How to Know When Psychotherapy is Really Working [1]

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Traditionally, evaluations of therapy occur as outcome studies. It is relatively straightforward to look at someone months or years after therapy ends and compare her state of mind and functioning with the way she was when she began treatment. It is true that there are many accidental and confounding variables that can provide alternative explanations other than treatment efficacy for gains that are measured after therapy is over. Nonetheless, it is possible to make a fairly decent after-the-fact assessment of improvement or lack of improvement, regardless of the reality that one may not know for sure that the change or lack thereof resulted solely or mainly from the treatment intervention.

We can all recognize, though, the importance for both client and therapist of finding an accurate and reliable way to evaluate an ongoing treatment process. The therapist needs to know whether what she is doing is effective and, if not, how to make the process more effective through self-examination, seeking therapy or supervision for herself, or, in some cases, by referring the client to another therapist. The client, who is investing time, money, and emotional capital, also needs a way to know if the treatment is working. Yet both therapist and client can find it very challenging to assess the effectiveness of an ongoing treatment process. To illustrate:

Let's say the client responds quickly and dramatically to starting treatment, and nearly all of the symptoms that brought her for help disappear. Does this improvement represent real progress, that is, does it reflect an effective treatment process, or does it signify a "flight into health," a false cure that will disintegrate if therapy ends?

Conversely, let's say that immediately after entering treatment, the client gets worse. Is this a sign of an inadequate, that is, an iatrogenic treatment or is it an expectable and normal part of the therapy process given the particular personality of this client. Alternatively, is it possible that the client's reaction is not attributable to the treatment process at all, but is being caused by some other loss, such as the death of a parent or spouse, a setback at work, or some other significant personal issue?

What if, as often happens, the client feels therapy isn't helping – how can the client determine if this concern reflects a genuine perception, or a false belief. Similarly, despite a substantial investment in the therapeutic process, therapists sometimes conclude that a given treatment has reached a dead end – that the client has made all the progress of which she is capable – how does the therapist decide whether this assessment is a genuine perception or a false belief?

I am going to approach the issue of how to determine whether a given treatment is effective from the perspective both of the therapist and also of the client. I am going to focus on Inner Humanism

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treatment, but many of the principles I will advance for evaluating treatment apply to other treatment modalities as well.

Those of you who are familiar with my books, *Smart Love, Addicted to Unhappiness*, and *Intrapsychic Humanism,* know of my discoveries about the nature of psychopathology. I will take a moment to provide a brief overview of the principles underlying Inner Humanism treatment for the benefit of those who may be hearing about this psychology for the first time.

One central discovery, which has since been supported and born out by many independent experimental studies is that children are born loving their parents and believing that their parents love them and want the best for them. One byproduct of this is that every baby is born to love whatever care she gets, that is, no baby can evaluate the care she gets. Babies also believe they are the cause of whatever care they get. So when babies are responded to accurately, according to their true needs, they equate their reaction to those responses with happiness they have brought about themselves. They grow up wanting more of the same happiness – they want others to treat them well, and they will grow up believing in their ability to give the gift of happiness to others as well as to themselves. They will have no needs for conflict, and, consequently, no difficulty making good choices and pursuing them effectively.

On the other hand, when babies' needs are not responded to accurately -- for example, parents follow sleep doctors' advice to let children cry themselves to sleep or listen to advice that tells them to force their two-year-old share, because children are born with no choice but to love whatever care they get, they confuse the unhappiness generated by these parental responses with happiness. Then they learn to need and want more of this unhappiness masquerading as happiness. As adults, they will unknowingly have conflicting motives both for genuine happiness and also for the unhappiness they have confused with happiness. All clients come to treatment because learned but unrecognized needs for unhappiness are robbing them of genuine pleasure in some area of life – they suffer emotionally (for example, they are depressed, phobic, manic, self-critical), their relationships are unrewarding, they are not happy or are not effective at work, or they struggle to maintain their health and fitness at an acceptable level. The learned needs for unhappiness that clients bring to treatment make their progress erratic. The more clients make progress and move in the direction of consistently following constructive motives, the more their needs for unhappiness will press for gratification until the inevitable backsliding occurs. As I will discuss in more detail shortly, I call this backsliding an aversive reaction to pleasure. When clients enter treatment, their learned needs for unhappiness are invisible to them, because unknowingly, long ago, clients mistook the unhappiness they seek for happiness. Either they don't see how they are getting in their own way, or they know they are causing themselves unhappiness, but these self-defeating behaviors seem either deserved or inevitable. The invisibility of needs for unhappiness caused by the unrecognized confusion of unhappiness with happiness complicates clients' and therapists' abilities to evaluate the effectiveness of an ongoing treatment process.

Let us turn now to the question of what it means to say therapy is working. Again, I would like to emphasize that while some of these criteria are specific to Inner Humanism treatment, most of them apply to treatment generally. *Genuinely beneficial psychological treatment of any modality is not possible unless the therapist has a regulating motive to help the client rather than to pursue a personal agenda*. Many of the evaluative criteria I am suggesting are based on distinguishing when therapists' responses are regulated by their caregiving ideals (in which case, the therapy is going well) and when

therapists' responses are being regulated by therapists' personal motives (in which case the therapy will be off track).

I am going to focus today on supportive rather than structure building treatment. Supportive treatment uses the therapeutic relationship to strengthen the client's constructive motives and to decrease the power both of the client's self-destructive or self-defeating motives, and also of the client's motives for a pathological type of pleasure (overeating, drinking too much, shopping to excess, etc.). Supportive therapy works when the therapist both supports the client's wishes to experience genuine pleasure in life and, at the same time, helps the client to see that many of her problematic behaviors have been in the service of gratifying heretofore unrecognized motives for unhappiness masquerading as happiness.

This process, in which the client increasingly develops the capacity for a healthy type of self-regulation, becomes most transparent and amenable to input within the therapeutic relationship. For example, clients have a chance to see their relationship conflicts play out with the therapist and to realize that any gratuitous alienation they feel from the therapist is a loss that they don't want to go on causing themselves. A common instance is clients who follow a session in which they were able to share a lot with their therapist by being very late to the next session or missing it entirely. While this reaction gratifies clients' needs for unhappiness in the form of distancing, at the same time clients experience the loss of the pleasure of closeness and sharing that would have occurred if they had had their full session. In effective supportive treatment, then, unrecognized needs for unhappiness eventually become not only known but also come to signify an avoidable source of loss.

In contrast, structure building treatment uses the therapeutic relationship to address the root cause of the clients' conflicts about making self-caretaking choices, namely, the confusion of unhappiness with happiness that occurred early in childhood and resulted in the presence of learned needs for unhappiness. Therapeutic action in structure-building treatment entails helping clients gain true regulatory control over their own inner well-being by offering genuine caregiving pleasure that clients ultimately recognize is superior to the unstable and illusional type of inner well-being they brought to treatment.

I am not going to discuss structure-building treatment, because by the time a person has been in treatment long enough and made sufficient progress to move into the structure building phase, both client and therapist will know that the treatment is working. The hallmark of structure-building treatment is that the client has arrived at a point where there is a newly created set of regulatory motives that don't partake of needs for unhappiness and, therefore, regardless of the extent to which regressions occur, the client will always maintain some degree of mutuality with the therapist.

The engine of therapy is the therapist's ability to place her personal motives under the hegemony of her caregiving motives. This is the real crux of whether therapy will be effective, not only in Inner Humanism treatment, but in all treatment, including, for example, cognitive-behavioral therapy or therapy based on object-relations theory. All of us have both personal motives and caregiving motives. Caregiving motives are motives to meet the developmental needs of one's children or one's clients. Personal motives are all other motives, for example, to get enough exercise, to have enjoyable relationships, to take vacations, and so on. In psychotherapy, the therapist's personal motives should appear mainly in the parameters of the treatment, for example, what days and hours the therapist works, the fee, when she takes vacations, etc. Sometimes personal motives are also introduced when the therapist gets married, gets pregnant, retires, moves to another city, etc. But in the actual treatment

hour, the therapist's responses should be regulated entirely by caregiving motives. For example, if the therapist is thrilled because her team won the world series and she is dying to talk about it, that wish is a personal motive and has no place in the therapy process. If the client never introduces the topic of the championship, the therapist should not bring it up and, even if the client refers to it, the therapist should talk about it only in ways that will be helpful to the client. For example, even if a client asks the therapist if she is a baseball fan, the therapist should not simply take that as an opening to talk about a subject that is very much on her mind but, instead, must decide whether even that much information will interfere with or facilitate the client's constructive motives. While this decision process sounds straightforward, in my experience as a supervisor, I have found that therapists' own personal motives are often invisible to them and are mistaken for caregiving motives.

If the therapist can subjugate her personal motives to her caregiving motives, her client will have the unbroken pleasure (recognized or unrecognized) of being the cause of the therapist's caregiving motives (the reflection of loss free agency), which is the experience she missed out on in childhood. This satisfaction is ultimately more compelling than the pleasure generated by satisfying an unrecognized addiction to unhappiness.

One difficulty is that given the variations in the strength of clients' addictions to unhappiness, therapy can progress with relative straightforwardness, or it can be occupied by long periods of client dissatisfaction. For this reason, effective treatment cannot really be distinguished from ineffective treatment by the yardstick of client satisfaction or short-term progress. As I shall discuss, the key is stable change over time, which occurs only when the therapist consistently and stably responds with caregiving rather than with personal motives.

Clearly, I cannot cover every criterion for effective treatment. In what follows, I have tried to focus on those aspects of an effective treatment process that are most experience-near for both client and therapist, namely: indications that the therapist is responding to the client with caregiving rather than with personal motives; whether the therapist is responding accurately to the client's aversive reactions to pleasure; and symptom improvement or lack thereof. I will also discuss how to evaluate client and therapist beliefs that the treatment is effective or is not effective, as well as how to evaluate the appropriateness of the therapist's interpretations of underlying meanings in the client's communications. Lastly I will consider the important distinction between client involvement and client dependency.

Let us begin by identifying ways to distinguish whether a therapist is responding to her client with personal or with caregiving motives. Given that most clients had parents who at crucial times responded to them with personal motives rather than caregiving motives, it can be very difficult for clients to assess the nature of their therapist's motives. For example, if a therapist acts from a genuine caregiving motive and suggests that a client postpone a marriage the therapist believes would be bad for the client, the client may conclude that the therapist is acting from the personal motive of wanting to interfere with the client's happiness. Or, if a therapist's response is being shaped by a personal motive, for example, the therapist wants to see the client get married and encourages her to join a dating service, the client may mistake the therapist's personal motive for genuine caregiving. The following are some specific guidelines by which clients can distinguish whether their therapist is responding to them with personal or caregiving motives.

The therapist offers advice. If the advice is coming from the therapist's caregiving motives, it will feel truly helpful and respectful. An example is a client who knew she had a blind spot when it

came to her boss and that her motives for conflict often led her to behave in ways that irritated him. She knew it was his birthday and had gone out and bought him a tie and then thought to ask the therapist if she thought she should give it to him. The therapist, who by that time had a good sense for the boss's personality, said that she thought he would think the client had crossed a boundary and that he wouldn't like it. The client was happy and relieved to have brought the problem to the therapeutic relationship and to have been spared the pain of causing herself another negative experience at work.

When a therapist's **personal** motives are in control, the client may experience the therapist's advice as artificial and imposed, or as covering territory the client feels entirely competent to handle on her own. An example is the client who liked to entertain and who mentioned in one session that she was having a dinner party that night. The therapist asked what she was serving and proceeded to give the client advice on how to cook the dishes, even though the client felt no need for this input. The client felt both depreciated and also as though her process had been hijacked by the therapist's remarks.

Another moment when it is possible to assess whether the therapist is responding with personal or caregiving motives is when the client is feeling negatively about her life, her work, her relationships, or the therapist. If the therapist is able to respond with caregiving motives, she will remain available to hear the client's dysphoria, even when she is the target of it, and to help the client mourn the loss it represents.

The client can be certain that the therapist is being regulated by her **personal** rather than by her caregiving motives if the therapist reacts to the client's negativity by expressing disappointment or irritation when the client's pain surfaces in an intense manner. An example is the therapist who responded to the client's renewed feelings of despair about her ability to lose weight by saying, "I don't understand why you feel that way when you were able to lose three pounds last week." The client felt the rebuke keenly, and, as a result, felt she had to watch what she said in her therapy to avoid angering her therapist. In general, it is a bad sign when clients who did not enter treatment with these concerns feel they have to monitor their words for fear of disappointing their therapist and being criticized.

A related instance in which the therapist responds with personal motives to the client's negativity is the therapist who buys into the client's feelings of self-deprecation, thereby endorsing and cementing them. Clients who are troubled by persistent bouts of self-rage, which occur in the therapy hour as elsewhere in their lives, hope deep down that the therapist will not view them as negatively as they see themselves. When the therapist seems convinced by the client's self-critical opinions, the client is harmed considerably.

An example is the client who was very bright but had trouble believing in his academic abilities because he was tortured by an internal voice that constantly accused him of being "stupid." He repeatedly told his therapist that he didn't think he was going to make it through architecture school, to which he had just been accepted, because he was sure he wasn't as capable as his fellow classmates would be. After the client reiterated this viewpoint in a number of sessions, the therapist replied, "Well, maybe it wouldn't hurt to put in an application in a related field, like design." The client agreed that this would be a good idea and that it was in keeping with his own desire to make the world beautiful, but deep down, he felt devastated.

Clients should not experience their therapist as accepting clients' worst feelings about themselves as reality. Rather, when a therapist's caregiving motives are in control, she will retain a balanced view of the client's capabilities no matter how negative the client's self-evaluation.

Another indication of whether a therapist is being regulated by personal or caregiving motives is whether the therapist attempts to impose her own agenda on the client. As long as the client is not pursuing self-destructive motives, the therapist should remain open to whatever life choices the client makes, and should focus on increasing the effectiveness of the client's pursuit of these choices, whatever they are.

The client can regard it as a bad sign when her therapist has an agenda that is different from hers, for example in relation to: job change, divorce, dating, wanting children, choice of friends, political or social views, etc. An example is the client who was in a marriage that was making her utterly miserable and who concluded after much soul searching and many months of discussing the marriage in her treatment sessions that she wanted a divorce. When she conveyed this decision to her therapist, the therapist responded that she didn't think the client had worked hard enough on saving her marriage to be able to reach that conclusion legitimately and that she should continue to work on this issue in her treatment.

Fortunately, the therapist had previously shared with the client that her own marriage had been rocky but that she had stuck it out. The client wisely decided to seek treatment elsewhere with a therapist who didn't have an agenda in this area.

When a therapist's *caregiving* motives are in control, she will not initiate displays of physical affection or make out of context statements about the client's virtues – this restraint allows the client freedom to have and express any negative feelings she may have about the treatment or the therapist. Therapists who heap praise on clients or begin or end sessions with physical affection, such as hugs, are giving clients the message that therapists need clients to feel positively about them. While once in a while a client who has been through a very emotional positive or negative experience (has had a baby, has just heard that a parent died, etc.) may give the therapist a hug, these occurrences are rare and should always be initiated by the client. When therapists initiate hugs or make them a regular part of the therapy process, these physical displays of affection interfere with the therapeutic process by giving the client the message, "You should arrive (or leave) feeling good about me and our work together." The client who knows that a hug will begin or end every session does not have the freedom to really explore and share negative feelings. So while, manifestly, hugs are a sign of closeness, in reality they can be coercive and distancing.

One sure way to distinguish a therapist's personal motives from her caregiving motives is how she reacts to experiencing her own angry, irritated, bored or other negative feelings toward the client. There are schools of thought that recommend that the therapist share negative feelings with the client on the grounds that this sharing is justified by the client's behavior, deepens the relationship, provides the client with reality testing in the relationship, and so on. However, this kind of therapist transparency always stems from personal rather than caregiving motives. In fact, any and all negative feelings about the client always originate in the therapist's personal rather than caregiving motives and, therefore, should never be shared with the client. Rather, the therapist has some internal work to do to understand why her personal motives, which are causing the irritation, anger, dislike, disapproval, etc., are regulating her caregiving motives, when it should be the other way around.

I cannot overemphasize that when a therapist's **caregiving** motives are in control, she will view the client's criticisms, complaints, backsliding, missed appointments, failure to progress, etc. as expressions of problems the client brought to treatment that the therapist is trying to help her with, and

not as behaviors that are personally aversive to the therapist. When these behaviors are viewed through the perspective of the therapist's caregiving motives, they will stimulate the therapist to reflect on the most helpful response to the client, rather than to think about her personal reactions, which ideally she will be aware of, but which she will have no need to act on.

When therapists share negative feelings about the client with the client, they are in essence attempting to control the client in order to sooth their own inner disquiet – they are trying to get the client to "shape up" and stop making them feel uncomfortable. In other words, when the therapist tells the client that she is feeling angry, bored, irritated, etc., the client hears the therapist saying, "I don't like you when you do this." In order to be liked by the therapist, the client will try to change her behavior.

In contrast, when the therapist's responses remain regulated by *caregiving* motives, the client who is unhappy or critical will get the message that the therapist doesn't change toward her when she is feeling negatively, but remains just as motivated to help her as when she is feeling happy and positive. This perception advances the client in the painstaking process of coming to perceive the superiority of genuine caregetting pleasure over the familiar but inferior pleasure produced by learned needs for unhappiness masquerading as happiness.

I would add that therapists' expressions of boredom or irritation can take unusual forms. I once heard a lecture by an eminent psychoanalyst who said that when his clients "deliberately" bored him by droning on repetitively about their problems, he would communicate his displeasure "subtly" by "humming." Hopefully, his clients realized that they were being responded to with personal not caregiving motives and took themselves elsewhere.

Also helpful in assessing whether a therapist is responding with personal or caregiving motives is the way she handles the details of her personal life. In general, the therapist whose *caregiving* motives are regulating the treatment process will restrict details of her personal life to direct responses to client questions or topics, will keep these details to a minimum, and will be selective about divulging them in terms of whether this will be helpful to a particular client at a particular point in the process. Therapists whose *personal* motives are in control will often give the therapeutic relationship a social cast by frequently or regularly engaging in a discussion of their personal lives, opinions, troubles, or history. Therapists may present this relating of personal information as caregiving intimacy. The client may feel pleased that the therapist is sharing so much of herself, and that social pleasure may obscure the client's nagging sense that these personal details are transforming the treatment process and making it about the therapist rather than about the client.

Another test of the therapist's ability to put caregiving over personal motives occurs when the therapist makes the inevitable caregiving lapse (forgets a rescheduled appointment, makes an insensitive comment, etc.). The therapist whose caregiving motives are in command will respond to her own caregiving lapses with the willingness to take responsibility and listen to the client's point of view, whereas the therapist whose personal motives are in the driver's seat will handle her errors by blaming the client, denying the lapse, or by taking other evasive actions designed to keep herself from having to acknowledge her error.

At the other extreme, there are therapists who respond to their own caregiving lapse with harsh self-criticism, which feels entirely warranted. However, this response actually signifies that the therapist has some internal work to do. A therapist's self-critical feelings in response to a caregiving lapse is a personal motive because it is about the therapist, and not about the client. When a therapist responds to

a lapse accurately, that is, with caregiving rather than with personal motives, she will focus on the effect of the lapse on the client and on helping the client mourn the loss in the best possible way, and not on her own shortcomings. To the extent she focuses on herself, it will be in a rage-free attempt to understand the lapse so as to prevent its reoccurrence.

The final point in my discussion of the importance of distinguishing whether a therapist is responding with personal or caregiving motives concerns whether the therapist responds to *increased client involvement* with availability and pleasure at the client's progress (with caregiving motives), or with distancing in the form of creating conflict, rebuffing closeness, interpreting pain etc. An example is a client who had for many months appeared quite uninvolved in the therapeutic relationship to the point that she never commented on or appeared to notice interruptions due to the therapist's vacations or illness. Moreover, she was almost always five or ten minutes late to her sessions, a loss she also never seemed to notice. One day the therapist came back from lunch half an hour before the client's appointment and discovered her sitting in the waiting room. The therapist reacted with a personal rather than a caregiving motive saying, "Did you get your appointment time confused? It's not for another half an hour?" The client looked ashamed, left, and came back late by the usual ten minutes. If the therapist had responded with *caregiving* motives, she would have realized that the client was manifesting an increased involvement by being early and would have simply smiled warmly and said, "I'll be with you in a little while."

I turn now to other criteria that client and therapist can use to evaluate the therapy process in midstream. In all of these, however, the predominance of the therapist's caregiving motives or personal motives remains an important variable, so these criteria are meant to be descriptive, rather than logically exclusive categories.

One form of client distancing that is so common that it merits its own discussion is the *aversive reaction to pleasure*. The learned though unrecognized needs for unhappiness that every client brings to treatment make the client's progress erratic. The more a client moves in the direction of consistently following constructive motives, the more her needs for unhappiness will press for gratification until the inevitable backsliding occurs. I call this backsliding an aversive reaction to pleasure.

Aversive reactions to pleasure are a part of the healing process because they make heretofore unrecognized learned needs for unhappiness amenable to the treatment process. Aversive reactions to pleasure are as present in the treatment relationship as they are in the client's life, and they always involve some sort of distancing by the client from the therapist. Aversive reactions to pleasure can become constructive experiences for the client only when the therapist is aware of the dynamics of the aversive reaction and is able to respond with caregiving rather than with personal motives. Then, as the client becomes more aware of the way in which genuine pleasure triggers the need for the inferior pleasure of isolation and distance or of self-defeating behaviors, the inferior pleasure represented by the aversive reaction to pleasure incrementally loses its appeal.

In contrast, when the client has an aversive reaction to the pleasure of a moment of increased involvement with the therapist and reacts by distancing herself (that is, the client comes late or misses the next session altogether, is suddenly very critical of the therapist, or spends the session talking about details with little emotional meaning) the therapist whose personal motives are in control may feel surprised, irritated, as though the client's seeming progress was an illusion, or may respond with some other way of distancing herself emotionally. Personal motives may also cause therapists to accept their

clients' aversive reaction to pleasure as reality, that is, as "all there is," thereby preventing clients from understanding or losing interest in the unrecognized need for unhappiness underlying the negative feelings.

An example is the client who had worked hard in his treatment on improving his relationship with his thirteen year old son. The client, whose own parents had been very critical and harsh, was given to provoking his son by being overbearing and then responding punitively when his son resisted his commands. In one session, the client told the therapist with much pleasure that the previous evening he had come home to find his son in the den eating fast food and watching TV. The client started to yell at his son to "pick up that mess" and "eat in the kitchen," but when he looked at the boy he could see how much he was enjoying himself. Instead of starting a fight, the client sat down next to his son and watched the program with him. Then at the end he helped him pick up the empty food cartons. The therapist felt very pleased at the client's progress and happy with her own efforts.

To the therapist's surprise, when the client came for his session the following week, he looked very dejected. He told the therapist that he had blown up at his son because he hadn't taken the garbage out on time and had actually taken the overflowing garbage can and had dumped it on the floor in his son's room. The therapist felt horrified, and was especially appalled because she felt that the previous week had shown that the client could control himself if he wanted to. She did nothing to interfere with the client's berating of himself because she felt it was "reality testing." The client left the hour feeling even more self-critical and hopeless than he had when he entered.

If the therapist had both understood the dynamic of aversive reactions to pleasure and also had been regulated by her caregiving motives rather than by her personal motives, she would have responded very differently. For example, she might have said that while she could hear how disappointed the client felt at having blown up at his son, this lapse could be seen as part and parcel of the progress he was making. She would have reminded the client of the giant leap forward he had made the previous week. She would add that this recent incident was a reaction to the new-found pleasure the client had experienced with his son, which led to the client's unrecognized attempt to recreate the familiar, conflicted way of relating that was so comfortable for him given the childhood he had had.

This response from his therapist would have helped the client to put his outburst in perspective – to see it as a temporary setback in the progress he was making rather than as a sign of a black and incorrigible nature. He also would have been that much closer to gaining regulatory control over his need to follow relationship pleasure with relationship pain.

Another criterion that therapist and client often use to evaluate the efficacy of an ongoing therapy process is symptom improvement. This particular criterion, while valid in many cases, can also be extremely misleading. For example, there are clients whose character structure drives them to be "good patients," with the result that their symptoms improve almost immediately upon entering treatment. If the therapist isn't careful, the client will conclude that the therapy has been wonderfully effective, thank the therapist, and leave, only to find that most if not all symptoms return in fairly short order. In this case, the therapist needs gently to help the client remain in treatment long enough to realize that she does not have to improve dramatically in order to engage the therapist's caring and that, in fact, the therapist understands that some backsliding is normal and inevitable. Put differently, this client needs help to realize that the one symptom that hasn't changed is the painful feelings that ongoing struggles

with herself would cause the therapist to dislike her or lose interest and that she has to make the therapist look good and, therefore, feel good by getting well immediately.

Conversely, many clients are convinced that they have not changed at all as the result of treatment, and they accuse the therapist of not helping them. This belief may be true, in which case the therapy really is not effective. It may also represent an aversive reaction to the pleasure of getting better, which is causing the client to ignore the improvements she has made and to dwell only on symptoms that are proving refractory. Clients who feel nothing has changed might evaluate the reality of this belief by taking an inventory of the difficulties they were experiencing when they entered treatment and evaluating whether some, if not all of these symptoms are improving or significantly improved. Clients cannot rely solely on whether they feel happy, because sad and self-critical feelings are often the last symptoms to change and, in fact, may take center stage as other symptoms improve. Clients who were accustomed to explaining feelings of depression or self-rage by pointing to disappointing aspects of their lives, often feel puzzled and upset when the painful emotions remain even though their lives have improved. However, it is at this point that painful emotions can most effectively be addressed, because it is clear to the client that they are only there because they are satisfying learned though heretofore unrecognized needs for unhappiness and not because their lives are in chaos.

In general, with the exception of clients suffering from severe personality disorders, after a year clients should see improvement in at least some of the symptoms with which they entered treatment, even if that improvement is unstable. It is a cause for concern if after a year clients see no improvement in their original symptoms or are troubled by the appearance of new, severe symptoms, such as suicidal ideation, that are not transitory. With the possible exception of the treatment of severely borderline clients, in an effective treatment there should not be a significant, long-lasting increase in self-rage, suicidal thoughts etc. In general, when clients continue to suffer from the same symptoms with which they entered treatment or experience new, significant symptoms, both client and therapist need to consider whether the treatment is working, and not just assume that the client is difficult, resistant, or untreatable. Clients in this situation can seek another opinion, and therapists can seek consultation or treatment for themselves.

We should note that there are instances in which clients feel that new symptoms, including suicidal thoughts or depressed feelings, have emerged but, on reflection, these clients realize that in fact these thoughts and feelings have always been present, but were not noticed or were attributed to outside influences. This is a sign of therapeutic progress.

Sometimes in the course of an effective treatment, due to the continuing presence of learned needs for unhappiness, the original symptoms may be replaced by other, less severe symptoms. One client, who was in danger of being fired because he behaved so resentfully toward his boss whenever he was asked to do something and was a reluctant and resistant team member, realized that he was importing childhood battles with authority into the workplace and hurting himself in the process. Over the next few months he made tremendous strides toward becoming a willing employee and team player and his job became more secure. At the same time, he reported that his wife was complaining that he was "snappish" with her when she asked him to do chores such as taking out the garbage. The client himself realized that he was transplanting his conflicts with authority to a new area and that he did not want his marriage to suffer. He began to work on this new, but less self-destructive symptom.

We emphasize that there are clients who continue to feel negatively in their treatment sessions, even as their lives improve and they feel much happier and more effective in the "real" world. Children, especially, tend to have aversive reactions that can cause them to go for months and even years without talking much to the therapist or, even, consciously liking treatment. If their treatment is effective, children will experience dramatic improvements in their social, academic, and family lives outside of the treatment hour. In this case, the therapist does not need to worry if the child goes for long periods of time with little communication.

In some ways, it is more problematic to evaluate the quality of a therapeutic process when clients are convinced their treatment is helping them than when they are worried it isn't effective. The problem is that feeling good about one's treatment and one's therapist is not necessarily a sign the treatment is working. Clients are understandably not inclined to "look a gift horse in the mouth" and question their positive feelings.

If a therapist needs her clients to feel good about her, she may do everything in her power to prevent clients from feeling angry or negative about her, including: becoming silent or irritated when the client is negative or quarrelsome, and conversational and warm when the client is idealizing her; interpreting all of the client's negative feelings as transference; and subtly or not so subtly endorsing the client's self-rage, which makes the client insecure about her critical perceptions of the therapist.

Clients who feel positively about their treatment and their therapist should ask themselves whether they also feel good about how their angry or negative feelings are responded to, that is, whether they feel the therapist helps the client with her negative feelings and neither endorses them nor becomes irritated by them. Moreover, the client needs to consider whether the close feelings she has for the therapist reflect genuine caregiving pleasure or a non-therapeutic social closeness. If they represent a **social** type of closeness, the positive feelings will rest on admiration for the therapist; on a feeling of being privileged because the therapist has shared details of her life; on the impression that the therapist likes and approves of the client; or on the fact that the therapist is willing to run the client's life for her. If closeness to the therapist is based on **genuine caregiving pleasure**, it will arise from the experience of being accurately understood and unconditionally responded to.

It is equally important that the therapist be able to distinguish client compliance from genuine therapeutic involvement. Therapists must always monitor and evaluate whether their personal need to be liked and to feel effective is interfering with their caregiving ideal of responding with caregiving motives, which include making room for and helping clients with negative feelings of alienation, anger, contempt, and so on.

We would like briefly to comment on an aspect of treatment evaluation that applies mostly to the therapist, namely the ability to distinguish content and process meanings. In intrapsychic treatment, we distinguish between client communications that have process meanings and those whose significance is content only. The *process* meaning of a communication relates solely to the conflict between the client's motives for genuine caregetting intimacy with the therapist and the client's motives to avoid this intimacy and to pursue learned needs for unhappiness. The *content* meaning of the client's communication encompasses all other significance of that communication besides the process meaning.

The distinction between content and process meanings rests on the significance any association has in relation to the therapeutic goal that the client increasingly acquire the capacity and desire for stable involvement in the mutuality of the caregiving relationship, which signifies an increasingly stable

motive for constructive pleasure. This distinction is dynamic in that it is person and situation dependent. In a treatment that is going well, therapists will be able to track the process meaning of their clients' communications both within sessions and between sessions.

An example of a process meaning is the dream of a client who in the previous session had shared with his therapist the fact that he had been visiting pornographic internet sites, a troubling habit he had been too ashamed to mention previously. In the next session, the client reported a dream in which he was in a jail cell sentenced to life imprisonment. The stench of the jail was overpowering, and he was terrified by the menacing look of his cellmate. The client awoke covered with sweat and terribly frightened. He had no idea what the dream represented. The therapist, who saw the process meaning, suggested that the client was having an aversive reaction to the pleasure of sharing more of himself in the previous session. The dream was saying that the result of sharing his "shameful" behavior would be the punishment of isolation and the hostility of others (most especially, the therapist) rather than the actual result, which was increased intimacy with the therapist and better regulatory control over his self-defeating impulses. In other words, the client was using the dream to undermine the pleasure of sharing more of himself with the therapist by trying to convince himself that the therapist would be angry at his sharing, rather than happy that the client was able to bring this longstanding problem to the therapeutic relationship.

For therapy to be effective, it is crucial that therapists keep their fingers on the pulse of the process meaning of their clients' communications. When a therapist loses the thread of the process meaning, it is a sign that something has gone awry. The therapist should use this experience of being out of touch with the process meaning to think back over the last few sessions to try to retrieve the process and, if that effort doesn't work, to get some supervisory help.

The last criterion for evaluating effective treatment we will discuss today can be summed up in the contrast between dependency and involvement. It is not uncommon for clients to leave treatment because they feel it has made them dependent and that, therefore, the treatment is not helping or has reached the end of its usefulness. Therapists, too, not infrequently conclude that clients have become "too dependent" and that either the therapist should be less active, the frequency of client visits should be cut back, or the client should stop treatment altogether in order to try to "fly on her own."

The problem with this way of thinking on the part of both client and therapist is that it confounds two very different types of relating, namely involvement and dependency. Dependency is unhealthy. **Dependency** occurs when the therapy has gone off track and on an ongoing basis, the client feels thoroughly inadequate and helpless without the therapist. **Involvement** is healthy and necessary to a successful treatment. The involved client is able to come to the therapeutic relationship for help distinguishing constructive motives from self-defeating motives, for help strengthening constructive motives vis-à-vis destructive motives, and for help in avoiding self-destructive behavior. An involved client feels empowered by the therapeutic relationship and knows that it enables her to function better than she could on her own.

The irony is that all people with learned needs for unhappiness, which includes all clients entering treatment, are dependent on gratifying these learned needs for unhappiness in order to maintain their inner equilibrium. So long as needs for unhappiness persist and have power, in an effective treatment relationship, the client's choice is not between dependence on the therapist and independence without her. Rather, the choice is between depending on the gratification of needs for unhappiness to

maintain inner stability, which means continuing the painful status quo, and involvement with the therapist to nurture inner stability, which is constructive, growth-promoting, and forward moving. True independence from the therapist occurs not by leaving the therapist's office, but by freeing oneself from the periodic need to rely on self-defeating behaviors to feel whole. Put differently, only through involvement with the therapist can the client truly free herself from the dependency on self-defeating or self-destructive behaviors.

The misidentification of positive involvement with the therapist as a harmful dependency arises from the trauma of a childhood in which parents had aversive reactions to the pleasure of caring for their children and made children feel that their normal, age-appropriate needs for love and care were somehow bad, shameful, draining on the parents, or infantile.

Clients and therapists often attach negative meanings of dependency to the positive experience of involvement. For example, clients who realize that they don't feel as good or as functional when their therapist is on vacation may castigate themselves for being weak and conclude that the therapy is fostering an unhealthy dependency, when in fact they are having a normal and expectable reaction to the absence of the therapeutic mutuality. That is, for much of the duration of treatment, there is no reason to think that clients should feel as good or function as well when the therapeutic mutuality is not concretely available to help them turn away from the siren-call of needs for unhappiness. As treatment progresses, clients' involvement in the therapeutic relationship will become internalized, with the result that they can turn to that positive, internalized relationship rather than to learned needs for unhappiness when the therapist is on vacation.

Both client and therapist need to remain aware that moments of increased involvement on the client's part will frequently be followed by aversive reactions to that pleasure. An example is the client who had always reacted to his therapist's vacation by denying that it had any meaning for him. After one vacation he was actually able to tell his therapist that he had missed her and that he was aware of how much better he felt knowing she would be there at his regular time. The therapist commented on the progress represented by this newfound awareness and the client's ability to share it with her. That night the client had a dream, which he shared with the therapist the next day, that he was locked in a closet by his mother and that the closet looked like a shrunken version of the therapy room. His mother told him that he couldn't come out for a week and that he couldn't have food or drink during that time.

The client thought the dream was explained by an unpleasant phone call he had had with his mother the night before, in which she was badgering him to come home and pay her a visit. The therapist added that another layer of meaning was probably contributed by the part of the client that experienced the increased involvement of the previous session not as the liberating pleasure of a greater caregiving mutuality, but rather as a snare that would leave him feeling boxed in, isolated, and deprived.

My goal today has been to suggest concrete ways to evaluate a therapy process that is ongoing. I have tried to show that on the client side this assessment can be complicated by characterological pessimism and also by aversive reactions to pleasure, which can cause negativity and distancing in response to a process that is going well. Client assessments can also be complicated by compliance – the wish to be a good client, which can make the client overly optimistic about the process and uncomfortable bringing in negative or critical feelings.

Therapists' evaluations of their work can be distorted by their inability consistently to respond to clients with caregiving motives rather than personal motives. When personal motives are in control, therapists may derail the process by giving clients the message that they are doing something wrong if they are unhappy or negative or, in contrast, therapists' personal motives may actually stimulate client negativity due to therapists' own aversive reactions when clients become increasingly involved with them. Therapists also sometimes unknowingly undermine the treatment process by gratifying other personal motives, as when they inappropriately give advice or talk about their personal lives.

On the other hand, when therapists' caregiving motives are regulating their work, the process will truly be about their clients. Therapists will not react to client negativity, self-deprecation, or positive idealizations with personal motives such as anger, frustration, disappointment, or pride, but instead will provide a stable caregiving relationship that can encompass each and every feeling clients bring to it. The pleasure of being listened to and responded to in this unique way stimulates clients to seek more of this genuine, constructive pleasure in their relationships, work, and in their lives generally and is the hallmark of an effective treatment process.

Evaluation of the quality of an ongoing therapeutic relationship is the responsibility of both client and therapist. Any problems that are identified can deepen and strengthen the therapeutic relationship if therapists are able to respond by reexamining and reordering the balance between personal and caregiving motives and by seeking consultation where appropriate.