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EMPIRICAL PAPER

"It was like having half of the patient in therapy": Therapists of nonimproved patients looking back on their work

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Abstract
Objective: To explore therapists' experiences of therapeutic process in psychoanalytic psychotherapy with nonimproved young adults. **Method:** Eight nonimproved cases were identified according to the criterion of reliable and clinically significant change in self-rated symptoms. Transcripts of therapist interviews (8 at baseline and 8 at termination) were analyzed applying grounded-theory methodology. **Results:** A tentative conceptual process model was constructed around the core category *Having Half of the Patient in Therapy*. Initially, the therapists experienced collaboration as stimulating, at the same time as the therapeutic relationship was marked by distance. At termination negative processes predominated: the patient reacted with aversion to closeness and the therapist experienced struggle and loss of control in therapy. The therapists described therapy outcome as favorable in form of increased insight and mitigated problems, while core problems remained. **Conclusions:** This split picture was interpreted as a sign of a pseudo-process emerging when the therapist one-sidedly allied herself with the patient's capable and seemingly well-functioning parts. The therapists' experiences could be compared to the nonimproved patients' "spinning one's wheels" in therapy. The therapists seem not to have succeeded in adjusting their technique to their patients' core problems, despite attempts to meta-communicate.

Keywords: psychoanalytic/psychodynamic therapy; long term psychotherapy; outcome research; process research; grounded theory; therapist perspective; negative processes

Clinical or methodological significance of this article: The present study provides a unique opportunity to follow the therapists' experiences of their work with nonimproved patients at the outset of treatment and at termination, with important implications for clinical practice and psychotherapy training. An early contradictory picture of the patient as a person and of the therapeutic process is demonstrated to be a warning sign. A continuous reevaluation of the patient's core problems may prevent the therapist one-sidedly allying herself with the patient's more capable and seemingly well-functioning parts.

Despite the substantial evidence for the effectiveness of psychotherapy a significant number of patients fail to improve. The rate of patients who experience no change comprises 35–40% in randomized clinical trials (Lambert, 2007) and 57% in routine clinical practice, where treatments averaged four sessions (Hansen, Lambert, & Forman, 2002). Furthermore, 5–10% complete treatment worse off than before (Lambert, 2013a, b). Deterioration rates among youth are larger, 14–24% (Warren, Nelson, Mondragon, Baldwin, & Burlingame, 2010). One in 20 people responding to a British national survey reported lasting bad effects from psychological treatment (Crawford et al., 2016). A substantial variance in treatment outcome between different therapists is well documented. Therapists may be more important for therapeutic success than the type of intervention they deliver (Owen, Drinane, Idigo, & Valentine, 2015). Still, while therapist differ in their average outcomes, most therapists have some successful outcome cases (Baldwin & Imel, 2013; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Wampold & Brown, 2005), making them "experts" with particular patients. On the other hand, even the most effective therapists have experience of some unsuccessful treatments – patients who did not improve (Bystedt,

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Rozental, Andersson, Boettcher, & Carlbring, 2014). Thus, most therapists have experiences of both successful and unsuccessful treatments. What makes the difference? It is an open question what makes well-trained psychotherapists fail in the therapy process (cf., Merten & Krause, 2003). As concluded by Baldwin and Imel (2013, p. 292), "we need to attend and to learn more about within-therapist differences."

We also know that therapists are seldom able to correctly identify deterioration in their patients (Gold & Stricker, 2011; Whipple & Lambert, 2011), to see their own treatment failures (Kächele & Schachter, 2014), and are unfamiliar with methods and criteria for identifying and preventing negative outcomes (Bystedt et al., 2014). Still, the therapist's awareness of unsuccessful treatment may significantly improve clinical outcomes (Hatfield, Frantz, McCullough, & Krieger, 2010). Clinical errors have recently obtained growing attention in psychotherapy research (Budge, 2016). Nevertheless, nonimproved cases are seldom scrutinized. Nonimprovement could be conceptualized as a lack of good outcome and thus include dropout or premature/unilateral termination, nonresponse, partial or slow change, deterioration, negative side effects, and relapse (Lampropoulos, 2011). Additional challenges in measuring outcome and defining therapeutic success and failure include whose perspective is being used (patient, therapist, or researcher), what types of outcomes are measured with which methods, and appropriate time point of outcome monitoring. In order to better understand the mechanisms of unsuccessful treatments we need quantitative assessments as well as individual idiographic approaches (Barlow, 2010).

Looking at the psychotherapy process as interplay between patient, therapist, and therapeutic approach can help us understand which specific factors can lead to improvement, stagnation or deterioration. In previous studies, we investigated nonimproved patients' view of the therapeutic processes (Werbart, von Below, Brun, & Gunnarsdottir, 2015), as well as how therapists experience and reflect on their own clinical work in successful cases of psychoanalytic psychotherapy (Werbart, Missios, Waldenström, & Lilliengren, 2017). The therapists' experiences of their work with nonimproved patients might be a rich source of clinically relevant knowledge of negative processes. Hopefully, such studies can contribute to diminishing the gap between systematic psychotherapy research and clinical practice.

The present study explores therapists' experiences of therapeutic process in psychoanalytic psychotherapy with nonimproved young adults who lack statistically defined symptom reduction at termination. Our specific questions were: How do therapists describe their work in these particular cases and themselves as the particular patient's therapist? How do the therapists describe their patients, the therapeutic relationship, and the therapy outcome? Which factors and processes seem to have been crucial for the unsuccessful outcome from the view of the therapist? Additionally, we also investigate if there are any particular characteristics of the therapists' experiences already observable at the outset of treatment, as reported in baseline interviews. To meet these objectives, we apply quantitative inclusion criteria to a qualitative grounded theory study.

Method

Setting and Treatments

The present study is based on archival data from the Young Adult Psychotherapy Project (YAPP), a prospective, naturalistic, longitudinal study of psychoanalytic psychotherapy at the former Institute of Psychotherapy in Stockholm, Sweden. Of the total of 134 patients (the vast majority of them self-referred) aged 18–25, 92 applied for individual psychotherapy. The presented complaints included low self-esteem (97%), depressed mood (66%), anxiety (55%), and conflicts in close relationships (66%). About one-third of patients had self-reported personality disorder (DIP-Q; Ottosson et al., 1995).

The psychotherapies in YAPP were open-ended and aimed at overcoming developmental arrests and improving the patient's adaptive capacity. The patients offered individual psychotherapy stayed in treatment for a mean of 22.3 months ($SD = 17.2$; $Mdn = 20$; range = 0–85) with a frequency of one or two sessions per week. The individual treatments were conducted by 34 therapists who all shared a psychoanalytical frame of reference. The therapists met weekly in clinical teams to discuss clinical experiences and treatment problems. Treatment outcome was studied at termination, at 1.5-year, and at 3-year follow-up (for further details, see Lindgren, Werbart, & Philips, 2010; Philips, Wennberg, Werbart, & Schubert, 2006; Werbart et al., 2015).

Selection Criteria

The primary outcome measure was the *Global Severity Index* (GSI) of the *Symptom Checklist-90-R* (SCL-90; Derogatis, 1994). We defined "nonimproved cases" as patients who reported a symptom level in the clinical range at pretreatment, and no reliable symptom reduction or even deterioration at termination, according to Jacobson and Truax (1991) criteria. The cut-off between the clinical and

nonclinical range was determined in accordance with their criterion (c), as recommended when the distributions of the functional and dysfunctional population overlap. Comparing the pretreatment YAPP sample to Swedish norms, the GSI cut-off was calculated as 0.90. Reliable change (RC) is achieved if the RC index, based on the difference between two time points divided by the standard error of difference, is equal to or larger than 1.96 ($p < .05$) (Jacobson & Truax, 1991). Clinically significant improvement (CI) implies both RC and crossing the cut-off between clinical and nonclinical population. A negative change score above 1.96 was regarded as a reliable deterioration.

At pretreatment, 70 patients (80.5%) belonged to the clinical range. At termination, 20 of them had no RC and 3 had deteriorated according to Jacobson and Truax's criteria, whereas 29 patients showed CI, and a further 2 RC only. The therapist sample in the present study was drawn from a previous study of 20 nonimproved patients' view their psychotherapy (Werbart et al., 2015). Due to the general research design, the therapists were interviewed in every second case. Thus, of the 16 therapists of nonimproved patients in the previous study 8 therapists could be included (3 therapists of deteriorated and 5 therapists of patients with no RC).

Patients

The eight patients were women and their average age at treatment start was 24.0 ($SD = 1.41$; range 18–25). Essentially, they reflect an urban context of the study. Four patients lived alone, two patients lived with a partner, and further two lived with their parents. None was married or had a child. Six were students, one worked full-time and one combined work with studies. All patients were born in Sweden with both parents of Swedish origin. Seven patients had at least one parent with a university degree, thus indicating a high socioeconomic status within their family of origin. Three patients had previous outpatient or inpatient psychiatric contact; two patients had previous psychotherapeutic contact. Five of the patients reached criteria for DSM IV-TR (American Psychiatric Association, 2000) Axis I diagnoses and four patients had Axis II diagnoses; one patient had no psychiatric diagnosis (Table I). The mean GSI-score pretreatment was 1.59 ($SD = 0.50$) and did not differ from a YAPP subsample of 16 successful cases ($M = 1.56$; $SD = 0.51$; Werbart et al., 2017). The mean time in therapy was 19.0 months (range 7–48; $SD = 8.49$), as compared to 27.6 months average treatment duration in successful cases. At 3-year follow-up two of the patients were still nonimproved and one deteriorated, whereas three patients showed CI and further two RC only (Table I). Three of the five improved patients started or underwent new psychotherapies during the follow-up period.

Therapists

The eight patients were treated by seven therapists; four female and three male; two were social workers, four psychologists and one psychiatrist. The average age of the therapists at treatment start was 52.9 ($SD = 7.53$; range 36–60). Six therapists were senior licensed psychotherapists with 6–14 years' experience after being licensed ($M = 11.4$, $SD = 2.88$), four of them with advanced training in psychodynamic therapy and two with psychoanalytic training; each working as a teacher and supervisor in an advanced psychotherapy training program; one therapist had basic training in psychodynamic psychotherapy.

One of the included therapists had two nonimproved patients in this study, and in addition two patients with CI and one patient with missing outcome data on termination. Six therapists had one nonimproved case each in this study. Three of

Table I. Patient and therapy data ($N = 8$).

Case code	Patient gender	Diagnosis		Therapy duration months	Therapy frequency per week	Therapist gender	Outcome	
		Axis I	Axis II				Termination	3-year follow-up
A	F	Dysthymia	NOS	48	2	F	Deterioration	CI
B	F	–	NOS	21	1–2	M	No change	No change
C	F	OCD	–	22	1	M	No change	RC
D	F	Dysthymia	NOS	25	1–2	M	Deterioration	Deterioration
E	F	–	–	13	1	F	No change	CI
F	F	Acute stress disorder	–	28	2	F	No change	RC
G	F	–	NOS	13	1	F	No change	No change
H	F	Anxiety disorder NOS	–	7	1	F	Deterioration	CI

Note: CI = clinically significant improvement; RC = reliable change only.

these therapists had only one patient each in YAPP; one therapist had in all four nonimproved patients and two further patients with RC at termination; one therapist had two nonimproved patients; one therapist had one nonimproved patient and one patient with RC. Thus, the therapists could be unsuccessful with some patients but successful with others.

Interviews

The therapists were interviewed about their view on their work with each nonimproved case separately at baseline (i.e. after initial consultative sessions and close to the first therapy session; $n = 8$) and at termination (i.e. shortly after the last therapy session; $n = 8$), in all 16 interviews. The semistructured *Private Theories Interview* (PTI therapist version; Werbart & Levander, 2006) collects narratives on problem formulations, ideas of background, ideas of cure, descriptions of changes, and retrospective views of what in therapy promoted or hindered change, and what could have been different. The informants were asked to elaborate their answers to these main questions and to give concrete examples and illustrative episodes. The interviews were conducted by researchers trained in the PTI technique of "bracketing" their own professional knowledge and understanding of the emerging interview data, maintaining an attitude resembling that of social anthropologist meeting unfamiliar cultural phenomena rather than that of a clinician, thus facilitating the expression of the participant's own implicit understanding and refraining from making own interpretations. This interview technique includes the dual bracketing process of putting aside the interviewer's assumptions and engaging participants to elaborate their accounts, as described by Fischer (2009). The interview protocol also included the *Object Relations Inventory* (ORI; Diamond, Kaslow, Coonerty, & Blatt, 1990; Huprich, Auerbach, Porcerelli, & Bupp, 2016). Two ORI questions were included in this study: "Please give a description of your patient" and "of yourself as just that particular patient's therapist." The spontaneous response was followed by an "inquiry" in which the interviewer probingly repeated descriptive words mentioned by the patient, for example, "You said confused?" The audio-recorded interviews lasted about 60 minutes and were transcribed verbatim.

Grounded Theory Analysis

The 16 interview transcripts were analyzed with basic grounded-theory methodology (GT; Charmaz, 2014; Fassinger, 2005; Rennie, 2006). GT aims at generating tentative conceptual models grounded in empirical data, and is often considered as a method of choice when studying interactive, reciprocal processes and underexplored fields of knowledge. TAMSAnalyzer software (Weinstein, 2012) was used in the coding process involving *open*, *axial* and *selective coding*, as well as constant comparative analysis (Strauss & Corbin, 1998). The qualitative analysis was conducted by the third and fourth author (not previously involved in any study within this project), female students in a 5-year psychology program (psychodynamic orientation), as a part of their master thesis. The analysis was audited by the first author, a male senior researcher and psychoanalyst. The second author, a female researcher and psychodynamic psychotherapist, was involved in the interpretation of results. Inevitable, our own familiarity with a psychoanalytically informed therapeutic setting set a frame for our understanding of the therapists' experiences. Thus, in line with Henwood and Pidgeon's (2003, p. 138) concept of theoretical agnosticism, we adopted a critical, skeptical stance toward possible theoretical interpretations and previous research findings throughout the study. For example, we avoided psychoanalytical terms and parlance, as long as the participants did not use it. The analysis was carried out in the following steps, although with constant back-and-forth movement between textual data and conceptualization:

Open coding: At this step, each coder analyzed half of the material, starting with reading the interview transcripts line by line. All utterances (sentences and paragraphs) reporting the therapists' experiences of the therapy process, perceived changes and helpful or hindering treatment aspects were assigned open codes summarizing the content as closely as possible to the informant's phrasing.

Axial coding and constant comparative analysis: At this stage, focus shifted from analysis of individual cases to patterns across cases. Codes that seemed closely related in meaning, theme or content were gathered into categories (code families). The coders continuously discussed emerging categories, compared, and scrutinized their code lists, striving for consensus coding. As categories were revised and elaborated, a process of examining the relationship among the categories was initiated. Questions about the relationships between categories were checked against the original transcripts to explore the context in which the informants described their experiences. Throughout the process, each coder wrote memos describing the properties and scope of each category as well as the relationships among categories.

Selective coding: As the coding progressed, the categories were graphically connected into diagrams to visually depict their tentative relationships.

The coders discussed and examined theoretical memos integrating ideas about the overall model structure. As the conceptual model evolved in the process of consensus discussions, the coding became more selective and guided by categories rather than new open codes. This allowed a core category to emerge and capture on a meta-level the essence of the process, while retaining a relationship to all other categories, as integrated in the conceptual model. In this process, we strived to refine the final set of categories in order to make them non-overlapping and distinguished from each other.

Credibility checks and triangulation: After each coder completed the coding of half of the interviews and the accompanying consensus discussions, the coders exchanged interviews and coded them anew. This step of researchers-triangulation aimed to increase analysis trustworthiness and to check the conceptual model against the data (Elliott, Fischer, & Rennie, 1999; Malterud, 2001; McLeod, 2013; Morrow, 2005; Rennie, 2006). Differences in opinions were discussed in relation to the original transcripts until consensus was reached. Category labelling and the conceptual model were reviewed and revised by the first author. To further enhance the validity of the study, the tentative model, descriptions of categories and included quotations were sent to two experienced psychodynamic therapists for external examination. Their answers comprised their own reflections on similar experiences, but no objections to the presented results. Based on these audits, the model was judged to be grounded in data.

The frequencies of cases contributing to each category were scrutinized as an additional validity check and reported for each time point using nomenclature from consensual qualitative research (CRQ; Hill et al., 2005): General = all or all but one of the cases (here 7–8); Typical = half of the cases up to the cutoff for general (4–6); Variant = at least two cases (2–3).

Results

The grounded-theory analysis revealed a paradoxical picture of the therapists' views of their patients and the therapeutic relationship, clearly mirroring the therapists' confusing experiences in cases of non-improvement. The therapies started as a stimulating yet emotionally only partial therapeutic relationship, which over time developed in a negative way. This enduring paradox and its evolvement from baseline to termination are described below and further elaborated under the heading Interactions and Transformations, and in the Discussion section. The emerging categories are illustrated below by verbatim quotations from interviews at baseline and at termination. The first person singular is used in the descriptions of categories, pointing to the observed phenomenon and the prototypical participant. For practical reasons, all patients and therapists are designated "she." The frequencies of subcategories at therapy start, termination and in total are presented in Table II.

Core Category: Having Half of the Patient in Therapy

The therapist experienced that parts of the patient never entered into the sessions already at the beginning, and increasingly so over time. The therapist expressed that important parts of the patient's problems, personality features or life circumstances remained obscure throughout the therapy and were impossible to talk about or work with therapeutically, no matter how the therapist tried to bring this up. However, contrary to this, the therapist early could

Table II. "Having Half of the Patient in Therapy": Experiences of therapists of nonimproved patients.

	Baseline		Termination		Total	
Subcategories	(*n* = 8)	Label	(*n* = 8)	Label	(*n* = 8)	Label
1. *Experiences of the Therapeutic Process*						
1.1. Stimulating collaboration	7	General	6	Typical	8	General
1.2. Distance in the therapeutic relationship	8	General	7	General	8	General
1.3. The patient reacts with aversion to closeness	2	Variant	4	Typical	4	Typical
1.4. Fruitless battles	2	Variant	6	Typical	6	Typical
1.5. The therapist loses control of the process	2	Variant	5	Typical	6	Typical
2. *Experiences of Therapy Outcomes*						
2.1. Therapy resulted in increased insight	0		7	General	7	General
2.2. Problems have been mitigated	0		7	General	7	General
2.3. Favorable outcomes of therapy	0		8	General	8	General
2.4. Core problems remain	0		8	General	8	General

Note: Frequencies of cases in each subcategory at therapy outset, at termination, and total (labeled following Hill et al., 2005).

feel being unusually creative and free, liking the patient or being exceptionally moved by this particular patient's predicament. The therapist experienced the patient as reserved and emotionless, at the same time describing the therapeutic collaboration as stimulating and being in touch with the patient. Thus, a contradiction was present in the therapeutic work and relationship from the very start of therapy. The patient was experienced as fond of working with insight and making an effort in therapy. As the therapist felt greater closeness in therapy and that progress was made, the patient reacted with aversion and increased distance to the therapist. Efforts to reduce the distance and create an attachment resulted in fruitless battles. The therapist felt losing control of the process, unable to balance between closeness and distance.

> It reflects pretty much how her life is like. On the surface everything looks very competent and good. But you still have a sense that there is something going on under the surface. And I can't get the hang of what's going on there. [Termination]
>
> It has been a dilemma really, because as soon as I said something like "so how is it going with you not eating," or something like that, then I become the mother who invades her, who controls her, who controls her eating and takes over. But if I do nothing, it remains split off and does not enter the room. [Termination]

The core category *Having Half of the Patient in Therapy* is surrounded by 9 subcategories gathered into two thematic domains.

1. *Experiences of the therapeutic process*

Subcategories in this domain capture the therapists' experiences of what was positive and what was problematic in the therapy process.

1.1. *Stimulating collaboration*

Generally, the therapist experienced the therapeutic work in this particular case as unusually stimulating and pleasant to start with. The patient's stories aroused initial interest and involvement, as did the patient's problems or capacities. The therapist could experience the patient as extraordinary verbal or capable, quick-witted and fond of therapy work, despite a traumatic background. The therapist experienced herself as unusually alert, free or creative, and could describe a liberating feeling that things will turn out and clear up with time, and that they were working successfully. It was easy to like the patient and feel empathy, and the therapist felt important, as the patient dared to open up and show confidence in an unusual way. However, the therapist could describe being suspicious of how easy it was for the patient to absorb insights and to connect. Perhaps the patient just adjusted herself to the therapist and the patient's eloquence was just an idle chatter.

> … that I sometimes have pondered that it's partially so easy for her to grasp things. That she accepts what I say – it's as if "that's what I need" – rather than asking "is this true for me?" or "is that really correct?" That it's somehow too easy. Of course it is a long working through, but still, we had soon entered what I see as part of her problem. And she took it like that, without fending off. [Baseline]
>
> She is damned quick-witted, a pretty intriguing girl, a lot of thoughts and ideas and good access to her feelings, after all, and willing to make use of this form of, you know, talking about things, thinking and reflecting. I think she has kind of liked it, found it pretty exciting. [Termination]

1.2. *Distance in the therapeutic relationship*

From the beginning, the therapist generally experienced an increasing distance in the relationship to the patient. The patient showed few emotions in therapy and kept a distance to the therapist by ceaseless or intellectualizing talk or by dwelling on her problems. The therapist understood the patient to have difficulties in letting the therapist approach her and the therapist felt emptiness in their relationship. The therapist could understand the patient's absence from sessions or delay as her attempt to control closeness and distance in their relationship. Central aspects of the patient's problems and life circumstances could come up as therapy was about to end. The therapist could also be bewildered by the patient's contradictory appearance and behavior, or by not understanding the patient's inner world.

> It's kept in a very impersonal way, though it is still personal. The language is impersonal. It's ambiguous. She speaks about very deep private matters, but her language is [impersonal]. [Baseline]
>
> She has a certain distance; she has a hard time letting her feelings flow, and expresses nothing strong about her bond to me either. [Termination]

1.3. *The patient reacts with aversion to closeness*

Typically, the therapist described that the patient reacted with growing aversion to the therapeutic progress and to increased attachment to the therapist in the course of therapy. The patient re-established the physical or psychological distance to the therapist by canceling sessions, being suspicious of the therapist or ceasing to relate to the therapist as a living person. This pattern could be established already at the outset of therapy.

> … and to dare to open up. I experience this as a kind of trust, but then she fails to come for two appointments after that. [Baseline]

> The more therapy meant to her, and the more I meant to her, the worse, the more dangerous the therapy became for her and the more she needed to turn me into a no-body. During that time I was functioning pretty much as an extension of the furniture in the room, I was part of the fitting-up, so to say, I was not a living person. [Termination]

1.4. *Fruitless battles*

Typically, the therapeutic collaboration turned into unproductive battles. The therapist described that the patient experienced questions, confrontations, and interpretations as threatening. The patient could feel threatened when the therapist called attention to her own perspective, different from the patient. The therapist could try to approach the patient by disclosing her own emotional reactions or interpreting transference, and the patient seemed to experience this as invading, according to the therapist. The therapist could be stubborn in her attempts to get in touch, and the patient could react with verbal attacks or a superior attitude. The therapist felt abandoned by the patient, disappointed or provoked, while the patient had difficulties in accepting the therapeutic frames.

> She was quite demanding and offensive at first. I mean she behaved like the upper class girl she was afraid to be perceived as. [Baseline]
>
> Frequently she saw my interventions as criticism, pretty often, if I was too straight forward, and I understand that as a lack of trust, as her paranoid side. [Termination]

1.5. *The therapist loses control of the process*

Typically, the therapist with time experienced a lack of control of the therapy process. The therapist conceived the patient's problems as unusually severe and felt perplexed, contaminated by the patient's problems, confused, and unable to think. At termination, the therapist could be overwhelmed by emotions, unable to bear the patient's despair and to preserve the therapeutic boundaries, overinvolved, and losing her professional stance. It could feel like being dragged into a black hole or fighting to stay above the surface, being lost and powerless.

> It is so massive, both her blues and resistance, so I don't really know what to do, I feel myself perplexed. [Baseline]
>
> It was calm on the surface of her speech, but [my] countertransference was so powerful, I was confused, I felt I was drawn into some damned depth and sometimes had to work my way up in order to be able to get her something back, so there was a mighty force under the surface. [Termination]

2. *Experiences of therapy outcomes*

Subcategories in this domain describe different aspects of what was achieved in therapy and what remained unprocessed according to the therapists.

2.1. *Therapy resulted in increased insight*

Generally, the therapist was convinced that the patient gained increased insight in her inner life, acquired more knowledge of her own wishes, aspirations, and resistances to the therapist's efforts. The patient won new understanding of her own contributions to her life situation and, consequently, an increased sense of agency. Furthermore, the patient became able to pause and reflect on her own behavior or question herself. The patient developed a more realistic picture of herself and others, which also could be accompanied by a feeling of loss and sorrow.

> She is much freer than before therapy, she has a better eye on herself, she knows a lot more about her problems. … previously she was somehow pseudo-aware, but now she's actually much more aware of her problems and she has the opportunity to work on them, if she dares and if she wants. [Termination]

2.2. *Problems have been mitigated*

Generally, the therapist described that the patient's initial symptoms had declined in strength. The patient could test new ways of managing her life, and act and relate to others in a more nuanced and reflective way. The patient gained increased capacity to stand the pain, and she gave more vital impression. Even if the patient still could have self-destructive impulses, she began to manage them in new ways.

> It's like there are now some cracks in it, she realizes it's not compact but it's still there as an important driving force, and also her spontaneous feeling of being self-sufficient, to be better off on her own is still there, but this is not as unreflecting as before, not as self-evident. [Termination]

2.3. *Favorable outcomes of therapy*

Generally, the therapist experienced that the therapy did some good for the patient, for example the patient could exhibit trust in the therapeutic relationship and relate in new ways to others, could know that it was possible to go back to the therapist, or had got better tools to face difficulties later in life. The therapist could describe outer changes in the patient's life as a product of therapy. Even if the symptoms were not really relieved or the problems were not solved, the therapist believed that the patient started a development she would continue on her own after termination. Perhaps a longer therapy would be more helpful, but a good preparatory work was accomplished.

> As a result of therapy she has more and more concluded that no, that's not really what she wants, that she now looks in the artistic direction. I don't think she really knows exactly what, but in any case it is where her interest leans to, and I think it fits her better, it is my impression from her listening to her own voice. [Termination]

2.4. *Core problems remain*

Despite several improvements, all therapists described that the patient's core problems, at least in their essential features, were still there at termination. The therapist could describe that the patient's greater awareness of her problems did not led to any substantial change. The therapist might also experience the patient's core problems as a part of the patient as a person she never might be free from.

> She still has difficulty with intimacy and she still is lacking trust both in herself and in others. So that's her core problem, I suppose. [Termination]

Interactions and Transformations over Time

The tentative conceptual model of therapeutic processes in cases of nonimprovement (Figure 1) captures the therapists' contradictory views, how the relationship between these views evolved, and how the contradictions persisted at termination. At the outset of therapy, the therapeutic processes were fairy similar across cases. Initially, the therapists shared a general and overlapping experience of *Stimulating collaboration* and *Distance in the therapeutic relationship*. The seemingly contradictory processes could be described as two sides of the same coin: the patient's fascinating verbal capacity and her distancing, ceaseless or intellectualizing talk. In course of time, the therapist could feel that a constructive therapeutic work was ongoing, while her picture of the patient remained vague. Subcategories of the *Experiences of the Therapeutic Process* (the first domain on the left side) interact with each other in unique ways in each particular case, all contributing to the core category *Having Half of the Patient in Therapy*. These paradoxical experiences were still present, but less frequent at termination, whereas the therapists' experiences of their patients' aversion to closeness, fruitful battles, and loss of control of the process were more frequent at termination. Thus, the therapists' experience of lacking access to central parts of the patient was more prominent at termination:

> She is talented and imaginative, and she uses this as to distance herself from me. Thus, there's a seduction in her way of talking, but after a while you discover the emptiness of what she says. [Termination]

The initial contradiction between stimulating collaboration and a distanced relationship was more marked with time. At termination, the therapist described that negative processes had taken over. The patient reacted with *Aversion to closeness* and the therapy was characterized by *Fruitless battles*. The therapists described their escalating perplexity and powerlessness, resulting in the therapist *Losing control of the process*. Not all of these negative processes were mentioned in each particular case; however, all therapists described at least one of them, and frequencies of these subcategories increased at termination.

The right side of Figure 1 represents therapy outcomes, as generally described by the therapists at termination. *Therapy resulted in increased insight* and *Mitigated problems*, thus leading the therapists to conclude that the therapy had *Favorable outcomes*. At the

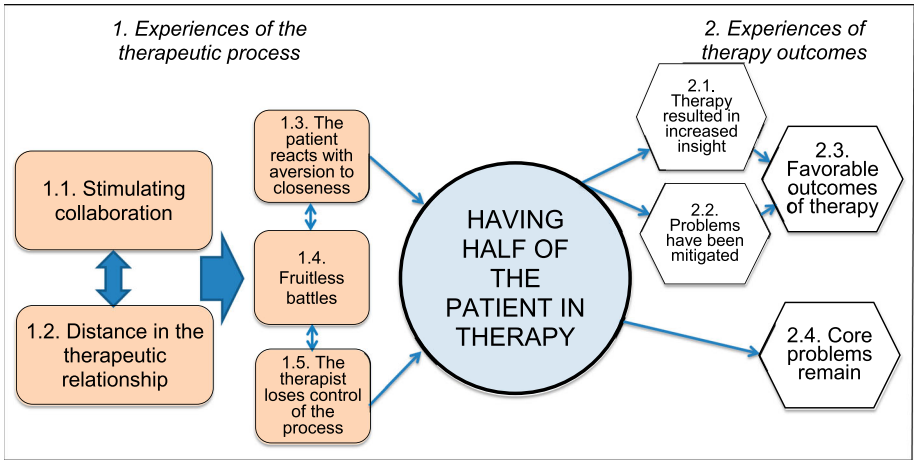

Figure 1. Tentative conceptual model of therapeutic processes in cases of nonimprovement, grounded in the therapists' view.

same time, all therapists concluded that the patient's *Core problems remain*. There is a remarkable lack of any connection or interaction between these irreconcilable outcome subcategories.

Discussion

This study aimed to explore the therapists' view of psychotherapy in cases of nonimprovement at termination, according to the criterion of no RC in self-rated symptoms. The main result was the incoherent, split picture of the therapeutic process, emerging from the therapists' narratives. From the start, the patient was experienced as having unusually difficult problems and *at the same time* being competent, capable, successful and unusually verbal. In retrospect, the therapist described a good and stimulating collaboration *in parallel* with a sense that the patient was holding back in the relationship. Initially, these dualities were interconnected, reflecting simultaneous but contradictory aspects of the therapists' experiences. Eventually, increasingly strong negative forces and reactions of both the patient and the therapist took over. The more the therapist tried to deepen the relationship to help the patient reach her unformulated experiences, the more the patient withdrew, adding to the therapist's confusion, therapists reported. Over time, the therapists became frustrated and unable to find a way to move further with their patients, being stuck in a struggle. The therapist perceived that the patient reacted with aversion to closeness in the therapeutic relationship or to the therapist's active attempts to reach the patient's "split-off parts," i.e. feelings and thoughts the patient did not easily accept as parts of herself. On the other hand, not intervening but instead awaiting the patient's own attempts to bring these parts into therapy increased the distance in the therapeutic relationship, and the therapist's picture of the patient remained diffuse. Thus, the therapist experienced a "Catch-22" situation: whatever the therapist did, the result was increasing distance or struggle. Closer to termination, the therapist reacted with strong emotions and experienced loss of control in therapy.

At termination, the therapist described favorable outcomes, despite the fact that nothing happened in terms of fundamental change in the patient. According to the therapist, therapy resulted in increased insight and mitigated problems, while the patient's core problems remained unchanged. At this time point, the two pictures of the outcome were disconnected, presented side by side with no links between them. Thus, strong vestiges of the therapists' contradictory view of their patients and the therapeutic process persisted in the form of their belief that useful things actually had happened in the treatment, even if the patients did not get any better. The tentative conceptual model illustrates this increasingly dissociated process and outcome. These interactions went on for months and years, because neither therapist nor patient experienced their meetings as meaningless enough to end, yet failed to involve "the whole patient" in therapy.

To contextualize the therapists' views by comparing them with patient perspectives of the same process might give further understanding. In a study of 20 nonimproved patients, from which the present therapist sample was drawn (Werbart et al., 2015), the patients also experienced the therapeutic relationship as distanced. However, the theme of the patient's aversion for closeness was absent in the patients' narratives; instead they described the relationship as artificial, attributing this to the therapist. At termination, therapy was experienced as overly focused on problem insight and past history, and the therapist as passive and reticent. While they saw active components in therapy and their own activities in life as beneficial, therapy itself was experienced as ongoing without moving forward. Nonimproved patients experienced "spinning one's wheels" in therapy with a too passive therapist, whereas their therapists in the present study described "having half of the patient in therapy," while being particularly committed and active.

Thus, there is a marked difference between the patients' and the therapists' experiences of the therapeutic process in cases of nonimprovement. We interpreted experiences of nonimproved patients as an unbalanced therapeutic alliance, with a good-enough emotional bond, but not enough agreement concerning therapy goals and tasks (Werbart et al., 2015). Conversely, the present study showed that the therapists experienced deficiencies in the emotional bond. However, both patients and therapists shared an experience of remaining core problems and that therapy was insufficient. The results from the two studies taken together indeed imply that therapists and patients did not find a common idea of what should be focused in therapy: the therapists tried to bring up countertransference as a means to address relational problems, but the patients did not mention this as helpful and wished for focus on concrete life matters. Thus, neither the goals and tasks in therapy seemed shared nor did they develop a trusting emotional bond.

More surprisingly, some of the themes in the present study were also present in a parallel study of therapists' experiences of the therapeutic process in successful cases, drawn from the same total patient population (Werbart et al., 2017). In both cases, the

therapists felt especially motivated to be this particular patient's therapist and they reported having worked more actively than with other patients. However, the duality of stimulating collaboration from the outset of therapy and early distance in the relationship seems to be unique for therapists' experiences in nonimproved cases. It could be interpreted as a motor in the acceleration of negative processes of the patient's aversion to closeness and the therapist's experience of struggle and loss of control. At termination, the result is the therapists' powerfully dissociated picture of favorable outcomes and remaining core problems.

Thus, what distinguishes the experience of therapists in nonimproved cases from therapists' experience of successful therapies? The split picture described above can be interpreted as a sign of a pseudo-process emerging when the therapist one-sidedly allies herself with the patient's more capable and seemingly well-functioning parts. Our interpretation is that emotionally laden subjects were hard for the patients to approach and bring up, and the therapists, despite their attempts, did not manage to help them do so. Dissociation of emotionally laden subjects seems to have been the core problem of these patients. Thus, the therapists of nonimproved patients seem to have overestimated the patients' functioning and underestimated the scope of their problems. To do so is generally correlated with lower outcome (Barber, Muran, McCarthy, & Keefe, 2013, p. 466). Both patient and therapist described from their different viewpoints that the therapist did not understand the patient, which might have added to the patient's experience of an artificial relationship. Furthermore, in cases of nonimprovement the therapists in the present study seem not to have succeeded in adjusting their technique to their patients' level of functioning, despite their attempts to meta-communicate. In contrast, in successful cases, the therapists described monitoring from the beginning the patient's resistances and ways of being with the therapist, as well as their own ways of being with the patient (Werbart et al., 2017), thus possibly being more able to work through ruptures in the working alliance and potentially prevent negative outcomes.

Our study indicates that the therapists' experiences of their work with nonimproved patients were not only negative. On the contrary, an important component of processes in these cases has been early positive countertransference and experiencing the therapeutic collaboration as especially stimulating, which might seem peculiar or contradictory. This experience was particularly strong at the outset of therapy, and can make it difficult to distinguish negative processes from the processes in successful therapies. In a study of countertransference in successful and unsuccessful cases of psychotherapy Hayes, Nelson, and Fauth (2015) found, correspondingly, that the therapists who were interviewed about unsuccessful cases articulated *less* unpleasant feelings and problematic cognitive reactions than did the therapists who were interviewed about good outcome cases. The nonimproved patients in our study seem to have avoided emotionally conflict-laden areas, and the therapists were impressed by the patient's imposing capabilities, but disregarded the patient's inconsistencies, vulnerabilities and deficits. In attachment terms, the patients might not have experienced the relationship as secure enough to approach the most difficult problems. Whereas patients in successful therapy described a secure relationship (Palmstierna & Werbart, 2013), nonimproved patients described it as "artificial" (Werbart et al., 2015). In contrast to successful cases (Werbart et al., 2017), the therapists of nonimproved patients could not maintain an equidistant stance and balance between supporting the patient's more mature parts and adequately confronting her more distorted parts. Therapists in our study tried to address these problems, but experienced that their patients avoided the closeness needed to create sustainable change. It is also possible that the therapists' theoretical and technical approach was not adjusted to these patients' difficulties or not compatible with the patient's ideas of cure.

To add further possible interpretations, the therapists' narratives could indicate that the patients suffered from severe interpersonal problems. In the initial interviews, the patients were described as unable to handle and regulate closeness and distance in their relationships outside of therapy, which we understand as difficulties for the patient and therapist to establish a secure relationship. At termination, the therapists described how the patient's problems invaded the therapeutic relationship. The therapists' descriptions of abrupt changes between closeness and distance might indicate that the patient's disorganized attachment strategies have been activated in the therapeutic relationship (Mikulincer & Shaver, 2007). The therapist's responses to the patient's attachment strategies are crucial for development of secure attachment to the therapist (Daly & Mallinckrodt, 2009; Mallinckrodt, 2010). Furthermore, the therapists' descriptions indicate limitations in their patients' mentalizing capacity. Possibly, therapists underestimated these difficulties and therefore did not adjust their interventions accordingly. The patient might have felt assaulted by the therapist's interventions and emotional reactions, or threatened by the therapist being her own person with a perspective different from that of the patient. To establish a

secure relationship, the therapist might have needed a change in their theoretical and technical approach.

The therapists' picture of their patients' "psychological mindedness" was ambiguous at baseline and even more equivocal at termination. That is, therapists described patients as reflective and interested in the interpretative work of therapy, but on the other hand also as hindering in this process by defending against difficult emotions and experiences. Early in treatment this was experienced as two sides of the same coin, whereas at termination this picture was increasingly split off. Therapists mentioned the defenses intellectualization, dissociation and splitting, which in a psychodynamic framework are used to describe how patients mostly unconsciously try to distance themselves from difficult themes which might arise in life and therapy. There also appears to be a development over time in the therapists' narratives. Initially, the therapist could be seduced by the patient's capable and seemingly well-functioning parts, but what seemed to be the patient's fascinating verbal and reflective capacity eventually appeared as empty chatter, pseudo-relatedness or struggle. The same therapist who initially experienced the patient as fond of working with insight could feel at termination that it was impossible to work with insight due to the patient's fragile ego structure.

To conclude, having half of the patient in therapy can be emotionally trying and evoke strong, contradictory countertransference reactions. Throughout the treatment, the therapists experienced themselves as being particularly committed and active, strongly affected by the patient's predicament, and the therapeutic collaboration as unusually stimulating. Initially, the therapists described themselves as having warm feelings towards the patient, being curious, free and flexible in therapy, being particularly suited to help the patient, and hopeful of deepening the therapeutic relationship with time. At termination, they additionally experienced the therapeutic relationship as marked by fruitless battles and loss of control of the process, feeling despaired, helpless, and frustrated. Both positive and negative countertransference reactions can result in the therapist overlooking information not congruent with the initial impressions of the patient (Hayes et al., 2015). The ways therapists mind their own experiences and mine their strong emotions affect the process and outcome of treatment by influencing the therapeutic relationship and the competent application of therapeutic techniques. Effective therapists can use their negative reactions as a source of clinical information regarding patients' maladaptive patterns and to differentiate these from their own unresolved problems (Wolf, Goldfried, & Muran, 2017).

In our study, the therapists' unprocessed positive regard of the patient seems to have contributed to the therapist underestimating the patient's problems, as well as to the therapists' conviction of being on the right track and that only more time and work were needed, not a new understanding or change of focus. They do not attribute the limited progress in therapy to their own limited understanding of the patient's problems, but rather to the patient's lack of will to open up and try harder. Taken together, this resulted in an inability to adapt their technique and to address their interventions to the patients' core problems (Gold & Stricker, 2011). For example, the therapists described that their attempts to meta-communicate about what was going on in the therapeutic relationship failed, as the patient could experience transference interpretations (i.e. the therapist's talk of what is going on in the patient-therapist relationship patient and how this reflects the patient's other important relationships) as threatening, and disclosure of the therapist's emotional reactions as critique. Norcross and Wampold (2011, p. 101) instructed: "[t]herapists who attack a client's dysfunctional thoughts or relational patterns need, repeatedly, to distinguish between attacking the person versus her behavior." It is possible that the therapists' restricted awareness of their own countertransference contributed to difficulties in taking a "third position" together with the patient and to challenge the patient's pseudo-mentalization.

Strengths and Limitations

The present study contributes to our growing knowledge about similarities and differences in therapeutic processes in successful and unsuccessful psychotherapies. Our quantitative selection criteria, based on therapy outcome at termination, combined with qualitative analysis of the interviews, enabled us to make explicit therapists' tacit, implicit knowledge of therapeutic processes in these particular cases. The access to baseline interviews opened a window on therapist experiences at the outset of treatments in cases of nonimprovement at termination. However, no session recordings were available; thus we lacked a window on the therapists' in-session behavior. Furthermore, the present study is limited to young adults in psychoanalytic psychotherapy. It is possible that the patients' avoidance of closeness in the therapeutic relationship is more marked at this stage of life. The previous studies of nonimproved patients' experiences (Werbart et al., 2015), as well as patients' and therapists' experiences in successful cases (Palmstierna & Werbart, 2013; Werbart et al.,

2017) gave a broader context to our results. Still, the number of cases that could be included in the present study is limited – even if the 16 interviews with therapists of 8 nonimproved patients gave enough material to reach the saturation point in the constant comparative analysis, i.e. the point at which no new insights were obtained, no new proprieties were identified, and no issues arose regarding the categories (Bowen, 2008; Charmaz, 2014).

Implications for Psychotherapy Practice and Training

Several implications for clinical practice and psychotherapy training might be drawn from our findings. In order to prevent suboptimal outcomes, the therapist has to be observant of contradictions and incompatibilities in her early assessment of the patient, the therapeutic relationship, and the therapeutic process. When the therapist's positive therapy experiences and a feeling of stimulating collaboration exist parallel to experienced distance early in the therapeutic relationship, it might be an indication that the therapist is in touch with only a limited part of the patient's problems and of the therapeutic relationship. In such cases, when the patient does not participate with her whole emotional life, this might be the patient's core problem. If the therapist one-sidedly focuses on the more well-functioning parts, there is a risk of no therapeutic change. This kind of incompatibilities and split tendencies in the therapist's experiences may be difficult to recognize by novice therapists and experienced therapists alike, and has to be addressed in psychotherapy training and supervision.

Furthermore, our study indicates the importance of continuous assessment of the patient's functioning, in order to find the right interventions. In psychodynamic terms, this includes assessment of defenses, attachment strategies, mentalization capacity, and ego structure. During the course of psychotherapy, the therapist has to be open to reconsider the initial assessment when new signs indicate overestimation of the patient's capabilities (cf., Markowitz & Milrod, 2015). Learning how to maintain an equidistant stance to the patient's capabilities and problematic areas, and to balance supportive and challenging aspects of the therapeutic relationship may be an essential component of psychotherapy training. Despite experience, the therapist might need supervision or discussing the case with a trusted colleague to be observant of and be able to make active use of her countertransference. Increasing therapists' awareness of their own both positive and negative reactions to patients may be an important educational goal contributing to therapists' overall effectiveness (Hayes, Gelso, & Hummel, 2011). Despite several relevant studies of therapists' contributions to negative processes (summarized in Hilsenroth, Cromer, & Ackerman, 2012), therapists are generally unfamiliar with methods and criteria for identifying and preventing them. Clinical implications of our growing knowledge of negative processes have still to be implemented in continuing education (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010).

Implications for Research and Future Directions

The present study confirms the conclusion from a previous study of therapists in successful cases (Werbart et al., 2017): the therapist's expertise is to be viewed as "case dependent." In contrast to effective therapeutic dyads, we found this time *ineffective dyads*. We still need more research and adequate, multiple methods to study specific combinations and interactions of patient, therapist and relationship factors contributing to negative psychotherapy outcomes. According to Baldwin and Imel (2013, p. 292), "it is critical that we begin to understand why a given therapist has an above average outcome with some clients but below average with other clients." Given that the therapists in the present study could also have successful cases (and successful therapists could have nonimproved patients), the next step is to study contrasting cases of successful and unsuccessful treatments from the same therapists (ongoing), thus holding the therapist factor constant. Another area for further studies can be therapists' experiences of their work with nonimproved patients in more directive therapeutic modalities. Is the phenomenon of having "half of the patient" in therapy more general in cases of nonimprovement or is it limited to psychoanalytic psychotherapy?

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