Psychodynamic Practice: Individuals, Groups and Organisations

'Formal' feedback in psychotherapy as psychoanalytic technique

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'Formal' feedback in psychotherapy as psychoanalytic technique

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Introduction

I did a PhD in the 1990s on what people referred for psychodynamic psychotherapy thought about disclosing their emotions to others. I found an almost universal pattern of 'habitual non-disclosure' on the part of my interviewees and went on to develop a taxonomy of the reasons people gave for keeping their own counsel. This included, unsurprisingly, a fear of being labelled or judged by others, and 'signal' emotions such as shame and guilt (Macdonald & Morley, 2001). It struck me at the time that, even if people did not feel they could share their emotions, they were able to talk fluently about their reasons for holding back. Looking back later, when I was a trainee psychotherapist, it seemed that, without knowing David Malan's work, I had stumbled across an element of his 'triangle of conflict' in the lives of the people who shared their experiences with me (Malan, 2001). The participants in my study were eloquently describing the 'anxiety pole' – the inhibitions, internalised from attachment relationships, which kept their underlying feelings out of bounds. It felt like rich therapeutic territory, and in my subsequent clinical career I have never regretted the years I spent listening carefully as people told me why they did not wish to talk.

This step from silence to the disclosure of the reasons for keeping silent, from aloneness to relevant communication about feelings, seems to me to reflect one of the most precious strands in the psychodynamic tradition. We could, perhaps, call it the 'radical acceptance of people's emotional experiences'. It involves a therapeutic stance and set of practices that facilitate the client's efforts to move out of emotional isolation and to tell and make sense of their unique story in an empathic therapeutic relationship.

Warning: therapeutic 'truth' can seriously damage your client's health

Freud famously experimented with hypnosis and then free association as means of helping patients speak about the unsayable traumas in their lives (Breuer &

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Freud, 1895/2004). However, this open and receptive orientation to patients' experience has often been lost in the psychoanalytic tradition as Freud and his followers sought to assert the objective 'truth' of psychoanalytic insights and downplayed the less formal, relational qualities which characterised Freud's own clinical work (Wachtel, 2008). Many former psychoanalytic patients have written in a balanced and reflective way about the harm they feel they endured at the hands of therapists who appear to have deployed psychoanalytic concepts or language in ways which pathologised, blamed or demeaned them (e.g. Bates, 2005; Sands, 2000; Sutherland, 1998). Here is a particularly lurid example from the psychologist Stuart Sutherland's autobiographical book 'Breakdown':

> He [the therapist] said: 'It seems you have missed out on all the best things in life'… At one stage he diagnosed me as a repressed homosexual, and in the course of my telling him some incident from my childhood, he leant forward and said […] 'Did you not feel then as though you wanted your father to fuck you until the shit ran out?' (location 535, kindle edition)

Meares and Hobson (1977) have outlined how psychotherapists can become 'persecutory' and Wile (1984) provides a close examination of published case studies by two influential psychoanalytic theorists, Kernberg and Kohut, in which he suggests that many manifestations of what is described as the patient's psychopathology can be seen as understandable reactions on the patient's part to therapist comments which appear persecutory, rejecting or blaming. In these cases, the therapist may actually express the kind of hostile judgements which the participants in my PhD were afraid would result from an open disclosure of their feelings.

 One of my psychodynamic heroes, Hans Strupp, a pioneer in the empirical study of brief psychodynamic therapy and one of the founders of the field of psychotherapy research, left us with a number of rich studies of the interplay of hostility between client and therapist. In brief, Strupp and his colleagues (1980) found evidence that even very subtle negative or blaming comments on the part of the therapist appeared to have a negative impact on the outcome of brief psychodynamic psychotherapy. These were typically comments that could be seen as both supportive and somewhat blaming. Strupp and his colleagues' work adds empirical weight to the theoretical insights of writers such as Meares and Hobson, Wile and Wachtel who caution against what might be called the 'pejorative tendency' in psychoanalytic practice.

 I was so intrigued by Strupp's work that I went on to do a study of my own using the same coding system (Macdonald, 2001; Macdonald, Cartwright, & Brown, 2007). I will share with you some examples from my study of subtly hostile therapist comments. They could all be construed as friendly or supportive comments, but in the context in which they appeared, and the tone of voice they were uttered, they were all given 'complex' codes, meaning that

the interpersonal message contained both friendly *and* hostile or controlling elements. They occurred in the course of an initial interview in an alcohol treatment clinic with an unemployed man who came across as quite sullen, distrustful, and very despairing:

> Therapist: 'I mean I don't think you've asked the right questions.' (Here the therapist implicitly criticises the client's construal of the problem)

> Therapist: 'Because she [the client's mother] had something to worry about with you! [Therapist laughs].' (The therapist appears to 'side' with the client's mother in making a joke at the client's expense)

> Therapist: 'What can you do? You're not writing yourself off!' (This is one of a number of comments in which the therapist appears to dismiss the client's repeated attempts to convey the depth of the despair he is in)

Detailed qualitative and quantitative analysis of the interview in which these comments occurred (Macdonald, 2001) suggested that these comments were part of a subtle enactment of a problematic interpersonal pattern of the client's in the therapeutic relationship. Elements of distancing and dismissiveness in the client's way of communicating seemed to pull a somewhat cajoling, controlling, distancing response in the therapist, in a way that seemed to conform to the client's recurring narrative of being dismissed by others when seeking help. Interpersonal dynamics of this kind may go some way towards explaining why this client did not, in the end, engage in treatment following this interview.

Strupp and his colleagues' work in this tradition suggests, in their words, that whilst the '*absence* of a negative interpersonal process may not be sufficient for therapeutic change, the *presence* of even relatively low levels of negative therapist behaviour may be sufficient to prevent change' (Henry, Schacht, & Strupp, 1990, p. 773). A psychodynamic therapist himself, Strupp acknowledged how easy it is for therapists to get drawn into such behaviour. As he put it, 'the plain fact is that any therapist – indeed any human being – cannot remain immune from negative reactions to the suppressed and repressed rage regularly encountered in patients with moderate to severe disturbances' (Strupp, 1980, p. 953).

A further aspect of the Vanderbilt studies is that Strupp's team trained therapists in techniques designed to enable them to recognise transference patterns, formulate in advance how they might get drawn into transference enactments and use this knowledge to further the therapy. Unfortunately, this rare empirical study of psychotherapy training failed to demonstrate improved performance following training. There was even some evidence that some therapists – those who had a tendency to be more self-blaming – became *more* hostile towards their clients after the training. These therapists appeared to put fidelity to the

model above the relationship with the client (Henry, Schacht et al., 1993; Henry, Strupp et al., 1993). Perhaps, this shows how easy it is for us to develop problematic attachments to our theoretical model, privileging our theoretical 'knowledge' and loyalty to our psychoanalytic 'parents', above the relationship with our (relatively lower status?) clients. Incidentally, this study's failure to show any benefit of training is consistent with the wider literature on training in psychological therapy, which shows little impact of either therapist experience or level of training on client outcomes (Atkins & Christensen, 2001; Beutler et al., 2004).

Strupp's work adds a psychodynamic texture to our understanding of the therapeutic relationship. The art of therapy requires us to maintain an empathic, valuing stance even when this is extraordinarily difficult due to the 'pull' of the client's hostility. Some recent research by one of Strupp's former students, Tim Anderson, suggests that such 'faciliative interpersonal skills' account for 'therapist effects', the tendency of therapists to differ from one another in their degree of clinical effectiveness (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009). If we are going to do our best as therapists we need to do everything we can to maintain an accepting stance towards our clients. Indeed, we should seek every means to identify and repair the inevitable 'ruptures' this relationship will be subjected to.

In the next section, we will go on to look at a further problem faced by therapists – the difficulty of predicting client outcomes. We will then consider 'formal feedback' as a promising technique for minimising both the problem of maintaining a faciliative stance in the heat of the therapeutic relationship, *and* the problems we will now discuss relating to our awareness of client progress.

Limitations of the therapist as expert

In the 1950s, psychologist and psychoanalyst, Paul Meehl, started a debate, which was perceived by many as an attack on the clinical professions. Meehl published a series of studies demonstrating that simple mathematical algorithms, based on limited data, tended to outperform clinical predictions, even when these clinical opinions were based on detailed interviews (Grove & Meehl, 1996). More recent research suggests that, consistent with Meehl's findings, and rather counter-intuitively, psychotherapists have great difficulty in predicting which of their clients is at risk of treatment failure. Hannan et al. (2005) asked both trainee and qualified therapists (of varied theoretical orientations) to predict which of their clients (550 of them in all) was likely to suffer deterioration of their symptoms. There was only one correct prediction, although a total of 40 clients actually deteriorated. A computer algorithm, derived from a large database of psychotherapy cases with symptom measures at every session, was much more accurate. The algorithm predicted 36 of the 40 who deteriorated. Contrary to expectations, in this study, the 22 experienced clinicians were no

better in their predictions than 26 trainees who also took part. The only correct prediction was, as it happened, made by a trainee. A more recent study by Chapman et al. (2012) echoes these findings: group therapists were unable to predict outcomes of group members and failed to predict any of the 10 cases (out of a total of 64) who reliably deteriorated.

Another way of looking at this issue is to examine clinicians' clinical notes to see whether therapists appear to be aware of symptom deterioration (assessed independently using a questionnaire). Hatfield, McCullough, Frantz, and Kreiger (2010) looked at clinicians' clinical notes in cases where questionnaire scores showed significant deterioration in the client's symptoms compared with the previous session (the questionnaire scores were not fed back to the therapist). They found that the deterioration was only referred to 21% of the time in the therapist's notes. When they looked at a subgroup where there was massive self-reported client deterioration, they found that in a full 70% of cases, there was no mention of this in the clinical notes.

Perhaps, the judgements of these therapists were skewed by 'positivity bias' – people's tendency to seek a positive image of themselves 'with such vigour that reality is at times selectively interpreted and at other times ignored' (Mezulis, Abramson, Hyde, & Hankin, 2004, p. 711). A large body of the literature in social psychology illustrates the ubiquity of such biases (Mezulis et al., 2004). This may seem unsurprising given what we know about defences against painful awareness. But how carefully do we consider the impact of our own biases once we have qualified? Studies show that therapists' assessment of their own performance is unlikely to be reliable, reflecting what is referred to in social psychology as an 'above average effect'. In a study of therapists' self-perceptions, not a single one of the 129 therapists who took part saw their performance as 'below average' compared with their peers, and 50% saw themselves as performing in the top 10%. Furthermore, nearly half (47%) of these therapists did not think that any of their clients deteriorated in therapy, and those who did accept this possibility estimated a much smaller proportion than has generally been observed in the research literature (Walfish, McAlister, O'Donnell, & Lambert, 2009, described and cited in Lambert, 2010). Dew and Reimer (2003, described in Saptya, Riemer, & Bickman, 2005) carried out a separate study which also highlighted the 'above average' effect in therapists' self-assessments.

Of course, judging ones' performance against peers as a psychotherapist is difficult. We work behind closed doors, we rarely actually see one another at work, rarely meet each other's clients (unless they are seeking help after an unsuccessful therapy) and rarely get unbiased feedback on the impact of our work. Knowing exactly how well a client is doing outside their sessions with us is difficult. Clients cannot tell us everything that might be relevant in the short time they spend with us. They make judgements as to what to reveal and what to conceal in therapy (Regan & Hill, 1992) and their mental states are of course opaque to us (Fonagy, Gergeley, Jurist, & Target, 2003). In the final

part of the article, we will look at an innovative clinical technique that can be used as a corrective tool for both of the clinical difficulties we have reviewed so far – the difficulty of sustaining a radical acceptance of the client's subjectivity, and the difficulty of really knowing how the client is doing. This technique continues the tradition of creative experimentation associated with Freud's early discoveries in psychoanalysis. Only, in this case, the pioneers have already documented the impact of their experiments in an impressive series of research trials.

Formal feedback as a therapeutic technique

The chances are that if anyone has persuaded you to 'measure' your therapeutic work by using an outcome questionnaire at the beginning and end of each therapy, they told you to do this as a way of proving your worth to remote potentates, such as 'commissioners' or senior managers. That was certainly the case with me. Outcome measurement had a similar status to oral hygiene – its necessary, I'm willing to do it, but I'm not likely to write home about brushing my teeth! However, the status of outcomes monitoring looks set to change. Over the last 15 years, therapist and researcher, Mike Lambert, has pioneered the use of outcomes measures as a means of helping therapists reach more of their clients, leading more of them to a positive outcome. He does this by using questionnaires as a source of feedback to the therapist on their clients' progress – in effect using formal questionnaires to reflect an image to the therapist of client realities that may not otherwise come into view. As Lambert views it, the purpose is to alert the therapist as soon as possible to indications that therapy may not be going according to plan. Lambert has found that (a) alerting the therapist when the client's scores indicate that there is an increased risk of poor outcome combined with (b) giving the therapist a structured 'support tool' to help identify problems (such as client ambivalence) which might get in the way of progress, resulted in a more than 50% reduction of 'off-track' cases who deteriorated, and around a 50% increase in 'off-track' cases who went on to significantly improve or recover (Lambert, 2010; Lambert & Shimokawa, 2011). In other words, for people who are at risk of a poor outcome in psychotherapy, formal feedback tools appear to make a significant difference. It is as if the 'feedback' acts as a kind of safety net enabling therapist and client to 'recover' the therapy when it has got off to a poor start, or progress has stalled.

The feedback systems that have been most studied to date have two properties in common. First, they include a sessional check-in with the client's problems involving the use of an outcome measure. This is used to create a space for reflection on the client's progress in therapy. What sense does the client make of the items and the scores? How does the client link the problems they are experiencing with the work they are doing in the therapy? How do they understand any changes that are reflected in the measure? Secondly, each

system includes a way of systematically checking out the client's perspective on the 'process' in therapy. This is a key component of Lambert's Clinical Support Tool, which, if you remember, is used when the client is considered to be at enhanced risk of treatment failure. Another system that has been shown to make a difference, devised by Scott Miller, Barry Duncan and their colleagues, uses an alliance measure at the end of *every* session. This systematically prompts client and therapist to reflect on their agreement about the tasks and goals of each session, as well as their level of attunement (Miller, Duncan, Sorrell, & Brown, 2005; see also Duncan, 2010). These process measures function as a safety net primed to catch misunderstandings and other problems in the therapeutic relationship before either party disinvests in the therapy.

A psychoanalytic technique?

Lambert's feedback technique is practical, empirical and essentially atheoretical. It is certainly not bound to any model of therapy and it capitalises on (though is not necessarily bound to) advances in IT that make the processing and display of information easy and accessible.

Why, then, claim it as a psychoanalytic technique?

Firstly, feedback brings more of the client into the therapist's view. Like free association, it helps client and therapist to bypass some of the barriers to frank and open-ended communication about the client's suffering, and how the therapeutic conversation relates to that suffering. We have long been used to legitimising commentary on our clients' doubts about therapy, or their resistance, through discussion of the client's latent communications in dreams, fantasies or behaviour. However, here, we go one step further and institutionalise an expectation that, in every session, clients practice articulating their honest perspective on the distress in their lives and what is happening in therapy. We are, in effect, creating a ritual where this commentary is 'normalised'. Such explicit permission to reflect openly in the context of an attachment relationship can frequently form the basis of a corrective emotional experience in its own right if the client feels the therapist is genuinely interested in their feedback.

Secondly, the 'process' element of formal feedback (i.e. either the formal feedback on therapy process that is triggered when a client is 'off track', or the use of an alliance questionnaire at the end of every session) directs client and therapist attention towards what is happening in the therapeutic relationship. Understanding the fluctuations and nuances of therapeutic relationships is, as we know, a signature strength of the psychodynamic tradition. However, given the opaque nature of mental states and client deference, even therapists well versed in identifying subtle enactments of client relational patterns are likely to learn more through actively soliciting formal feedback in this way. I have found that using such formalised process feedback fits well with the relational psychoanalytic perspective of Safran and Muran (2001). Safran and Muran's

work addresses the issue of how to resolve ruptures in the therapeutic relationship and has been refined in a longstanding programme of research. It provides useful answers to the issue of how to respond to client feedback if it is negative (for instance if the client reveals that they are dissatisfied with you or their therapy). They suggest that an overarching goal for the therapist should be to cultivate 'mindfulness in relationship'. Their contemporary psychoanalytic principle of owning one's own part in relational enactments also appears to me to contribute usefully to the 'process safety net' facilitated by formal feedback.

Finally, the use of feedback highlights the client's own role in the therapeutic process and helps to deconstruct unhelpful 'medical model' assumptions of client passivity and therapist omnipotence. If the formal feedback (and the client's understanding of this) points to progress being made, the therapist can focus on the client's role in changing – reinforcing the client's ego-strength. If the feedback is not so good and the client is faltering in the therapy, then this should lead to a collaborative enquiry that encompasses what is happening in the therapy room, what is happening outside the therapy room and what is happening in the client's internal world.

One common objection to using feedback is the belief that requesting feedback will make the client feel that they are under pressure to perform for the therapist. I do not find this to be a frequent issue in my own caseload – generally the rationale for formal feedback makes sense to clients and they use it proactively in the way that it is intended. However, it is true that some clients perceive it as a demand that they should 'get better' and fear that they might be rejected if their scores are not 'good enough'. In such cases the feedback system has helped to crystalise an enactment of a relational theme. I believe that it is possible to work with material of this kind in the same way that one would work with a client's experience of other aspects of the therapeutic frame (e.g. a client's perception that when the therapist ends the session on time this is 'uncaring').

Conclusion: nuggets from psychotherapy research

I have shared with you some of the discoveries I came across on my journeys into the world of psychotherapy research, which started many years ago when I embarked on a PhD about people's emotional isolation. In particular, I have shared the 'research treasures' that I have ended up bringing back into my clinical practice. You will not be surprised to hear that I now use a feedback system in my own clinical work. I hope the ideas and research we have looked at in these pages make sense of why a psychodynamic therapist might go down this route. I will end with the hope that others will join in me in trying out, developing and reflecting on this new 'psychoanalytic technique'. It seems to me that a psychodynamic perspective has much to contribute to the future understanding and sensitive practice of 'formal feedback' in psychotherapy.

Notes on contributor

James studied English Literature before doing a degree in psychology at the University of Strathclyde, a PhD at the University of Warwick, and a DClinPsych at the Salomons Centre, Canterbury Christchurch University College. He has worked for the last 15 years in the NHS before leaving in 2013 to become Director of Clinical Training at CORE-IMS (which provides software and training for using feedback in psychological therapy) and working in private practice in Oxford.

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