What makes good therapists fail ?

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Abstract

This article is centered around the problem of how to understand why well-trained psychotherapists who do not make ”technical errors” can and do fail in the therapeutic process. Studies related to the social interactive nature of psychic distrubances that can clarify the issue are revised. A 30 year-long research tradition is integrated (Krause, 1982; Steimer-Krause, 1996; Krause, 1997; Krause, 1998) and observations reveal that patients with specific psychological disorders establish specific relationship patterns in “everyday”-interactions with the majority of the partners they interact with. These patterns are mostly unconscious. Nevertheless, they can be measured through non-verbal interactive microbehaviours observed in facial expression. Our study demonstrated how unconscious non-verbal phenomena have a specifically powerful impact not only on the behaviour of the interaction partner but also on the affects that are predominant in the chronification of maladaptive patterns.

The second part of this paper emphasizes how the major curative power in the psychotherapeutic interaction is related to a form of abstinence of non-verbal unconscious affective patterns, while the failure of well-trained psychotherapists is usually linked to getting tied in these micro-momentary affective choreographies, which can be specifically described.

Research also demonstrates that implementation of relationship patterns has to be conceptualized as a dyadic process and especially that the therapist’s facial affective behaviour as opposed to that of healthy laymen, is a good predictor of therapeutic outcome or failure.

What makes psychological disturbances so persistent?

There is a broad consensus that the rate of spontaneous remission of mental disturbances is remarkably low (Grawe, 1992). When one considers the tremendous amount of suffering involved, this is a paradox. Why should any reasonable person insist in so intensely harming him or herself or others? Once this point is reached concepts like repetition-compulsion, maladaptive patterns (Luborsky, 1977), schemata (Horowitz, 1997) or even the death drive (Eissler, 1971) are usually brought theoretically into action, and the burden of this paradox is thus placed onto the patient. We will agree that such concepts are o.k. but also that they need to be wide enough to include the partner of the interaction into the repetition-compulsion. In this respect, we can demonstrate how the longevity of mental disturbances is related to a high level of stability in the internal feelings and the unconscious behavior of the interactive partner of the patient.

Patients with specific psychological disorders establish specific relationship-patterns. They enact these in an unconscious manner and with most of the people they interact with. The relationship-patterns not only comprise a specific manner of expressing oneself but also puts into scene the specific reactions of interacting partners (Krause, 1982; Steimer-Krause et al, 1990; Schwab & Krause, 1994; Krause et al, 1998; Schwab et al., 1997; Schulz, 2000).

One of the ways in which the implementation of a relationship-pattern can be achieved is by inducing a specific affect (Krause, 1990) or action tendency (Frijda, 1986) into the interacting partner. One example of this is the dyadic interaction observed between severely disturbed patients suffering from paranoid schizophrenia (Steimer–Krause et al., 1990) and healthy subjects and another interaction between patients with severe psychosomatic disurbances like ulcerative colitis and healthy subjects (Krause, 1998). In both cases, the latter reduced their affective expression downwards to level of the disturbed patients. The reduction pattern seems indicative of low-organized structural personality

dimensions, which suffer from a lack of mentalization capacities (Fonagy, 1991; Fonagy & Target, 1998; Schulz, 2000). The affective reduction pattern does not hold true for psychic disturbances centered around unconscious neurotic conflicts. In hysteric conversion reactions, we have typically found an excess of affective micro-reactions of conflicting nature which produce an augmentation on the behavior of their partner. All this has a strong although unconscious influence on the experience of emotions (Krause, 1982; Hufnagel et al., 1993; Steimer-Krause et al., 1990; Frisch et al., 1995) and this can be conceptualized as a countertransference reaction. The whole pattern of unconscious affective interactions, object representations, and feelings can be described as the specific intersubjective field of a dyad (Benecke et al., 2000) and can vary according to the above-mentioned structural personality variables. In the case of subjects with a high degree of mentalization the frequency of negative facial affects like anger, contempt, and disgust is correlated positively to the emotional experience of joy (Hufnagel et al., 1993), while in the case of schizophrenic as well as of psychosomatic patients, frequencies of negative facial affects, such as contempt and disgust are correlated to negative feelings.

Research shows that in subjects with high mentalization facial affect is an attribution to the mental objects they are talking and thinking about while in the case of patients with a low degree of mentalization facial displays of contempt and disgust enters directly into the relationship as a rather direct interaction-regulator. These two functions of facial-affective signs can be disentangled by use of the contextual gazing. Facial-affective signs related to the interacting partner occur in different gazing contexts than those related to objects not present (Merten, 1997).

Thus, negative facial displays of healthy subjects most often occur within the context of verbal comments use objects as referents while those of low-structured patients do not show this kind of relationship.

Negative affects that are not tied to verbal comments handicap the relationship-regulation. In the dyads of patients where the personality organisation is low, they merely serve as signals to the actual interacting partner. A weakness in the quality of relationship between patients and interacting partners is also indicated by the following results:

In all dyads, frequency of negative affects (anger, contempt, disgust) is significantly reduced during mutual gazing (Merten, 1997). In dyads with low mentalization patients, however, this reduction is dramatically more pronounced. Only three to six percent of negative affects are shown during mutual gazing which corresponds to 21 to 29 percent of the total sampling time. In high mentalization dyads, 17 percent of the negative affects are shown during mutual gazing which amounts to 35 percent of the total time of observation. Subjects with high level of mentalization can afford to do so basically because what exists is a positive relationship – as indicated by mutual smiling during mutual gazing - and the above-mentioned relationship of negative affects linked to verbal contents. This type of interaction allows the display of a high amount of negative affects during mutual gazing without weakening the relationship. What is signaled within the intersubjective field is that the interaction has quality attributes of liveliness, high cathexis, interest, and engagement and is by no means experienced as hostile.

How is the psychic disturbance implemented in the intersubjective social and mental field?

Taking these results into account, we can no longer attribute the repetition-compulsion to the patient alone. The enactment of the process has to be understood as a dyadic interaction to which both interacting partners contribute. Patients as well as healthy subjects anticipate further development of ongoing interaction by cognitive-affective modelling (Patterson, 1991; Krause, 1997; Bänninger-Huber, 1992, 1996). Cognitive-affective modelling of patients can be characterized by specific conflicts for example, a wish for closeness and at the

same time the fear of intimacy – which will directly influence the kind of relationship that can be established. In schizophrenic patients, it was demonstrated that they themselves do not always avoid closeness but that they succeed in inducing distance in their interacting partners (Steimer-Krause, 1996). This corresponds in the dyadic process to what elsewhere was described as ”projective identification” (Ogden 1988, Porder, 1991). Merten (1996) has shown how this projection is implemented by means of nonverbal behavior. We have observed that similar processes take place in psychotherapeutic interactions and that they constitute the emotional quality of the intersubjective field and of the therapeutic relationship, which is the most important aspect of the therapeutic bond.

What characterizes the therapeutic relationship in contrast to an everyday relationship?

The comparison of facial-affective behavior in ”everyday”-situations and psychotherapeutic situations yielded the following results: the overall facial affectivity of patients and therapist is reduced when compared to that of subjects in ”everyday”-interactions. Joy and disgust are especially displayed less by patients and therapists, while fear and surprise are more often shown by patients in the psychotherapeutic situation. The therapists also show more surprise than subjects in ”everyday”-interactions. Patients and therapists often display less contempt than healthy subjects in ”everyday”-interactions, but patients show contempt twice as much as therapists. In comparison to ”everyday”-interactions simultaneous Duchenne Smiles (indicative of felt happiness) of both patient and therapist are significantly reduced. Healthy subjects in ”everyday”-interactions show three times more simultaneous Duchenne Smiles than patients and therapists.

How is the therapeutic relationship related to therapeutic outcome ?

From the outlook of clinical praxis and analytic theory where therapeutic alliance is considered the most important predictor of psychotherapy outcome, these results may seem peculiar. The conceptualisation of therapeutic alliance and ways to measure it, however, differ considerably (Orlinksky et al., 1994) and are often inadequate from a conceptual point of view (Krause, 1997).

On the conceptual side, Strupp (1994) proposes a definition by Gaston (1990) who distinguishes 4 components of the therapeutic alliance: 1) the working alliance, 2) the affective bond of the patient to the therapist, 3) the empathic understanding and involvement of the therapist and 4) mutual agreement on goals and tasks of the therapy. The affective bond of the therapist to the patient is not mentioned, probably because it is considered as part of the therapist's involvement. Orlinsky et al. (1994) distinguish *task-oriented team work* from the *social-emotional* aspect of the therapeutic alliance. The social-emotional aspect is subdivided into communicative contact and mutual affect.

If we classify the results of the studies discussed in the metaanalysis of Orlinsky et al. (1994) these subdivisions yield high effect sizes, although the original studies are heterogenous in respect to the procedures used to operationalize and measure aspects of the therapeutic alliance. One of the flaws of the study is that in the end it is not clear what specific aspects of the therapeutic alliance process correlate with the therapeutic outcome. For instance, Orlinsky et al. (1994) use terms like ”mutual affect” or ”reciprocal affirmation” but the empirical findings subsumed differ enormously in respect to operationalisation. A study of Collins et al. (1985) was subsumed to reciprocal affirmation, and what was actually observed was to what extent affective exchange between patients in the waiting room occurred, as reported by the staff, on one item of the Ward Atmosphere Scale (Moos, 1974).

The therapeutic alliance is a necessary condition for a successful therapeutic process. Nevertheless, Merten et al. (1996) stipulated in their discussion, the

results of investigations of the relationship between therapeutic process and outcome depends upon whether ratings are made by therapists or patients (Strupp et al, 1977, Orlinsky et al. 1994). Schindler (1991) found that patient and therapist ratings of therapeutic process seldom correlate. In order to avoid this bias of perspective in assessing process characteristics, one has to make use of the objective approaches of communicative contact and mutual affect. Following Orlinsky et al. (1994) objective indices of the global quality of the therapeutic bond were only used by Grawe (1989, 1990), Neimeyer et al. (1991), Barker et al (1988) and Bowers & Clum (1988). Yet, when one looks closely at these studies, the measures they use are not objective ones but only indirect ones, as they combine the subjective responses of patient and therapist. Therefore, in these studies no objective indexes for patient and therapists contributions to the global quality of the therapeutic alliance have been used..

In regard to the social-emotional side of the therapeutic alliance, namely, communicative contact and mutual affect, only three studies used objective indexes to study patient and therapist expressiveness as parts of communicative contact (Roshal, 1953; Barrington, 1961; Minsel et al, 1972). The number of studies that analyze expressiveness in therapists is small and there are only two studies that investigated communicative attunement of patient and therapist (Saunders, Howard & Orlinsky, 1989). Orlinsky et al. (1994) list three studies with positive effects of what they refer to as reciprocal affirmation. Collins et al. (1985) have already been mentioned. Rudy et al. (1985) use an indirect measure matching patient and therapist ratings. Buckley et al. (1981) asked therapists after 1 to 18 years of completing their own personal therapy to narrate the beneficial or harmful effects they had experienced and found that improvement in all areas were positively correlated with mutual liking. In the cases in which negative affect predominated in the therapy, it was found that patients had implemented maladaptive relationship-patterns that were interacted with their therapists which were not resolved in the treatment. A question in this respect is

if ratings with temporal distances of years are still commensurable to those collected at the end of the treatment or one or two years after the end of treatment.

If we take into account the studies described above, we can conclude that the therapeutic alliance is important, but also the personal, social-emotional side of it particularly needs further and objective scrutinization in order to to enrich the knowledge of its interactive components. Communicative contact and mutual affect introduced by Orlinsky et al. (1994) as categories are promising, but the analysis of the primary studies is disappointing in the sense that emotions and reciprocity in process are only insatisfactorily investigated and there is actually no study in which objective means to analyze the affective behavior of therapist and patient are used.

What makes up the curative factors of the therapeutic relationship?

We consider that given the above-mentioned findings on nonverbal interaction styles, implementation of patterns of relationship and adaptation might be of interest, particularly if the curative power of successfull therapeutic relationships could be related to the fact that there are therapists who do not submit themselves unconsciously to the adaptation patterns the patients normally impose on their interaction partners. In doing so the countertransferencial side of the repetition-compulsion could be avoided, even if it is only on an unsconscious behavioral level.

With this question in mind, Merten et al. (1996) analyzed two cases of 15 sessions of psychoanalytic focal treatments, one successful and the other one with an unsuccessful outcome. What they found was that in the less successful one an unresolved conflict of the therapist fitted into the problem of the patient with the consequence that both the patient as well as therapist enacted it The outcome was bad, despite the fact that they both expressed a lot of mutual liking displayed by mutual smiling and that they exhibited a huge amount of positive reciprocity. In the successful therapy, compensatory affective behavior

prevailed. The therapist showed negative emotions while the patient smiled. At the present, we can broaden the same kind of results onto a sample of 11 treatments handled with different techniques of treatment. (Krause & Merten, 1999).

Our sample was constituted by 11 very experienced therapists of cognitive-behavioral, psychoanalytic and client-centered theoretical orientation, who treated severely-disturbed patients in a brief psychotherapy setting of 15 hours during which they were videotaped by two cameras. The patients were selected by the therapists as being very severely disturbed, of which nine had been treated before without success. Facial-affective behavior in the first eleven therapy sessions was related to therapeutic outcome which was assessed by both patient and therapist.

How is the implementation of relationship-patterns tied to therapeutic outcome ?

The analysis of facial behavior in therapy-sessions yielded the following results: facial activity in the first session was highly variable across patients and therapists. Patients displayed facial events in a range from 145 to 641 events per session, therapists from 48 to 226. In 10 of the 11 therapies, the patients facial activity was higher than that of their therapists. Taking into account only primary affects, only 8 patients were more expressive than their therapists. In general, the therapists showed less idiosyncratic facial behavior, less affective blends and more "pure" primary affects than the patients.

Facial behavior of the therapists did not exhibit any change that could be related to differences in their theoretical orientation. The variance between therapists of the same theoretical orientation was even higher than that found between the groups of different theoretical orientation. Facial behavior depends more on individual characteristics and/or dyadic adaptation processes than on theoretical orientation.

In dyadic interactions between two healthy persons, the most frequent facial affective event was felt happiness. This occurred during therapeutic interaction

only in 6 therapists and 5 patients out of a sample of 11. The others showed mainly contempt or disgust and in one dyad anger was the most frequent facial affective event. The "Leitaffekt", which is the most predominant and constantly displayed affect, was shown in different frequencies. One patient displayed 187 facial events interpreted as disgust during the 50 minutes of the first session but only once expressed felt happiness. These affects can be considered as indicators of interactive and self-regulatory processes, which is a way of defining transference as a function and could be related to therapeutic outcome. Nevertheless, neither the affective valence of the "Leitaffekt" of the patient nor its frequency correlated significantly with one of the outcome measures (Perspective of therapist with frequency: r=.23, p=.49; Patient: .22, p=.54; FBL: .08, p=.83, all 2-tailed).

In line with the above-mentioned results on adaptation, therapists whose facial affective behavior responded to the facial control of their patients could be expected to be related to poor therapeutic outcome. Indeed the relative frequency of the "Leitaffekt" of the therapist correlated negatively with his own outcome rating which was given usually half a year later ($r=-.63$, $p < .05$, $N=11$). Therapists who displayed high amounts of **one single** facial affect during the first session rated in therapeutic outcome as ”worse” after the 15th session and this was irrespective of the type of ”Leitaffekt” displayed. This could be interpreted as a consequence of the implementation of a maladaptive repetitive pattern which reduces the normal variance of affectivity.

Insert Table 1

This hypothesis is supported by the fact that three **different** negative affects (anger, contempt and disgust) in the amounts shown by the therapist were positively correlated with his own outcome rating (r=.81, p=.003, N=11) and

with the change assessment scores of a questionnaire for symptoms (pre-post differences, r=.54, p=.11, N=10).

The proportion of felt happiness of patients and negative affects of therapists correlated with all three outcome measures as depicted in table 1. In therapies in which the patient expressed many positive affects and there were only a few negative affects on behalf of the therapist outcome was worse. Successful therapists compensated the too much of positive affects with their own negative affects.

The correlations reported above between frequencies of facial affects and therapeutic outcome do not cover the actual implementation of maladaptive relationship-patterns. The actual implementation of maladaptive relationship-patterns takes place on the level of dyadic emotional patterns that describe emotions of patient and therapist as they occur simultaneously or within a short temporal distance. Emotional patterns describe individual and dyadic emotional processes as they show up in facial-affective behavior of patient and therapist. They also contain information about emotional self-regulatory processes as well as about the quality of relationship-regulation between patient and therapist. Definitions and properties of emotional patterns are given in Merten (1996); an algorithm to detect ”hidden real time patterns” was developed by Magnusson (1996). The application of the algorithm of Magnusson revealed that dyadic patterns of Duchenne Smiles (that is, smiles that appear simultaneously or almost simultaneously in the interaction) occured in nearly all analysed therapies and that no pattern of negative affects on behalf both participants was found. Therefore, motor mimicry of facial-affective behavior - as far as it is registered by EMFACS - only takes place in the case of a positive emotion when indicated by a Duchenne Smile.

In cases where negative affects are part of a dyadic pattern, the negative affect is compensated by a social smile or a Duchenne Smile of the partner. In addition, several therapy-specific patterns describe core psychodynamic conflicts of the

patient. To give an example, a patient with a conflict with attachment and separation engaged in a good amount of positive facial-affective behavior with the therapist, but also displayed a pattern of anger followed by an expression of fear that could be directly matched to the conflict of the patient. This and other cases are described elsewhere in detail (Merten et al., 1996; Benecke et al., 2000; Merten, 2000).

Table 2 shows the correlations between characteristics of emotional patterns in different therapies and therapeutic outcome. One major result is that the frequency of dyadic emotional patterns correlates negatively with therapeutic outcome in all three perspectives, while maximum complexity of the patterns also correlates negativeley in the same manner.

Insert table 2

A specific subcategory of emotional patterns is that composed of the appearance of a Duchenne Smile in both interacting partners which occurs simultaneously. The frequency of simultaneous Duchenne Smiles correlates significantly with therapeutic outcome, namely from the perspective of the therapist (table 2).

In addition, we found a curvelinear quadratic relation between the frequency of mutual smiling iniciated by the therapist and therapeutic outcome (P=.038, b2=-.64). Therapies in which not even one incident of positive mutual smiling initiated by the therapist appears were rated on a medium level of outcome. In the therapies in which the process was deteriorated or the patient dropped out we found more than four incidents of mutual smiling initiated by the therapist. The therapies with highest outcome rate lie in between the two above-described cases.

It can be concluded that the implementation of relationship-patterns is indicated, in general, by high frequencies and high complexity of dyadic patterns and also by the presence of too many patterns of positive emotions from both interacting partners. Furthermore, this kind of implementation is correlated bad therapeutic outcome.

If the therapist gets involved in the maladaptive relationship-pattern and it is not resolved during the course of treatment,, the dreaded pattern will be repeated and further reinforced. This assumption was confirmed by the following results. In therapies with better outcome conflict-indicators augmented to a certain point in treatment and tended to decrease in later sessions. Indicators for bad outcome were high complexity in dyadic relationship-patterns and their predominace in high frequencies in the last session. In these cases therapists were unable to recognize and/or resolve the maladaptive relationship-pattern they were involved in.

Summary

High stability in psychic disturbances is attributed to a successful unconscious implementation of maladaptive relationship-patterns in ”everyday”-interactions. This process is to be understood as a dyadic interaction in which both subjects, the healthy person as well as the patient contribute, and in which. differences in facial-affective behavior of both interacting partners can be observed. Dyadic interactions between healthy subjects are characterized by less positive affects in the facial-affective behavior of both partners, while dyads of patients with diminished or totally hindered mentalization capacities in interaction with healthy subjects typically exhibit a single negative ”Leitaffekt on both sides.

Psychotherapeutic interactions differ from ”everyday”-interactions between healthy subjects mainly in respect to these adaptation phenomena. Experienced therapists regardless of their theoretical orientation proved to be emotionally abstinent, at least in their facial affect display. Emotionspecific differences were found in the expression of distance-regulating emotions like joy, contempt and disgust, that were reduced, and in information-processing emotions like surprise and fear, that were shown with higher frequency than in ”everyday”-interactions. The latter indicate that new informations have to be assimilated, although information-processing is usually hampered by the onset of defense-mechanisms that are triggered by the signalization of fear.

The reduction of joy in the psychotherapeutic interactions analyzed in our study was attributed not only to illness of the patient but also indicates the presence of abstinence in most therapists. In relation to the implementation of maladaptive relationship-patterns in therapeutic relationships, dyadic aspects of facial affective behavior are special indicators of the affective bond and meaningful predictors of therapeutic outcome.

”Leitaffekt” of patients in the first therapy session does not correlate - nor does any other variable of the facial affective behavior - with any outcome perspective. Surprisingly, facial affective behavior and dyadic variables of the therapist were found to be much more related to outcome perspectives than facial-affective behavior of patients. Therefore, an important finding is that the therapist’s facial affective behavior is a especially useful predictor of therapeutic outcome. What characterizes most successful therapists is the absence of a single, high frequent ”Leitaffekt”. From another perspective, we might say that therapeutic failure is related to a loss of variabilty in the expressive regulatory system of the therapist.

Results related to facial affective behavior in patients and therapists, its significance for the affective bond and its relation to therapeutic outcome can be summarized in the following manner. Therapist’s differential negative facial expressiveness seems to be a necessary condition for a problem-oriented therapeutic process. The therapist’s negative affects can be indicators of different psychological contents however: They can be reactions to the patient’s actual behavior or its narratives, but they can also be tied to the behavior of protagonists talked about in the narratives. In both cases they represent important starting points for the understanding of the patient’s problems which are centered around affective conflicts with others, themself and/or the therapist.

Succeesful implementation of maladaptive relationship-patterns is indicated by large amounts of emotional dyadic patterns and high complexity of these patterns. Although a certain amount of dyadic patterns is characteristic and

necessary for all dyadic interactions, large amounts in therapeutic interactions imply the danger of conflictive involvement of the therapist. Large amounts of positive local reciprocity are particular predictors of bad outcome; but nevertheless, a certain amount of reciprocity is necessary to establish an affective bond between patient and therapist. In this manner some of the experienced therapists were able to handle a good amount of negative expressiveness in their patients. Displays of positive affects of the patients is also crucial for therapeutic process and has to be dealt with. The more successful therapists did this in a compensatory fashion. The less successful ones reacted more often reciproquely and even initiated positive reciprocity themselves several times.

The concept of ”Leitaffekt” and the variables centered around it integrate most of these considerations. An outstanding positive ”Leitaffekt” on the side of the therapist indicates a behavior that is more similar to everyday interactions with healthy partners than a problem-oriented one in therapy. A intense negative Leitaffekt on the side of the therapist can be overwhelming and can totally hinder the establishment a positive relationship. Consequently, facial affective behavior was well balanced in successful therapists and can be considered as the result of a compromise between negative affective involvement and positive affiliation.

Tables

Table 1: Facial-affective behavior and therapeutic outcome

		Outcome perspective	
Predictor	Therapist	Patient	Combined
%"Leitaffekt$_T$"	-.63*		
Negative affects$_T$	+.81*		
Happy felt$_P$/negative affects$_T$	-.64*	-.55$^+$	-.76*

Spearman correlations, * $p < .05$, $^+$ $p < .10$

%"Leitaffekt$_T$": relative frequency of most frequent facial affect ("Leitaffekt")

Happy felt$_P$/negative affects$_T$: Proportion of patient's happy felt expression and therapist's negative affects

Table 2: Correlations between facial-affective behavior and therapeutic outcome

		Outcome perspective	
Predictor	Therapist	Patient	Combined
Maximum complexity of patterns	-,69*	-,43	-,68+
# of dyadic patterns	-,58+	-,81*	-,75*
Simultaneous Duchenne Smiles	-.63*		

Spearman correlations, * $p < .05$, + $p < .10$

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