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On Side Effects, Destructive Processes, and Negative Outcomes in Psychoanalytic Therapies:

WHY IS IT DIFFICULT FOR PSYCHOANALYSTS TO ACKNOWLEDGE AND ADDRESS TREATMENT FAILURES?

HORST KÄCHELE AND JOSEPH SCHACHTER

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HORST KÄCHELE, M.D., Ph.D., AND JOSEPH SCHACHTER, M.D., Ph.D.

On Side Effects, Destructive Processes, and Negative Outcomes in Psychoanalytic Therapies:

WHY IS IT DIFFICULT FOR PSYCHOANALYSTS TO ACKNOWLEDGE AND ADDRESS TREATMENT FAILURES?

Abstract. Side effects, adverse treatment reactions, and negative outcomes are relatively neglected topics in the vast clinical literature on psychoanalytic therapies. This article discusses numerous contributory elements and zooms in on the contribution of therapist factors. We present definitions, briefly summarize the state of outcome research and specifically mention the high attrition rate in psychotherapy and psychoanalysis. Factors shown to contribute to negative effects include incorrect diagnoses, unfavorable external conditions, constitutional factors and modifications of the ego. We concentrate on examining the role of countertransference and other therapist factors. The article closes with a clinical perspective that raises a question about the analyst's ethical responsibility to inform new patients about the possibility of side effects, damaging consequences, and incomplete or negative outcomes.

Keywords: Dropping out of treatment, negative treatment outcomes, negative therapist factors, countertransference, positive treatment outcomes, ethical responsibility to inform.

Introduction

I am invisible, understand, simply because people refuse to see me.. .. When they approach me they see only my surroundings, themselves,

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or figments of their imagination. – indeed, everything except me" (pp. 3–4) wrote Ralph Ellison (1952), a black man in a white United States. Black men were seen as threatening by many whites and appeared as invisible. At an even more graphic level, many German Jews, despite growing evidence, were unable to "see" the deadly intent of the Nazis and remained in Germany until it was too late. Indeed, Freud himself did not "see" the necessity to leave Vienna until his daughter, Anna, was arrested briefly.

Psychotherapeutic and psychoanalytic failure are largely invisible to many therapists who refuse to see them. Treatment failures may be seen as threatening by many therapists in that they may seem to undermine the effectiveness of their therapeutic role. Failure of psychotherapeutic and psychoanalytic treatment is a major clinical problem of substantial dimensions, which must be acknowledged so it can be dealt with by empirical research. Research efforts to date have been limited in part because of the lack of theoretical conception of how to define, classify, and assess side effects and negative outcomes of treatment; we need the cooperation of clinicians and researchers in this enterprise.

Side effects of an intervention (be it a drug or psychotherapy) may be positive or negative; in any case the main effects of a treatment have to be justified and patients have to be informed about the frequency of side effects. Empirical research on these phenomena is limited, partly because there is a lack of theoretical conception of how to define, classify, and assess psychotherapy side effects and negative outcomes. Linden (2013) recently proposed a model for the definition, classification, and assessment of psychotherapy side effects. Not all unwanted events (UE) may be regarded as adverse treatment reactions (ATR); one would have to demonstrate a causal link to identify an unwanted event as side effect (see Table 1).

Negative processes during an ongoing treatment may be due to a disorder′s autonomous course, as happens all too often in the case of severe anorexia nervosa. They also may be conceived as either consequences of patients′ incapacities to use treatment at a specific moment in time or of some patients' chronic tendencies to sabotage any treatment, as has been conceptualized in the "negative therapeutic reaction" phenomenon. Thomä and Kächele (1994a), however, have suggested that it may be most illuminating to look for therapists′ share in such developments. True destructive processes in psychotherapy and psychoanalysis

Table 1

Definition of Side Effects Different from Treatment Failure, Deterioration, and Malpractice (Linden, 2013)

Side Effects	Definition
Unwanted event (UE)	All negative events that occur parallel or in the wake of treatment
Treatment-emergent reactions (TER)	Any UE that is caused by the treatment
Adverse treatment reactions (ATR)	Any UE that is probably caused by correct treatment
Malpractice reaction (MPR)	Any UE that is probably caused by incorrect or improperly applied treatment
Treatment non-response (TNR)	Lack of improvement in spite of treatment. It is a UE; it can be or cannot be an ATR or an MPR
Deterioration of illness (DOI)	Worsening of illness during therapy or any other time in the course of illness. It is not necessarily a UE; it can be a UE and can be or cannot be an ATR or an MPR
Therapeutic risk (TR)	All ATRs that are known. Patients have the right to be informed about severe or frequent or impairing TR as this is the basis for giving their informed consent for treatment
Contraindications	Conditions of the individual case, which make severe ATR highly probable. An ATR of treatment in spite of given contraindications are one form of MPR

do happen mainly in the context of severe transgressions of the rules of abstinence (Gabbard, 1989).

Failures in psychoanalytic psychotherapy and psychoanalysis, as in any medical enterprise, are robust widely occurring phenomena. However, it 70

is striking that psychotherapists and psychoanalysts generally fail to address this critical clinical problem. For example, the electronic database PEP, covering thousands of references, reveals only four references to "psychoanalytic failure," whereas "psychoanalytic theory" garners 648 references. Only five, among the many hundreds of Anglo-American psychoanalytic books that have been published, focus on treatment failures: *Success and Failure in Psychoanalysis and Psychotherapy* (Wolman, 1972); *Why Psychotherapists Fail,* (Chessick, 1983); *The Prison House of Psychoanalysis* (Goldberg, 1990); *Failures in Psychoanalytic Treatment* (Reppen & Schulman, 2002); and *The Analysis of Failure: An Investigation of Failed Cases in Psychoanalysis and Psychotherapy* (Goldberg, 2012). In *The Primordial Mind in Health and Illness*, Robbins (2011) reports on cases where he did not succeed in treatment. In terms of a comparative perspective on psychoanalytic therapies from different schools–ego psychology, relational therapy, or Kleinian approaches–there are, to our knowledge, no data available. Although we think psychoanalytic psychotherapy and psychoanalysis are more than mere neighbors (see Grant & Sandell, 2004), for didactic reasons we maintain a distinction in our discussion.

The State of Outcome Research

We first 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 confident that psychotherapy is more likely to improve patients than to harm them. The overall effect sizes–a statistical measure that allows comparing the effects of various interventions in medicine, psychology, and pedagogy–are substantial. These effects are as large–or even larger–than the effects reported, for example, for antidepressive medication, and they are larger than those produced by a variety of methods typically employed in medical and educational interventions (Lambert & Ogles, 2004).

These findings, however, represent average scores. Changes occurring in both experimental and control groups show a significant increase in the variability of criterion scores, which become manifest at posttesting in the treatment groups. This implies that some treatment cases improved whereas others deteriorated, thus causing a spreading of these scores. The phenomenon of deterioration, although familiar to many clinicians, has remained a neglected topic in treatment research even though it was

pointed out 40 years ago by Bergin (1963). So the issue is really quite dramatic; not 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.

Attrition in Psychotherapy and Psychoanalysis

Patient attrition in psychotherapy is a common clinical phenomenon. A review of research (Garfield, 1986) reported that more than 50% of patients withdrew before the eighth session (Straker, 1968; Bakelund & Lundwall, 1975; Reder & Tyson, 1980). Bakelund and Lundwall noted that in the long run it is the patient who leaves rather than the one who remains in treatment who is the typical patient (see Table 2). In a later meta-analysis of 125 studies on psychotherapy dropout (Wierzbicki & Pekarik, 1993), the mean attrition rate was 47%. "Remarkably . . . " noted Barrett, Chua, Crits-Christoph, Gibbons, and Thompson (2008), "clients continue to disengage from mental health services at a rate comparable to that found more than 50 years ago" (Rogers, 1951, p. 247). Barrett et al. add, "More than 65% of clients end therapy before the 10th session (Garfield, 1994), with most clients attending fewer than 6 or 8 sessions"

Table 2

Psychotherapy Attrition Rate

Authors	Date	Attrition	Time Interval
Garfield	1986	50%	First 8 sessions
Lorion & Fellner	1986	47%	Indefinite
Sledge et al.	1990	32%	Time limited
Sledge et al.	1990	67%	Brief psychotherapy
Wierzbicki & Pekarik	1993	47%	Indefinite
Garfield	1994	47%	Indefinite
Elkin et al.	1999	50%	First month
Sparks et al.	2003	47%	Indefinite

(Phillips, 1985, p. 248). Variations in the definition of dropout have influenced the findings. Barrett et al. summarized the data as follows: "Of 100 prospective clients contacting a mental health clinic, only 50 will attend the initial evaluation, 33 will attend the first treatment session, 20 will remain by Session 3, and fewer than 17 will remain by Session 10" (p. 253).

Attrition was greater for African-American and other minority groups, for less-educated and for lower income patients. Piper et al. (1999) compared 22 patients who left time-limited psychotherapy with 22 matched completers; none of the pretherapy predictors significantly differentiated the two groups, though several of the therapy process variables, including the therapeutic alliance, patient exploration, and focus on transference did distinguish the two groups. Barrett et al. (2008) discussed numerous strategies to reduce attrition: role induction, motivational interviewing, active involvement with the client, therapist feedback, and enhancing the therapeutic relationship.

It is not surprising that borderline patients demonstrate an inordinately high attrition rate in psychotherapy relative to other diagnostic groups. Borderline patients form intense and unstable relationships relative to other diagnostic groups. Skodol, Buckley, and Charles (1983) reported a 67% attrition rate among borderline patients after three months of psychotherapy. Waldinger and Gunderson (1984) found a 46% attrition rate within six months; only one-third of their sample completed treatment. Likewise, Gunderson et al. (1989) reported that 52% of borderline patients left treatment by six months. Smith, Koenigsberg, Yeomans, Clarkin, and Selzer (1993) found attrition rates of 31% and 36% at three and six months, respectively, for borderline patients. However, use of a self-psychological approach to treatment found a reduced attrition rate with borderline patients of only 16% at three months (Stevenson & Meares, 1992).

Less acknowledged than these data about attrition in patients in psychotherapy is the similarly high attrition among psychoanalytic patients. Published clinical examples in the available literature span more than half a century; approximately 30–60% of psychoanalytic patients leave treatment before reaching a mutually agreed termination (see Table 3).

How can we understand the apparent failure of most psychoanalysts to acknowledge and address this clinical problem of widespread attrition? We offer a speculation. One observation is that many–probably most–senior analysts are reluctant or unwilling to present treatments of their

Table 3

Psychoanalysis Attrition Rate

Authors	Date	Attrition	Time Interval
Glover	1955	55%	Indefinite
Hamburg et al.	1967	43%	Indefinite
Hendrick	1967	40%	Indefinite
Sashin et al.	1975	31%	Indefinite
Erle	1979	38%	Indefinite
Erle & Goldberg			
Study I	1984	27%	Indefinite
Study II	1984	44%	Three years
Weber et al.	1985	55%	Indefinite
Kantrowitz	1993	60%	Indefinite
Cooper et al.	2004	29%	Indefinite
Hamilton et al.	2007	31%	6 months
Cogan & Porcerelli	2008	39%	18 months

own patients either to their own institute or to a conference audience. Another related observation is that, likewise, many–probably most–analysts are unwilling to give permission for the study of their treatment, either of a past or present patient. These observations suggest that many analysts have an underlying uncertainty or insecurity about the effectiveness of the treatment of their own patients. We suggest that it is this anxiety about the effectiveness of the treatment of their own patients that, perhaps unconsciously, leads them to turn a blind eye towards widespread evidence of failed treatment.

In striking contrast, the data from *psychoanalyst-patients* indicate that approximately 80% of them remain in treatment, whether with a training analyst or a nontraining analyst, until reaching a mutually agreed termination (Schachter, Gorman, Pfäfflin, & Kächele., n.d.), i.e., only 20% drop out. This investigated cohort of psychoanalyst-patients are all graduate analysts and therefore does not include those who dropped out of a training analysis. We do not have data about drop-outs from training analysis, though apparently very few have done so. We concur with

Marmor's (1986) suggestion that this large reported difference in mutually agreed termination of 80% for psychoanalyst-patients compared to 50% for nonpsychoanalyst patients may be due to the psychoanalyst-patients greater positive professional stake in all psychoanalytic treatment based on a personal identification as psychoanalysts. For a psychoanalyst-patient to recognize a failed personal psychoanalytic treatment might shake the foundation of his or her chosen profession. We believe that the issues of failed psychoanalytic treatment for psychoanalyst-patients differ markedly from those for non-psychoanalyst patients"(Schachter et al., n.d.). Still, it is refreshing to learn what 75 psychoanalysts found helpful and hurtful in their own analyses (Curtis, Field, Knaan-Kostman, & Mannix, 2004).

Since Bergin's 1963 article, "The Effects of Psychotherapy: Negative Results Revisited," 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 unfavorable 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 biological given (instincts) and of conflicts;
4. Unfavorable 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 later comment on them. However, what one misses 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 in almost all forms of psychotherapy.

In his recent critical evaluation, Goldberg (2012) characterizes several categories of analytic failure:

1. Cases that never get off the ground or never seem to start.
2. Cases that are interrupted and so felt to be unfinished by the therapist or analyst.
3. Cases that go bad.
4. Cases that go on and on without obvious improvement–losing one's patience.
5. Cases that disappoint.

These descriptive categories leave open the question of why the psychoanalytic treatments failed. We therefore discuss some factors that may pertain to both psychotherapy and psychoanalysis; later we will focus on the therapists' contributions to constructive and destructive processes and their relation to treatment outcomes.

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. As an illustration, we mention the advent of specific borderline treatments that have clearly improved the outcome for this difficult-to-treat patient group; the treatment manuals (e.g., DBT, TFP, MBT) all work with careful diagnostic evaluation!! (Sandell, 2012; Kächele, in press).

As patient diagnosis and degree of disturbance are related we should not be particularly surprised about this finding. However, particularly for borderline disorder patients 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, Brown, & Oliver, 1973), borderline patients (Weber et al., 1966; Horwitz, 1974; Fonagy et al., 1996); and studies with disturbed participants in encounter groups (Liebermann, Yalom, & Miles, 1973) demonstrate that a worsening of patients' conditions sometimes occurs and that therapeutic techniques are probably responsible for this deterioration. This is not to minimize the point that patients' characteristics also contribute to this deterioration, which we shall learn more about when discussing other factors.

Unfavorable External Conditions

Unfavorable external conditions might lead to what Freud had categorized as a "secondary gain from illness." In a discussion of this phenomenon, Thomä and Kächele (1994a, p. 133) 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, 1953b, p. 160). In evaluating the external forces that co-determine 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 (1953a). 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, 1953a, p. 43). Precisely a case exhibiting a stable structuring of symptoms is characterized by a course in which the primary conditions are so mixed with the secondary motives that they can hardly be distinguished. There is very little systematic research on the embedding of this internal neurotic mechanism in the context of life circumstances. The various follow-up studies on untreated patients could illustrate such considerations.

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The case of the Wolf Man probably would serve as a good example where a dramatic worsening of the patient's life circumstances contributed to his identifying himself as a lifelong patient (Gardiner, 1971; Obholzer, 1982).

The attitude of the family sometimes contributes to treatment failures. The Hamburg study on anorexia (Engel, Meyer, Hentze, & Wittern, 1992) reported that long-term recovery was significantly related to the developmentally necessary separation from the family. Long-term mortality (!) was higher among those adolescent girls that remained with the primary family environment compared with anorectic girls who left home; however we do not understand why remaining at home impacted on the fatal outcome.

Reality factors–education, class, economic status–may also contribute to negative development of the therapeutic relationship. What is true of all somatic diseases applies also to psychological disorders: poor education and low social class, especially low economic status, have antitherapeutic 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 strata (see Kächele, Richter, Thomä, & Meyer, 1999). Caspar and Kächele (2008) pointed out that incorrect self-exclusion of patients–patients that could profit from treatment–contributes to negative effects indirectly.

Constitutional Factors

The role of constitutional factors, like strength of instincts, goes back to Freud's (1953c) 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).

Whatever "strength of instincts" may mean, the well-known psychoanalytic researcher Luborsky (1975) 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. 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 into the DSM as Global Assessment of Functioning (GAF), research has demonstrated across many studies that the mean moderate predictive power displayed a correlation of 0.27 (7% of the variance) on the outcome of psychotherapy. Freud's idea that the sicker the patient, the harder it will be to make therapeutic gains, has been well corroborated (p. 546).

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 of 42 patients in treatment within the famous Menninger Hospital in Topeka, Kansas. Some of the patients treated became so-called "lifers," permanent users of psychotherapeutic support systems (p. 561). However, one might raise the question where,

if anywhere, these people might have received the proper treatment that could have changed their sad course. There are reports in the literature that some patients indeed need very long treatment to finally recover. The patient Christian Y, treated in high-frequency psychoanalysis by H. Thomä, needed 600 sessions to resume his normal life as a student of law; following which the treatment took another 10 years in low-frequency analysis to obtain a really satisfying personal and professional outcome (Thomä & Kächele, 1994b, p. 398).

Transference and Countertransference

The last item of this list invokes the central psychoanalytic technical topic: the concatenation of 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 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 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 confront her tormenting parental figures, after which the hysterical symptoms stopped. However, much too often, the clinician's countertransferentially colored view of these negative outcomes puts the burden of responsibility on 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 often from mishandling of the therapist's role in such a drama.

What Do We Know about "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, Fox, & Lessler, 1969). As a consequence of this pioneering study he was commissioned by the U.S. 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,

Hadley, & Gomes-Schwartz, 1977). In this research, one of the most frequent sources cited for negative effects in psychotherapy was the therapist. Many experts agree that "poor clinical judgment" or a general "fallibility of the therapist" are significant factors 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; the second pertains to health delivery systems that do not require adequate 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 leads to these negative effects in brief therapy. The most dramatic factor in identifying success and failure in psychotherapy was a measure named "Errors-in-Technique-Scale." This scale indicated that the 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 Program 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, Schacht, & Strupp, 1986).

A therapist´s misuse of his or her position is today considered a very important factor that contributes 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 (1979), published her analytic training experience with three analysts under the title "Flowers on Granite: An Odyssey through German Psychoanalysis." Her first female training analyst was able to resonate reasonably well with the somewhat whimsical patterns of behavior of this still late adolescent person, until she moved to 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 master her young life. She broke off analysis, moved to another town, and after some trouble found a young male training analyst. There things developed even worse. By her own report, she experienced borderline states with psychotic breakdowns. All this is detailed in the book, with a painful repetitive quality.

Dörte von Drigalski's book was very successful with the public, but less so with the professional world. There was never any official echo from 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 (e.g., Märtens & Petzold, 2002).

The most recent painful German 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 the lonely woman fell open to transferential

wishes for contact. The therapist, however, was not willing to give her what she wanted–although he clearly had induced these wishful states of desire. This interaction is typical. Many senior therapists transgress boundaries for several "good" or "bad" reasons. What then usually follows are protracted encounters that turn the therapy from blissful moments to chronic nightmares.

Ricks (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 analyzed 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 the less disturbed clients, there were striking differences in their therapeutic styles and (most significantly) in their outcomes with the more disturbed boys. For all the cases in the sample, 55% were judged to have become schizophrenic in adulthood. Only 27% of therapist A's cases, however, had such an outcome, whereas 88% of therapist B's cases deteriorated to such a state. The caseloads of the two therapists were equal in degree of disturbance and other characteristics at the beginning of therapy.

In analyzing the differences in therapist style, it was found that therapist A devoted more time to those who were most disturbed, whereas 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.

Today this topic is discussed under the heading of "optimal match" or "fit." Incompatibility between the patient's and the therapist's personality may significantly contribute to negative effects in psychotherapy. A growing number of studies have reported a significant, positive association between "fit" and satisfaction with the outcome of treatment (Shapiro, 1976; Kantrowitz, 1986, 1993; Leuzinger-Bohleber, Stuhr, Rüger, & Beutel, 2003; Tessman, 2003; Carr, 2006; Bush & Meehan, 2011; Schachter, Gorman, Kächele, & Pfäfflin, 2013).

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)? The research team around Rolf Sandell, a psychoanalyst and well-known researcher, has developed the Therapists Attitudes Scales (Sandell et al., 2004) and demonstrated in the Stockholm Psychoanalysis Project that therapist attitudes influence change during treatment (Sandell et al., 2007). A latent class analysis clearly distinguished successful from unsuccessful therapists (Sandell et al., 2006).

Clinical Perspectives

Psychoanalytic clinicians rarely speak about their everyday personalities; they prefer to speak about a "work-ego" observing their countertransferences. Ever since countertransference was transformed from a despised Cinderella into a radiant beauty (Thomä & Kächele, 1994a, p. 81), we can observe a truly enthusiastic "the more, the better" reception from within the psychoanalytic community: to observe this, one needs to study educational papers in the *International Journal of Psychoanalysis* (Gabbard, 1995; 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. In recent years reliable measures on habitual countertransference have been published that differentiate local, circumscribed countertransference reactions from more general, pervasive attitudes of a therapist (Gelso & Hayes, 2007; Betan & Westen, 2009; for a summary, see Kächele, Erhardt, Seybert, & Buchholz, 2013); as we now have these tools it might be appropriate to test out their usefulness in supervision.

Summarizing their clinical experience, Thomä and Kächele (1994b) concluded that certain therapist factors, not always identified as countertransference, are likely to contribute to a development of destructive processes:

1. Attempts to master crisis situations solely by working with transference and resistance are insufficient if they do not lead to an impro-vement in the patient's real life situation.
2. When a patient has no partner, focusing on unconscious transference wishes is also likely to have an antitherapeutic effect because, once again, the forced reference to transferential wishes can arouse unrealistic hopes.
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 MAY obstruct the interpretation of aggressive impulses, especially with the patient's use of the threat to commit suicide as a way to coerce the analyst.
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 may be so strong that it may make it difficult for them to be able to focus on the neurotic components of a patient's hopes.
6. Often a therapist, under the burden of 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 attempts to alleviate these feelings by getting tied up in telephone conversations justifying his or her procedure. This may promote the patient's secret hopes of overcoming the limitations of the therapeutic setting.

7. Sometimes the therapeutic framework only regains its importance the moment that the therapist admits his failure and announces that this means the termination of therapy.

Ethical Responsibility to Inform Prospective Patients about Treatment

It is uniformly regarded as an ethical imperative for the provider of medical treatment to offer to the prospective patient an estimate of the probability that treatment is likely to be successful, plus an estimate of the likelihood and nature of possible complications. Failure of the medical provider to provide such information to the prospective patient may be the basis of a malpractice charge. To the best of our knowledge, such information has rarely been provided by therapists in the practice of psychoanalytic or psychotherapeutic treatment. Until recently, practitioners had relatively little information they could impart to the prospective patient. There is now, however, substantial empirical data about the effectiveness of these treatments, the possibility and nature of possible complications, and the probability of successfully completing the treatment, which could be communicated to the prospective patient. The therapist could refer to the resolution of the American Psychological Association confirming the effectiveness of psychotherapeutic treatment. Yet, we are unaware of any practitioner attempting to provide such information.

Based on our long-term clinical experience, psychotherapeutic practitioners seldom provide such information to prospective patients. We suspect it is because such information would have to include some statement about incomplete treatment and failure of treatment, and we believe that therapists continue to have difficulty acknowledging the presence of these common, significant negative events. They may also be concerned that such information may have a negative impact on the patient's expectations for benefit from treatment (see Kirsch, 1999).

Professional organizations of therapists, such as the International Psychoanalytic Association, American Psychoanalytic Association, and the American Psychological Association have ethics committees, and we recommend that these committees consider the appropriateness of the ethical imperative of therapists informing prospective patients about the varieties of outcomes of treatment.

Conclusion

The message that runs through this report is this: Negative outcomes are likely to happen both in psychotherapy and psychoanalysis. If leaving

treatment prematurely and either failing to achieve therapeutic benefit or worsening of the emotional disorder are included, this probably includes 50% of all patients who initiate treatment. Of patients who initiate psychoanalytic treatment, only approximately 50% go on to reach a mutually agreed termination. However, as Luborsky, McLellan, Woody, O'Brien, and Auerbach (1985), Okiishi, Lambert, Nielson, and Ogles (2003), and Sandell et al. (2006, 2007) have demonstrated, therapists vary in their competence, so the early identification of poor work-performance in therapists in training should be of great concern in terms of our professional responsibility.

We think that systematic scrutiny of side effects and negative developments of psychoanalytic therapy should receive a more attention. In medicine, monitoring for unwanted effects has lately been given a high priority for determining the standards of care. A similar effort in the field of psychoanalytic therapies would be timely. Shame for not being successful is a bad advisor. Casement's (2002) book, *Learning from our Mistakes,* provides a message. Impressive examples through retroreports from experienced clinicians about their patients and by some of their patients about their own treatment has demonstrated that we can learn a great deal (Thomä & Kächele 1994b; Schachter, 2005; Breger, 2012).

We recommend that the ethics committees of psychotherapists' professional organizations consider the appropriateness and value of the ethical imperative of therapists imparting information about the range of outcomes and possible difficulties of psychotherapeutic and psychoanalytic treatment to prospective patients, which is standard procedure in medical treatments.

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Q24 Joseph Schachter, M.D., Ph.D., Columbia University Psychoanalytic Center for Training and Research, $2,253,000 Research Grants. Recently, Chair, Committee on Evaluation of Research Proposals and Results, IPA, Author of "Transference: Shibboleth or Albatross?"; "Transforming Lives"; and with Horst Kächele and Thomä, "From Psychoanalytic Narrative to Empirical Single Case Research" and 60 papers. He is a member of the International Psychoanalytic Association and an honorary member of the William Alanson White Institute.