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“It was hard work every session”: Therapists’ view of successful psychoanalytic treatments

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ABSTRACT

Objective: To explore therapists’ experiences of the therapeutic process in successful cases of psychoanalytic psychotherapy. Method: A two-stage, mixed-method design was used. Sixteen successful cases were drawn from a sample of 92 young adults in psychoanalytic psychotherapy according to Jacobson’s criteria for reliable and clinically significant improvement. Therapist interviews at baseline and termination were analyzed applying Inductive Thematic Analysis. Results: Three core themes emerged: Being Particularly Motivated to be This Patient’s Therapist, Maintaining a Safe and Attentive Therapeutic Position, and Assiduous Work Every Session. The therapists experienced positive feelings towards the patient from the outset of treatment and described active, relational work that included paying attention to incongruities in the patient’s self-presentation and being mindful of patient’s avoidant behavior. The therapist’s motivation and attentive position made it possible to balance support and challenge in the therapeutic relationship. Conclusions: Successful therapeutic work presupposes positive expectations, an active therapeutic stance and assiduous work session-by-session. Therapist expertise may involve the ability to mobilize and work effectively with patient-specific resources and obstacles from the beginning of treatment. In addition to identifying the characteristics and actions of effective therapists, research should also focus on processes emerging within effective therapeutic dyads.

Keywords: psychoanalytic/psychodynamic therapy; long term psychotherapy; outcome research; process research; qualitative research methods; therapist perspective; therapist expertise

Clinical or methodological significance of this article: Our study indicates several factors that seem to characterize therapist expertise and can inform psychotherapy training. Successful therapeutic work presupposes positive expectations, an active therapeutic stance, courage to challenge the patient, and assiduous work session-by-session. Therapist expertise may involve the ability to mobilize and work effectively with patient-specific resources and obstacles from the beginning of treatment. In addition to identifying the characteristics and actions of effective therapists, research should also focus on processes emerging within effective therapeutic dyads.

Patients’ experiences of psychotherapy have been explored in numerous studies since the 1960-ties (for reviews, see, for example, Elliott & James, 1989; Levitt, Pomerville, & Surace, 2016; McLeod, 1990a; Timulak & Rosaleen McElvaney, 2013) but there is a general paucity of studies exploring therapists’ view of the therapeutic process (McLeod, 1990b, 2013; Rennie, 2002). Furthermore, studies that have explored therapists’ in-treatment experiences have typically focus on how therapists react and manage particular challenging clinical situations (e.g., Beck et al., 2005; Coutinho, Ribeiro, Hill, & Safran, 2011; Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Molto, Binder, & Nielsen, 2010; Williams, Polster, Grizzard, Rockenbaugh, & Judge, 2003) or experience working with “difficult” patient groups (e.g., Bimont & Werbart, 2017; Binder, Holgersen, & Nielsen, 2008; Roubal & Říhaček, 2016; Treloar, 2009). Another line of research has also explored therapists’ experiences of particular processes, such as alliance formation, or their views on facilitative factors in therapy in...
general (e.g., Binder et al., 2008; Levitt & Williams, 2010; Lilliengren & Werbart, 2010; Pearson & Bulsara, 2016).

However, while investigating how therapists manage challenging clinical situations or view mechanisms of change in psychotherapy are clearly important research areas, it is notable that very few studies have explored how therapists’ experience the therapeutic process in successful outcome cases specifically. It may be argued that studying therapists’ view of successful cases is of particular interest since, by definition, such treatments involve processes that lead to good outcomes. Successful treatments may contain particular challenging situations that are productively resolved and/or they may involve processes that prevent ruptures and impasses from taking place in the first place.

In recent years, there has also been an increased awareness in the field that therapists differ in their overall effectiveness and calls have been made for more research focusing on the “therapist factor,” including “therapist expertise” (Baldwin & Imel, 2013; Hill, Spiegel, Hoffman, Kivlinhan, & Gelso, 2017; Tracey, Wampold, Lichtenberg, & Goodyear, 2014). Still, while therapist differ in their average outcomes, most therapists have some successful outcome cases (Baldwin & Imel, 2013; Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011; Okiishi, Lambert, Nielsen, & Ogles, 2003; Wampold & Brown, 2005), making them “experts” with particular patients. Consequently, therapists’ views of the treatment process in specific successful cases may shed light on important therapeutic processes regardless of the individual therapist’s overall effectiveness.

A deeper understanding about what characterizes the treatment process in successful cases may also point to factors and skills that are particularly important for developing therapist expertise. For example, Henriksen (2016) interviewed therapists working with adolescent patients about their experiences during the initial sessions in treatments with subsequent successful outcomes. The results indicated that an important skill for successful outcomes included managing patients’ ambivalence about entering psychotherapy by maintaining a positive, hopeful attitude and expressing confidence in the therapy process, while at the same time supporting the patients’ agency and competence.

In another study, Hayes, Nelson, and Fauth (2015) explored therapists’ experience of countertransference in both successful and unsuccessful therapies in a sample of 18 therapists with diverse theoretical backgrounds. An unanticipated finding was that the therapists who were interviewed about good outcome cases articulated more unpleasant feelings and problematic cognitive reactions than did the therapists who were interviewed about unsuccessful cases. The authors suggested that, in successful cases, therapists might be more aware of negative emotional reactions and, thus, might also have been more able to manage and use them to facilitate the treatment process. Consequently, in line with research on countertransference in general (Hayes, Gelso, & Hummel, 2011), increasing therapists’ awareness of their own negative reactions to patients may be an important educational goal that may increase therapists’ overall effectiveness.

In the present study, we aim to explore how therapists experience, make sense of and reflect on their own clinical work in successful cases of psychoanalytic psychotherapy. Our specific questions are: How do the therapists describe their patients and what characterizes their experience of the therapeutic process? How do they describe their work in these particular cases and themselves as the particular patient’s therapist? Which central themes, factors, and processes seem to have been crucial for the successful outcome from the view of the therapist?

While the definition of “successful outcome” in psychotherapy may vary depending on the specific research questions, study design, and the perspective of the researcher (Ogles, 2013), it may be argued that such outcomes should involve significant reductions in patients’ self-reported distress levels (e.g., Goodyear, Wampold, Tracey, & Lichtenberg, 2017). Therefore, using a two-stage mixed-method design, we started with selecting successful cases based on the criterion of reliable and clinically significant change in patients’ self-rated symptoms. Next, rather than asking the therapists to describe their work in general, we interviewed each therapist about their experiences of working with each successful case separately. Additionally, we also investigated if there are any particular characteristics already observable at the outset of treatment, as reported by the therapists in baseline interviews.

1. Method

1.1. Setting

The successful cases were drawn from a patient sample of young adults in psychoanalytic individual psychotherapy, included in a longitudinal, prospective, naturalistic study (Young Adult Psychotherapy Project; YAPP). The treatments were conducted at the former Institute of Psychotherapy, at that time part of the publicly financed psychiatric care in Stockholm County, Sweden. Of the total of 134 patients (73% female; mean age $= 22$; range $= 18–25$; $SD = 2.2$) 92 were offered individual psychotherapy and
42 group therapy. The main complaints were low self-esteem (97%), depressed mood (66%), anxiety (55%), and conflicts in close relationships (66%) (Wiman & Werbart, 2002). Furthermore, about one-third of patients had self-reported personality disorder according to the DSM-IV and ICD-10 Personality Questionnaire (DIP-Q; Ottosson et al., 1998).

The treatments in YAPP aimed at overcoming developmental arrests and improving the patient’s adaptive capacity. The goals, duration, and frequency of therapy were adjusted to individual patient needs and formalized in a written, renegotiable contract between therapist and patient. The individual psychotherapies were conducted by 34 therapists who all shared a psychoanalytical frame of reference, even if working quite autonomously and had varying preferences regarding theory and technique. No manual was used, and treatment fidelity was not controlled for; however, the therapists met weekly in clinical teams to discuss clinical experiences and treatment problems. On average, the individual treatments in YAPP lasted for 22.3 months (SD = 17.2; Mdn = 20; range = 0–85) with a frequency of one or two sessions per week.

### 1.2. Categorization of Outcomes and Inclusion of Cases

The primary outcome measure was the Global Severity Index (GSI) of the Symptom Checklist-90-R (SCL-90; Derogatis, 1994). At baseline, patients were classified as belonging to the clinical range or functional distribution. The cutoff was determined in accordance with the Jacobson and Truax (1991) criterion (c), as recommended when the distributions of the functional and dysfunctional population overlap. Comparing the YAPP sample to Swedish norms, the GSI cutoff was calculated as 0.90.

At termination, patients were classified as showing clinically significant improvement (CI; reliable change [RC] and crossing the cutoff between clinical and nonclinical population), as RC only, or as nonimproved (no RC or reliable deterioration). RC is achieved if the reliable change 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).

To be regarded as “successful case” for inclusion in this study, the patient had to belong to the clinical range at baseline and to the functional distribution at termination, and the improvement on GSI had to be statistically reliable. Further, therapist interviews at termination had to be available. At baseline, 70 patients (80.5%) belonged to the clinical range; at termination, 29 of them showed CI, further 2 RC only, while 20 patients had no RC and 3 had deteriorated according to Jacobson’s criteria (missing outcome data in 16 cases). Owing to research design, the therapists were only interviewed in every second case in individual psychotherapy. Thus, of the 29 cases that fulfilled the criterion of belonging to the clinical range at baseline and showing clinically significant and reliable change at termination, 16 cases could be included in the present study (Figure 1).

### 1.3. Patients

For the 16 included cases, the average age at treatment start was 21.6 (SD = 2.2; range 18–25). Twelve of the patients were women and 4 were men. Seven patients lived alone, 4 patients lived with a partner, 4 patients lived with their parents, while one patient lived with a friend. None were married or had a child. The most common occupation was full-time study (9 patients) followed by full-time work (4 patients) and work in combination with studies (3 patients). Fourteen patients were born in Sweden and 2 in Asian countries (one adopted); 14 with both parents of Swedish origin, one patient with one parent having foreign origin and another one with both parents having foreign origin. In all, 10 patients had at least one parent with a university degree, thus indicating a high socioeconomic status within their family of origin. Seven patients had previous outpatient or inpatient psychiatric contact; 9 patients had previous psychotherapeutic contact. There were no apparent differences on these background variables between this subsample, the total YAPP sample (Philips, Wennberg, Werbart, & Schubert, 2006), or a YAPP subsample of 20 nonimproved patients (Werbart, von Below, Brun, & Gunnarsdottir, 2015). The mean GSI-score at baseline (M = 1.56; SD = 0.51) was comparable to the nonimproved subsample (M = 1.59; SD = 0.50) and decreased at termination to 0.49 (SD = 0.20), suggesting a large within-group effect size of d = 3.01 (Cohen, 1992). The mean time in therapy was 27.6 months (range 9–51; SD = 12.0), as compared with 21.3 months (range 2–48; SD = 10.9) in the nonimproved sample.

At baseline, 11 of the patients reached criteria for DSM-IV-TR (American Psychiatric Association, 2000) Axis I diagnoses: one with social phobia, one with dysthymia, one with adjustment disorder with depressive mood, 4 with major depressive disorder (of which one in combination with social phobia and one with anxiety disorder not otherwise specified), one with anxiety disorder not otherwise specified, one with generalized anxiety disorder, and 2
with substance dependence. Additionally, 6 patients had Axis II diagnoses: one paranoid and depressive personality disorder, one paranoid and avoidant personality disorder, one borderline and avoidant personality disorder, one histrionic personality disorder, and 2 with personality disorder not otherwise specified. Two patients had both Axis I and Axis II diagnoses, while one patient received no psychiatric diagnosis. There were no differences in the proportion of diagnoses between cases with clinically significant improvement (69% Axis I and 38% Axis II) and those not fulfilling this criterion (67% Axis I and 44% Axis II).

1.4. Therapists
The 16 patients were treated by 14 therapists; 9 female and 5 male; 9 were social workers, 4 psychologists, and one psychiatrist. The average age of the therapists at treatment start was 57.1 (SD = 5.3; range 46–64). All therapists were senior licensed psychotherapists with 3–15 years’ experience after being licensed (Md = 13, M = 10.7, SD = 3.9), 10 of them with advanced training in psychodynamic therapy and 4 with supplementary psychoanalytic training; each working as a teacher and supervisor in an advanced psychotherapy training program. Four therapists had two successful cases each. Two of the patients were treated by two different therapists: one patient changed therapist after 13 months when the therapist retired and the patient continued with a new therapist for 27 months, while the second patient changed therapist after 5 months due to dissatisfaction with the therapist and continued for 35 months with a new therapist. The 12 female patients were treated by 9 female and 3 male therapists, whereas the 4 male patients were treated by 3 female and one male therapist.

1.5. Interviews
The therapists where interviewed at baseline (i.e., after initial consultative sessions and close to the first therapy session) and at termination (i.e., shortly after the last therapy session). The interview protocol included the Private Theory Interview (PTI; Werbart & Levander, 2006). The PTI (therapist version) is an in-depth interview that aims at collecting the participants’ subjective meaning making concerning (1) their patients’ presenting complaints, (2) their view of the background to these problems, (3) their ideas of cure, (4) descriptions of changes during and after therapy, and (5) retrospective views about what contributed to change, what comprised obstacles, and what could have been different. In line with a basic phenomenological approach, the interviewer starts with open-ended questions and then asks the participant to elaborate the answers in
these five main questions as well as give concrete examples and illustrative episodes when applicable. The interviews were conducted by researchers trained in the PTI technique of “bracketing” their own professional knowledge and understanding of the interviewee, maintaining an attitude resembling social anthropologist rather than that of a clinician, and refraining from making interpretations and summaries. Thus, 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 encouraging?”

The audio-recorded interviews lasted about 60 minutes and were transcribed verbatim. For the 16 cases included in this study, a total of 29 interviews with their therapist were available, 13 conducted at baseline and 16 at termination.

1.6. Qualitative Analysis

In order to answer the research questions, inductive thematic analysis was regarded as the method of choice. The 29 interview transcripts were analyzed following a step-by-step procedure (Braun & Clarke, 2006):

(1) In the first step, two independent judges (the second and the third author) repeatedly read all interview transcripts in order to be familiar with the depth and breadth of the content, searching for meanings and patterns.

(2) In the second step, each judge started to generate initial codes as close to the original transcript as possible (semantic coding). The aim of this data-driven coding was to identify basic segments of the transcripts relevant to the phenomenon in focus, collating data relevant to each code and forming preliminary labels to represent emerging commonalities. Subsequently, the judges analyzed two interviews together to obtain consensus of what in the interviews that should be regarded as pertinent to the research questions.

(3) In the next step the judges discussed the generated codes, compared each other’s code lists and revised them. The codes considered similar or related to each other were gathered in code groups or preliminary themes. Thereafter the judges worked through the material together and coded it again. When new themes emerged, they were compared to the earlier, which led to a continual development of main themes and subthemes. At this stage, three core themes emerged which formed a basis for a first tentative model (thematic map). The evolving model was continuously reviewed in collaboration with the first author throughout the work process.

(4) With this model as a starting point the themes were reviewed once again against the interview transcripts. The model was repeatedly tested against the data for further adjustments and improvements, striving for meaningful coherence of data within themes (internal homogeneity) and for clear and identifiable distinctions between themes (external heterogeneity).

(5) This step involved identifying the “essence” of what each theme was about and determining what aspect of the data each theme captured. Eventually a satisfying consistency between the relevant text passages and the model was accomplished. The material from 16 cases and 29 therapist interviews provided enough data for the themes to saturate, which means that inclusion of additional data in the stepwise analysis no longer revealed any new themes, properties, or relationships among them (Morse, 1995; Rennie, Phillips, & Quartaro, 1988). Thus, the tentative conceptual model was deemed to be grounded in the data and capturing the essence of the commonly experienced phenomenon in focus. An illustration of the coding process is provided in Figure 2.

The procedure of independent coding, consensus discussions, working together, and audits by a senior researcher was inspired by the consensual qualitative research (CQR; Hill et al., 2005) and aimed at increasing the trustworthiness of the analysis (Williams & Morrow, 2009). The frequencies of participants contributing to each theme were scrutinized as an additional validity check and reported using nomenclature from CQR (Hill et al., 2005), following criteria for larger samples (Knox, Schlosser, Pruitt, & Hill, 2006): General: ≥90% of the cases;
Typical: ≥50% to <90%; Variant: ≥20% to <50%; Rare: <20%. These frequency labels are reported for each core theme and subordinated theme at baseline, at termination, and total (despite the time point).

2. Results

The thematic analysis yielded three core themes, representing central phenomena of the study: Being Particularly Motivated to be This Patient’s Therapist, Maintaining a Safe and Attentive Therapeutic Position, and Assiduous Work Every Session. One further core theme, Having Confidence in the Patient’s Capability to Direct the Life after Therapy, functioned as an indicator of the successful therapeutic work. The constituent subthemes are presented below in order of their total frequencies despite the time point (Table I). The interactions between core themes and subthemes are presented in a tentative conceptual model of therapeutic processes in successful individual therapies, grounded in the therapists’ view (Figure 3).

2.1. Being Particularly Motivated to be This Patient’s Therapist

Generally, the therapists felt strongly motivated when working with their patients. This theme comprises the therapists’ experiences of the patient or of working with the patient that had motivating effects on the therapist. The therapist’s motivation was evoked by the patient as a person, as well as by seeing the patient as a particular and interesting case. The first thematic domain has to do with being emotionally motivated and touched by the patient’s predicament, whereas the second domain has to do with being cognitively motivated and catches the intention to master the challenge and to solve the therapeutic task.

2.1.1. Motivated by the patient as a person

2.1.1.1. Feeling attraction and sympathy for the patient. The therapists generally gave positive descriptions of their patients’ outer appearance and inner qualities. The patients were beautiful, pretty, charming, sweet, intelligent, talented, psychologically minded, eloquent, creative, etc. Furthermore, the therapists experienced their patients as likable, sympathetic and attractive.

This is a very, I mean it’s a [laughter] lovable girl. You become so … she’s so charming and sweet, she’s so pleasant, you get the feeling that everyone really stands by her and really wants to help her and not let go of her too. [Termination]

The therapists early expressed both their more neutral opinions and their more emotionally charged idiosyncratic impressions of the patient as a unique person. The therapists’ predilection for this particular patient’s personal characteristics contributed to their motivation. They wanted to help a person they spontaneously liked.

2.1.1.2. Paying attention to the patient’s potential. Generally, the therapists saw an unfulfilled potential in their patients. They might notice hampered creativity, unkempt appearance, or unexploited talent. It might also be a potential for genuine relationships or capacity for love. Furthermore, the therapist can experience the patient’s potential to profit from psychotherapy, for example, the patient’s capability to symbolization or understanding the therapeutic procedures.
She has of course begun to discover her own capacities. I think that the therapy has helped a lot there. She begins to feel seen and she has been seen. I think she feels kind of encouragement to look for what is restrained. There is a creativity that is very restrained. [Baseline]

The therapists perceived unrealized capabilities in their patients and this further strengthened their wish to be helpful to the patient.

2.1.1.3. Feeling compassion for the patient. Typically, the therapists felt compassion and concern for their patients. They might be moved by the patient’s suffering and experience tenderness or motherly feelings.

She tells me that she gets home at 4 o’clock and that she hooks up with different guys, like chance acquaintance. We have not gone into that in more detail, but I can certainly feel some concern for what she is doing. [Baseline]

The therapists’ emotional reactions to the patient’s symptoms, inner pain, and outer actions colored their motivation with personal or parental qualities.

She has had a tremendous strength, I think, a strong desire to change because she has had a very great suffering, this girl, all her life, I think. [Termination]

Implicit in the therapists’ formulations is a dialectical synergistic interplay, starting from the very beginning, between perceiving the patient’s motivation and being motivated as therapist to this particular patient.

2.1.1.4. Experiencing the patient as motivated. Typically, the therapists believed that their patients were motivated for psychotherapy. They noticed that the patients tried hard and rarely canceled a session. The patients understood that they had problems and genuinely wanted to get help.

Note. Frequencies of cases in each core theme and subtheme at baseline, at termination, and total (labeled following Knox et al., 2006).
I think I have an aptitude for this, as background, which allows me to know something about this. It catches something I experienced myself in my childhood and that makes me be very explicit in a special way. [Termination]

Notably, the therapists were motivated to use their own life experiences of hurt, loss or disappointment to promote active therapeutic work.

2.1.2. Motivated by this particular and interesting case

2.1.2.1. Noticing incongruities in the patient.
Generally, the therapists noticed incongruities in the patient’s ways of being, talking, and relating to the therapist. They were observant of the patient’s speech and body language, sensitive to contradictions between form and content, and they noticed gaps and discrepancies in their picture of the patient.

This is a young man who is a mixture of gifted, intellectually well-equipped, in one respect successful, but then there is something else, something a bit neglecting about him...his hair hanging, his clothes have seen better days, it is some tension between potency and neglect. [Baseline]

Noticing incongruities in the patient seems to arouse the therapists’ wish to be helpful and motivate them to use their best endeavors when working with this particular patient.

2.1.2.2. Noticing the patient’s negative characteristics. Typically, the therapists also briefly mentioned some negative characteristics of the patient, such as being languid, annoying, impatient, nonchalant, etc.

She had, you might say, some kind of nonchalance that could get my back up, some kind of upper class manner. [Termination]

Describing the patient’s negative characteristics, the therapists demonstrated that they strained to see all sides of the patient. They noticed dysfunctional areas to work with in therapy, the challenge being to work with a patient the therapist found difficult or resistant in some way and to reflect on why it is so.

2.1.2.3. Feeling particularly suited to be the patient’s therapist. As a variant, the therapists reported that they felt themselves being especially suited to treat the patient. They experienced a...
resonance in their relationship to the patient and saw the therapeutic couple as a particularly good match.

We don’t talk so often about it but I think it plays a major role, because when a patient and therapist couple becomes well-functioning it can be something like this, I think, a quite irrational factor of deep recognition on some level. [Baseline]

The mutual attunement, as experienced by the therapists, contributed to their feeling of being the best choice for their patients.

2.1.2.4. Approaching the patient as a challenge. On rare occasions, the therapists described the patient’s problems and sufferings as a challenge. They could see the patient as a difficult case, providing them an opportunity to test their therapeutic strength.

It was a bit thrilling with this very square and concrete and scientific and all this, it was also sort of challenge how she could function so simplistic, so I think it also aroused my interest. [Termination]

Nevertheless, the challenging aspects of the therapists’ professional motivation were implicit in all sub-themes in the second motivational domain.

2.2. Maintaining a Safe and Attentive Therapeutic Position

Generally, the therapists were aware of, and made use of the structural asymmetry inherent in the patient–therapist relationship to the benefit of the treatment. They were observant of the patient’s as well as their own in-session behavior. They strived to maintain their therapeutic stance throughout the treatment, while attentively monitoring the therapeutic process. The included subordinated themes refer to making active use of the formal aspects of the therapeutic encounter as a guarantor of professionalism and as a springboard for scrutiny of what is going on in the therapeutic relationship. This included being attentive to the patient’s needs and progress, being observant of the patient’s resistances and lack of mutual contact, questioning both participants’ relational longing, and offering themselves as a role model within a safe relationship.

2.2.1. Firm, yet flexible therapeutic frames. Typically, the therapists stressed the importance of being explicit and consistent with the therapeutic frames, but also of knowing how and when to be flexible. In some circumstances they were ready to renegotiate the therapeutic contract, for example, intensifying the frequency, if necessary, or prolonging treatment beyond the initial agreement.

And he goes on fighting and perhaps is very depressed the first two semesters, but then something happens and I prolonged the therapy. First, we should work for a year and so we re-examined the contract and prolonged up to this summer. [Termination]

The therapist’s attentiveness to the patient’s needs and progress, followed by joint negotiation of the therapeutic frames, was a distinguishing quality of the therapist’s position in successful cases.

2.2.2. Sensitivity to the patient’s avoidant behavior. The therapists were typically observant of the patient not working in session or avoiding sensitive material. They pointed out to the patient her evasiveness and encouraged the patient to try to understand the underlying dynamics. Furthermore, they emphasized the seriousness of the therapeutic work and they did not let the patient waste her time.

He is in a way self-propelled, also in his way of managing therapy sessions. Here I see a problem, because he is too self-propelled, and I have to be observant not to be lulled into a false tone that everything is okay. [Baseline]

Maintaining a safe and attentive therapeutic position involved a “hermeneutics of suspicion” regarding signs of the patient’s resistant behavior.

2.2.3. Sensitivity to signs of distance in the therapeutic relationship. Typically, the therapists were observant of the patient’s obstacles to be genuine or to lack of mutuality in the therapeutic relationship. They were especially sensitive to signs indicating that the patient might drop out of treatment.

I feel he has been very positive, and he thinks it’s very good contact, but I think that is just as defense, as … I don’t experience at all like we have any contact. But he is so keen that everything should be fine. [Baseline]

Another aspect of the “hermeneutics of suspicion” was critical examination of the quality of the therapeutic relationship, looking for signs of detachment or pretended affiliation.

2.2.4. Sensitivity to the yearning for intimacy. Typically, the therapists were aware of, and alerted by their own needs in relation to the patient. They also had to fend off pressure exerted
by the patient’s infantile needs. The therapists strived to preserve an optimal balance between closeness and distance in the therapeutic relationship.

I've been very fond of her if truth has to come out, I've thought a lot about her and it is something I had to work on in my countertransference. [Termination]

Holding that nothing ultimately means what it first seems to say, the therapists’ safe and attentive professional position comprised questioning their own involvement and relational longing.

2.2.5. Being a role model and parental figure for the patient. Typically, the therapists reported functioning as a role model, a parental figure, or someone the patient looked up to. They thought that the difference in age and their greater life experience was beneficial for young adult patients.

I guess I am sort of a peaceful person, and I suppose she experienced this as something good; I think it has been important for her to be with an adult who sort manages herself, since she hasn’t been surrounded by such persons. [Termination]

Within the secure therapeutic frames, the therapists offered themselves as a new object of new relational experiences with marked parental qualities. This characteristic is also implicit in all other sub-themes contributing to the therapist position.

2.3. Assiduous Work Every Session

Generally, the therapists believed that successful therapy rest on hard work every single session. The efficient and powerful therapeutic work was heavy, challenging for the patient as well as the therapist, trying to one’s patience and requiring courage and persistence. Yet, the therapists felt that they got in touch with their patients. The therapists had to take a firm grip on the process in therapy in order not to let the patient avoid essential but painful topics, at the same time promoting trust and confidence, encouraging autonomy, and challenging the patient’s ways of being and relating. The included subordinated themes refer to key components of efficient and powerful therapeutic work, rendered possible when the therapist’s motivation and position were present.

2.3.1. Getting in touch with the patient. Generally, the therapists experienced having got in touch with their patients. They noticed that the patient felt understood and liked, and that the therapist confided in and had good hope for the patient. The therapists felt that the affection was mutual and that they related to each other in a genuine way.

I really like her and I think she eventually noticed it, though I know she was not sure of it almost all the time. [Termination]

Genuine relatedness was both a precondition and a sign of assiduous work. Furthermore, the therapist’s tolerance for the patient’s ambiguity was one aspect of genuine relatedness, rendering the assiduous work possible.

2.3.2. Being patient, courageous, and persistent. Generally, the therapists experienced that they had to be persistent and to do a tough work every single session not to lose the grip on the therapy. They exerted themselves to be patient, to retain the focus and to endure being there for the patient even when no progress had been made. They stressed the importance of having courage not to avoid difficult topics and to stand the burden of the patient’s suffering. Furthermore, they reported having worked more actively in this particular case then with other patients.

Thus, the assiduous work was characterized by the therapists’ “never ever give up” attitude.

2.3.3. Encouraging autonomy. Typically, the therapists supported signs of independence in their patients, encouraged them to challenge themselves and to help themselves in their life outside therapy, as a way to strengthen the patients’ agency and self-confidence. The therapists were careful not to prolong therapy unnecessarily and could let the patients themselves decide when and how to end therapy or decide already at the outset of treatment the date of the last session, thus avoiding the patient becoming too dependent on the treatment.

Because otherwise I have spoken about the risk of this kind of bonding to me, that is a binding parallel to family bonds. That’s what I’ve experienced, that also made it very clear to me that we have to finish now, because we have achieved enough for me to trust that now she has to get out in life. [Termination]

This progressively widening focus on the patient’s agency and independent life outside of psychotherapy is a striking parallel to the trying parental task of
successively “kicking out” the maturing child from a dependence relationship.

2.3.4. Playing down attitude to awkward issues. Typically, the therapists showed a playing down attitude when approaching some material viewed by the patient as extra sensitive, thus letting the patient understand that they themselves were not frightened, disgusted or intimidated. By this attitude, they wanted to serve as a model to new ways of dealing with strong emotions. They strived to establish a relaxed and creative climate, with room for humor and playfulness.

I have not been ironic or arrogant, but I’ve been able to allow myself some little witticism, capturing like “life, so what,” this attitude she has liked a lot. [Termination]

The undertone of playful distance from outside the patient’s uneasy and painful predicament could facilitate the mutually trying work.

2.3.5. Promoting trust and confidence. Typically, the therapists described this particular therapeutic relationship as safe and full of confidence and trust. They believed that the patient’s trust in the therapist is essential in any effective therapeutic treatment. If they noticed the patient’s lack of confidence, they addressed that before proceeding with the treatment. A sign of trust could be when the patient started to “open up” and telling things for the first time, not feeling judged by the therapist. The therapists were convinced that the therapeutic frames with continuity and stability promote trust in therapy.

He has described his thoughts more and more unprejudiced when his confidence has grown and then it has become possible for me to make interpretations that he has been able to take. [Termination]

Fostering patient’s trust in therapy and the therapist made it possible for both of them to take new steps in the therapeutic work.

2.3.6. Daring to challenge the patient and the therapeutic relation. Typically, the therapists used the therapeutic relationship to challenge the patient’s ways of being. They encouraged the patient to explore difficulties in the therapeutic relationship and the patient’s negative thoughts and feelings towards the therapist. They stressed the importance of an “affectionate confrontational” attitude, trusting that the therapeutic relationship would sustain working through potential ruptures and boundary transgressions.

I remember I said to him, “it is as if you couldn’t imagine that I could be jealous of you.” I think that it was such a key reply, that this was present in our relationship, and the relationship did not break. [Termination]

Consequently, the challenging aspects of the assiduous work contributed to the successful treatments having a quality of high-risk undertaking, balanced by the therapist’s trust in the therapeutic frames and relationship.

2.4. Having Confidence in the Patient’s Capability to Direct the Life after Therapy

Typically, the therapists felt optimistic when it comes to the patient’s ability to cope with life after termination of therapy, while emphasizing the importance for the patient to pursue the work initiated in therapy. They believed that the therapy had given the patients an increased capacity to take on challenges in life, while acknowledging uncertainty of the future.

Thus, I am very hopeful when it comes to this woman. I think … this is well her mission in life to hold on and keep a watchful eye on these aspects. [Termination]

Thus, the accomplished assiduous work makes the therapist trust the patient’s capacity to maintain the therapeutic gains, but also to continue the therapeutic work by her own.

2.5. Interactions and Transformations

The “assiduous” work emerged in interplay between the therapist’s particular motivation and the therapist’s safe and attentive position (Figure 3). As reflected in the interviews, the therapist’s ability to help their patients seemed to depend on their ambition and readiness to do so. Accordingly, all therapists described being especially motivated and suited to help that particular patient, both as a person and as an interesting case. The therapeutic relationship was experienced as important and emotionally charged for the therapist, and not only for the patient. This emotional investment on behalf of the therapist was counterbalanced by a safe and attentive therapeutic position, enabling the therapist to maintain an optimal balance between closeness and distance in the therapeutic relationship, while safeguarding stability, professional stance, and
personal integrity. Thus, the therapeutic position did not only protect both participants, but was in itself a vehicle for approaching and getting in touch with the patient. By virtue of the professional attitude and therapeutic frames the therapists provided time and space for development of a mutual relationship. The therapist’s position, in dynamic interplay with the therapist’s motivation, was a prerequisite for the assiduous therapeutic work every session, eventually resulting in confidence in the patient’s capability to deal with current and future challenges in the patient’s life after therapy termination.

The relations between the subthemes composing the therapist’s position and the assiduous work might be seen as pieces in two puzzles, together creating a comprehensive picture of these core themes. The subthemes constituting the therapist’s motivation were interrelated in a more complex way. The therapist’s motivation could be evoked by being emotionally touched by the patient as a unique person, as well as by experiencing the patient as a particular and interesting case. In the first case, the therapist derived motivation from personal feelings of sympathy for the specific patient and a genuine desire to alleviate the patient’s suffering, whereas in the second case the therapist was intellectually stimulated by the patient’s unique condition, deriving motivation from curiosity and desire to take on a challenge. Obviously, the two domains are not mutually exclusive. In the first domain, feeling attraction and sympathy was reciprocally linked to feeling compassion for the patient. The therapists recognizing oneself in the patient tended to report feeling compassion for the patient, as well as feeling particularly suited to be the patient’s therapist in the second domain. Paying attention to the patient’s potential was mutually linked to feeling attraction and sympathy and influenced by experiencing the patient as motivated. Furthermore, there was a bilateral connection between paying attention to the patient’s potential and noticing incongruities in the patient. Noticing incongruities and noticing negative characteristics of the patient, in reciprocal interaction, resulted in approaching the patient as a challenge.

The frequencies of themes at baseline, at termination and in total are presented in Table I. The core themes Being Particularly Motivated to be This Patient’s Therapist and Maintaining a Safe and Attentive Therapeutic Position were general both at baseline and at termination. Within the motivation theme, Feeling attraction and sympathy and Experiencing the patient as motivated, as well as Noticing incongruities in the patient, Noticing the patient’s negative characteristics of the patient, and Approaching the patient as a challenge decreased in frequency at termination, while Feeling compassion for the patient increased. Within the position theme, Firm, yet flexible therapeutic frames, Sensitivity to the yearning for intimacy, and Being a role model and parental figure increased in frequency at termination, while Sensitivity to signs of distance decreased. Assiduous Work Every Session was typical already at baseline and was represented by all therapists at termination. All subthemes of Assiduous Work Every Session increased at termination and became typical, indicating that the assiduous work developed gradually as the therapeutic relationship deepened. Having Confidence in the Patient’s Capability to Direct the Life after Therapy, for obvious reasons, was absent at baseline, but typical at termination.

Which aspects of effective therapeutic work were observable already in the initial interviews at the outset of treatment? From the beginning, the therapists described positive feelings towards their patients and showed curiosity about their problems. They early on got an idea of how to approach the patient’s problems, and they felt particularly suited to be the patient’s therapist. At the start of psychotherapy, all of them described feeling attraction and sympathy for the patient and all noticed incongruities in the patient. Furthermore, they experienced the patient as motivated, noticed negative characteristics of the patient, and approached the patient as a challenge more frequently at baseline than at termination. The two motivational domains were thus clearly present already at the outset of therapy. Two components of the therapist’s position stand out as typical at baseline: the therapists were sensitive to patient’s avoiding sensitive material or not working in session, and to signs of distance in the therapeutic relationship. Monitoring from the beginning the patient’s resistances and ways of being with the therapist, they seem to have been more able to work through ruptures in the working alliance and potentially prevent early dropping out of therapy.

3. Discussion

The results of this study suggest that successful psychoanalytic treatments are characterized by the therapists experiencing a positively charged therapeutic relationship and their adopting a particular therapeutic stance, leading to an experience of working hard together with the patient. Interestingly, the therapists described feeling attraction and sympathy towards the patient very early in treatment, perhaps indicating that the bond component of working alliance (Bordin, 1979) started to unfold from the very first meeting. Another possible interpretation is that this early positive reaction reflects the patient’s “unobjectionable” positive transference, viewed as a
“vehicle for success in psychoanalysis” by Freud (1912/1958, p. 105). In any case, these early positive feelings, accompanied by paying attention to the patient’s potential and experiencing the patient as motivated, seemed to have been important for increasing the therapists’ motivation and engagement in the therapeutic work with this particular patient.

In addition to the positive feelings aroused at onset of treatment, the therapists’ in this study seemed sensitive to the particular patient’s complexities and incongruities and also noticed negative characteristics, such as dysfunctional areas and resistances. They further described a number of therapeutic interventions they used at the outset of treatment, such as pointing out incongruities in the patient, the patient’s avoidance of difficult topics, and signs of distance in the therapeutic relationship, as well as encouraging the patient’s autonomy. This early dual focus on both possibilities and hindrances to the therapeutic task seemed to strengthen both the patient’s and the therapist’s motivation. This is in line with studies indicating that core effective ingredients in the initial phase of treatment, regardless of treatment modality, involve exploring patient’s expectations and fostering positive expectancies, educating patients about the actual treatment process, and collaborative goal formation (Ackerman & Hilsenroth, 2003; DeFife & Hilsenroth, 2011; Henriksen, 2016; Oddli & Halvorsen, 2014).

Moreover, the therapists in our study described being mindful of and sensitive to issues of proximity and distance in the interaction with their patients: to the patient’s avoidance of difficult matters, lack of contact, and yearning for intimacy, but also to the therapists’ own longings for closeness and other emotional needs activated in the therapeutic relationship. Too warm feelings were seen with some suspicion by the therapists and they seemed to actively avoid being “seduced” by their patients. Likewise, they were watchful for their negative feelings aroused by the patient’s avoidant behavior and lack of contact. Thus, in line with the study by Hayes et al. (2015), the therapists seemed to be quite aware of countertransference feelings in these successful cases. They also seemed to be able to use these feelings constructively to empathically understand the patient’s struggle, at the same time as they were mindful of not letting their own feelings obscure the therapeutic task.

While the therapists stressed the importance of emotionally charged relationship, they also emphasized the need not to make the patient too dependent on the therapy. They actively supported the patient’s autonomy and encouraged them to challenge themselves and to help themselves in their life. This is in line with studies indicating the importance of promoting patient’s agency in treatment and in-session risk taking (Angus & Kagan, 2007; Levitt & Williams, 2010; Williams & Levitt, 2007). Thus, successful treatments may be characterized by the therapist managing to establish a sound balance between patients’ needs for dependence and autonomy in the therapeutic relationship.

Additionally, the therapists appeared to meet their patients’ narratives with a playing down, laid-back and straightforward attitude, sometimes with a humorous tone or a twinkle in the eye. Through their seemingly unconcerned attitude they could convey that the anxieties the patient linked to some ideas not necessarily were justified or that they together at least could “laugh at the misery.” By actively giving permission and showing acceptance for feeling and thinking in ways previously perceived as forbidden by the patient, the therapists could get their patients to feel relieved (cf., Lilliengren & Werbart, 2010). By treating their patients in a non-judgmental way, the therapists could instill confidence and trust that the issues that brought them to therapy could be understood and coped with (cf., Ackerman & Hilsenroth, 2003). At termination, they were confident of their patients’ capability to take on new challenges in life, still feeling that it was a lot of work to be done by the patient after therapy.

At the same time as the therapists conveyed a laid-back attitude they also clearly described the therapeutic process as a challenging and risky task, requiring courage and persistence throughout the whole treatment. In particular, they stressed their efforts to “get in touch” with the patient and not to let the patient avoid essential but painful topics. Rather than letting the treatment process unfold in a completely unstructured or “random” fashion, the therapists seemed devoted to keeping the treatment focused on the patients’ core issues and using every session for “working through.” This stance seems close to what is typically associated with short-term dynamic therapies (Messer & Warren, 1995), even though the treatments in YAPP were open-ended and the average treatment duration was close to two years. This may suggest that an active and focused therapist stance is as important for successful outcomes in long-term dynamic therapies as it is in treatments of shorter duration (Hilsenroth, Cromer, & Ackerman, 2012; Katzman & Coughlin, 2013; Migone, 2014). The therapists’ narratives also suggest a close interrelationship between strengthening the therapeutic relationship and active use of the therapy-specific technique in successful cases, as mirrored in the themes composing the tentative conceptual model. From this perspective, the working alliance is not an independent factor; rather, there is a complex
synergic, dialectical interplay of technical and relational aspects of effective therapeutic work (cf., Ackerman & Hilsenroth, 2003; Zilcha-Mano & Barber, 2014; Zilcha-Mano, Dinger, McCarthy, & Barber, 2014).

Patients’ experiences of psychotherapy might shed further light on how therapists act and relate in successful treatments. According to a recent qualitative meta-analysis of patients’ psychotherapy experiences (Levitt et al., 2016), the therapists’ helpful characteristics and activities include engaging patients’ curiosity in pattern identification and narrative reconstruction, being caring, understanding and accepting, safeguarding professional role and maintaining boundaries, talking explicitly about both parties’ roles and power dynamics in the therapeutic relationship, and recognizing patients’ agency. These characteristics seem much in line with how the therapists in this study describe themselves in the context of successful treatments. Further, in a previous study of the 11 most successful cases drawn from the same population of 92 young adults in individual psychotherapy (Palmstierna & Werbart, 2013), both patients and their therapists experienced the therapeutic work in a strikingly similar way: they described working actively towards joint goals, overcoming obstacles to their collaboration, explored what was painful, and that therapists actively promoted the use of new skills after termination. Conversely, in a study focusing on nonimproved patients’ experiences (Werbart et al., 2015), the patients described the therapeutic relationship as distanced and artificial. They had difficulty understanding, especially initially, the therapeutic method and the nature of the therapeutic relationship, and they wanted more therapeutic activities, structured work, concrete advice, and being challenged rather than focusing on past experiences. It seems the treatments of nonimproved patients lacked both the initial positive engagement and the challenging working through phase described by the therapist in this study.

3.1. Implications for Training and Development of Therapist Expertise

Our study indicates several factors that seem to characterize therapist expertise and can inform psychotherapy training. For example, expertise in these successful cases seemed to have involved the ability to notice and mobilize patient-specific resources, as well as work effectively with potential patient-specific obstacles, from the very beginning of treatment. This could be addressed in psychotherapy training by constructing specific case formulations that include both patient’s resources and potential hindrances, as well as providing practice in formulating interventions based on those factors. Video-based supervision may be used to develop therapists’ ability to notice how patient characteristics may influence the therapeutic process moment-by-moment.

Further, being aware and able to skillfully manage both positive and negative countertransference feelings evoked by this particular patient seems to have been central for success in our study. In particular, therapist expertise may involve the ability to use one’s own experiences of hurt, loss or disappointment to empathize with the patients and promote active therapeutic work. Also, being aware of one’s own relational needs may increase the ability to accurately assess the patients’ needs and adjust therapeutic interventions accordingly. This aspect of therapist expertise may best be addressed in supervision where the therapists’ reflection on their subjective experience and its potential impact (for better or worse) on the therapeutic process can be promoted.

The therapists in our study early conveyed a certain confidence and trust in their method and in themselves as this particular patient’s therapist (cf., Frank, 2004; Wille, 2012). They experienced themselves as “experts” with their particular patient and this confidence seemed to function as a backdrop for daring to challenge the patient and the therapeutic relationship with their interventions. Still, their self-confidence was also accompanied by a dose of suspicion, a critical examination of potential pitfalls in the therapeutic process (compare Paul Ricoeur’s “hermeneutics of suspicion”).

Additionally, the therapists in our study also appeared to appreciate being challenged as therapists and were open to learning from this particular case in order to further develop their competences. These attitudes seem close to what has previously been found to characterize “master therapists” (Jennings & Skovholt, 1999; Jennings, Sovereign, Bottorff, Mussell, & Vye, 2005; Nissen-Lie, Monsen, & Rønnestad, 2010; Skovholt & Jennings, 2004). Thus, therapist expertise may involve an ability to maintain a balance between trusting one’s method and at the same time being open to learning from each particular case.

From the therapists’ narratives, a picture emerges of successful treatment as high-risk undertaking. The therapists’ positive feelings towards the patient, recognizing oneself in the patient, and feeling particularly suited to be this particular patient’s therapist all entail potential pitfalls of therapeutic misalliance and an overinvolved therapist in collusion with a chosen “special” patient’s needs and wishes. The opposite risk is of an invading therapist persistently tracking inconsistencies, dysfunctional areas and
resistances in the patient, thus challenging the patient beyond the patient’s capacities. Novice therapists and inexperienced professionals might be especially vulnerable to such negative developments. Thus, learning how to maintain an attentive position, demonstrated by the therapists in our study, may be an essential ingredient both in psychotherapy training and in continuing education.

3.2. Implications for Research on Therapist Effects

Several of the subthemes of therapists’ experiences of effective therapeutic work are congruent with Wampold’s (2011) description of fourteen qualities and actions of effective therapists. However, there were also some unique characteristics of the patient–therapist dyad, such as feeling attraction, sympathy, and compassion for the patient, recognizing oneself in the patient, and feeling particularly suited as the patient’s therapist. This suggests an idiosyncratic dimension of the effective therapeutic work, beyond the therapist’s general characteristics and actions, a highly personal aspect of the unique relationship to the eventually improved patient, present from the very beginning.

The therapists in the present study, similarly to “master therapists” in Sullivan, Skovholt, and Jennings (2005), seem to have had an ability to balance safe and challenging aspects of the therapeutic relationship. However, this balance stands out as unique for each patient–therapist dyad. Previously, Wampold (2001) argued that effective therapists are skilled in promoting strong therapeutic alliance with several different kinds of patients. According to him, the therapist’s alliance-fostering capability is of greater importance than good patient–therapist match. In a naturalistic study, Kraus et al. (2016) showed that therapists classified as “exceptional” were significantly more likely to remain above average outcomes with future cases. Likewise, Nissen-Lie et al. (2016) suggested that therapists effective within one outcome domain were also effective within other domains as well, and they suggested that therapist effectiveness could be conceived of as a global construct. On the other hand, Silberschatz (2017) demonstrated that the extent to which the therapists were responsive to their patients’ plan for therapy was a strong predictor of treatment outcome. Thus, the question remains about not only inter-individual but also intra-individual differences in the therapists’ effectiveness (Baldwin & Imel, 2013, p. 292).

Our study indicates that in addition to studying characteristics and actions of therapists with superior outcomes compared to their peers, we also need to focus on effective therapeutic dyads. From the therapists’ point of view, the successful therapeutic work was co-constructed by the patient and the therapist, and all therapists described their work in these particular cases as in some way different from their other cases. Accordingly, five of the 14 therapists in our study also had nonimproved patients: one therapist with one deteriorated patient, one therapist with four nonimproved patients, and three with one nonimproved patient each. Four of these therapists were included in a previous study of nonimproved patients’ view of their therapists and treatments, based on the same patient population. Thus, perhaps therapist expertise is better viewed as “case dependent” rather than as a “trait” among some especially gifted therapists.

3.3. Strengths and Limitations

One asset of the present study is the focus on specific successful cases rather than therapists’ total clinical experience. Furthermore, the prospective research design rendered it possible to explore the therapists’ experiences at the outset of treatments later on classified as successful, thus not relying solely on retrospective recall. Another advantage is the use of “objective” outcome criterion in terms of reliable and clinically significant symptom reduction. However, this criterion does not take into consideration other dimensions of improvement, other outcome measures, and improvements as assessed by the therapists or as experienced by the patients. Nevertheless, the therapists in our study expressed that their patients improved in several areas beyond symptom reduction, as also described in qualitative studies of patients’ experienced changes (Binder, Holgersen, & Nielsen, 2010; Palmstierna & Werbart, 2013). On the other hand, as a consequence of the naturalistic design, we cannot claim that the observed symptom reduction was a result of psychotherapy.

The main limitation of the present study is the lack of a “window” on in-session behavior of the therapists. Furthermore, the present study is limited to young adults in psychoanalytic psychotherapy. Emerging adulthood has been described as action-oriented rather than self-reflective developmental stage of exploring future possibilities and roles in life (Arnett, 2000; Pearls, 2008; Santrock, 2009). It is possible that the therapists’ active stance, flexible frames, encouraging autonomy, and being a role model and parental figure matched their patients’ age-appropriate needs.

It may be argued that the therapist experiences of these successful treatments were driven by particular
patient characteristics. While we cannot rule out this possibility, it is notable that the patients were quite diverse in terms of their diagnostic and we found no apparent differences in background variables, initial symptom severity or proportions of diagnoses between patients with successful and unsuccessful outcomes in the YAPP project.

Still another limitation is that the patients’ narratives in these successful treatments are not included in the present study (however, presented in a previous publication; cf. Palmstierna & Werbart, 2013). Moreover, unsuccessful therapies from the same therapists are not reviewed (however, see future directions below).

3.4. Further Directions

A comparison of therapists’ experiences in successful cases with how they experience the process in cases with nonimprovement and/or deterioration may elucidate additional factors important to consider in training and supervision. Furthermore, given that successful therapeutic work in our study emerged as phenomenon within effective therapeutic dyads (rather than as features of especially gifted therapists), another move forward is to study contrasting cases of successful and unsuccessful treatments from the same therapists (ongoing), thus holding the therapist factor constant. Contrasting cases within the same therapist may be useful for identifying particular constellations of therapists’ reactions that could facilitate or obstruct the therapeutic process. Still another area for further studies would be therapists’ experiences of successful treatment in other therapeutic modalities. Are the experiences in this study specific to psychoanalytic work or do they represent common therapist experiences in successful cases across schools of therapy?

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