Examination of a Case of "Treatment Failure" in Long-Term Psychoanalytic Psychotherapy for Treatment-resistant Depression

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Abstract: Randomized controlled trials have reported psychoanalytic psychotherapy to improve longer-term post-treatment outcomes in patients with treatment-resistant depression. In this case study, we examine the therapy process of a female trial participant diagnosed with treatment-resistant depression. Structured clinical assessments indicated that the patient's level of depression remained unchanged during and after treatment. Over the course of the therapy, she repeatedly broke away from important others and finally also from the therapy itself, which we linked to the impact of earlier experiences of abandonment on her internal world. In the discussion, we present a variety of reflections that were put forward by the authors during a series of case discussion meetings. Some of these reflections relate to how the inner world of this patient might have triggered a negative therapeutic reaction and a destructive pattern of repetition. The interpretative stance, in which the therapist interpreted this reaction as indicative of a psychic conflict and linked this conflict to the therapeutic relationship, seemed to be experienced by the patient as unhelpful and persecutory. Other elements that were brought up include basic distrust, lack of symbolization and trauma in the patient, as well as the constraints of the research context.

Keywords: long-term psychoanalytic psychotherapy; treatment-resistant depression; repetition compulsion; treatment failure; object relations theory

The work presented in this paper grew out of the Tavistock Adult Depression Study (TADS), a pragmatic randomized controlled trial (RCT) of long-term psychoanalytic psychotherapy (LTPP) for treatment-resistant depression (TRD) that was conducted at the Tavistock & Portman NHS Foundation Trust in London, United Kingdom (Fonagy et al., 2015; Taylor et al., 2012). All patients enrolled in the study met the diagnostic criteria for major depressive disorder (MDD) of at least 2 years' duration and had at least two previous failed treatment attempts. The findings of the trial showed that treatment effects of LTPP over treatment as usual (TAU) were modest for this severely affected group of patients at the end of treatment. However, a statistically significant difference emerged over the long-term follow-up in favour of the LTPP condition: 2 years after completion of the treatment, 44% of participants receiving LTPP no longer met diagnostic criteria for MDD, compared with 10% of those receiving TAU. Although these findings are promising in that they indicate that LTPP is an effective treatment option for individuals with long-standing severe depression, the results also indicate that a proportion of individuals do not benefit. Of the 67 participants who were allocated to LTPP, eight withdrew from the treatment. Participants who benefitted from LTPP were more likely to be employed and to have attained higher education, and had less frequently attempted suicide in the past, in comparison to participants who did not benefit from LTPP. The two groups did not differ with respect to other demographic and clinical variables.

The aim of the present paper is to investigate the treatment processes of one case included in the trial, and to formulate ideas about the reasons for its unsuccessful outcome (unsuccessful according to the criteria used in the trial; we will return to this in the clinical discussion). The psychoanalytic psychotherapy that the patient received followed the treatment model provided at the Tavistock Clinic, but with a specific focus on treating depression that was manualized for the RCT (Taylor, 2015). Thus, this case study

complements the RCT in the sense that it will describe how a treatment intervention that worked for many patients was not effective in reducing symptoms of depression in a particular case. As such, this detailed case study of a failed treatment offers clinicians and researchers a unique opportunity to understand the processes involved, and to learn from them to improve future treatment for similar cases.

Method

Participants

Tara (alias) is an adult woman who lived alone with her two daughters at the start of her treatment. She was referred to the TADS due to long-standing problems of depression, which had not lessened despite various medical and other psychotherapeutic treatments. Tara provided written informed consent (approved by the NHS West Midlands Research Ethics Committee) to participate in the study. All possible identifying information has been changed to protect confidentiality. Tara was selected for this case study because structured clinical assessment indicated that her level of depression remained high at the end of the treatment period and at the end of the 2-year follow-up period.

Tara's therapist is an experienced female psychoanalytic psychotherapist. The research team (all White) consists of five researchers with different levels of clinical and research experience. The first author is a male associate professor who is a trained psychoanalytic therapist and has 16 years of clinical experience. The second author is a female assistant professor who is a trained psychodynamic psychotherapist. The third author is a female student who is completing an MSc in clinical psychology. The fourth author is a professor of psychoanalysis with extensive clinical experience. The fifth author is a training and supervising psychoanalyst, an honorary consultant psychiatrist and psychotherapist, as well as a visiting professor.

The therapy

The LTPP offered as part of the TADS consisted of 60 (50-minute) sessions of face-to-face, once-weekly individual psychoanalytic psychotherapy over the course of 18 months. The therapy followed a manual devised by Taylor (2015), which is indicative rather than prescriptive. According to the principles of the manual, therapists are asked to be receptive and open to whatever is transmitted consciously and unconsciously by the patient, and to make emotional contact with the points of maximal significance. These may relate to moments of anxiety, of passion, of depressive pain or guilt, or of a combination of any of these. The therapist is also asked to attend to impulses and anxieties that emerge before the start of the treatment and that might disturb the treatment process even before it starts.

The therapist's tools are listening, prompting, commenting, exploring, recognizing, drawing attention to, opening up, and interpreting. The therapist puts their understanding or misunderstanding into words and, through this intervention, tries to establish a point of mutual contact with the patient. The manual emphasizes the need to pay particular attention to internal object relations that are understood to cause anxieties and that may affect the patient's mood and state of mind. To aid the development of an understanding of these internal object relations, the therapist is asked to focus on both the immediate and more distant areas of the patient's life outside therapy, and the here-and-now of the transference–countertransference relationship. As emphasized in the manual, the particular LTPP model aims for the patient to gradually internalize a psychological capacity to relate to pathogenic personal experiences, memories, feelings, beliefs and relationships in a reflective, yet also more active, manner.

Data analysis

This case study uses the range of the data and material collected as part of the trial. The audio recordings of the sessions were transcribed and the (anonymized) material was subject to successive rounds of qualitative data analysis in accordance with the principles of the

Consensual Qualitative Research for Case Studies approach (Jackson, Chui & Hill, 2011). Qualitative interviews conducted by the second author with the patient and the therapist at the end of the follow-up period (about 39 months after the start of the treatment) were also included in the data analysis. Initially, the first author familiarized himself with the clinical material and summarized each session to get an initial grasp of the therapeutic process. He then selected five extensive excerpts from the transcribed sessions and presented these to the second, fourth and fifth authors. They met twice to discuss the excepts and come to a joint understanding about the treatment process through critical discussion.

Next, an experienced psychoanalyst, who was not made aware of the purpose of this study or the outcome of Tara's therapy, was asked to write a psychoanalytic case formulation. He had participated as a therapist in the TADS but he was not Tara's therapist. The case formulation needed to address the following topics: the main complaints and symptoms, the patient's inner world and object relational functioning, the central psychic conflict(s), and the emerging transference to the therapist. The case formulation was based on the transcript and audio recording of the intake session and the first and second therapy sessions. The psychoanalyst who wrote the case conceptualization is not one of the authors and he was not involved in the case discussions. The reason to ask a person external to the research team was both pragmatic (time-constraints) and methodological (to have a case formulation that was not influenced by the outcome of the treatment).

This case formulation was then used by the first and third authors to further understand the treatment process. As part of this process, the third author also familiarized herself with the clinical material. As the first author wrote successive drafts of this paper, the first and third authors met regularly to further discuss the material. The final paper was read by the second and fifth authors, and their comments led to final modifications. In the writing of this paper, the guidelines for the writing of psychoanalytic clinical case studies provided by

Willemsen et al. (2017) were followed: (1) balance protection of confidentiality with the inclusion of basic information about the case; (2) explain why this case was selected for the study; (3) include information about informed consent and disguise; (4) include relevant patient background and context of referral; (5) distinguish between patient's narrative and therapist's interpretations; (6) make explicit which interpretative heuristics and theoretical framework were used; (7) pay attention to one's own position and counter-transference; (8) leave room for interpretation and doubt; and (9) answer the research question. The final paper was also discussed with Tara's therapist and she was given the opportunity to make suggestions or comments.

Results

History

Tara reported having had feelings of depression since she was a teenager. These did not, however, prevent her from finishing secondary school education, finding a stable professional position in health care, and starting a family. Her current mental health issues started 10 years ago, after her older sister's abrupt death in especially traumatizing circumstances. What particularly upset Tara was that her grandparent, in whom her sister had confided, had never informed her about her sister's health difficulties and deteriorating state. Moreover, this grandparent was never willing to talk to Tara about her sister's death.

In the years after the death of her sister, Tara received psychological treatment. No further information was available about this treatment except Tara's expression that she found it helpful. During the period of this therapy, she divorced her husband. Her state of mind was somewhat better in the period after the divorce, and then it worsened again. She then found out about the possibility of receiving treatment as part of the TADS. She contacted the TADS team, but then waited several months before she made an appointment for the intake session.

At the root of her depression there is another loss: her mother left the household when Tara was 2 or 3 years old. She does not know why, and she does not know what happened with her mother afterwards. Nobody in the family, not even her father, ever talked with her about this event. It is blank in her mind. Only once did she speak with her mother after she had left: “I must have been about 15 – I happened to answer the phone and it was my mum on the phone. And I don’t remember any of the conversation, all I remember is this emotion of feeling so overwhelmed.” (session 1)

Tara was raised by her grandparents, with whom she developed a very troubled relationship. She felt like an outcast in the family. She was convinced that her sisters were favoured by the grandparents, and she referred to a number of incidents in her youth to support her point (e.g., about how they were given more food at dinnertime, how they were allowed to go to the movies but she was not, and how she had to sit on a separate sofa from them). She was convinced she was treated in that way by her grandparents because she had been her mother’s favourite.

Presenting complaints and assessment

Tara struggled to motivate herself to do anything, in particular in relation to her job. At the start of the treatment, she had been on sick leave and staying at home for several weeks due to depression. Her employer had recently given her a written warning. Her house was a mess. She found it very difficult to get out of the house or to attend social events and family gatherings. There were days when she stayed in bed all day. Sometimes, she was overwhelmed by a feeling of sadness and cried herself to sleep. She complained about long-standing feelings of depression and of feeling rejected and not understood. This complaint was mainly addressed to her family and, more recently, also to her employer. She felt she had no support from either, despite her attempts to reach out to them. A few months before the start of her treatment, Tara sent an email to all her family members to explain her situation,

but she received very little response. This triggered a lot of anger in Tara as it yet again confirmed to her that they were not willing to understand and help her.

At the start of treatment Tara has a DSM-IV diagnosis of MDD with melancholic features as ascertained by the Structured Clinical Interview for DSM-IV (First et al., 2001). The MDD was still present 18 months later and at the end of the 2-year follow-up period (42 months after the start of treatment). Her score (24) on the Hamilton Depression Rating Scale (Hamilton, 1960) at the start of the treatment represents a severe rating, and it is still severe at the end of the treatment period (17) and at the end of the follow-up period (21). She reports not having had a single depression-free day at the start of the treatment, at the end of the treatment, and at the end of the follow-up period. Throughout the whole duration, Tara was taking antidepressant medication.

Case conceptualization

According to the psychoanalyst who wrote the case formulation, there was evidence of a powerful internal object in Tara, who was superior, harsh, cruel and hostile towards any sign of need for help. The presence of this superior and cruel internal object pulled her away from getting help. In his opinion, there was excitement in submitting to its demands. Tara seemed to be attracted to a masochistic and destructive stance of suffering alone while rejecting help. This could be inferred from a number of observations. The long period between Tara's initial contact with the TADS team and the actual start of her treatment could be interpreted as indicative of a reluctance to seek the help she needed. During this period, she had obviously had a very difficult time: according to her reports, she cried herself to sleep, she was unable to do her work, and she became more and more stressed about an upcoming family gathering. Tara's reluctance to start treatment was further evidenced by the fact that she did not attend the first appointment and was late for the second. This also set the tone for the rest of the treatment, which was characterized by lateness, cancellations or non-attendance.

This masochistic stance towards suffering alone, however, was countered by a tendency in Tara towards what is positive for her. The psychoanalyst who wrote the case formulation noted that, despite her depression, Tara was very committed to getting better. When the therapist enquired about suicidal ideation, Tara expressed very clearly that she would never do that because of her children. On the two occasions when she came close to taking her own life, it was the thought of her daughters that prevented her from proceeding. The children functioned as a third object who offered protection from her own destructiveness. The psychoanalyst inferred in his case conceptualization that the superior, harsh, cruel and hostile internal object is disconnected from the psychic reality: on the one hand there is the destructive internal object and on the other hand there is the rest of psychic functioning. As a consequence, so he hypothesized, it would be difficult for the therapist to reach this disconnected internal object in the context of the therapy.

Finally, the psychoanalyst pointed out that Tara identified with an abandoning maternal object who does not want to know about her helplessness and pain of loss but prefers to leave to an idealized existence elsewhere. This referred to Tara's experience of being abandoned by her mother. By identifying with the maternal object, so the psychoanalyst hypothesized, a powerful unconscious projective identification might have taken place, in which the pain of loss is felt by others. This was a way of dealing with the loss, but one that would lead to the repetition of the experience. This was inferred from a number of examples that point to a tendency in Tara to abandon important objects in her life at the start of therapy. First, there was her work. She felt very misunderstood by her employer and preferred to quit her job after about two decades in steady employment. Second, there was her family. She felt rejected and judged by members of her family, and she felt that they had never responded to her requests for help. As a consequence, she wanted to break away from her family and not see them any more. Third, there were her daughters. Between the first and second sessions,

Tara arranged for her children to stay at their father's home for the summer. Tara said that she had arranged it that way in order for her to concentrate on her job and to have some pleasant time with friends. In his case conceptualization, however, the psychoanalyst interpreted this as an abandonment of a good object.

Based on the intake session and the first two therapy sessions, the psychoanalyst expressed a concern for the further development of this therapy: during her previous therapy, Tara had focused on separating from her husband. The concern was that she would use this therapy to destroy more important aspects of her life.

Qualitative description of the treatment process

This qualitative description focuses on the nine sessions Tara attended in the context of the TADS over a period of 6 months (from July to January the next year) before dropping out. The treatment started with a missed encounter, as Tara was 45 minutes late for her first session and the therapist had, by that time, left the building. Tara was very upset by this and she created something of a storm in the institution, with reception staff running around and calling the therapist on her phone. Despite their efforts, the patient had to return home without seeing the therapist. The therapist's main interpretative interventions during the first session focused on Tara's hesitance to start therapy. The therapist understood this hesitance as the expression of a psychic conflict about accepting help. She pointed out that although Tara complained about not being heard and being ignored by others, she might also find it very challenging if someone were to really listen to her, as this might get her in touch with painful emotions:

Therapist	[…] well most of the time you feel that people don't – take an interest or they don't notice or they don't want to know and that's horrible and painful. But I think you're also telling us that when somebody does take the trouble to sit down with you and really try to work out what's going on, then tha- that can be equally painful. And because it al- it's almost like then you yourself have to know a little bit more about just how awful it can feel at times inside you.
Patient	Mm.

T As I think
P Yeah, it's diff- it- it is, it is quite hard. I mean, I'm sitting here and I can feel the tears building up.
T Mm.
P And at the same time I'm saying 'no, you're not gonna do that, they're not gonna do that'.
T Mm. Because?
P It's a sign of weakness, I think. Um – and you're never allowed, I was, or I was never allowed to express any of that sort of weakness at home – growing up. Um, for me it is quite difficult. Um, I'm a l- I'm a lot better than I used to be.

The therapist's intervention touched a sore spot and Tara's response illustrated how she dealt with mental pain by hiding behind a very hard shell to protect herself, and through denial ("I'm a lot better than I used to be").

The therapist's immediate response to Tara pulling away was to point out what might be happening in the here-and-now in terms of unconscious phantasies. She made a transference interpretation:

T Well maybe you think I I I don't want you to come and be upset.
P No, no no no no. No, no no. It's not, it's not actually to do w-, it is, it's all, it's it's to do with – me and the way um – – I think I've always had to be – um – and it's a c- I guess it's a coping mechanism as well. If I don't let the tears out then, there's also that fear that if you let the tears out then they will just flood.

Tara's reaction to this interpretation illustrated how difficult it was for her to reflect on what might be going on with the therapist, which triggered a rationalization ("it's a coping mechanism"). But most importantly, in her reply, Tara signalled the risk she is taking by coming into treatment: the tears might just flood. After this first session, Tara arranged for her daughters to stay with their father over the summer.

The second session was emotionally more intense, and Tara became tearful at one point during the session. Tara expressed fears about losing her job, losing her house and losing her children due to financial problems. This triggered enormous sadness in Tara and she became very emotional. She expressed that she felt she had been fighting all her life and

that she was now tired of fighting: “Just want somebody to just give me (sniff) a bit of space, some time to sort of, yeah. Just not have to fight all the time for myself.” Towards the end of the session, the therapist pointed out how Tara, despite her tearfulness and display of real feelings, also carried on speaking in a very reasonable way. Tara recognized this contradiction:

P […] I feel like I’m a contradiction.
T Mm?
P Um – there is that side of me that’s real and I want it, to just let it all out. But at the same time there’s that fear that if I let it all out, what’s going to happen.
T Mm?
P And, um, the feeling you need to hold back.
T Mm.
P Um – and be practical and carrying on doing the things you’re meant to do because they have to be done. Um;
T Mm?
P If I fall apart – who’s going to pick up the pieces?

Tara’s sense of isolation came out clearly in this passage. As she had done in the first session, a little later in the second session, the therapist tried to encourage Tara to reflect on the conflicting feelings she might have experienced in relation to seeking help: “I think you’re describing some real worry actually that yet again something will be repeated here with me. You know, some question of whether I will really hear you.” But as in the first session, Tara reacted with denial (“Um, not something - - I’m aware of.”), illustrating how difficult it was for her to reflect on the relationship she had with the therapist. After this session, Tara spent some time in the bathroom of the treatment institution to recover from the overwhelming session.

The third session started with Tara’s announcement that she had not been able to return to work after her sick leave had ended. During the session, the therapist expressed concern about Tara’s increasing isolation, as her children would be away over the summer

and she (the therapist) would be taking annual leave. Tara confirmed that she felt some panic, but she said this with a neutral tone of voice, or she dismissed it:

P Mm, yeah. It is, um, it's just; I suppose it's one of those things, you have to get on with it and do it. And I know, I think if there wasn't summer holidays and if (name of children) were at home then it would probably, possibly, be a little bit easier.

In the third session, as in the previous two sessions, Tara shared a lot of relevant details about her life, including the disappearance of her mother, the troubled relationship with her family, the important place her daughters had in her life, and her difficulties at work. Yet, what is striking is that underneath this collaborative engagement in the therapeutic relationship appeared a gradual disengagement from all important interpersonal relationships in her life: her work, her family and her children.

The fourth session did not happen until 2 months later. First, the therapist was on her summer break, and then Tara had to cancel two successive sessions due to illness. Tara was 20 minutes late for her fourth session. She started by announcing that she would probably be dismissed from work on the grounds of ill health. She was very glad about this: "I'm completely free… I can be my own person, I can do what I want to do without (employer's name) coming over me again". Then she said that she wanted to talk about her deep desire to confront her sister. She explained how much she had helped her sister in the past, how she had always been available to her in times of need, but that she never got anything in return from her. Tara was particularly angry because she thought her younger sister did not keep the memory of their older sister alive. Tara explained that she wanted to confront her sister about all of this and then cut her off.

As in the first three sessions, the therapist drew a link to the here-and-now through transference interpretations. She pointed out that Tara must have thought that the therapist had forgotten about her, just as her younger sister had forgotten about their older sister, over the

past 2 months where they did not have any sessions. She added that Tara must have wondered why the therapist had not called her over this long period and perhaps begrudged that it is always her (Tara) who has to take the initiative. The therapist made several interpretations of this kind despite Tara's unresponsiveness towards them. Tara did not seem willing to think about the possibility that there might be a link between what might have been happening within the relationship with the therapist and what she reported was happing in her life outside the therapy.

The therapist also continued to point to a conflict Tara experienced in relation to coming into treatment (at least, this seems to be the therapist's guiding hypothesis):

T And so that leaves you pulled in two different directions. You both want to come and you don't want to come. You want to know about this, this unhappiness and deal with it and you also think, no, the best thing to do is to stay far, far away from it.
P It's fear, it is, it's fear of what; how I'll react to this, um.

As she did before, Tara answered that she did not feel confident to confront the pain; she emphasized that she feared she might completely break down. Tara did not come to the next two appointments.

This was followed by three sessions in which there was genuine engagement in the therapeutic process. Confronting guilt and loss was the main theme of these sessions, which was notably very painful and difficult to bear for Tara. In the fifth session, Tara explained again how she now really wanted to confront her sister about her not showing any interest in her and her children. She repeated her wish to leave it all behind: "Because I tell you what, if I could pack up my stuff and I could pack up (name of children) I would go. I would just disappear." The therapist offered a view of a possible conflict in this situation: on the one hand there was a wish to contact her sister and a hope to have a real conversation, but on the other hand there was the urge to cut the relationship off. She then related this to their relationship and Tara's

possible unconscious fear of being not heard and misunderstood by the therapist, and a feeling she might not receive help from her. Tara did not agree, however: "N-. – – Not that I'm aware of myself." In the days following this session, Tara started to think about whether it would be better for her children if she was not there. As far as we know, this was the only time she had suicidal thoughts in the whole period of treatment.

Tara started the sixth session by saying "It's confession time." She said she felt very nervous about coming today. A song had popped into her head the day before, a song from when she was little: "Where's Your Mama Gone?". Talking about this memory, Tara expressed sadness but also irritation. She thought her grandparents had played or sung the song repeatedly to taunt her: "I remember hearing it and – – it was like being taunted and even now I think about it, it feels like I'm being… Just hearing it in my head, it feels like they're taunting me still that, er, my mum had left and I had nobody else that; because they weren't that fussed about me." What appeared poignant here was that in relation to the experience of the loss of a good object, a bad taunting object appeared. In her intervention, the therapist pointed to the link Tara hinted at, a link between the loss of her mother and something cruel and accusatory. Tara agreed with this, and said that "the words that echo in my head quite often are constantly being told – that I look like my mum, I was my mum's favourite". She reiterated that she was treated badly and therefore avoided spending time at home as a teenager. The therapist linked this to their therapy and how Tara might be avoiding coming to see her in order to check whether she (the therapist) actually wanted her to come. In response to this intervention, Tara acknowledged for the first time that something had been holding her back from coming today: she had been all ready to leave but then started to dither. She explained she was afraid to come and talk about the song.

Tara then became very emotional. She talked about how she had always experienced a lack of understanding in her family and at work: "especially the last couple of years when I've either, I've either not gone [to work] because I really can't face it or I've turned up late and

then it's sort of 'why did you come late? You could've come earlier'. There's always the (sniffs) um, the lack of understanding that I str- I struggle to actually get myself there." During this session, she showed some insight into her ambivalence about coming to therapy.

T […] I think there is an anxiety there about well – – a- are you going to get a bad response. You know are you going to be rejected in some way or told that you're bad. And a- a- as much as sort of; consciously you know that you're coming here for help. I think you know the very fact that this is so strong in you means that you, you can't come.

P I, I struggle with it. I do struggle with it. It is, and I know it is because that's, I said 'that's the way it's always been'. And trying to, um, – – move away from that and understand. Consciously I know it's not, that's not the case (sniffing). And I can talk myself and look obviously you know I was dithering and I sort of said what are you doing? And consciously thinking what are you doing? You're wasting time. And you were, you know, you were, you were ready well in time because you knew you had phone calls and things to do, so you know you want to go. But at the same time it's like faffing around and, and catching myself faffing around. So I do, but I do, - ye- yeah I, I agree with what you're saying. It is, it is very hard to um – get past that, there um – – – I'm sure I can manage it at some point, um, but I don't know how long it will take. I hope I can.

She admitted that there was a kind of force holding her back. Tara's use of the phrase "confession time" suggested that she experienced it as a sinful force that kept her from reaching out for what she needed. It is important to notice that this insight was not simply claimed (as in, "now I see") but it was actual and *experienced* as part of the therapeutic relation. The insight did not concern a general truth ("that's the way it's always been") but something that Tara was now contemplating in relation to the therapist as a person with whom she had a history. Tara was emotional throughout the session. This was the first session in which the theme of loss was much more central, whereas the theme of cutting ties because people did not treat her well was more prominent in previous sessions.

It is clear that Tara was engaging more with the therapeutic process and that she was beginning to be able to think about her possible contributions to her difficulties. She was also much more in contact with feelings of loss. However, it is also evident that she continued to

struggle to tolerate these ambivalent feelings and had not yet found a way to bring them together. As she returned home after this session, she collapsed and was bedridden for several days due to pain in her knee and hip. In a later session she did link this collapse to the emotional intensity of the session.

Despite this challenging experience, Tara returned the following week (seventh session), when she expressed ambivalence about her urge to cut off her family. For the first time, Tara talked about a nice member of the family who had tried to contact her by phone and how she felt guilty towards this family member for not returning the call. The therapist noted that Tara was getting in contact with a complex feeling of guilt. Tara responded differently to the transference interpretations. When she was complaining about how her family always asked her to do things and that this put her under a lot of pressure, the therapist said:

T Hmm but; and the same has applied here hasn't it very clearly. You know, that it- it's Tuesday at four o'clock is a time when you're expected here. And it feels like I then become like the grandparents (laughs) who's sort of saying well where are you, you've got to be here, you know. U- u- u- um – and it sort of switches it around entirely as if then I'm the sort of demanding one who needs you here for my benefit. And it almost – completely bypasses any possibility that you might be here because you could get something that you needed for yourself.

P Um – it might have been I think initially, um, but a lot of it was – – – um, almost reacting to the way things have been in my past, in my life where I've dealt with different people, family, work, what have you. Um – but I think – – – – that's changed since last week in the fact that I did actually feel like – – I'd got somewhere – last week. Um, and then I can actually get something.

Unlike in previous sessions, she expressed doubt about breaking away from her family. Towards the end of the session, she again expressed feelings of guilt she feels towards some of the good and supportive members in her family.

She then missed six appointments, and during her eighth session, Tara announced that she had cut off the relationship with her sister:

P I don't know what possessed me. I just – – decided I needed to put a- an end to things with my sister. And I knew I'd never tie that down to a – a time or a, or a date or anything, erm – so I just sent her a text message telling her that I just, you know, I can't do this anymore. You don't treat me like a sister, so I disown you. Erm, there will come a time, I literally said there will come a time when you're going to need someone, and I'm not going to be there for you. And that, that is the time when you'll realize what you've lost.

She continued to say that she had felt a huge sense of relief afterwards. In the days after she sent the text message, two family members had called her and made reproaches towards her for not coming to family meetings. Tara concluded that these family members did not understand what depression is and did not understand how hard it was for her to leave her house. The therapist linked this to therapy and asked whether Tara had also experienced the therapy as being unhelpful and not understanding. Tara confirmed this but also referred more positively to the previous session: "I think there was something until, I think, the last time we met. I, I felt that there was something different then." Before the previous session she had had a fear of being put down by the therapist if she were to open up, just as her family always did, according to her: "I feel like I'm forever getting put down no matter what I do." This gives an indication about how she had experienced the therapist in the previous sessions.

The ninth session was a month later. She again started by making a confession: she nearly did not make it to the session because she had had a major anxiety attack that morning. She explained that she was unable to do anything in the house and to take care of her children. She felt very ashamed of herself. She (again) explained how she did not get help from her family and how nobody really believed how unwell she was. The therapist linked this to the therapy and how Tara might also fear not being believed or even fear being judged by the therapist. Tara confirmed this partially: "I think – probably is an element of that although my the – the logical side of me says, 'don't be silly.' Because I know that's not true. But then there's the other side, and I think it's; – – I guess it's – – – ah ah ah all the years of, sort of, – talking to people that were in professional, uh, capacity and sort of being – dismissed and

fearful." A little later, the therapist pointed out that there are people in her surroundings who do offer help and understanding. Tara acknowledged this, but said "Maybe I feel like I don't deserve it." The therapist then related this back to the context of the therapy by pointing out how Tara had been depriving herself from getting the therapy she needed. Tara seemed to take this interpretation on board, and returned to her childhood:

P (Stutter) It's always been, you know, – again it all stems to childhood.
T Mm.
P – You know, sort of like, well, – you were your mum's favourite therefore you don't deserve – the love and attention – that she would've given you.
T So that was what was said to you that you, you were your mum's favourite?
P It wasn't. It was constantly said to me! You were your mum's favourite and you looked like; it rings around in my head – constantly.
T Mm.
P Um – and there was like that was – – – that was their excuse.
T For- for- not, – for not looking after you or for not?
P – Well, for treating me the way they did. It was; – I I I I, – my sisters were – always the favourites.

In this extract, the therapist stayed close to the patient's material and pointed out the statement that is crucial to making sense of Tara's position in relation towards her family: "you were your mum's favourite". The therapist then pointed out the contrast between Tara being "mum's favourite" and being abandoned by has mother.

T But then if, I wonder, if if th- there's another question that goes around your head that says, well, if I was my mum's favourite, then why did she leave?
P – – – – – I don't actually know but that's one of those things people never talk about is why she left.
T Mm.
P And I have wondered about that. And the only thing I can think of is, – you know, she was – in her 20s. She was – born in (country), suddenly got married, came over to a new country with a new family, – you know. Three kids within the space of four years of marriage.
T Mm.
P And I wonder if it was possibly postnatal depression that she just couldn't cope.

This gives an interesting insight into how the identification with her mother is linked to

the depression. She described herself exactly in the same words: “I can't cope. Uh, I’m failing everything.” This part of the session was clearly also very emotional for the therapist, who tried to slow down Tara (“I guess, we must – m- must take it a bit slowly”) and got confused when making an interpretation (“And; but you know even – – (exhalation) I’m not sure what I’m saying (patient laughs), but it it’s it’s it’s terr-, you know, it’s clearly touching something very painful in you.”). Towards the end of the session, the therapist made a long interpretation to point out that this feeling of not deserving something good, or not deserving help, prevented Tara from accepting help and accepting what is good in her life. She invited Tara to use her therapy for the remaining year to gain a better understanding of what it is that prevented her from coming to her therapy. This was a commitment Tara could not make: “I think I’ve got to the point, I just I- I- I just take it day by day now.” She then said that people had high expectations of her and that this put her under pressure, and that she did not want to do that (referring to the therapist’s suggestion). It would just make her feel worse, she explained. It is evident that she felt that the therapy and the therapist were putting her under a lot of pressure. This was the last session. As part of the TADS, the therapist and the research team were occasionally in contact with Tara. As Tara’s mental state deteriorated further, the therapist suggested that her GP make a psychiatric referral, which was also taken up by Tara.

Follow-up with patient and therapist

Thirty-three months after dropping out of the treatment, Tara was interviewed by a researcher. Asked about her relationship with the therapist, Tara explained that she had initially felt uncomfortable because of the therapist’s neutral attitude towards her, but that she had gradually started to experience her as very understanding and helpful. When asked about dropping out of therapy, Tara gave several reasons: the journey from her home to the therapist was too long; she was experiencing all kind of difficulties at work and in her family at the

time; and she feared that she would not be able to recover if she really opened up in therapy. When she was asked to talk about what she found helpful and unhelpful in therapy, Tara expressed regret about not being able to engage more fully in the therapy. Nevertheless, she added: "even those few [sessions] did make a big difference to me […] I think the key thing probably was… was helping me to actually stop sort of functioning and really look at what was happening and what changes I needed to make." From her perspective, the therapy had allowed her to make some important changes in her life, and this was a good thing. Despite this change, Tara was still clinically depressed at the time of the interview. Her daughters were also still living with her ex-husband and she had not found a new job. However, her attitude towards her depression had evolved: "It's a big thing for me to actually realize that yes, this is part and parcel of my life." She was more accepting towards her own situation and her mental state, and she was also more open about it towards others. At the time of the interview, she was attending group psychotherapy sessions and she had found support from peers in a mental health support group.

The therapist was also interviewed approximately 33 months after Tara had dropped out of the treatment. She reported that the treatment process had been quite painful for her as she had the strong feeling of being useless for Tara and failing her. The therapist linked this to the process of the therapy and the reactions that Tara had elicited in her:

> "I – I had a- often had a feeling of well I- I… should be trying to hel- I *should* be helping her. You know, she's sort of presenting herself as, she's so desperate, in such an awful position, in so much need of help, but w- pushing away th- the help the whole time, and … and er … making me feel, as whatever I had to offer, just wasn't right or wasn't enough."

The therapist reported at times feeling angry and impatient when Tara did not arrive for her sessions. She also felt confused and worried about the possible risk of suicide. According to the therapist, Tara was able to make some use of the therapy, but only a little. She thought that Tara was not able to engage more deeply in the process because getting better would

imply a process of mourning and a confrontation with feelings of guilt: “It’s almost like if she got better, she was killing the mother”.

Discussion

Trying to understand why a treatment process failed is a delicate task, as it can very easily devolve into finger-pointing by commentators who have the benefit of hindsight. During our discussions of the case material, we have tried to respect the complexity and subtlety of the therapeutic process by considering both the positive and the negative aspects of the patient’s and the therapist’s unique contribution, the effect of their interaction, and the influence of the wider context. We have also talked about what treatment failure means in this case, as the patient, therapist and researchers all identified moments and processes of real therapeutic work. Here, we will present the main points that were raised during the discussions. As the exchanges did not converge to a single consensual understanding of the treatment process, we will report various perspectives on the material. We hope this divergence of perspectives will nourish the reader’s reflections on the material.

The origins of any depression reach back beyond the patient’s more recent experiences of loss, and go back to their early object relations and involve processes of identification (Taylor, 2015). In the case of Tara, there were a number of contemporary issues related to her work and to her family, and also the grief over the death of her sister about 10 years before. However, this grief was rooted in the much older loss of her mother. Given this early loss, the development of an internalized good object might have been difficult. The lack of care and understanding Tara currently experienced in relation to her environment might have reflected the absence of a caring and understanding internal object. According to the psychoanalyst’s case formulation, there was evidence of a powerful internal object who was superior, harsh, cruel and hostile towards any signs of need. This kind of disturbing uncomfortable internal

world does not help a person to have a clear sense of what is good for them and to work towards it with perseverance and determination. Tara might not have had a firm grasp of the way in which a session can be helpful, and she might easily have been subject to horrid affects and inclinations deriving from loneliness, feelings of persecution by absence, hopelessness, resentment or hostility. We do think, however, that Tara slowly and hesitantly began to have an experience of sessions as helpful, and that she demonstrated a genuine engagement in the analytic work, especially around sessions five to seven. Paradoxically, this progress then led to the emergence of suicidal thoughts, a physical collapse, anxiety attacks and finally the interruption of the treatment. The concept of negative therapeutic reactions helped us to shed some light on this breakdown of the therapeutic process.

Freud coined the term *negative therapeutic reaction* to refer to the clinical phenomenon in which some patients seem to cling on to illness where cure is possible: what usually leads to "an improvement or temporary suspension of symptoms produces … an exacerbation of their illness" (Freud, 1923, 49). He identified this as the most powerful of all obstacles to recovery (p. 49). In addition, according to Freud, the negative therapeutic reaction is the result of unconscious guilt and the difficulty, perhaps refusal, of giving up the punishment of suffering (Freud, 1923). In relation to Tara, the psychoanalyst postulated that her submitting to the demands of a harsh cruel internal object seemed to procure a masochistic satisfaction in suffering alone while rejecting help.

After Freud, the negative therapeutic reaction has also been described as a defensive manoeuvre in patients to avoid a greater tragedy. Building on Klein's theory, Joan Riviere (1936) argued that the inner world of the depressive position can be described as one in which "all one's loved ones within are dead and destroyed, all goodness is dispersed, lost in fragments, wasted and scattered to the winds; nothing is left within but utter desolation" (p. 313). In order to keep this inner reality at bay, some patients remain impermeable to the

influence of the psychoanalyst, because unmasking the dreaded psychic reality would mean realizing it. This type of patient has no faith in getting well, in the sense that they do not really believe it possible that any change or any lessening of control on their part could bring about anything but the realization of disaster for all concerned. In Tara's treatment process, we noticed a similar fear that, if she lets out "that side of me that's real," everything will fall apart. She asked the therapist who will pick up the pieces if she falls apart. She is probably convinced that nobody will.

What makes the risk of a disaster so great, according to Riviere, is that the patient feels guilty for having destroyed the love objects in his inner world. Out of guilt, the patient cannot allow themselves to get better in therapy: every one of these acts and thoughts of selfishness and injury to others has to be reversed, to be made good, by sacrifices on the patient's own part. In other words, the patient has the feeling that they deserve no help until their loved ones have received full measure. Adding to Freud's explanation, Riviere points here towards an altruistic motive that is behind the negative therapeutic reaction. She writes that "it is the love for his internal objects, which lies behind and produces the unbearable guilt and pain, the need to sacrifice his life for theirs … that makes this resistance so stubborn." (p. 319) This offers an interesting alternative reading of Tara's conflictual relationship with her family. Behind the reproaches towards her family, the expressed wish "to put an end to things with my sister," and the actual ruptures, which dominated so many of the sessions, there might have been a fundamental love and wish to repair the damage Tara had done to her inner objects. The wish to confront her younger sister might at a deeper level have been the expression of a wish to keep alive the internal bond with the older sister they had lost prematurely.

Despite her attempts, Tara had great difficulties in attaining reparation of her object relations. Weiss (2020) points out that the impossibility of reparation creates repetition, and it

is repetition that augments guilt and leads to further damage. As Tara struggled to access more complex feelings of guilt in the treatment, reparation was also out of reach, and her situation got worse. Repetition can be a way to maintain a status quo, by returning to something one has known from the past and by compulsively doing it over and over again. In the case formulation, the psychoanalyst pointed out that Tara identified with an abandoning maternal object. It seems that during the treatment, as an opportunity for change started to become real, unconscious guilt about the damage done to internal objects forced Tara into a pattern of repetition compulsion. This might explain the repeated pattern of breaking away from significant others during the treatment process: from her children, her work, her family and, finally, from her therapist.

This then also led us to consider the transference. There is some evidence that the therapist was experienced by Tara as an object that criticized her and put her down. The interventions of the therapist were not heard as insights coming from a good object, but as accusations coming from a cruel and critical object. The more the therapist tried to make the patient understand certain unconscious patterns, the more the therapist became associated with the cruel superego. The cruel superego punished the ego for the wish of getting help by forcing her to retreat in her own private world of masochistic suffering. Part of the patient tried to protect the therapeutic work, but this was disconnected from the attacks on her need and turning to masochistic self-sufficiency.

Another perspective that we considered in seeking to understand the challenges in Tara's treatment process is trauma theory and the notion of lack of symbolization (Bohleber & Leuzinger-Bohleber, 2016; Leuzinger-Bohleber, 2021). The abruptness of the abandonment by Tara's mother, in combination with a social environment that refused to talk about it, might qualify this experience as traumatic. The fact that Tara's father and wider family never talked about the mother and her abandonment created a void in the meaning structures that

underpinned Tara's view of herself, others and the world in general. In relation to this void, Tara is in a passive, helpless, speechless position. This is illustrated by her reaction when unexpectedly, as a teenager, she picks up the phone and hears her mother's voice on the other end of the line. Tara is unable to say anything; she is completely overwhelmed by emotions. Afterwards, she has no memory of the words her mother spoke to her.

As a consequence of early childhood trauma, patients might fail to develop basic trust (Bohleber & Leuzinger-Bohleber, 2016). The void in the meaning structures results in a loss of trust in the shared, symbolically mediated world. The Other is no longer perceived as a guarantee for the subject's existence. The confrontation with the absence of an adequate response by the Other returned in the silence of Tara's grandparents about her older sister's premature death and, a few months before the start of the treatment, in the lack of response when Tara sent an email to all her family members informing them about her state of depression. Then, at the very start of the treatment, Tara was not able to meet with her therapist as she was 45 minutes late for her first session and the therapist had already left the building. In the follow-up interview, the therapist said that, in hindsight, this missed encounter was the bedrock on which all subsequent sessions took place. The lack of basic trust might also have prevented Tara from opening up in therapy for fear of being left to "pick up the pieces" herself if she broke down. Tara seemed to have no confidence in the support that the therapist could have offered her in such an event. It could well be that the pre-imposed treatment length of 18 months might have already made it more difficult for Tara to develop a deeper trust in her therapist. In a sense, one could argue that a new experience of abandonment was already scheduled into the treatment format.

Clinical Implications

The concepts of negative therapeutic reaction, trauma and repetition compulsion have inspired therapeutic pessimism, even though Riviere warned against this conclusion in 1936. On the

basis of our understanding of the dynamics in this case study, we want to formulate some ideas about what therapists might consider – and do – in similar clinical situations. Riviere herself, for instance, points towards a solution on the basis of her argument that the negative therapeutic reaction is based on love and self-sacrifice. She writes: "we can counter this resistance only by unearthing this love and so the guilt with it. … So it is the positive transference in the patient that we must bring to realization; and this is what they resist beyond all" (1936, p. 319). In a similar vein, Blass more recently suggested the use of "transference interpretations in the service of Eros, atonement and self-giving" (2020, p. 1201). She suggested that the analyst's interventions should come from a love of the other and of truth, and that the analyst should work towards a truer and more loving relationship to reality. In the treatment of Tara, this might mean that one focuses less on the aggressive, masochistic aspects of her inner life, and more on her love for others and her wish to repair damaged relationships. But even then, this will be a difficult process that can be expected to take much more time than Tara would have been able to get in the context of the TADS.

Tara's therapist relied quite frequently on the use of an interpretative stance, including a lot of transference interpretations from the very first session onwards. One of the main topics of the therapist's interpretations concerned Tara's reluctance to fully engage in the treatment. The psychoanalyst who formulated the case conceptualization saw this as an expression of a conflict between a genuine wish to get better and a masochistic tendency to suffer alone. From the very first session, the therapist offered a considerable number of interpretations that pointed out this conflict. The question is whether it was not too soon in the treatment process to point out the possible existence of an internal conflict within her, as there had been barely any time to develop a safe and trusting therapeutic relationship. This question goes right to the heart of the debate between Melanie Klein, who insisted on the importance of early interpretation, and Anna Freud, who was convinced of the necessity to develop a safe

and trusting therapeutic relationship first. The study of Tara's treatment process indicated that she seemed to have perceived the interpretations as a critique of her behaviour and as a personal rejection, as if she had failed to meet someone's expectations yet again. Several excerpts from the therapy sessions illustrate how these interpretations did not seem to have been experienced as a good provision from a good object. This possibly confirmed Tara's negative view of herself and her sense of isolation even further. This was further compounded by the transference interpretations that invited Tara to reflect on the therapeutic relationship. It seemed that Tara was only at the start of being able to think about her experience of the therapeutic relationship, because a safe and trusting therapeutic relationship was only starting to develop. This is not a critique of the therapist's approach. We were actually impressed by the perceptiveness of the therapist, the intelligence of the interpretations and the elegant way in which she made connections between the past and the present. She was particularly good at keeping in touch with the emotional process the patient went through during and between the sessions, and she shared this with warmth and empathy with the patient. This therapist does not correspond to the stereotype of the cold and aloof psychoanalyst. However, it might have been better for Tara if the therapist had eased her into the particular psychoanalytic way of thinking by providing some explanations and wording the interpretations more carefully as possibilities. It would probably have been helpful for Tara to have more support as she started to think about her internal world, to uncover possible conflicts within that internal world and to see these conflicts in the current relationship with the therapist. It might also have been helpful if the therapist had not been constrained by the framework of a fixed number of weekly sessions imposed by the TADS.

Nonetheless, following these suggestions would not guarantee a successful process. We think it is important to be aware of the potential impact of aggressive and punitive forces on the treatment process. Tara seemed to have needed a prolonged period of giving her

therapist a hard time through the repetition of the experience of abandonment. There may be a need for the patient to have times at which revenge is taken on objects that are felt to have slighted them or caused them injury. The therapist was repeatedly given the experience of the "Where's Your Mama Gone?" song. This appeared to form an important part of the dynamic between her and the therapist, which would have needed to be contained, understood and worked through with time. According to Weiss (2020), the regaining of a capacity to mourn and to make reparation is perhaps the only path to find a way out of the grip of the repetition compulsion. Although difficult to sustain as a therapist, the repetition compulsion can be a form of cooperation that is essential to a therapy, permitting a working through. This is a difficult dilemma when it involves cutting oneself off from one's only source of connection. We would argue that during sessions five to seven, Tara was able to make contact with deeper levels of mental pain, that she started to see the therapist as a person with whom she had a history, that she developed an ability to reflect, and that she started to do therapeutic work that might lead to mourning and reparation. However, there were also many moments when the therapist might not be able to do much more than instil hope and keep the perspective of future treatment alive.

Limitations

The present study aimed to formulate an understanding about what might prevent LTPP from being effective for the treatment of some individuals with TRD. A first limitation of this study concerns the criterion for defining treatment failure. We selected the case on the basis of lack of symptomatic improvement, which was the criterion used in the trial. However, psychoanalytic treatment does not aim for symptom change in the first place, but for structural change in personality functioning. The closer scrutiny of the therapy process revealed that there were moments and processes of real therapeutic work, and during the follow-up interview Tara described how this therapy had helped her to make some important

changes in her life. After reading this manuscript, the therapist noted that this case study also illustrates that any one treatment is part of a greater whole: this "failed" treatment allowed Tara to break down, get psychiatric help and access a supportive therapy group. Therefore, we cannot conclude that the treatment was a complete failure in the psychoanalytic sense. A second limitation of this study resides in the fact that it concerns a single case and that generalization to broader populations of patients with TRD is limited. Therefore, it would be valuable to contrast our results with findings from other case studies on the treatment of TRD.

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