What do patients want?

Psychoanalytic perspectives from the couch: an overview

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Clinical implications and conclusions

Do patients change because of psychoanalysis or in spite of what analysts do?

Guerrero (2001, IPA Congress, Nice)

Introduction

This research was a PhD thesis which explored psychoanalysis from 'on' the couch asking the question "What do patients want?" An initial literature review highlighted the under-utilization of rich personal accounts written by patients about their psychoanalytic experiences. Instead, studies generally explored aims, processes, and outcomes from the point of view of the analyst/therapist. I therefore decided it was important to gain insight into the analytic experience from the patients' perspective, exploring what they wanted, whether they believed their needs were met, and what factors facilitated or impeded the analytic process. For this purpose I chose a qualitative methodology (interpretative social science) which privileges the perspective of the research participants rather than the researcher; it focuses on subjective meaning i.e. it provides an understanding of those studied, and insight into how members of a particular population make sense of their experience. In-depth interviews were used as the main sources of data.

From a large number of volunteers 18 participants who fulfilled the research criteria were chosen i.e. those who had completed/ended analysis with a professionally recognized psychoanalyst (see criteria Appendix 1). The in-depth interview consisted of an open-ended question: "*Would you* p*lease tell me about your analytic experience*". This question asked of each patient, elicited most of their experience. Then, at the end of each interview, I asked the following three direct questions:

- Why did you volunteer for the research?
- Would you recommend analysis to a colleague or friend?
- What would you consider to be a good analysis?

All interviews were audio-taped and transcribed by me, then coded into conceptual categories and themes, using a thematic analysis approach as expounded by Miles and Huberman (1984). I then drew upon psychoanalytic theory, and the original thinking of the participants, to interpret and present new understandings of the process and the meaning attributed to their analytic experiences.

Key findings and recommendations for further research

The chapters were arranged in the format of an ongoing journey (Appendix 2). In this paper I have identified the key findings (Appendix 3**)** and then, because of time constraints, I present details from a few of the major themes, illustrated with interview material. Clinical implications are then briefly presented, with suggestions for future research. Much of the discussion and relevant literature has had to be curtailed in this overview, thus limiting the richness of these accounts..

The desire to revisit the experience

When beginning this research it was suggested to me that only people who had had bad experiences would wish to talk, thus my sample would be skewed. However, as evidenced the participants came from a very representative group of analytic patients. There was also the surprising, overwhelming response to participate, which seemed to indicate that there was a widespread interest, or need, for people who had been in analysis to tell their stories. This was confirmed by their own responses when asked as to why they volunteered. An argument could thus be made that endings in analysis leave some patients in prolonged mourning, or with feelings of unfinished business.

Lack of clarity about 'what is psychoanalysis?'

One of the challenges I encountered through the research was the difficulty, if not impossibility, of finding a common definition for 'psychoanalysis'. This problem became evident when recruiting participants and I met a widespread ignorance in the 'lay' public concerning the nature of psychoanalysis. Several people, keen to be interviewed but found not to meet the criteria, expressed disappointment.

Some of the confusion was partly due to a naivety about all forms of therapy 'fitting' the same model; with others the confusion lay through a common misrepresentation by some health professionals who were not trained as analysts, yet were advertising that they were running psychoanalytic practices. When this occurred, the respondents automatically equated these practitioners with psychoanalysts; they did not know the difference from their actual experience. The branding or labelling of particular professional practices as psychoanalytic is clearly widespread and does no justice to psychoanalysis. If patients are unsatisfied they, in turn, can misrepresent their experiences of 'psychoanalysis' when they have not been in treatment with people who are qualified to practice what is being offered. This confusion about the nature of psychoanalysis and its clinical practice was quite pervasive, and as

supported by the literature, occurs even amongst the profession itself. My experience at the IPA Nice Congress, 2001, was an endorsement of such diversity about psychoanalysis, and how it works.

Patients' expectations

Patients undertake an analysis for multiple reasons, some stated clearly at the beginning, as for example, wishing to work with personal, relationship or work failures; other reasons are not so conscious but emerge through the analytic process. There are nevertheless universal expectations, as evidenced by my findings; patients reported that they wanted to feel heard and facilitated in their exploration of painful internal conflict, and by an analyst skilful enough to deal with all their communications in the transference. This research however, demonstrated that a satisfactory working through period did not always occur, and such 'universal' expectations were not invariably met.

Tabin (2002) described one of the reasons why it has been difficult to listen to patients' expectations and understand more about the analytic process from their viewpoint. He stated that when analysts are discussing their work with peers or attempting to learn from published clinical cases, the literature is usually provided by the analysts and not the patients; information from the latter has been difficult to acquire. Successful analyses are not easy to follow-up while failures are even less accessible, unless the patient seeks further analysis and then, as reported by Tabin (2002) "the previous analysis is seldom given importance in accounts of subsequent work" (p.103). It is thus not surprising that the patients' expectations and hopes are not readily understood; or, as stated by Hinshelwood (1997), a paradox arises when the analyst believes he/she knows best what the patient should think and decide, and yet wants the patient to have found a mind of his/her own by the end of the analysis.

The importance of choice & adequate assessment procedures

The assessment period at the beginning of an analysis links with patients' expectations. Little has been published about preparing the patient for psychoanalysis. One of the key findings from this research was the significance of patient choice and the initial engagement with the analyst; these two factors, which demonstrated patients' agency (or not) in the process, seemed to have a considerable impact upon the ongoing treatment and eventual outcome of the analysis. Given this importance, an appropriate choice of analyst would seem crucial to those seeking analysis.

One of the participants stated how, from the beginning of her analysis, she wanted to be a "patient-partner" not a "patient-victim" Min's capacity to think about what would be the most useful for the

ongoing work of analysis, and her needs being met by an accommodating analyst, was a significant factor in the success of her analysis.

> I had made decisions about how it was going to be for me and I was clear that was what I was going to negotiate with the analyst… Right from the word go I wanted it to be as much in my territory as it was in the analyst's. And I wanted to be a patient partner; I didn't want to be a patient victim
>
> Min

However, many patients in this research drew attention to the rather perfunctory way in which they ended up working with their particular analyst, and the general lack of preparation provided during the initial assessment period.

> I had no idea how it worked. What he did do was go over at great lengths about what was the frame, and the issue of holidays. There were other issues, but in terms of what analysis is about I didn't know much. You need to be able to put the experience down to something, to make sense of the experience. It is such an open process. It would help to say a little about the basics like 'say whatever comes to mind'.
>
> Jenny

> I didn't have a clue… I began to explain why I was there, expecting him to ask me some questions, talk to me or do something... What would have helped was some dialogue like 'Look, this is the way I work'. If there had been some conversation about that it might have helped; instead he told me very little about what was going on.
>
> Rick

As noted, questions patients raised were disregarded by some analysts or met with silence. It was thus not surprising to me that one patients in this study, Simon, could come to the end of his analysis and still express ignorance about the nature of his experience; or cite a book he said he had read by Skynner & Cleese entitled "Talking to a Stranger", which provided him with information about the process he was undertaking.

Other patients reported considerable knowledge of psychoanalysis, and even supervisory experience, yet articulated concerns that they did not fully understand its practice when they entered analysis, and then were not prepared adequately. In the early stage when patients find themselves entering unknown territory, clarification of psychoanalytic goals would seem imperative. A sense of powerlessness, and subsequent helplessness, left them later expressing dissatisfaction or leaving the analysis prematurely.

Others however, like Min, experienced a collaborative engagement from the start. The latter fostered a "patient-partner" rather than a "patient-victim" mentality.

Very different conceptual views are held about the value of assessments, and these would seem to be based on the way analysts perceive the different roles and function between assessment and psychoanalysis proper. Stepping out of the classical position to adopt a more active role in learning about the patient is considered by some analysts to contaminate the ongoing process and therefore is undesirable. I would argue however, that the lack of clarity or reluctance around thoughtful assessment procedures denies a valuable opportunity for the analyst to get to know the patient, in a structured way, as a person and within a particular context. I believe that the assessment period provides the space for the analyst to explore the expectations and needs of the patients, thus enabling them to make a connection where they feel listened to and heard, and know that they are taken seriously. It would also seem relevant to provide an experience to the patient in this early phase which provides some indication of what psychoanalysis is about, instead of primarily explaining about rules and boundary issues, as was described by many of these patients.

Another important factor is in terms of the analysts' own feelings and knowing whether they can work with a particular patient. There is an assumption that once the analysis begins everything will fall into place and 'any analyst can analyse any patient'. This research demonstrated quite the opposite with a number of premature terminations and 'serial' analyses as a result of unsatisfactory or 'failed' analyses. When a patient enters analysis with specific issues around relationships, if they cannot achieve some working through in a better relationship with the analyst, they can remain "stuck" in a bad one. They are repeating earlier patterns, as that is the only position they know. The experience of Sig illustrates this dilemma.

> I said to him 'I'm looking for someone who can help me understand myself a little better. And I don't think you are fostering the kind of relationship that leads me on to be more open, more willing to use your interpretations. I feel like in a way you are repeating the relationship I had with my father'.
>
> Sig

If there is enough incompatibility to raise questions about a good working relationship, it would seem imperative for the analyst to able to refer on to another analyst.

The significance of the analyst's personality in engaging with the patient

The powerful transference/counter-transference relationship between patient and analyst formed the larger part of patients' reflections on their experiences. The patients described the ways in which their analyst functioned in this relationship, linked with their perceptions of specific human qualities in the analyst.

In recent years analyst/therapist qualities, which contribute to therapeutic change, have become among the most frequently studied variables (Beutler, Machado & Neufelt, 1994). Research has increasingly demonstrated evidence of the analyst/therapist as a significant agent of change, independent of technique and theoretical orientation (Crits-Christoph & Mintz, 1991; Luborsky et al, 1986; Bergin & Garfield, 1994; Kantrowitz, 1995; Anastasopoulos & Papanicolaou, 2004). From the findings in this research I would like to further argue that it is the quality of the analyst's engagement in the relationship which is the most important factor, and this is based on their human qualities as demonstrated by these patients.

The majority of patients (13:18) were practicing psychotherapists and their sophisticated thinking was reflected when they spoke about the ongoing process and analytic relationship. Transference was understood by most patients as the core element in the analytic process; they provided vivid examples to illustrate how they perceived whether their issues were worked through, or not, in the transference with their respective analyst. Kerry remarked "It was the most amazing process. It just emerged. And the way it came out in the transference and the intensity between the two of us was kind of horrendous, but so intimately intense, and sort of wonderful at the same time". She described some ill-defined sexual abuse with an uncle when she was very young and also experiencing some really bad behaviour with other men. During her analysis she suffered from chronic cystitis and had to stop a few times to go to the toilet en route to the session. Kerry talked about how she would lie on the couch and writhe around in pain, experiencing real discomfort. She explained how she was also completely paranoid about using the analyst's toilet and used to think "I hope he doesn't come in", even resorting to telling him not to do that. At the same time she described many florid projections:

> I was quite mad, like there would be a cardigan or something draped over the back of a chair and I'd think 'Are they his trousers, are his trousers off?' It was mad. I was quite fearful even of him sitting behind me and feeling like he was going to reach over and touch me or something like that. That was a particularly difficult time. All this stuff was coming out that I couldn't control… I don't know how it got broken – maybe it just got worked through over and over again... I remember him baiting me,

> sort of fishing; and playing with him like he was perfectly trustworthy and friendly And all the stuff had broken. It went from this incredible fear to playing with him; it was amazing.
>
> Kerry

Issues to do with the engagement were paramount. The patients described qualities such as "attunement", "receptivity", "nurturing", "holding and containing", "being 'in sync", "humour and playfulness", and "acceptance of reality" – all of which were present in the experiences of some patients and facilitated a positive connection with their analyst in the transference. Two patients detailed very positive maternal transferences to their analysts.

> I would lie on the couch and I would stick my daughter on the breast and she would suck away and fall asleep. And I would talk to him (analyst). You couldn't separate me from my child. I thought it was an absolutely magical time. I had my baby on my nipple and I was dealing with things about my mother and my family and I felt I was repairing lots of damage by being mother to my kids. It was great.
>
> Jean

> And the mothering of me… T (son) would have come along when I was in my second year of analysis. I used to take him along every day, drag him out and take him along, but essentially that was the only thing that saved me. I wouldn't have been able to do it without that. I think it helped me because **he** (the analyst) **looked after me** and that **enabled me to look after my son.** And that's how I learnt. How he looked after me, I kind of learnt how to do that... I have **very positive feelings** about the whole thing; like it was actually quite special.
>
> Audrey

It could be assumed that these nurturing or 'maternal' characteristics would be a given in any analytic experience, but as the study revealed, this was not the case. Some of the patients, and in particular the three who ended their analyses prematurely, perceived their analysts as "authoritative", "unwilling to engage", imposing extended periods of "punitive and critical silences", "disconnecting", "mediocre" and at times even "cruel".

All patients articulated clearly how they were able to depict differences in their analyst's capacity to function in a helpful or unhelpful way by virtue of their unique human qualities, rather than their specific training and acquisition of theoretical knowledge which every analyst accomplishes. How analysts apply their training, using their own human qualities, would seem to be the major difference in whether the analytic treatment is successful, or not. This is a key finding from the research and one

which has important implications when thinking about training policies and practices for therapeutic treatment.

It is, of course, very difficult to accept these accounts as "the last word" when this research gave a voice to patients only, and not their analysts. However, as there was some consistency provided in these experiences, and particularly when three analysts each had two patients in treatment who described similar experiences. I think it warrants some thoughtful consideration of the patients' perceptions, which cannot be dismissed lightly.

The analyst's 'transference' - or 'unhelpful' counter-transference

Peers in my seminar group, and some analysts I spoke with, were critical of any communications from the analyst as being able to be thought of outside the transference. This notion was also raised and discussed by me as one of the challenges to this research. This insistence by my peers was in spite of providing details of analytic work in which some patients clearly considered the analyst as making extra-transferential interpretations; as for example, Lucy's account of sending a postcard to the analyst whilst on holiday and his personal response. She was sophisticated enough in the analytic process to understand that this enactment by her called for exploration by her analyst rather than a "thank you" and then closure. Another example, which I believe relevant, was the analyst's response to Lucy when she remarked on the "leggy brunette' whom she saw leaving her analyst's rooms.

> One day one of the worst things happened. I said to him (analyst) 'I saw a leggy brunette coming into your place when I was leaving the other day' and he said, which I think was a terrible, terrible thing: 'that was my youngest daughter; what did you think of her?' Well, of course, then the whole house blew up. The world just disintegrated. And we never worked through it...
>
> Lucy

These illustrations would appear to support Lucy's beliefs that her analyst, at times, worked in the concrete rather than the symbolic, thus stepping outside his role as an analyst working with the transference. These patients were knowledgeable enough, and able to articulate that they knew the difference between transferential issues and what was real.

The examples presented here, and others discussed in the previous chapters, would seem to demonstrate counter-transference reactions arising from within the analyst himself, rather than responses generated merely by the patient's material. This thinking is supported in the recent literature

(Eagle, 2000; Gabbard, 1995; Sandler, 1987, 1993; Spillius, 1992) which acknowledges that not all counter-transference difficulties can be blamed upon the patient, and that re-traumatization can occur when the analyst's personal agenda is brought to the analytic situation (Racker, 1968; Strupp & Binder, 1984; Sandler, 1987). When a stance of neutrality is not maintained, certain cues emanate from the analyst to the patient, to which the patient in turn reacts (Eagle, 2000) and transference does not emerge independent of the analyst's social and interpersonal characteristics and reactions (Aaron, 1992).

Writers such as Casement (2002) and Reppen & Schulman (2002) have emphasized the importance of analysts acknowledging failures in their experiences with their patients, or being able to hear when patients communicate to them that they are not receiving the kind of help they need. Recognition of such impasses would be helpful to both analyst and patient who, with this acknowledgement, might then be able to continue in the same analytic relationship, or if the impasse continues, the patient then accept a referral to another analyst. It is not a failure, or shameful, to acknowledge limitations in the analytic relationship and the possibility that other analytic 'couples' might be able to function in a more constructive way when personalities, and other differences, are conceded as distorting or disrupting the analysis.

I have used the term counter-transference throughout the thesis but this is not one which was provided by the patients themselves; after examination and interpretation of the data it seemed to me that this was implied when the patients were discussing personality issues of their analysts. Some patients' reports of responses by their analysts to verbal communications indicated that these responses might link better with ideas from McLaughlin (1981), who postulated that, at times, the analyst's attempt at interpretation can be prompted by his/her own transferences, rather than counter-transference, and thus not restricted to a patient-centred focus. I considered that this distinction might relate to Lucy's examples above. Her illustrations of how she sometimes perceived her experience do seem to demonstrate a 'transference' reaction from her analyst, and not necessarily thoughts and feelings which reflect "what is going on in the patient's inner world" (Eagle, 2000, p.36), and denote counter-transference.

One patient, Steve, commented on the analyst being "a victim of his own craft, of his own therapeutic approach" which brings to mind a third source of counter-transference (Stein, 1991; Purcell, 2004). They suggested that the analyst's theory can interfere with his/her functioning and therefore be considered as an unhelpful form of counter-transference. Steve's point illustrates this when he ended

his analysis stating that he believed his analyst was "sensitive, skilled, ethical and professional" but still declared: "I don't think it really worked for me… I would really like to have closure but I don't know how to achieve it. It's like a lasting impression of a slightly bad taste".

Steve made a clear distinction between his perception of the analyst as a person, and the analyst's perceived 'misuse' of theory, which he saw as detrimental to the analytic process. Other illustrations which I believe refer to a 'misuse' of theory, as counter-transference, were the periods of prolonged silence as endured by Rick; and Sig's description of the analyst telling him he was working from "his own agenda". In both these experiences the analysts could have more usefully explored further 'how' and 'why' these patients remained "stuck".

These experiences are an example of the patients' sophisticated thinking about the analytic process. I would argue they clearly illustrate the 'complexities of the clinical situation which develop between patient and analyst' and which Roth & Fonagy (1996) emphasized were very important for research to capture.

Significant issues around 'termination'

Earlier in this chapter I made a link between the patients' eagerness to talk about their experiences and the termination phase. It is only recently that a follow-up on termination experiences has begun to be addressed in the psychoanalytic literature (Conway, 1999). The 'unfinished business' which can remain with patients after their analysis was also addressed by one of the patients Steve in his statement fifteen years later: "I didn't ever achieve closure…The whole process has sat with me in a very odd way, in a very unfinished way. I find that disturbing…"

One cannot overestimate the importance of the termination phase, clearly articulated by Min who stated: "I think it's important that a good analysis, when it terminates, it doesn't close the door. It's about having a good beginning, a good middle and a continuing end". What this highlighted for me was the artificiality of the psychoanalytic reference to "terminations" and also how this term itself might be thought about by patients because of its link with an abrupt ending – or death. I checked the thesaurus for alternative meanings and came up with: extinction, annihilation, execution, slaughter, butchery and massacre.

Diverse experiences of the ending of analysis were reported by patients and discussed in detail. Unilateral decisions to finish, with consequences for the patient regardless of who makes the decision, have been reported as common experiences (Novick, 1997).

As suggested above, the difficulties inherent in the ending of an analysis did appear to have considerable impact on the eagerness by participants to talk about their experiences and to some extent the opportunity to fulfil, to some extent, the purpose of closure. This was partially acknowledged by Kate, who also implied the loss of the analytic hour in which she could speak freely. She stated: "I thought it would be a good opportunity to reflect on my analysis because you don't really get a chance to do that about lots of things, unless someone is interested to listen to you for an hour".

I draw attention however to Lucy, as her interview and the distress it caused her, left me feeling quite concerned. The possibility for talking prompted her response to the advertisement but did not appear to offer relief from her anguish, not only about "a horrible experience", but also at feeling that she and her analyst had never reached closure. Her reasons for entering analysis with a phantasy of finding a "good daddy", unlike her real abandoning father, were never resolved. As a result, it seemed that she felt she had done some irreparable damage to prevent the 'good' father emerging, while she was left feeling "a paraplegic who can't walk". Her interview appeared as a cathartic experience where she was able to pour out memories she related to as both hateful and loving, but in the end said that the analysis left her feeling: "that it was a hell of an experience". It struck me that our interview left her with similar powerful feelings of grief. Lucy did not seem to have the opportunity for a real mourning, and she reported how she was unwilling to try again as she was now really hard to please: "I think I want to get this impossible person, this all-knowing, all-wise being. And I don't think they exist".

The ending of analysis affects how a patient can process what has occurred over many years and look to the future; it also is linked with the whole journey. Those patients who had positive experiences talked of having some negotiation period for finishing their analysis, and presented clear evidence of analytic work which they considered as liberating, and generated personal transformations both internally as for example "plumbing changed", "considerable psychic changes", and externally in relationships, work and other general life experiences; for others the actual ending of analysis was coloured by the ongoing experience. For these patients with less than satisfactory or 'bad' experiences, it could be argued that the ending of the analysis brought up images and feelings of again being left with 'bad' or non-caring parents – some of the very reasons which brought them into the analysis in the

beginning. What is more concerning is that patients who have had a bad experience believe it is their fault and cannot allow themselves to think about the analyst as failing them. Instead they take ownership of the failure as theirs.

This research has demonstrated important issues to do with termination procedures which do not always seem to be understood from the patients' perspective and adequately addressed. Every patient experiences the pain of separation at the end of such a long and intensely emotional relationship; however, the interminable nature of this pain, when it has been an unsatisfactory experience, would seem to indicate some urgency for the provision of more thoughtfulness in clinical practice around endings in analysis. The analysts themselves experience something very different at the end of their training analyses; they are initiated into the psychoanalytic 'family' and continue the relationship as a colleague and, "perhaps even intimate friends" (Novick, 1997, p.152) of their training analyst, whilst the patient must say goodbye. With little or no real acknowledgement of these differences, as "the candidate can avoid the mourning that is seen by many as the central task of the termination phase" (Novick, 1997, p.152), analysts can become unmindful of the huge separation and loss experiences of their patients. This is compounded by what is implied by the actual psychoanalytic terminology used. The experience also of 'having an analysis', a term commonly used, raises the notion of analysis as a 'product' rather than a 'process', which is ongoing and emotionally charged.

I am reminded of how attachment theory is now very prominent in psychoanalytic work in relation to separation and loss, and wonder how the endings in analysis could be thought about in similar terms. This important phase cannot be avoided but rather needs more thoughtful space in the mind of the analyst, with perhaps an opening to consider a later follow-up period. The eagerness of patients to participate in this research indicated a strong wish to tell someone their story and suggested some closure was required when such a space was not provided elsewhere.

Where there has been recognition of a failed analysis, or what patients have perceived as unsatisfactory experiences, I would suggest that recommendation to another analyst for a 'review' period could be beneficial and go some way to affording closure. If analysts themselves can acknowledge that the analysis was not satisfactory or even a failure (Casement, 2002), it is hoped that patients could be referred elsewhere for some healing work. Termination procedures are highly significant to experiencing the analysis as a positive (or not) ongoing journey; they require thoughtfulness and

consideration to the painful mourning which takes place; and a timing for ending the analysis which is mutually agreed upon by both patient and analyst.

It would seem important to note here that some patients in this research did, on their own initiatives, seek further and different forms of therapy following their unhelpful analytic experiences, and the diverse ways of endings in their analysis.

What do patients want?

The aim of this research was to explore psychoanalysis from the patient's perspective. It was not my intention to discuss "good" and "bad" experiences per se, but rather to delineate the factors which patients perceived as helpful to their analyses or impeded the process to the extent it became unworkable and the relationship could not be sustained. Not any one analysis was entirely "good" or "bad" but had elements which could be teased out as contributing to the overall experience.

In focussing on a direct question at the end of their interviews the responses from patients included a list of human characteristics in the analyst which they stipulated as essential for a 'good' analysis, plus aspects of technique for example: "kindness", a "greater presence", ''humaneness, possibly the only thing that you actually need", a "sense of love". Some of the qualities related more specifically to the analyst's technique: "the analyst being 'skilled' enough to work with any confrontation without him/herself becoming embroiled in the conflict", "more preparation and a sense of the broader plan…", "some feedback - that this person is letting you know he is hearing what you are saying" and "more thoughtfulness on the impact of interpretations". The comment about interpretative technique and congruence with the patients' communications was brought up by a few patients as, for example, Carmel stated: "I think there are some people who just work from a space where they believe they know what is right and not from the patient being right. And that is very dangerous, if you think of transference and the fear and pain. And they are considered the experts".

This quality of being listened to, like many of those presented above, is an aspect of the analyst's technique which would be considered as a given in all analyses but obviously was not always experienced. Marg commented on the importance of "sorting out" the confusion which patients bring to the analysis for assistance in working through, which would also seem a major part of the analyst's function in his/her usual analytic practice. These stories however demonstrated very diverse analytic

experiences, and in their exploration it was very clear what patients believed was necessary for analyses to be successful – in other words, what patients want and expect from psychoanalysis.

Clinical implications for psychoanalytic practice

Guerrero, a presenter at the Nice Congress (2001) raised an interesting question which is related to these findings. He asked: "Do patients change because of psychoanalysis or in spite of what analysts do?" If this question had been asked of the patients I interviewed I believe the following comments, brought up spontaneously by two of the patients, would have been fitting responses to Guerrero. Tony, when reflecting on his experience, said: "I'm sure it [the analysis] did help me but I'm not sure how… I would have changed as a person anyway so it's difficult to say"; whilst Rick remarked how his analyst provided the opportunity for him to make sense of his life but "nothing more helpful" than what he could possibly have done if he merely "sat in a corner and did my own thing". Other patients however were able to report that at the end of their analyses it had been "so liberating", and "completely changed" their lives.

This research, which listened to the patient's voice, has contributed many significant findings to the developing body of knowledge related to patients' experiences of psychoanalysis. Given the consistency in responses from the eighteen patients interviewed, it is important to take seriously the meaning of these strongly held views of the patients, and which were maintained over considerable periods of time. One patient who reflected on his experience after 15 years admitted that he had never sat for so long without changing his views or gaining any closure.

What does it mean for psychoanalysis, and the techniques of its practitioners, that these patients emerged with such varied experiences as presented here? Clinical training and theoretical knowledge cannot account for such different outcomes, or in the patients' perspectives of the ongoing process and relationship. What emerged as the most important aspect of the analytic journey was the relationship, a finding supported by recent literature. This research however, has drawn attention to the quality of engagement in the relationship which was the critical factor leading to the respective outcomes. These patients identified the specific human qualities in their analysts which were useful to the therapeutic relationship and those which were not. Where these qualities were not experienced the patients were able to think clearly about the analytic process and, with some sophistication, suggested those characteristics which they believed were essential to good analytic work. The qualities they listed form

a significant finding for analysts to consider when reflecting upon their work with patients, particularly if the experience does not seem to be working successfully.

Casement (2002) draws attention to psychoanalysts who sometimes arrogantly believe that they know best, thus when anything goes wrong in the analysis the patient is held accountable. Failures are attributed almost entirely to the patient's pathology while the analyst fails to recognize that it could perhaps be the style of his/her clinical work which is problematic for the patient (Casement, 2002, p.xiii). It has also been argued, by some analysts, that patients cannot know what they want because of the unconscious factors. In spite of this, my research demonstrated some very sophisticated thinking by the patients and evidence of knowing exactly what they wanted and how they hoped their needs would be met. It is a reminder of the importance of being able to listen to what patients are saying.

This research also raised many questions about crucial analytic policies and practices. Specific attention was drawn to the assessment and preparation of patients and the ending or termination phase, both stages which would seem to require a much greater focus in psychoanalytic training programmes and subsequent clinical practices.

This paper has identified key findings which could lead to further very interesting and worthwhile research in the future. The findings also raise important issues in thinking about how psychoanalysis can continue as a significant form of therapeutic treatment in a climate where other modalities are now producing promising results; these are being supported by funding bodies which seek evidence of economically efficient and effective clinical practice. Patients seeking therapy are also more discerning now, more assertive and less willing to remain in a treatment which is not attending to their needs.

This raises another important point: when the relationship is of such significance, more so than interpretations as revealed by this study and other modalities place emphasis on the relationship as well, what can psychoanalysis offer that is different? We are all aware, of course, that psychoanalysis provides a much more in-depth treatment for enduring symptoms, but these can only really be addressed when there is a 'good' working relationship to start with, which this research demonstrated was not always possible.

The major confusion about the very nature of psychoanalysis itself, and who is qualified to practice or speak about it, is also a problem to address. This lack of a clear consensus can have a considerable

impact on the knowledge base and understanding of clinical practice. With such diversity in theoretical schools, particularly to do with the aims and essential elements of psychoanalysis, it is challenging, if not impossible, to inform clearly defined and consistent Institute policies. This makes it very difficult for the lay person seeking psychoanalytic treatment to be sure that he/she is actually receiving what is being offered, by a practitioner qualified to practice.

Conclusion

Listening to the patient's voice has enabled the emergence of another side to the analytic 'story'. Through these patients' narratives I have argued the importance of including their experiences in literary accounts of psychoanalytic treatment, process and outcome research. The narratives demonstrate the significant contribution that patients can make in what analysis has to offer, and therefore able to add to the knowledge base of psychoanalysis, analytic training procedures and clinical practice.

In conclusion, and in answer to the research question "What do patients want?" Min seems to have captured the essence of all patients' experiences when she stated: "I want to be a patient-partner, not a patient-victim".

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Appendix 1

Participant demographics

11 women and 7 men

Age range 31 to 60

13 psychotherapists; 3 working in allied health; 2 in professional public practice

All completed (or ended) an analysis with a professionally trained analyst from the three Australian state-based Institutes of the IPA, the Jungian Society, or the Lacanian School of Psychoanalysis

Interval time between analysis and interview: one just completed up to 15 years.

Average 2-5 years

Appendix 2

Data chapter themes

Beginning the psychoanalytic journey

Reflecting on the analytic experience:

- Transference/ counter-transference
- The quality of engagement
- The analyst as father

Endings and later reflections

General discussion and clinical implications

Appendix 3

Key Findings

Confusion around ‘what is psychoanalysis?’

Expectations – how they were met/not met

Importance of choice & clear assessment procedures

‘Patient-partner’ not ‘patient-victim’ mentality

Significance of the analyst’s personality

Analyst’s ‘transference’ - or ‘unhelpful’ counter-transference

Relevance of gender

Third party influence

Importance of proper ‘termination’ procedures

Agency as a predictor of better outcomes

Unexpected ‘reluctance’ to recommend analysis to colleagues or friends