RECOVERY AND NON-RECOVERY AFTER PSYCHOTHERAPY WITH TRANSFERENCE INTERPRETATION: TWO CASE STUDIES

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ABSTRACT
The First Experimental Study of Transference Interpretation (FEST) is a dismantling, randomized clinical trial of the long term effects of transference interpretation (TI). This paper examines two case studies of women with poor quality of object relations (QOR), one who was rated as recovered after psychotherapy and one who was not. Both received TI. In general, women with poor QOR needed TI to recover, but some members of this group did not recover, even with TI. The therapist’s negative countertransference and tendency to use controlling interventions was more pronounced with the poor outcome patient. In addition, the poor outcome patient had three sub-threshold personality disturbances as well as obsessive-compulsive personality disorder. She experienced substantial emotional and some physical abuse in childhood. She was less motivated before therapy and more evasive during therapy than the patient with a good outcome. The good outcome patient also had obsessive-compulsive personality disorder (PD) but no subthreshold PDs and her childhood home environment was more secure although the parents were distant. She was more open towards the therapist than the poor outcome patient. This paper illustrates that different people require different techniques even though they belong to the same group (low QOR) that, in the FEST study, did well with TI.

KEYWORDS: psychotherapy, case studies, psychodynamic, randomized trial
INTRODUCTION

Transference interpretation has traditionally been considered as key to stable change in psychotherapy. (Freud 1912, Gabbard 2000, Greenson 1994, Stone 1967). In both traditional psychoanalysis and psychodynamic psychotherapy, emphasis has been placed on the change-inducing effect of analysis of the present relationship to the therapist. (Sifneos 1992, Malan 1976). As described by Strachey, 1969, the patient’s problems play out in the therapy situation. Reactions based on experience with parents and important others gradually develop towards the therapist. How they are met in the present is considered to be of crucial significance. In his classic article on mutative interpretation, Strachey explains how transference must gradually be interpreted so the patient can become aware of the contrast between his feelings and the real nature of the therapist.

Use/non-use of transference interpretation and its effect on outcome was the focus of a randomized clinical trial using a dismantling design; the First Experimental Study of Transference Interpretation (FEST) (Høglend, Amlo, Marble, Bøgwald, Sørbye, et.al.2006). The group who received transference interpretation and the group who did not improved equally. However, the study found that within the sub-group of women with poor object relations (n =22), the specific effect of transference work was large. (Ulberg, Johansson, Marble & Høglend, 2009). In the transference group (N=11) 55% of the patients were recovered, whereas in the comparison group (N=11) none were recovered. Transference interpretation obviously has a strong potential to improve outcome in this sub-group, but 45% were not recovered. Marble, Høglend and Ulberg, (2011) found that patients with low pretreatment motivation who received transference interpretation experienced deterioration of their ability to self-protect and this may be a partial explanation for why some people did not recover. In order to investigate differences between a recovered and an unrecovered case, two
patients, both women with poor object relations who received transference interpretation, were selected. At three-year follow-up, one had achieved clinically significant change (recovery) on all outcome measures, the other was somewhat improved, but not recovered on any outcome variable.

Both patients were given transference interpretation by the same male therapist. In addition to having poor quality of object relations, both women had an obsessive compulsive personality disorder and suffered from mixed anxiety/depression. However, there were additional factors that distinguished them which are described in greater detail on page 11.

The differences between them likely contributed to their differences in communication; direct and open, as opposed to scattered and evasive. Their different styles of communication and the therapist’s response to them may have been central to the different outcomes, e.g. Henry, Schacht & Strupp, (1986), found low change patients were less disclosing and more deferential than high change patients. Communication problems have been emphasized by Kiesler (1982) who stated that the patient’s ingrained pattern of communication and the way the therapist responds to it is key to outcome. Something similar was suggested by Caston (1986) who described the patient’s unconscious plan to overcome difficulties and the need for the therapist’s help to disconfirm pathogenic beliefs that are played out in therapy rather than respond to them like the original caregivers. Many others have emphasized the quality of interaction between therapist and patient. Svartberg and Stiles, (1992) found that a friendly, non-controlling focus on the patient by both patient and therapist was a better predictor of outcome than therapist competence. Maintaining and exploring the relationship are primary according to Henry et.al., (1986). They found that in high change cases, both patient and therapist focused on the patient in a friendly and non-controlling way. High change therapists were more helping and affirming than low change therapists. Low change therapists were also
significantly more blaming than high change therapists. Najavits and Strupp, (1994), also found that effective therapists receive more affiliative codings from raters.

Closely related to communication is the therapist’s countertransference (CT). The concept of countertransference was originally defined by Freud (1910) who considered it to be a limitation of the therapist, negative reactions to the patient that should not occur. Others, e.g. object relations theorists like Heiman (1950) expanded the definition to include all the therapist’s reactions, positive and negative, conscious and unconscious. She pointed out that therapist responses could be used to better understand patients’ feelings and unconscious mental life. Ogden (1979) has described in depth a special form of CT, related to projective identification, a defense mechanism that can produce dramatic emotions in the therapist that seemingly have no reasonable explanation. He describes in detail how unacceptable feelings can be forced into another person who may then either process them and make them acceptable or not tolerate them and act them out in some way. Understanding countertransference in general, and the individual therapist’s specific tendencies in particular, is essential in order to create an optimal therapy experience for the patient. Dahl, Røssberg, Bøgwald, Gabbard and Høglend, (2012), found therapists’ positive CT in the form of feeling confident, was significantly correlated with patients’ experience of being helped and understood. Therapists’ feelings of inadequacy in the countertransference were negatively correlated with patient experience of being helped and understood.

Another factor that has traditionally been considered central to positive change throughout the history of psychoanalysis (Sandler, Dare & Holder, 1973), is insight, i.e. increased understanding of the self, behavioral patterns and motivations. According to psychoanalytic theory, interpretation of transference may increase insight which in turn may lead to better interpersonal functioning (Gabbard & Westen, 2003; McGlashan & Miller,
Insight gained through the therapist’s interpretation of transference may contribute to integration of intellectual and emotional self understanding (Kernberg, Diamond, Yeomans, Clarkin & Levy, 2008; Messer & McWilliams, 2007; Strachey, 1969). Johansson, Høglend, Ulberg, Amlo, Marble, et.al. (2010), reported that insight developed during the course of therapy was a mediator of the specific long-term effect of transference interpretation among low QOR patients. Insight increased dramatically during treatment when patients received transference interpretation, but less so during treatment without transference interpretation.

Finally, the mental image (introject) of the therapist after therapy is thought to be a factor that maintains change, as when the child learned how to treat the self through interaction with the parents. (Sullivan, 1953). The introject is thought to be central in recurrent maladaptive relationship patterns, i.e. the patient behaves as if others are like the parent and this elicits the feared behavior. Henry, Schacht and Strupp, (1990) suggest how the therapist may be cast in the role of the critical parent to confirm the patient’s existing critical introject and be pulled into a negative pattern with the patient. Von der Lippe, Monsen, Rønnestad and Eilertsen, (2007), have described a similar interaction.

RESEARCH HYPOTHESES

Based on the limited empirical literature described above, we postulated the following contributions to outcome:

1) Therapist factors. Therapist affiliation and countertransference (CT) are likely to affect outcome. Higher levels of therapist affiliation /positive CT will produce a better outcome and lower levels of therapist affiliation/more negative CT will produce a poorer outcome.

2) Interaction factors. The quality of collaboration between patient and therapist will affect outcome. Therapist and patient focused on the patient in a friendly, non-
controlling way will produce a better outcome; patient and therapist focused on the patient in a less friendly, less autonomous way will produce a poorer outcome.

3) Patient factors. Productive patient participation is likely to be based on high motivation, insight, affiliation for the therapist, openness, and less deference. High levels of these qualities will be likely to characterize the patient with the best outcome, lower levels of the same factors will characterize the patient with the poorer outcome.

4) The patient’s internal representation of the therapist (introject) will be stronger when outcome is more favorable.

METHOD
The methodology employed in the FEST study has been extensively described elsewhere (Høglend et al, 2006, 2008) and is briefly restated here. One hundred patients were randomized to dynamic psychotherapy with or without TI (fifty-two with TI, forty-eight without TI). They had weekly 45-minute sessions for one year. All sessions were audio-recorded. A treatment manual was used (Høglend, 1990). Manuals in dynamic psychotherapy are manuals of principles rather than step by step procedures. Treatment was focused on affects, exploration of warded off material, current relationships, past relationships, the therapeutic relationship, interpretations of wishes, needs and motives, repeatedly working through central themes, as well as the principles outlined by Sifneos, (1992) and Malan and Ferruccio (1992). Quality of Object Relations Scale or QOR, (Høglend, 2003; Azim et al., 1991) was the pre-selected primary moderator in the study protocol. QOR measures the patient’s life long tendency to establish certain kinds of relationships with others, from mature to primitive. Quality of Object Relations represents a personality style associated with the capacity to establish and maintain a collaborative relationship, for instance with the therapist, based on mutuality and autonomy. A low QOR score (below 5) indicates a history of less
gratifying relationships, characterized by need for dependency or over control.

**OUTCOME MEASURES**

Four measures of outcome were used to assess patients before, during and after therapy:

**Psychodynamic Functioning Scales (PFS)**

The Psychodynamic Functioning Scales (Høglend, Bøgwald, Amlo, Heyerdahl, Sørbye et al., 2000; Bøgwald & Dahlbrender, 2004; Hagtvet & Høglend, 2008) were developed to capture clinician-rated psychodynamic changes and interpersonal functioning over the previous three months. These six scales have the same format as the Global Assessment of Functioning, and measure psychological capacities over the previous three months. The scales are Quality of Family Relationships, Quality of Friendships, Quality of Romantic/Sexual Relationships, Tolerance for Affects, Insight, and Problem Solving Capacities.

**Global Assessment of Functioning (GAF)**

The GAF (DSM.3rd ed. APA, 1987) is a clinician-rated measure that captures symptoms and functioning.

There are no normative data for PFS and GAF, but a score of 71 or higher is defined in the descriptive levels of the scales as normal functioning. Patients who change more than measurement error and cross the cut-off scores into the distribution of non-clinical samples are changed to a clinically significant degree. To be rated as recovered in this study PFS must move from under 70 to over 71 (4.2 points), GAF from under 70 to over 71 (5.8 points), IIP reduced more than 0.37 (cut off 0.77), SCL-90 reduced more than 0.40 (GSI cut off 0.51) (Jacobson & Truax 1991).

**Inventory of interpersonal Problems-Circumplex versions (IIP-C)**

The IIP-C (Alden et al., 1990) is a self-report questionnaire that was developed to represent a comprehensive list of interpersonal problems reported by patients who seek out-
patient psychotherapy. This instrument was chosen because it is well validated and one of the most widely used self-report instruments in psychotherapy research.

Symptom Checklist.90(SCL-90)

The SCL-90 (Derogatis, 1983) is a well validated, 90 item self-report measure of psychiatric symptoms and distress.

THERAPIST MEASURES

Feeling Word Checklist (FWC-58)

The FWC-58 (Røssberg, Hoffart & Friis, 2003) is a registration of the feelings awakened in the therapist during the sessions (countertransference or CT).

Structural Analysis of Social Behavior (SASB)

The SASB (Benjamin, 1986; Benjamin 1996a; Benjamin, 1996b; Benjamin, 2000; Benjamin & Cushing, 2000), when used as a process measure, produces fine-grained analyses of the interaction between patient and therapist aimed at assessing emotional and unconscious aspects of therapeutic interaction. Using SASB it is possible to measure therapist affiliation towards and emancipation of the patient, and also patient affiliation towards therapist and experience of autonomy.

PATIENT MEASURES

Structural Analysis of Social Behavior (SASB)

As described above.

Therapist Representation Inventory (TRI)

The TRI (Geller & Farber, 1993) is a self-report measure of the patient’s internalized representations of the psychotherapist and the psychotherapeutic relationship

Insight Subscale of the PFS

The Insight Subscale is a clinician-rated measure that emphasizes cognitive and
emotional understanding of inner conflicts. It assesses understanding of personal patterns and their connection to past experience.

Motivation Scale

The scale (Høglend, 1996) is based on several of Sifneos’ (1992) criteria for motivation: 1) an awareness that symptoms are psychological, 2) a desire for self-understanding, 3) a desire for change, and 4) reasonable expectations.

INTERACTION MEASURES

Excerpts from three SASB-scored sessions for each patient

Transcripts of all SASB-scored transference interpretation and some extra transference interpretation from three sessions (early phase, mid-phase, late phase) are included to illustrate quality of collaboration, i.e. how well the patient-therapist dyad worked towards constructive change.

Structural Analysis of Social Behavior (SASB)

In addition to the measures of therapist and patient affiliation and interdependence, we can see the degree to which focus of both was on the patient (complementary interaction) in the form of graphs. We can also see from the clusters what kind of complementary interaction occurred, e.g. patient discloses and therapist affirms (Cluster 2), patient trusts and therapist interprets (Cluster 4), patient submits and therapist controls (Cluster 5) and how much of each kind of cluster activity occurred in the segment scored.

Fig.1 here

FREQUENCY OF MEASUREMENT

SASB

Three sessions, each representing a phase of treatment, were scored using the SASB:
session 7 (beginning of treatment), session16 (mid-treatment) and a session randomly chosen from the late-phase.

Questionnaires

FWC-58 was done after every session. IIP, and SCL-90 were administered five times: pre-therapy, after session 16, at the end of therapy, 1 year and 3 years after therapy ended. PFS and GAF were done four times, at therapy start, at the end, 1 year and three years after the end. TRI was administered three times: after the last session and at the two followup interviews.

THE PATIENTS

The patients were two women in their late 30’s, both with education beyond secondary school. Both qualified for the diagnosis obsessive-compulsive personality disorder on SCID-II. Both were troubled by pervasive, dysphoric feelings they attributed to childhood experiences; both were rated low (scores under 5) on the QOR scale. They were rated as similar on clinician-rated outcome measures, but were different on self-rated outcome measures, i.e. Jayne had more symptoms and interpersonal problems than Anne. (Tab.1).

Both patients expressed an interest in understanding themselves and a desire to change which resulted in an Insight score of 62 for both of them, Anne Solo (pseudonym), had a high score (6.17) on the motivation scale, while the other, Jayne Payne (pseudonym), had a relatively low motivation score (4.75). A low score (below 5) indicates dependency on external help, desire for magic solutions or exaggerated pessimism; higher scores are associated with understanding that change requires active work by the patient. Jayne also had three subthreshold PD scores, and she came from a chaotic family background with poor, uneducated parents. Anne came from a stable, academic family and also had been in therapy before. Both patients were on sick leave for most of the therapy.
BACKGROUND AND CASE FORMULATION

Anne Solo

Anne Solo was a self-referred, single woman in her late 30’s. Her current circumstances were that her mother had died after a long illness. She re-experienced a longing for mothering she never received and anger towards her distant mother. Anne was a small, slender, stylishly dressed woman who had a rather masculine, self-contained quality. Her goal for therapy was to be able to express vulnerability and the need for help and understanding. She was ashamed that she couldn’t use her good reasoning skills to get herself to do be more confident and express wishes and needs in her relationships.

She felt the reason for her inability to express her needs was that there was no encouragement to recognize or talk about feelings in her family and that there were too many children close in age for any of them to get much experience of individual attention and nurturing. Achievement was valued above everything else in the family and parental acceptance was contingent on being clever.

At the time of her initial interview, Anne Solo was about to begin a new, high-level teaching position, but said she was worn out from her last job where there were some problems with co-workers. Some years earlier she had had one year of group therapy and two years of individual therapy after she was left by the only man she had been involved with romantically. He had continually doubted his feelings for her and finally left her for someone else.

She had grown up in a large family, the second of 6, with parents who had little time for their children. Although she had many positive memories of her parents, she described her father as an idealistic sociologist and Marxist who was focused on the welfare of the masses, rather than the welfare of Anne and his other children. Her mother was completely dedicated
to helping him with his many projects and had no energy or, possibly, no understanding of her children’s emotional needs. All of Anne’s siblings had major emotional problems and only one had married. The family had moved every 3-5 years when she was growing up; she always had trouble finding friends and felt no one wanted to spend time with her if anyone else was available. Her kind but distant parents made her feel emotionally abandoned. She was anorectic for two years in her adolescence.

Case formulation

Kind, but distant and politically dedicated parents indirectly communicated the demand that Anne adapt to their needs, cope well and not make problems for them. She learned to subordinate her true feelings to the family ideal of being clever and strong. Uncertain of her own worth as friend or marital partner, she was reluctant to show a wish for intimacy and a nurturing relationship, and was depressed about what was missing in her life.

Annes’s ability to express herself directly in therapy and respond well to the therapist, who was her only close relationship, set the stage for a positive relationship to him.

Jayne Payne

Jayne Payne was an attractive woman with a flamboyant style of dressing, also in her late 30’s, married for 15 years with two children in primary school. She was referred by her general practitioner after a severe panic attack while at work the month before. Since the attack, she was constantly anxious and depressed. She was able to care for her children but avoided socializing outside the home and felt unable to return to work and interact with her co-workers because it quickly depleted her. Her family doctor had put her on sick leave. In addition to depression and chronic fatigue, she described a range of symptoms from irritable bowel, to insomnia to chronic pain in several organ systems. However, she tried not to dwell on these problems, saw a doctor only 3-5 times a year and coped by living a well-regulated life and exercising often.
She primarily wanted help to deal with her anxiety and the increase in pain accompanying it. She felt it was caused by the combined effects of stress at work and at home over time. She felt she wasn’t able to get her needs met and in her written description of primary problems she described a sense of “being in a centrifuge all the time”. She wanted to get more control over her life and felt her lack of self-confidence and early life experiences needed to be addressed in order for change to occur, but she also wrote that she did not want to use a lot of time in treatment.

She had a good job as a photographer, but was tired of it even before the panic attack that occurred at work and remained on sick leave for much of the time she was in therapy.

She had no previous psychotherapy as an adult, but was referred for treatment as a child due to obsessive rituals and fainting spells. She couldn’t remember how long this therapy lasted. Her early memories of both parents were primarily negative, particularly those of her abusive, drug-addicted, criminal father. Her mother divorced him when Jayne was a toddler but he continued to turn up unexpectedly and create turmoil. He did not harm Jayne physically, but beat her mother, yelled and smashed things. Whether present or not he was a terrifying spectre for her until his death several years before the therapy began. Her mother used Jayne’s fear of the father’s sudden appearances to make Jayne obey her. It is unclear how often he actually visited them; the mother’s frequent threats as well as her dramatic behavior may have been more difficult for Jayne, than that her mother sometimes slapped or spanked her. Her mother’s unpredictable emotions and general inability to nurture Jayne were the major components of Jayne’s everyday life. Jayne felt she constantly had to be hyper alert to what her mother needed and wanted. Currently she felt tired all the time and told of a need to perform obsessive cleaning rituals and constantly organize at home.
Case formulation

A chaotic childhood with unpredictable parents who were emotionally and sometimes physically abusive led to an exaggerated need for control. There were no models for her to identify with or to help her learn how to recognize and express feelings. Punishment was extreme, mostly in the form of rejection, shaming and humiliation, given on the basis of the mother’s moods rather than Jayne’s behavior. The patient had to bottle up feelings or channel them into physical symptoms. Increasing demands of motherhood, job and married life paired with inability to recognize or express her needs led to panic and withdrawal from social activity and job.

Jayne’s tendency to fear authority figures and become paralyzed or avoidant when challenged decreased the possibility of a positive relationship with the rigorous therapist.

THERAPY TRANSCRIPTS
Anne Solo

Anne Solo had 36 hours of weekly psychotherapy. All the recorded transference interpretations in the 7 minute SASB-scored segments from Session 7 (beginning), 16 (middle) and 23 (end) of therapy are included, as well as illustrative extra-transference work. Sessions 7 and 16 were chosen because they were preselected points of measurement as well as representing the beginning and middle of therapy. A third session was randomly chosen from the last phase of therapy.

Session 7

Mid-session: The patient has been speaking about her only romantic relationship
T What was good and what was bad about the relationship?
P I liked to talk to him, discuss things, get his viewpoints. The physical relationship was good, but there was a lot I couldn’t say to him and then there was the problem that he
didn’t think he had the right feelings for me.

T Can you say more about the needs you wished he could understand?

P I wanted him to convince me he cared about me and he was afraid to say anything that would commit him. That and I have always wondered ….

T You wondered ….

P … if we both had the same feelings, if he would have described them in a very different way than I do, if he had more stringent definitions of different feelings. Do you know what I mean?

T No, not exactly. I do understand that he had reservations that must have hurt you.

P Yes, of course it did.

**Session 16**

**Beginning of session**

P Last time I got the feeling I often get in other situations, that you felt, as I do, that I just flounder around and bore everyone around me.

T That I was tired of listening to you talk about “on the one hand, on the other hand.”

P Yes, then I just want to withdraw

T But you came back.

P Yes

T It’s not your fault that you flounder.

P Yes, it is. I generate these feelings, I can’t cope with my reactions in a way that isn’t clumsy.

T I don’t think “clumsy” is the right word.

P I don’t know what the right word is.

T Your chronic self-doubt can be wearing for those around you.

P Yes, I know, but...

T And what lies behind the doubt and what purpose does it serve? I don’t know if we can say we are agreed on that.

P Maybe we can.
**Mid-session**

T Partly what makes you angry, or maybe not angry but hurt and wanting to withdraw is when I point out some problem you have.

P Yes, and as I said …

T No one likes that.

P You hit the mark and I feel even more weak.

T Something you are aware of, so why should I rub it in.

P Yes, because what I want is to be convinced that it isn’t so awful, cheered on in a way to accept it, deal with it.

**Session 23**

Up to this time the patient has had sick leave arranged by the therapist and now feels able to begin work again.

End of session: The patient dreads the upcoming end of therapy in four months.

T You are afraid already. You have also said that you think I find you tiresome, but not so much that I can’t stand it.

P Yes, I did say that.

T Because you find the thought of the coming separation so painful.

P Yes, or yes and no, you have helped me with my feelings in a way, I feel you understand because of how you come back to things and how you ask and that you say if you don’t understand, but it’s how I so often experience things, that I don’t have this in daily life, I need to be understood, right? At the same time, I think …

T You feel some of your needs are met here?

P Yes, it’s not just, “Okay, I don’t get you, let’s talk about something else,” here at least it’s a point to figure out what is going on in me.

T You notice that I am interested in understanding you and want you understand yourself.

P Yes.

T And listen somewhat attentively in a way that doesn’t occur otherwise …
P Yes.

T Then I would say – oh, I see the time is almost up. I would say that if you feel your personal needs are satisfied by being here, it is through your own openness and taking emotional risks that it happens.

P Mmm.

T Do you not agree?

P Yes.

T There isn’t anything special about me, so if you feel this here, you can feel it other places too, but you lack the belief that it could happen. You are so used to defining yourself as the one who is not chosen and uncertain if you really matter in certain emotional arenas.

P Sometimes I think I can learn to believe in myself more.

**Jayne Payne**

Jane Payne had 39 hours of therapy. All the recorded transference interpretations from beginning, middle and end phase of therapy are included, as well as illustrative extra-transference interpretations, and summaries of therapist notes from other sessions.

**Session 7**

**Beginning of the session: The patient is sceptical about using medicine.**

T And you think maybe I am sceptical too, but I don’t say what I think.

P No.

T You want more advice and direct feedback from me.

P Yes.

T When it’s up to you to make decisions, you are unsure.

P Yes, but when you talk about looking up side effects, I think you are less concerned than the pharmacist I use who always stresses various dangers. I know I ‘m not careless about using medicine.
Otherwise, after the children are in bed, I feel pretty good, I maybe told you I am interested in interior design and keep the house looking nice.

End of session: the therapist points out the patient’s reservations regarding therapy sessions

You are happy on the days when you are completely free, but on the days you come here you are annoyed that it takes time and …

Mm, I like it well enough when I first get here, I combine it with shopping before I come.

Yes, but does it disturb you that you have to quit shopping and come here?

Yes.

It also disturbs you when your neighbour wants to chat.

Yes, but that’s different.

I’m just saying you have an emotional reaction in both cases.

But that time you were sick and called to cancel I thought, “Not today when I had so much to talk about!” Then the next time I felt like it would be fine if you weren’t here, but as soon as I knew you were coming it was okay.

And how was it today?

Today I was glad to come.

But you also have clearly begun to feel better and can enjoy some things more even though you are still afraid to go back to work. You have a conflict between bringing in income and taking care of your feelings.

Mm.

And you find it difficult that you are expected to take the initiative on your own behalf here. You would like more advice and feedback from me. But the point here is that you say what is important for you even if you feel it is foolish.
Session 16

Mid session

T  In marital conflicts like those you describe it is easy to find allies for either side. But this is between the two of you and there is a constant conflict. You nag and talk to him like he was a child, do this, do that ...

P  No, that is what I should do. I should have given him two empty buckets and told him to fetch water.

T  But he feels he is on vacation and doesn’t have to do things like that.

P  No. I can’t explain it. I heard him tell his parents what a great holiday we had at the cabin.

T  So you don’t nag.

P  No. There were several situations where it would have been natural for him to help the children but he left it all up to me. (Gives detailed description). It just sounds ridiculous, I know. You had to be there.

T  Then I could have been the judge of it all.

P  Right. I think you would have given up on him.

T  I thought you said before that work was evenly divided between you.

P  It might be that I’m changing and seeing things differently.

End of session

T  I wonder if what you are telling me about your cousin says something about how you feel about coming here.

P  Yes.

T  About getting affirmation or not getting it.

P  I don’t really get any, why should you … what is in my mind is that I’m totally out of
the routine I had for years. Something happened at work.

T  Mm.

P  and it has had consequences for how I am, how I see myself and you really don’t know anything about me other than what I tell you. And that is a lot of strange stuff. Like you are some kind of marital counsellor or …

T  Mm

P  It drives me crazy that I use all my time here talking about my husband. Last time I said I wanted to go back to school and when I told my husband he said it was 20 years too late.

T  But what about the affirmation you want here? Is that disappointing?

P  Errrrrr.

T  You feel it’s not pleasant, that my style is such that you have to begin. It’s hard.

P  Mm.

T  Several times you have said you feel tired when you leave.

P  Mm.

T  That you obsess. You get performance anxiety when you come here.

P  Mm

T  You feel you have important things to say but when you say them out loud you are afraid to sound… It seems like you get no relief from coming here, more like mixed feelings with some positive expectations but a lot of disappointment and a sense of getting worn out.

P  Mm.

T  Am I on to something?

P  Yes, it’s all so banal what I say. I think afterwards why didn’t I talk about what bothers me, but I don’t remember it when I’m here.

T  It’s tiring and frustrating.

P  Mm
T Last time you wanted to quit but I advised you to go this month too and think about it. Did anything occur to you while you were on holiday?
P No, it was just good to get away.

**Session 30**

Beginning of session: the patient complains about her job and that she can’t face going back.

T You were glad when your daughter got sick so you got a postponement. You feel I am pressuring you to go back.
P Mm.
T And I am. You have to do something. Either go back to work or apply for an extension of sick leave. What’s your reaction to this? That I continually remind you, you can’t put this off. I have to say things like now it’s time to apply, you have to get an application form, etcetera.
P But it’s not quite the same because…
T No, I had to say it, and you put off and put off.
P Yes.
T Procrastinate and “luckily” your daughter gets sick so you can procrastinate some more. You want a way out so you can have a month’s vacation more.
P Mm.
T It really isn’t that much time.
P No, it’s like when I see the tram coming and it’s exciting to run across the tracks. I know I can do it, but I might trip. I don’t know… about the sick leave. I feel bad when I think about it, but that doesn’t have to mean I will feel bad forever.
T No, but the longer you wait, the harder it will be to go back, that’s what generally happens. The question is, does what generally happens apply to you? I feel I have to remind you of that. What I’m saying is nothing new. You’ve said it yourself. It’s one of the things you are in conflict about.
P  Mm.
T  How do you feel? Is it painful to talk about? Do you get a headache when I remind you about your problems?
P  Yes, something like that. My mind goes blank. I feel embarrassed and my mind goes blank. I feel it’s so wrong to act like this. It’s not right to be like this.
T  Like you are?
P  Yes.
T  Or is it the way I am that it isn’t right to be? Nag you ….
P  Yes it is, it’s your job … or … it’s okay.
T  But you forgive me because it’s my job.
P  I’m not saying you don’t mean it, but it is a part of your job, I would think.
T  But you don’t react when I say it, so you don’t react the same way as when your husband says it and you get furious.

End of session: the same issues are still being discussed

T  No, all the things I say to you, you know, right?
P  Yes.
T  So I sit here telling you what you already know but can’t deal with.
P  Mm
T  You get irritated if someone close to you says something but you aren’t able to mobilize any anger towards me because therapists are supposed to be like this.
P  Mm
T  It’s their job.
P  Yes, I believe that.
T  Hmmm

Final minutes of session

T  Mm. But first you need to think what you need in this job. I assume if you go back
you won’t work full time, maybe 50%, that you can’t stand more than that. Is that about right?

P   Yes, for now, because you say so.

T   What do you think?

P   I think that would be ideal, but don’t know. Before sick leave I thought about working less because I was starting to get mixed up, didn’t know the entry codes for my apartment building and things. I wasn’t myself.

T   You were overtired, worn out.

P   I would forget I had passed the kindergarten when I was picking up my son.

T   Okay.

P   I did a lot of strange things. People wondered what was going on with me all the time.

RESULTS

Table 1 shows that at the three-year follow-up, Anne fulfils the requirements for significant clinical change/recovery on all measures. Jayne is improved, but still struggling with symptoms and interpersonal problems (most clearly exemplified by the IIP subscale, Exploitable/Low Self Assertion); she is also in the clinical range on the other measures.

Table 1  here

RESEARCH HYPOTHESES

1) Therapist CT, affiliation and control

Countertransference experienced by the therapist and the rater-scored therapist affiliation/interdependence are in the expected direction. (Tables 2 & 3). In Anne’s therapy, positive CT consistently outweighs negative CT. (Scores are +13/-0; +13/-2; +10/-2 for session 7, 16 and final session). Therapist affiliation scores for Anne are also high and fairly stable (56.2, 44.6, 52.5 for the three sessions). In Jayne’s therapy, positive and negative CT are evenly balanced from beginning to mid-therapy and negative CT is dominant at the end phase of therapy. (+8/-8; +10/-10; +6/-14 for session 7, 16 and final session). Therapist 24
affiliation for Jayne continually declines (50.8, 45.4, 33.5) Therapist control increases as therapist affiliation declines for Jayne (-24.3, -33.7, -44.1). In Anne’s therapy control is more variable ( -2.1, -43.0, -29.7).

Tables 2 & 3 here

2) Patient-therapist collaboration developed in the expected direction.

The interaction profiles for Anne and Jayne (Fig.2 and Fig.3) are both characterized by complementarity (the focus of the patient and the therapist is the patient, with patient and therapist in the same cluster), but there is more disclosure/less control in Anne’s therapy; less disclosure, more submission, more control in Jayne’s therapy. Both therapies included considerable cluster 4 activity, but it is important to note that activity between therapist and two different patients is not necessarily alike even if it is in the same cluster. The SASB system is structured such that each cluster shades into the cluster that precedes and follows it. Cluster 4 can range from more friendly guidance that the patient trusts to less friendly interpretation/confrontation that the patient is defers to. Transcript analysis of the two therapies leaves a subjective impression of more confrontation and submission in Jayne’s therapy, more guidance and trust in Anne’s therapy. Table 3 shows stable, positive affiliation between Anne and the therapist, consistently decreasing affiliation between Jayne and the therapist.

Figures 2 and 3 here

3) Quality of patient participation was also as expected.

Anne’s therapy was characterized by more disclosure (compare Fig.2 and Fig.3) more affiliation and less submission (Tab.3) and Anne’s affiliation scores (54.9, 45.9, 47.4) were
generally higher than Jayne’s scores (49.6, 45.4, 33.5) which progressively declined. The interdependence scores were not consistently in the expected direction for either patient. Anne was more autonomous at therapy start (+10.3), more deferential at mid-therapy (-31.4) and less deferential as therapy was ending (-8.3). Jayne’s interdependence scores were the opposite of Anne’s scores. There was more deference at start (-16.7), less at mid-therapy (-7.7); most occurred at the end of therapy (-21.10), and the scores did not vary as much as Anne’s scores. We do not know what is optimal, but some deference during therapy may be necessary for change to occur. Anne’s mid-therapy deference along with fairly stable, high affiliation may be an indication that the therapy was progressing well and she could allow the therapist to influence her. Patterns of deference/autonomy may also be important, particularly in combination with level of affiliation. Jayne’s deference throughout therapy together with declining affiliation suggest a form of insecurity or resistance. Her lower pre-treatment motivation score may also capture pessimism or resistance that was not the case for Anne who was highly motivated. Other noteworthy differences are that at the three-year follow-up, Anne no longer fulfils the criteria for a personality disorder; Jayne is unchanged. Anne’s insight increased substantially (62 to 80); Jayne’s increased little (62 to 65).

4) The therapist introject did not develop in the expected direction for Jayne. Jayne had a high score on continuing dialogue with the therapist (7.2 as compared with a mean of 3.6 for the whole group). She also had a high score for mourning the loss of the therapist (5, group mean 1.9) and for experiencing the therapy as a failure (4.3, group mean 2.1). Anne’s scores were, (dialogue, 6.2, mourning 3, and failure 1) which seemed more compatible with her therapy experience. It seems reasonable that she would miss the therapist, continue the dialogue and not feel the therapy failed. It is harder to reconcile that Jayne mourned loss of the therapist, also felt the therapy failed, and that she mentally continued the dialogue with the therapist.

DISCUSSION
Before treatment, Anne and Jayne were similar on several measures, as noted above. They differed with regard to personal problems, symptoms and motivation. They also had contrasting family backgrounds; Anne’s was more secure and Jayne’s was more chaotic. These factors were the first indications that Jayne might require a different approach than Anne.

After seven weeks of treatment, more negative factors began to appear. The therapist experienced as much negative as positive CT for Jayne and by 16 weeks his affiliation fell as his control increased. Her affiliation fell correspondingly. These trends continued and worsened until the end of therapy. The opposite was true of Anne’s therapy.

Roth & Fonagy (2005), have underlined several characteristics of patients who have a poorer than average response to therapy: avoidant and paranoid PDs, the combination of axis I depression and obsessive-compulsive disorder (ocd) symptoms together with low motivation, poor alliance and greater duration of ocd symptoms. Jayne had subthreshold paranoid PD and all the other above-listed characteristics except avoidant PD. Anne had no avoidant or paranoid PD, her motivation was high, alliance good and no early ocd symptoms. Roth and Fonagy recommend “stepped” care. i.e. change of treatment when response is poor and, because relapse is so common (75% after one year), that maintenance therapy should be considered, based on how chronic the problem is and the age of onset. (Jayne was first treated for ocd rituals in childhood). They also recommend cognitive-behavioral therapy (CBT) for panic (Jayne’s reason for referral) and for ocd symptoms. In addition, they point out that married people (Jayne) do better with CBT and single people (Anne) do better with interpersonal therapy.

Detailed examination of alternative interventions is outside the scope of this paper and the FEST project, which was based on dynamic therapy delivered “as usual,” the only variation being TI or no TI. However, the different responses of the two patients illustrate how important it is for therapists to be aware of the need to tailor interventions to patients.
Many dynamic therapists would argue that Jayne could have been treated more successfully within the parameters of dynamic therapy. (See below).

The difference in the quality of the two therapies is evident in the session 16 dialogues. As Caston, (1986), has pointed out, a successful intervention leads to constructive responses characterized by flexibility, boldness, and relaxation, expansion on the theme introduced by the therapist, more ability to explore and confront the self. The therapist’s direct and interpretive approach did lead to this result with Anne. She was consistently able to explore and confront herself and work with the therapeutic relationship, while Jayne consistently showed resistance to reflecting about problems and the relationship to the therapist. Anne and the therapist seemed to be on the same wavelength, and they constructed a joint understanding. With Jayne his use of provocative statements or questions led to confusion. Some of the best examples from both therapies are found in session 16.

When the therapist says to Anne (pages 16-17), “Partly what makes you angry, or maybe not angry but hurt and wanting to withdraw is when I point out some problem you have,” it leads to a mutual exchange ending with Anne S confirming, “yes,” expanding “you hit the mark,” becoming more bold and self-confrontive, “I feel even more weak.” Her willingness to explore the relationship and express feeling gives meaning and intensity to the session. Anne’s responses indicated therapist interventions were effective for her. They possibly allayed the fear of neglect that her distanced caregivers created, and alleviated her ingrained tendency to obsess. In contrast, when the therapist says to Jayne (page 21), “What about the affirmation you want here? My style is such that you have to begin. It’s hard. You obsess. You get performance anxiety when you come here,” Jayne is only able to answer with a submissive/non-committal, “errr” or “mm.” Her paralysis seems to affect the therapist too. He never helps her think why she finds it difficult to talk about their relationship or investigate the “strange stuff” she refers to in this session. Jayne’s inchoate responses suggest that her probable fear of negative reactions based on early experiences was provoked and her
ingrained tendencies to submit, become confused or distract were mobilized and reinforced. The therapist seemed to be unable to adjust his interventions with her.

As his feelings of being worn out, embarrassed, distant, sad, tired of the patient, resigned and angry, increased, the therapist could have broadened his choice of interventions had he understood his reactions as products of projective identification, i.e. feelings that Jayne was experiencing while not fully aware of them. She was unable to express them and they remained unattended; the therapist was left with the unresolved problems of his diminishing affiliation as well as his increasing desire to instruct and control Jayne.

Possibly in response to the increasing tension between herself and the therapist, Jayne sometimes complained about the cost and time required by therapy, illustrating the pull of hostility described by Von der lippe et.al., (2008). Her ambivalence and inability to use the therapy could have been addressed with motivation-enhancing interventions. Miller & Rollnick (2013) have described well the directive style of communication which produces anger and defensiveness as opposed to a more collaborative approach (not unknown among dynamic therapists) that encourages interest in change. Unfortunately, the therapist used more confrontation and interpretation, a tendency described by Høglend & Gabbard (2012) as an attempt to overcome resistance. They found a negative correlation between too many early transference interpretations in the low QOR group and positive outcome (r = -0.40). In Jayne’s case, the intensified transference work led to more submission and evasion. The therapist then became more frustrated and less supportive and a negative cycle became more and more entrenched.

A comparison of the two patients’ background stories adds to understanding their different responses. Anne seemed more likely to trust an authority figure/therapist and be interested in achievement in therapy. She grew up with well-educated, ambitious parents who created a safe environment although they were emotionally distant. Jayne, whose parents had no advanced education and were far from safe and predictable, might be expected to be more
sceptical, avoidant and less achievement-oriented. These characteristics may not only affect the patient-therapist interaction; they may also influence the development of insight which is necessary for change to occur. It seems not unlikely that the patient who is sceptical and avoidant might miss out on therapist input that could lead to insight, while the one who trusts and wants to achieve will do the opposite.

Jayne’s unstable, punitive parents could have created a predominant fear of abandonment and loss whereas Anne’s distant, achievement-oriented parents possibly created a predominantly perfectionistic and self-critical style as described by Blatt, (1997). The latter group responds better to transference interpretation. Blatt says one reason may be that transference interpretation relieves the perfectionistic self-critic, but provokes the fears of those who dread abandonment and loss. This did seem to be the case with Anne who responded to TI with strong, appropriate feelings and reflections while Jayne tended to retreat in fear with echoes of what the therapist said, one word replies or just sounds, as though the wrong response would lead to catastrophe. A difficult task in therapy is respecting the limitations of both patients and therapists while taking up the challenge to produce better outcomes.

Jayne’s pre-treatment description of feeling like she was in a centrifuge suggests a fragmented experience of self. Unlike Anne, she had other subthreshold PDs (depressive and paranoid) as well as the no longer used passive aggressive PD) on SCID-II, also suggesting a lack of coherent self. She had multiple somatic complaints, possibly due to chronic tension from many unresolved, unconscious issues. The fragmented self, the tendency to somatise difficult feelings, the probable lack of trust after years of emotional abuse and/neglect may have been difficult to address with 39 hours of therapy, even if the therapist had been more supportive. Anne, on the other hand, had previous therapy experience that may have helped her understand how to use the therapy optimally. She seemed to react to challenge from the therapist as the attention she longed for from her parents. It seemed to enhance her confidence.
and led to constructive responses that allowed her to develop and use her insight well.

Anne’s therapist representation at the end of therapy was as expected. She was not disappointed, she missed the therapist and continued the dialogue with him. Jayne’s therapist representation was possibly a combination of what was actually the case (she experienced the therapy as disappointing) and what she thought she should say (that she missed the therapist). The continuing dialogue could have been negative rumination or attempts to remember and do what she thought was expected.

CONCLUSION

Anne disclosed more than Jayne and received more affirmation and less control. She not only responded to interventions exploring the therapist-patient relationship and central problems that were defined before therapy, she also often took the initiative in both areas. Jayne held back and took a more deferential, uncertain, or, possibly, at times, a passive aggressive role. She was not able to work with TI interventions or central problems defined before therapy began and the therapist failed to find a way to help her get on track. He gave her less affirmation and used more control than he did with Anne. Therapist CT was more positive towards Anne than Jayne. His negative reactions to Jayne could have been used to better understand her and use more suitable techniques. Both patients made use of continued dialogue with the therapist to a greater degree than the patient group as a whole. Both patients mourned the loss of the therapist more than the patient group as a whole. It is likely that they did not experience dialogue and mourning in the same way, given the disparate outcomes. Anne did not experience the therapy as a failure, Jayne did.

These cases illustrate the importance of recognizing the limitations of both patient and therapist early on and planning how to deal with them in order to produce optimal outcomes.
REFERENCES


London: Hogarth


Research, 13, 271-292.


### Table 1

**Pretreatment/treatment/posttreatment/follow-up scores on outcome measures (PFS, GAF, IIP, GSI), Low self-assertion, Insight and therapist introject (TRI) for Anne S and Jayne P.**

<table>
<thead>
<tr>
<th>Measure</th>
<th>pretreatment</th>
<th>16. session</th>
<th>posttreatment</th>
<th>1 yr followup</th>
<th>3yrfollowup</th>
</tr>
</thead>
<tbody>
<tr>
<td>PFS</td>
<td>62.8</td>
<td>60.6</td>
<td>66.4</td>
<td>58.8</td>
<td>71.5</td>
</tr>
<tr>
<td>GAF</td>
<td>57.7</td>
<td>53.3</td>
<td>70.0</td>
<td>57.5</td>
<td>75.3</td>
</tr>
<tr>
<td>IIP</td>
<td>1.22</td>
<td>2.43</td>
<td>1.15</td>
<td>2.31</td>
<td>.84</td>
</tr>
<tr>
<td>GSI(SCL90)</td>
<td>1.26</td>
<td>3.17</td>
<td>.52</td>
<td>3.00</td>
<td>.16</td>
</tr>
<tr>
<td>Low self assertion</td>
<td>1.43</td>
<td>3.0</td>
<td>1.50</td>
<td>2.63</td>
<td>.50</td>
</tr>
<tr>
<td>Insight</td>
<td>62</td>
<td>62</td>
<td>72</td>
<td>50</td>
<td>75</td>
</tr>
<tr>
<td>TRI</td>
<td>1.0</td>
<td>4.29</td>
<td>3.8</td>
<td>5.6</td>
<td>1.6</td>
</tr>
</tbody>
</table>

### Table 2

**Summary of the weighted scores of the therapist’s negative and positive countertransference from sessions 7, 16 and last scored session for Anne S and Jayne P.**

<table>
<thead>
<tr>
<th></th>
<th>ANNE S</th>
<th>JAYNE P</th>
</tr>
</thead>
<tbody>
<tr>
<td>SESSION 7</td>
<td>Positive 13 Negative 0</td>
<td>Positive 8 Negative 8</td>
</tr>
<tr>
<td>SESSION 16</td>
<td>Positive 13 Negative 2</td>
<td>Positive10 Negative 10</td>
</tr>
<tr>
<td>LAST SCORED SESSION</td>
<td>Positive 10 Negative 2</td>
<td>Positive 6 Negative 14</td>
</tr>
</tbody>
</table>
Table 3
SASB audio-scored sessions: weighted affiliation and interdependence for the therapist and Anne S; the therapist and Jayne P. from session 7, 16, and the last scored session.

<table>
<thead>
<tr>
<th></th>
<th>ANNE S</th>
<th>JAYNE P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Affiliation</td>
<td>Interdependence</td>
</tr>
<tr>
<td></td>
<td>T    P</td>
<td>T    P</td>
</tr>
<tr>
<td>Session 7</td>
<td>56.25 54.86</td>
<td>-2.08 10.30</td>
</tr>
<tr>
<td>Session 16</td>
<td>44.06 45.93</td>
<td>-43.00 -31.39</td>
</tr>
<tr>
<td>Last</td>
<td>52.47 47.41</td>
<td>-29.69 -8.33</td>
</tr>
</tbody>
</table>
Fig. 1. The structural analysis of social behavior (SASB): the eight cluster version, modeled after Benjamin & Cushing (2000).

**Surface 1: Focus on other (therapist focus on patient)**

**Surface 2: Focus on self (patient focus on self)**

<table>
<thead>
<tr>
<th>EMANCIPATING</th>
<th>AFFIRMING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>separating</strong></td>
<td><strong>disclosing</strong></td>
</tr>
</tbody>
</table>

1. **IGNORING**
   - Walling off
   - 8

2. **ATTACKING**
   - Recoiling
   - 7

3. **LOVING**
   - reactive love
   - 3

4. **BLAMING**
   - Sulking
   - 6

5. **CONTROLLING**
   - submitting
   - 5

6. **PROTECTING**
   - trusting
   - 4
Fig. 2
Patient-therapist interaction for Anne and therapist, analyzed with SASB process-scoring for session 7, session 16 and last session.

Session 7

Session 16

Last session
Fig. 3

Patient-therapist interaction for Jayne, analyzed with SASB process-scoring for session 7, session 16 and last session.

Session 7

Session 16
Last session