

Introduction

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Instead of an enquiry into how a cure by analysis comes about (a matter which I think has been sufficiently elucidated) the question should be asked of what are the obstacles that stand in the way of such a cure [Freud, 1937, p. 221].

Analysts frequently discuss but rarely write about their clinical failures, even though all analysts have experienced failures. Oberndorf (1948) stated, “the goal which the patient aims to attain through treatment does not always coincide with that which the psychoanalyst hopes to achieve and neither of these estimates may correspond to that which the patient’s family or friends would consider a desirable outcome” (p. 14). We must add a caveat to Oberndorf’s statement. The term *psychoanalyst* has always reflected individual differences among practitioners. It is not, however, a unitary concept, either theoretically or therapeutically. What holds for each and every one of the perspectives and models that define contemporary psychoanalysis is a dialectical unity of opposites. We cannot discuss “failure” without also defining “success.” The evolving history of how psychoanalysis views success or failure would require a book-length treatise. We shall, therefore, present a cursory overview of historical trends, necessarily omitting many important contributions.

Ferenczi (1927) posited two factors as prerequisite for a successful analysis. The first was the necessity for a patient to distinguish reality from fantasy; that is, the ability to resolve the transference neurosis and to shift transference wishes from the analyst as a source of gratification to the world at large.

Ferenczi stated a second necessity: "Every male patient must attain a feeling of equality in relation to the physician as a sign that he has overcome his fear of castration; every female patient, if her neurosis is to be regarded as fully disposed of, must have got rid of her masculinity complex, and must emotionally accept without a trace of resentment the implications of her female role" (p. 84). This requirement meant the resolution of the oedipal conflict with the pain and freedom inherent in this ubiquitous human drama.

Freud's conceptualizations of "success" were closely tied to "models of the mind" (Sandler, Holder, Dare, and Dreher, 1997), prevalent during the theoretically diverse phases of his writing and thus evolved over time. During the earliest phase of trauma theory, he envisioned success as the synthesis of the ideational components of forgotten events with their affective core. During the topographic phase of theory formation the therapeutic aim was to make the unconscious conscious through interpretation and (re)construction. The structural/ego phase of Freud's theorizing, a model still prevalent today, views successful treatment with the dictum: "The business of analysis is to secure the best possible psychological conditions for the functioning of the ego; when this has been done, analysis has accomplished its task" (Freud, 1937, p. 250).

Contemporary American psychoanalysts have extended Freud's idea to include "the elimination of symptoms and inhibitions, modifications in character structure, improvement in capability to initiate and sustain fruitful object relationships, increased ability to work productively and creatively. Further goals are increased self-knowledge and self-acceptance, including the realization that perfection is illusory and unattainable" (Moore and Fine, 1990, pp. 185–186).

Kleinians view success not so much in ego terms and functions but, more globally, as a movement from the paranoid-schizoid to the depressive position. Concomitant with this

advance is the diminution of the use of primitive defenses, such as projective identification, and the development of the mourning process and the attempt at reparation.

For Winnicott (1960), success can be evidenced by the ascendancy of the “true self” as opposed to the “false self,” and the development of play as evinced in the transitional space that characterizes the psychoanalytic encounter (1971). For Balint (1968), success is the establishment of a “new beginning,” a rebirth with the joy and exuberance that accompanies it.

Kohut (1977) sees success as the continuation of the unfolding of the process of self-structuralization that is attained through the development of idealizing transferences and the activation of unfulfilled mirroring or idealized selfobject needs—a deficit rather than a conflict model.

This brief overview should make clear that the aims, and thus the definitions, of success are related to the views of the nature of the therapeutic process and the nature of human development posited by different schools within psychoanalysis. The concept of “failure” is directly linked to the baseline criteria of success. Ferenczi (1927), predating and inclusive of many of the views to follow, stated the two factors lead to failure: absence of competence and patience on the part of analysts, that is, a problem of technique; and failure by analysts to deal with the weak points of their own personality, that is, a problem of countertransference.

Freud (1937), particularly in “Analysis Terminable and Interminable,” highlights a multiplicity of factors that can lead to a failed analysis. Most of these variables are derivative of the biological bedrock that underlies psychological structures. Freud specifically mentioned the age of the analysand (50 being the cutoff point), adhesiveness as well as hypermotility of the libido, the negative therapeutic reaction, congenital weakness of the ego, intense early trauma, unconscious guilt, the female’s unwillingness to resolve penis envy, the male’s inability to confront his passivity toward another male, and, perhaps most important, the existence of the death instinct. Analysts’ contributions to failure come from unresolved countertransference problems. In this seminal paper, Freud suggested a reanalysis by practitioners every five years.

Anna Freud (1969), extending the framework of ego psychology, noted that a contributory factor to failure and, simultaneously, a veiled allusion to Kleinian treatment, is the desire to reconstruct the earliest preverbal phases of development for which evidence is mere speculation. Anna Freud stated: "I myself cannot help feeling doubtful about trying to advance into the area of primary repression, i.e., to deal with processes which, by nature, are totally different from the results of the ego's defensive maneuvers with which we are familiar" (p. 147).

Object relations theory and self psychology shift the focus for failure from the patient's resistances to the role of the analyst in the therapeutic process. Along with problems of specific countertransferences unique to the history and personality of each analyst, Kohut saw as problematic the inability of analysts to remain attuned to their patients' inner world through the use of introspection and empathy. In other words, empathic failures are seen as the main source of therapeutic failure.

Contemporary relational theorists, intersubjectivists, post-modernists, social constructivists, as well as some self psychologists and object relations theorists view failure as grounded in a statement by Racker (1968): Analysis is "an interaction between two personalities, in both of which the ego is under pressure from the id, the superego, and the external world; each personality has its internal and external dependencies, anxieties, and pathological defenses; each is also a child with his internal parents; and each of these whole personalities—that of the analysand and that of the analyst—responds to every event of the psychoanalytic situation" (p. 132). Analysis is, therefore, not only a dyadic process; for success or failure, the "fit" between analyst and analysand is paramount.

When we asked the contributors to this volume to be forthcoming and courageous in discussing examples of what they perceive as failed cases, we requested that they not write about cases that might have come to a less than desirable end as a result of ethical failures or external events, such as death, organic incapacitation, or physical relocations related to job or career. Our contributors represent a wide range of views within

contemporary psychoanalysis and they view failure from many different vantage points. In most cases what is emphasized is the analytic ego ideal, a component of our work ego. Their contributions lead us to conclude that our contributors are often too critical of themselves. Reflecting a contemporary spirit of openness, they seem too willing to blame themselves, and at times downplay the difficulty of working with the patients they write about. Their concepts of failure are highly individualized, which seems fitting for a discipline that is noted for its ambiguity and subjectivity.

Marvin Hyuman, at one end of a spectrum, questions the concept of failure. For him, the term is a residue of the medical model and obfuscates the fact that psychoanalysis is a form of self-exploration and self-inquiry, independent of so-called "scientific" criteria. Judith Vida also sees failure as a limited concept since growth does occur in the case presented, even if, by some analytic standards, it might be viewed as a failure. The adage, "the operation was a success but the patient died," is turned on its head—"the patient succeeded but the analysis failed"—leads us to repeat Oberndorf's (1948) observation as to whether our standards or the patient's should be paramount.

The other end of the spectrum is highlighted by Ann-Louise Silver's chapter on the failure of the institutional treatment of schizophrenics by psychoanalysis, which was a frustrating yet poignant experience for those involved. The views of our other contributors reside somewhere in between these extremes. Stuart W. Twemlow and Cecilio Paniagua discuss narcissistic elements as crucial to failure. Johanna Krout Tabin explores deeper level pathology that appears in serial or repeated failures, and Robert S. Wallerstein reconsiders a case from early in his career in a new light, that of failure. W. W. Meissner's chapter emphasizes the inability of his patient to truly engage and the patient's sexual panic that underlay that resistance. Alan Z. Skolnikoff demonstrates how the use of reality can become a resistance to the deepening of the analytic process.

Focusing on the analyst's contribution to the process, R. D. Hinshelwood, from a contemporary Kleinian perspective, discusses countertransference issues as directly related to failure.

In a similar vein, José Américo Junqueira de Mattos, presenting a frame derived from Bion's ideas, elucidates how the analyst's inability to follow the dictum of "neither memory nor desire" becomes a problem for treatment. Augusto Escribens introduces the concept of subjective theories of pathogenesis and of cure. He demonstrates how discordance, and at times consonance between analyst and patient can short circuit the analytic process. Emanuel Berman, from a relational–intersubjective position, discusses the concept of "fit" between analyst and patient and the need to understand the transference–countertransference dynamic. For Berman, this is the one constant in the unfolding of every analysis.

The contributors leave no doubt that psychoanalysis is happily inhabited by thoughtful, caring, and open practitioners who, regardless of societal and cultural emphases on immediacy and externalization, see the challenge and the need to understand self and others. Psychoanalysis is alive and well in their hands.

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