

Failures in Psychodynamic Psychotherapy

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This article addresses the issue of failures in psychodynamic psychotherapy. Drawing on the clinical and research literatures, and utilizing our clinical experiences, we first describe and define criteria for success and failure in treatment. We then review five factors that can lead to failure: client factors, therapist factors, technical factors, relationship factors, and environmental factors. We illustrate our presentation with a case example, and conclude by discussing ways in which the likelihood of failures in psychodynamic treatment can be lowered. © 2011 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 67:1096–1105, 2011.

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This article provides an overview of the factors that contribute to failures of psychodynamic psychotherapy. We refer to the clinical and empirical literature and rely on our combined experience of more than 75 years of practice.

The Definition of Failure

Psychodynamic psychotherapists have struggled mightily to define therapeutic failures, in large part because the definition of therapeutic success also has been elusive. Freud's early dictum that successful psychoanalysis leads to enhancement or improvements in the patient's ability to love and to work (*lieben und arbeiten*) has not been improved upon during the succeeding century of psychoanalytic theorizing and practice. This shortcoming is crucial to the central topic of our article, as we believe that psychotherapeutic failures must, at least in part, be defined contextually, in relation to what makes the experience of psychodynamic psychotherapy a success.

To complicate these matters a bit more, patients and therapists often define success differently. Most patients who seek out psychodynamic treatment do so in order to "feel better," (that is, to be less anxious, depressed, angry, or isolated), to get more out of life, to function better at work, and to improve their relationships with their partners, parents, or children. Some patients, but this seems to be an ever decreasing number in these times, come to psychotherapy with the goal of increased self-understanding.

Most contemporary psychodynamic psychotherapists would agree that symptomatic, vocational, and interpersonal improvements are necessary and desirable goals. However, psychodynamic therapists often evaluate their work by referring to such concepts and goals as "insight" and "character change." *Insight* usually is understood as increased understanding of one's psychological development and its impact on the present, and of the influence of one's unconscious mental life, including motivation, conflicts, identifications, and defenses. *Character change* refers to the lessening of ingrained patterns of intrapsychic and interpersonal responding, especially in the spheres of experiencing emotion, tolerating frustration, delaying gratification, and so on. Many dynamically oriented clinicians seem to value changes in these variables more than they care about symptom reduction or functional improvement, which they see as following what they regard as more important changes.

Because patients and therapists frequently may disagree about the definition of success in psychodynamic treatment, they also may disagree about the definition of failures in this

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approach. Patients most frequently focus on their presenting problems and goals when considering whether their experience in psychodynamic psychotherapy has been a failure. It would seem obvious then that those therapies that produce little or no change in symptoms, or which do not lead to hoped for improvement in particular relationships, career goals, or patterns of behavior (for example, procrastination, avoidance, lack of assertiveness) are in fact those therapies that the patient himself or herself would consider to be a failure. In this approach to identifying a specific treatment experience as a failure, patients in psychodynamic psychotherapy surely are found to be no different than patients in most, if not all forms of psychotherapy. It is not inaccurate to use the language of insurance companies in recalling that patients are consumers of psychotherapy, who buy (partially or fully) our services, and who have a complete right to get what they came for.

However, a psychodynamic psychotherapist might evaluate a specific treatment experience in which a great deal of symptomatic change had occurred as a failure, or conversely, might deem a therapy in which little symptom reduction took place, as a partial or even complete success. How so? We must return to those psychodynamic goals heavily emphasized by practitioners: insight and character change. Psychodynamic clinicians traditionally have considered those cases in which the patient develops little or no insight, and/or changes in these developmentally determined ways of processing experience, to be failures, regardless of the degree of symptom change or self-reported improvement and satisfaction on the part of the patient.

To understand the historical de-emphasis in symptomatic change as the primary criterion of therapeutic success or failure, we might turn to a specific example of this perspective. Levenson (1983) described a case in which the patient grew ever more competent in understanding his intrapsychic life and conflicts, and the interplay of those factors with his interpersonal difficulties. Levenson (1983) noted that he considered this case to have been quite successful, even though the treatment had little impact on the patient's symptoms. Why did this author draw this conclusion? Because the patient clearly had made changes: he was more comfortable with his emotions, more tolerant of himself and of others, and was better able to cope with and to adjust to demands in relationships. It would be difficult to argue that these are not important, hard won, and valuable gains. But, did they make the patient happy with the outcome of the treatment, as happy as the therapist? There is no mention of the patient's opinion.

To add a further complication, it is possible to conceive of a case in which the psychodynamic therapist is pleased because of the patient's increased insight and the patient is pleased because he or she now is feeling better. However, the patient's significant other thinks of the therapy as a failure because the patient's behavior has not changed. These competing views, each of which can be viewed as valid, are consistent with Strupp and Hadley's (1977) notion of a tripartite model of mental health and therapeutic outcomes.

In the last decades, with the encroachment of managed care, outcome accountability, and an emphasis on empirical validation of psychotherapy, psychodynamic psychotherapy has taken the patient's goals and concerns, especially about symptom reduction and improved functioning, into much greater account. We find this to be a welcome and desirable change. As a result, a contemporary definition of psychotherapeutic failure might include a shared emphasis on symptomatic relief and functional improvement on the one hand, and on attaining insight and modification of psychological structure on the other. In combing these criteria, we might arrive at a multilevel continuum of failure and success upon which the gains, or lack of same, could be plotted. We assume on the basis of our decades of experience, and our reading of the literature, that most cases will be less successful in certain areas than in others, and that there are relatively few cases that are complete failures or successes.

The Measurement of Failure

It is not unheard of for some psychodynamic therapists to use standardized measures, such as questionnaires or self-report psychological tests, to assess treatment progress and outcome. However, and perhaps unfortunately, such activity is typical of a minority of therapists who

work in this orientation, and probably only of those who are allied with an academic or research environment, or who work in a setting that requires more objective measures. It is particularly unfortunate because there is good evidence (Lambert, 2007) that the use of formal outcome measurements can enhance therapeutic outcome.

It is more common, though rarely the primary source of information about progress or failure of a case, for the therapist (with appropriate permission) to solicit information from significant others in the patient's life. Psychodynamic therapists who work with children and adolescents typically are in frequent contact with parents, teachers, and other professionals who are caring for or treating the patient. This type of collateral contact is less frequent in the treatment of adults, though it is by no means unheard of, especially if the patient is seeing a psychiatrist for medication, another clinician for another modality of psychotherapy (couples, family, group), or a physician for medical treatment.

More frequently, especially in private practice, to assess the possibility of failure in any case, psychodynamic psychotherapy relies almost exclusively on two methods and perspectives. The first is the patient's experience of his or her improvement or lack of same and his or her verbal report of this status; the second is the therapist's understanding of the patient's reporting, and his or her observations and experience of the patient within the context of the therapeutic interaction.

Unfortunately, exclusive reliance on self-observation and self-report by the patient may be an inefficient and unreliable method for assessing psychotherapy. Ironically, it runs counter to a basic premise of psychoanalysis, which argues that conscious knowledge about one's psychological functioning and experience is shaped, limited and distorted by a multitude of psychodynamic and interpersonal factors. Although we always attempt to honor the notion that the patient knows more about his or her experience and life than we do, we cannot ignore the limitations of self-report. So, how do we evaluate the accuracy of the patient's report about symptomatic change? Any experienced psychoanalytic therapist can, if prompted, recall cases in which a transference need to please the therapist, or a need to rebel against the therapist, or some other motivational conflict, pushed a patient to exaggerate or diminish his or her awareness of change in some symptoms or problems.

The therapist attempts to address this issue by comparing his or her observations of, and insights about, the patient with the patient's own reports. The level of congruence between the patient's report and the therapist's in-session experience of the patient is taken to indicate the validity and reliability of the former. More noticeable discrepancies between patient report and therapist perspective are taken to indicate that the patient's evaluation of improvement might be open to question. For example, a patient may report that his anxiety and depression have improved significantly. However, the therapist does not hear in the patient's descriptions of his activities any changes in mood, greater freedom from avoidance, or any other signs of these improvements. Furthermore, the patient interacts with the therapist in the same uncomfortable and unhappy way as at the start of treatment. From these data, the therapist might begin to speculate about reasons, transference and otherwise, that might lead the patient to report progress where none might really be found. Is the patient afraid of being seen as a failure? Is he afraid of the therapist's criticism, or of wounding the therapist? Only after these various sources of data are reviewed, including also the therapist's own needs to avoid the perception of failure (facilitated by ongoing examination of the therapist's own psychodynamics and countertransference) can the therapist come to some reasonable and reliable conclusion about the state of the therapy. In such instances where the patient, for whatever reason, chooses to embellish the success of treatment, formal outcome measurement also would be embellished and of little value.

The Variables Implicated in Failure

There are five sets of variables that may lead to the failure of psychodynamic psychotherapy. However, these variables often are not orthogonal: they shape and influence each other, and probably can be separated completely only on paper, within the abstract task of thinking and writing about psychotherapy.

We refer here to client variables, therapist variables, relationship variables, technical variables, and third-party variables. Client variables refer to transient and permanent qualities and characteristics of the patient that prevent the patient from succeeding in the treatment. There seems to be a cluster of personality traits and psychological problems that are linked to limited progress in psychodynamic psychotherapy (Binder, 2003): severity and chronicity of psychopathology, especially psychosis, personality disorders, and problems of impulse control; a lack of psychological mindedness (the ability to conceptualize one's problems in psychological terms and to observe one's own psychological processes); an externalizing orientation in which the patient attributes his or her problems to others and/or to external variables; and a need and wish for high levels of structure and direction. Patients coming to psychodynamic therapy with more of these characteristics, and greater degrees of these characteristics, are more likely to experience failure. This is because the treatment is based on assumptions that are contradictory to the patient's view of his or her problems, and therefore will be more rigorous and anxiety-producing than would be optimal for the patient.

There are other client variables that may lead to failure even if the person is healthier and more psychologically attuned. Those individuals beginning treatment with unrealistic goals about what can be accomplished, or about the ways in which their goals, realistic or not, can be achieved, are likely to find the therapy to be a failure, and to have the therapist agree in this evaluation. For example, a patient once consulted one of us (JG) and complained of acute loneliness and social isolation. She seemed to be suffering from a great deal of social anxiety, which she could trace to difficulties in her family of origin. She was a sophisticated person who seemed capable of the self-exploration necessary for success in psychodynamic psychotherapy. Yet after a few sessions, during which she was clearly irritated by any attempt to draw her out or to engage her in psychological exploration, she announced that she was leaving therapy, because, "I came here hoping that this would help me find someone to marry, and all this talk about my past and my feelings won't get me there." This example also points out how difficult it is to separate client variables from therapist, technical, and alliance variables. Had the therapist been more skilled in identifying this patient's goal, perhaps a different form of therapy could have been recommended, or some education about the process of psychotherapy could have been provided. Either might have prevented this mutually unsatisfying and abortive attempt at psychodynamic psychotherapy from taking its toll on both parties.

Therapist factors that contribute to an increased probability of failure in psychodynamic psychotherapy include attitudes and behavior on the therapist's part, and the therapist's difficulties in conducting psychodynamic psychotherapy in as competent as way as is necessary. Strupp, Hadley, and Gomes-Schwartz (1977) were among the first psychodynamic scholars to investigate empirically the therapist's contribution to psychotherapeutic failures and to worsening of the patient's condition. They found that failure was connected to the therapist's violation of the "commitment package": the expectation and perception on the part of the patient that the therapist was interested, caring, competent, and concerned with the patient's well-being and improvement. These authors noted that the patient's perception of the therapist as fulfilling the commitment package was more important than the validity or reality of these perceptions: As long as the therapist did not disabuse the patient of the accuracy of this view, the chances of therapeutic success remained high.

How would a therapist violate the commitment package? Essentially, by behaving badly, perhaps in ways similar to the stereotyped portrayals of therapists on television, in the movies, and now on the Internet. Overt displays of boredom, irritation, a lack of empathy, rudeness, and demonstration of self-interested or self-indulgent behavior all can have powerful detrimental effects on the patient and his or her view of the therapist. Such experiences are likely to worsen the patient's already shaky sense of self-worth, increase his or her feelings of hopelessness and helplessness, and therefore worsen symptoms of anxiety, depression, and other psychological problems. The therapist who fails to live up to the perception of commitment and caring that is expected and needed by the patient probably confirms and reinforces conscious and unconscious self and object representations that are negative, hostile, rejecting, or abandoning, and are at the core of the patient's psychopathology. It is easy to

understand how failure is the most likely, if not the only, outcome that could result from these therapist attitudes and behavior.

Research in the years that followed (Binder, 2003) clarified the potential negative impact of therapist attitudes and actions. In particular, it has been demonstrated repeatedly that the expression of hostile emotions and attitudes by the therapist toward the patient is the single most important therapist factor contributing to failures in psychodynamic psychotherapy. Again, this most probably is because these expressions of anger and hostility duplicate and re-enact central developmental, interpersonal experiences that contributed to the patient's current problems, thus confirming in the patient's mind the negative, hopeless, and self-hating images and ideas that prompted him or her to seek therapy in the first place. After all, if you think poorly of yourself, and your therapist, of all people, seems to think poorly of you as well, then how can you not leave treatment believing that this is an accurate and fair way to approach yourself?

As an example of these points, consider the case of a young woman who sought out therapy after being in treatment with another clinician for some time. In the initial assessment sessions, it became clear that this patient was suffering from a great deal of anxiety about physical illness and death, though she was in good health according to her physician. During subsequent sessions, she often would fade into long and uncomfortable silences, and seemed to be on the verge of speaking, but at the same time clearly was reluctant to tell what was on her mind. Finally, after much supportive questioning, she revealed that her previous therapist had labeled her worries about her health as "hypochondria," and that he had told her that this was a self-indulgent and unattractive approach to life. It is possible that the patient had misinterpreted what the therapist had meant or said. However, even if was a misperception, something in the therapist's words and actions conveyed disapproval and hostility to this patient, resulting in a violation of the commitment package, a rupture in the therapeutic alliance (to be discussed below as another source of failure), and the patient becoming more despairing, hopeless, and self-critical.

The ability to conform to and to promote the commitment package may be a partial psychodynamic analogue to the Rogerian dictum that empathy, genuineness, and positive regard are necessary conditions for psychotherapeutic success (Rogers, 1957). The commitment package may well be a necessary condition, but it is sufficient only when combined with technical competence, which is not an easy thing to achieve in psychodynamic psychotherapy.

Recent research on effective psychodynamic psychotherapy has identified three critical types of therapist competence: the ability to develop an accurate case formulation; the ability to establish and to maintain focus on core problems that are derived from that formulation; and the ability to quickly establish and maintain a therapeutic alliance to repair ruptures in that alliance when they occur (Summers & Barber, 2009).

Case formulation is the end process of the therapist's evaluation of the patient's presenting problems, history, current psychodynamic and interpersonal functioning, and level and type of psychopathology. It may or may not include an official diagnosis, but it serves the purpose of accurate and effective diagnosis: It identifies the most important issues and weaknesses to be addressed in the therapy, the patient's strengths, and the specific change factors that could be most effective for this particular patient. Most contemporary versions of psychoanalytic theory have embraced the concept that there is no "one size fits all" approach that will meet the clinical needs of each patient (Gold, 2010). For example, most psychodynamic clinicians have accepted that some patients are best understood as suffering from neurotic conflicts that can be addressed through exploration and interpretation, while other patients, especially those with a history of developmental trauma and attachment difficulty, probably need a more supportive, interactive approach through which corrective interpersonal emotional experiences can be internalized.

Many failures in psychodynamic psychotherapy thus can be traced to failures in the case formulation process. The therapist who does not understand the patient cannot provide effective therapy and, to refer back to our earlier discussion, will probably violate the patient's perception of therapeutic commitment, as there will be a mismatch between what is needed

and what is happening. We have observed this process repeatedly in our supervision of graduate students and of psychoanalytic candidates, particularly in their treatment of patients who suffer from severe narcissism. These patients are very vulnerable and often experience the therapist's questions, comments, and interpretations as attacks, put-downs, or as failures of empathy. Those therapists who did not include the patient's narcissism as a central concern in their conceptualization of the case, or who did not understand how to modify their approach based on these personality patterns, were most likely to become frustrated and angry, and then fail.

Many failures in psychodynamic psychotherapy can be traced to the therapist's failure to establish a central therapeutic focus, or to maintain that focus as the primary sphere of work as the treatment progresses. This is particularly disruptive in short-term psychodynamic therapy. There are several reasons for this. First, if the therapist has not developed an accurate and workable case conceptualization during the assessment, then it will be difficult, if not impossible, to identify the crucial issues that should be targeted for ongoing intervention. Second, many therapists continue to rely on the concept of free association as essential to the conduct of psychodynamic treatment, and therefore are loathe to decide that some areas of discussion are more important clinically than are others. Finally, despite the extensive literature supporting the necessity of keeping treatment focused in a disciplined way, many therapists have not been trained to think in this way.

It is also the case that an inflexible approach to therapy and to therapeutic protocols can contribute to failure. Research on adherence to psychodynamic treatment manuals suggests that rigid adherence can be as unproductive as a seat-of-your-pants approach, probably because such inflexibility interferes with the therapist's ability to adapt and to improvise in unexpected clinical situations (Binder, 2003).

The final therapist variable that we mentioned as a significant contributor to failures is the therapist's ability to monitor and manage the therapeutic interaction in such a way that alliance ruptures are anticipated, limited, and repaired when they occur. Additionally, the extent of the therapist's ability to recognize and to resolve enactments (the repetition within psychotherapy of problematic relationship patterns that are typical of those from the patient's past and current relationships) can be crucial in determining success. By definition, the therapy alliance and enactments are interactional in nature, and will be discussed as such below. At the same time, management and effective resolution of these clearly are the therapist's technical responsibility.

Any personal or professional difficulty on the therapist's part that interferes with these tasks can contribute significantly to the chances of failure. For example, the repair of an alliance rupture usually requires acknowledgment by the therapist of his or her contribution to that rupture, possibly in the form of insensitivity, a failure of empathy, a lack of tact, or a related lapse. Should the therapist be invested in not seeing or knowing about these miscues, it is unlikely that repair can take place.

One problem that frequently may lead to blindness about one's negative contribution to the therapeutic process is burnout. This work is demanding and often emotionally draining, as we listen to the pain and suffering of our patients. Sometimes, the demands of the work are too great for even the most dedicated of therapists. Hostile, rejecting attitudes and actions, or rote indifferent practice can be two results of burnout.

Difficulties in the therapeutic relationship are a central, if not the primary source, of failure in psychodynamic psychotherapy. Research consistently has shown that early establishment of a positive therapeutic alliance (perhaps by the third to fifth session) is highly predictive of successful outcome (Horvath et al., 2011; Safran & Muran, 2000). Additionally, both research and clinical experience teaches us that management and maintenance of a good alliance is crucial for success.

It should be noted that a therapeutic alliance comprises three factors (Borden, 1994): agreement about the goals of treatment; agreement about the techniques to be used to achieve these goals; and a strong bond between the patient and the therapist. We already have discussed the first two of these, and now will turn to the bond.

When we refer to the bond in the alliance, we actually are referring to an interactional, meta-factor. The alliance is determined by the attitudes, actions, and qualities of the two

participants involved in the treatment process, although recent research demonstrates that the therapist plays the major role in determining its quality across a variety of patients (Baldwin, Wampold, & Imel, 2007). It is the therapist's job to monitor and to intervene in alliance problems when they occur. If, as we have noted, there is a lack of mutual understanding about the roles that each party plays in the process and conduct of treatment, then a workable alliance is less likely to develop or to remain stable. The same limitations exist when there is a lack of, or confusion about, mutual and attainable goals for the treatment.

Certain patients come to therapy better equipped to establish workable alliances. Others, usually those persons with histories of early loss, interpersonal trauma, or disturbed attachment, have a far more difficult time in establishing the bond that serves as the interpersonal and emotion glue of the alliance (Borden, 1994). Some therapists are more flexible and better attuned to these differences in various patient's abilities to attach, and therefore more likely to be successful in working with more fragile and more easily disrupted alliances. Defensiveness, and especially defensive criticism or hostility directed at the patient when an alliance disruption has occurred, are certain contributions to potential therapeutic failures.

Some failures in psychodynamic psychotherapy can be traced to the influence of third parties. We refer here to the patient's spouse, parents, children, and friends, who may have a vested interest in the patient's problems and vulnerabilities, and who therefore are threatened by the patient's engagement in psychotherapy and seek to restore the status quo. These "neurotic accomplices" (Wachtel, 2008) often respond critically or punitively to the patient's efforts at change, resulting in powerful sabotage of the treatment. In certain extreme cases, these third parties may send a "it's me or the therapist" message to the patient. Those patients, and understandably there are many, who feel that they cannot afford to lose important relationships end up compromising their progress in therapy, or quitting therapy, to protect their attachments to these individuals.

A Case Illustration

In presenting a clinical example, we will not attempt to describe the entire process of the psychotherapy, but instead we will look at each of the five contributing factors identified above and discuss the impact of each.

Ms. K was a divorced woman in her forties who came to psychodynamic psychotherapy reporting chronic experiences of anxiety, depression, and loneliness. She had been in therapy several times in the past, and recalled that each episode had been somewhat helpful, but ultimately disappointing in producing her desired goals of complete alleviation of anxiety and depression.

Although Ms. K's goal of symptom reduction did not seem unreasonable at the outset, there existed a number of unspoken and unaddressed hopes connected to this goal. These latent dynamics can be seen now as important client factors that contributed to the failure of the treatment. Ms. K wanted therapy to work the way a pill is supposed to work: by ingesting what the therapist had to say, and by simply experiencing each therapy session without recognizing or accepting the need for active learning and participation on her part. A typical session began with the statement, "This is what has been bothering me this week," followed usually with a detailed description of the ways in which her job, her relationship with her son, or her date with the latest man in her life had failed to live up to her expectations. She did not seem to see or to take any responsibility for these disappointments, but focused almost exclusively on the ways she had been cheated, misled, and deserved better. About midway into most sessions, she would complete her report, and wait expectantly for the therapist to respond. She found any attempt to explore the repetitive nature of the sessions to be frustrating and hurtful, and usually would return to the same material after any intervention by the therapist, almost as if nothing had taken place.

In retrospect, psychodynamic psychotherapy was not the treatment of choice for this patient, though she had been in treatment with therapists of other orientations (including humanistic and cognitive-behavioral) with little difference. Her passivity,

externalizing focus, and inability to observe and understand her participation in the therapy all contributed to its failure.

The two most important therapist factors implicated in this case were an incomplete, inaccurate case formulation that led to a poor choice of a therapeutic focus, and episodes of irritation and hostility on the part of the therapist that badly affected the alliance and that repeated hurtful experiences from the patient's past. The case formulation was based on a conceptualization of the psychodynamic meaning and organization that gave rise to the patient's symptoms; although accurate, it was limited and incomplete. The formulation did not include an emphasis on the patient's narcissistic wounds, including her difficulties in regulating her self-esteem, her vulnerability to narcissistic injury, her entitlement, and her poor capacity for attachment.

Had these patterns been identified, perhaps they would have been the focus of the treatment. If so, the therapist might have worked in a more supportive, empathic way. More importantly, this formulation might have helped the therapist to identify the sources of his anger and irritation, and better enable him to fit within the specific "commitment package" that this patient needed. Instead, these negative feelings were expressed in indirect but important ways, leading to an enactment of central developmental experiences that had injured the patient significantly as a child.

In the discussion above, we have touched on the crucial technical factors that led to failure. This case would have probably been best handled by working at the supportive pole of the supportive-expressive continuum of psychodynamic psychotherapy (Summers & Barber, 2009), wherein the key change mechanism would have been corrective or reparative experience, rather than with an approach that relied more heavily on insight and interpretation. Additionally, the therapist failed to understand his emotional reactions as signals of an inaccurate formulation or as being caught in a potential enactment. He did not make use of consultations with colleagues, thus remaining mired in this negative process.

In examining the role of the alliance in the failure of this treatment, we conclude that an effective and stable alliance never was established. There was only a superficial and faulty agreement as to the goals of psychotherapy, and the techniques, as mentioned, were neither agreed upon nor suitable for Ms. K. In addition, because of the myriad client, therapist, and technical factors, a working bond was not established. Ms. K's troubled developmental and attachment history and her narcissistic approach to interpersonal relationships made it difficult, if not impossible, to experience the therapist as a complete and separate person with whom she could establish such a bond. Instead, she seemed to view the therapist as potentially serving some reparative functions, a task at which he continually failed. In his turn, by assuming that Ms. K was capable of a more mature relationship and alliance, which would support a more insight-oriented, interpretative approach, the therapist created an interactional situation that was damaging to the patient's already fragile sense of self. As frustration, irritation, and anger became shared experiences for both parties, any chance of correction and establishment of a useful alliance melted away completely.

Neurotic accomplices did not play a major role in this treatment, probably for two reasons. First, Ms. K had few significant relationships that could be threatened by her individual progress. Second, as should be obvious from the preceding descriptions, there was little chance that any observable progress would be made that could be sabotaged by any third party.

Unfortunately, this last statement was accurate. After about 8 months of weekly, uncomfortable sessions, Ms. K ended her treatment. There is, however, a happy ending to this story, one that in certain important ways allowed the therapist to test many of the ideas about failure described in this article.

About 2 years after this therapy ended, the patient returned. In an interesting parallel to Kohut's (1979) "The Two Analyses of Mr. Z" article, in which he described how a second analysis of a narcissistic patient was successful when conducted according to the principles of Self Psychology, the therapist used a revised formulation that put her narcissistic vulnerabilities and attachment problems at its center. This led to a more workable therapeutic situation in which more supportive and empathic understanding led to the necessary corrective experiences for significant improvement to take place.

Strategies to Prevent Failure

What can be done to reduce the likelihood of failure in psychodynamic psychotherapy? Herein we will discuss briefly some strategies we have found to be helpful, and those we have had recommended to us.

Perhaps the most obvious answer would be for therapists to keep in mind the factors addressed in this article, and to make use of them during all phases of assessment and treatment. This would begin with patient selection and end with termination of therapy. Just as the baseball players with the highest batting averages usually have the best eye for selecting hittable pitches, probably those therapists with the best success rates are most discriminating in matching psychodynamic therapy to those patients who are most likely to benefit from it. Although not a psychodynamic clinician, Beutler et al. (2005), on the basis of extensive research, has shown that patients who are high on reactance and internalization are most responsive to exploratory techniques in psychotherapy.

The necessity for an accurate, consensually determined set of goals and a case formation that identifies those psychodynamic issues that will, if addressed, allow those goals to be reached cannot be overemphasized. When the patient and the therapist are working in harmony, the chances of quickly establishing a positive and stable alliance are maximized, as is the likelihood of repairing alliance strains, should they occur (Safran & Muran, 2000).

The practice of psychodynamic psychotherapy is a difficult, often isolated task. It also is a demanding occupation, one in which the necessity for observation and scrutiny of one's experiences, emotions, motivations, and action is uniquely high and ongoing. Once the therapist has completed his or her training, he or she may never take the time or make the effort to review his or her work with colleagues or consultants. This personal and professional isolation is an extraordinary breeding ground for the development and maintenance of poor habits of practice and of personal blind spots. Therefore, a preventative for this pernicious isolation is ongoing involvement with other psychodynamic clinicians and with trusted peers of other orientations, who may provide a needed alternative perspective. This can take the form of workshops, seminars, peer supervision, and supervision or consultation with more senior colleagues. These opportunities to review one's work and to learn from the work of other therapists can keep the therapist focused, alert, and involved. Personal therapy or psychoanalysis for the therapist also often is an invaluable resource in dealing with the stresses and strains of clinical work, especially when the therapist becomes aware of emotional difficulties and countertransference reactions that are interfering with effective treatment.

When considering ways to lessen the damaging impact of third parties, or neurotic accomplices, on the outcome of psychotherapy, the therapist first must confront his or her assumption that psychotherapy always is a good for all involved. Many couples and family therapists have pointed out how disruptive individual treatment can be for the larger system (Heitler, 2001). What can be done to reduce the impact of neurotic accomplices on the patient and the effects of the therapy on the patient's significant others? Effective interventions include education of the patient and his or her family about psychotherapy and its likely outcome, referrals for individual, couples, or family therapy, and working with the patient to find ways to cope with and limit hostile, negative input from family members or friends as the patient changes.

In these ways, the extent and magnitude of failure can be reduced, although it is unlikely that it ever can be totally eliminated.

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