" or a general "fallibility of the therapist" are significant in producing negative effects.

The therapist variables fall into two broad categories, the first being deficiencies in training and skill, resulting in part from poor training facilities, and second being 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 when dealing with borderline patients due to the therapist inadvertently 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 such negative effects in psychotherapy resides in what can be termed a "complex of ignorance and inappropriate personality". This may or may not coincide with a poorly trained or incompetent person. Sachs (1983) conducted one of the most careful empirical investigations specifically aimed at illuminating the process that lead to these negative effects. The most dramatic factor 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 directly to a positive or negative change. Strupp´s own Vanderbilt-Research Programm also has shown that the 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 or her position today is considered as a very important factor that can contribute to negative effects. Typical deleterious personality attributes, mentioned by the expert respondents in the 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, absence of self-scrutiny

Information on the negative consequences of therapist maladjustment, exploitiveness, and immaturity can be gathered with ease from client self-reports. 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, also published her analytic training experience with three analysts under the title "Flowers on Granite - An Odyssey through German Psychoanalysis" (1979).. Undoubtedly she was a gifted, talented person. Her first female training analyst was able to resonate reasonably well with the somewhat whimsical patterns of behaviour of the still late adolescent person until she left for Paris, for personal reasons. Then von Drigalski was transferred to another (male) training analyst. From then on her analysis slipped more and more down into a devastating negative course. She felt rejected by the devaluating interpretations, especially about the very accomplishments that had helped her to master her young life. She broke off analysis, moved to another town, and after some trouble found a quite young male training analyst. There, things developed even worse. She by her own report experienced borderline states with psychotic breakdowns. All this is detailed in the book, with a painful repetitive quality.

To provide a literary perspective on this kind of publication, Keitel (1986) analyzed text from psychiatric patients and calls these texts „Verständigungsliteratur“ – communicative literature. These, mostly lay authors, seek understanding from other human beings especially from those that have been through the same negative experiences.

Dörte von Drigaliski's book was very successful with the public, but less so with the professional world[2] There was never any official echo from the Psychoanalytic Institutes to the publication of the report; but when an English translation 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' (or disaster) 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 issues around 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 thus the lonely woman fell open to transferential wishes for contact. The therapist however was not willing to give her want she wanted then – although he clearly had induced these wishfull states of desire. This interaction is quite typical. Many senior therapists transgress boundaries for several 'good' or 'bad' reasons (Reimer, 1999). What then followed were protracted encounters that turned the therapy from blissful moments to chronic nightmares (Brentano, 2006).

Rick (1974) presented one of the most striking examples available in the research literature. He examined the positive and negative changes conducted by two contrasting therapists. He analysed 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 particularly different for those less disturbed clients, there were striking differences in their therapeutic styles and (most significantly) 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 B's cases deteriorated to such a state. The caseloads of the two

[2] The capacity of D. von Drigalski to fight for her cause has been and still is remarkable.

therapists were equal in degree of disturbance and other characteristics at the beginning of therapy.

In analyzing the differences in therapist style, it was found that therapist A devoted more time to those who were most disturbed, whilst 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, however, seemed to be frightened by severe 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 unpromising one. He became caught up in the boys' depressed and hopeless feelings and thereby reinforced the client´s sense of self-rejection and futility [3]

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

The variety of factors discussed here may adversely influence therapy in a number of ways, including deleterious effects in 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 and create a dissonance in the therapeutic relationship

We conclude this section with the general comment that psychopathology or deficient skills in the therapist can 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 training and how can we do it (Pfäfflin & Kächele 2000)?

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[3] This report is based on Lambert & Bergin's description of the study, p.178

We append some more clinical perspectives.
Psychoanalytic clinicians rarely speak about their everyday personalities; they prefer to speak about ‘work-ego’ or countertransference. Ever since countertransference was transformed from a despised Cinderella into a radiant beauty (Thomä & Kächele, 1994a, p. 81), we can observe a truely enthusiastic “the more, the better” reception from in the psychoanalytic community: to observe this, one needs 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 we have mentioned points to the overwhelming influence of this phenomenon.

An early documentation of the enmenshment of transference and countertransference was provided by Elisabeth Zetzel’s (1968) discovery about the so-called ‘good’ hysteric. A study on the issue of suitability by the Boston Psychoanalytic Institute demonstrated that "hysterical patients, particularly 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 certain factors are likely to contribute to a development of destructive processes:

1. Attempts to master such crisis situations solely by working with transference and resistance are insufficient if this is not linked to an improvement in the patient's real life situation.
   For example, an unmarried elderly female patient with a young candidate-analyst had to be reconciled to the possiblity, in fact the probability that she might never marry; the fact that the analyst wakened up unrealistic hopes therefore has to seen as having 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 also likely to have an antitherapeutic effect because, once again, the forced reference to transferencial wishes can arouse 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 can employ the therapy as a weapon against her or his family members (mother/father). This may be a consequence of the therapist taking sides. As a result, the patient's aggressive impulses, the development of which was inevitable after her hopes had been disappointed, were directed onto someone outside the therapy, which paved the way for the later, unfavorable collusion.
4. Threats of committing suicide can lead to the analyst´s giving more sympathy to the patient than can be maintained in an analytic setting. This then obstructs the interpretation of aggressive impulses, especially with the patient’s use of the threat to commit suicide to coerce the analyst. Then a patient's pre-existing tendency to treat the analyst as a real partner will be strengthened.
5. In some cases, a lonely female patient is somehow aware of the male analyst´s personal situation, being single or divorced, and this is likely to increase any 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 himself, 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. The result is almost inevitable expectations and disappointments that have antitherapeutic consequences.
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 framework only regaines its importance the moment that the therapist admitts his failure and announces that this means the termination of therapy.

To end, we repeat a message that runs through this report: negative outcomes are likely to happen and the experts in 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 of great concern in our professional responsibility.

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