

**<sup>1</sup>Analyzing the San Francisco Psychotherapy Research Project**

**Seth Isaiah Rubin (San Francisco)**

**Nancy Powers (Idaho)**

**1 November 2005**

Seth Isaiah Rubin, Ph.D., FPPR, the Principal Investigator of the San Francisco Psychotherapy Research Project., is a clinical psychologist and analyst at the C.G. Jung Institute of San Francisco, serving as the Institute's Chair of the Research Committee. In private practice. Address: 2019 A Webster Street, San Francisco, CA 94115, USA.

Nancy Powers, Ph.D., the research assistant, is a clinical psychologist who currently practices in Idaho.

The "impossible dream" is over. No wonder that Dostoyevsky, in his diary, calls "Don Quixote" "the saddest book ever written." For it is, he adds, "the story of disillusionment."

Carlos Fuentes

Wisdom comes by disillusionment.

George Santayana

***Abstract***

---

<sup>1</sup> Special thanks are due to John Beebe who generously provided in-depth and skillful editorial help. Thomas Kirsch, as President of the IAAP, provided the original financial support for this research, which over the years was reinforced by the IAAP, CANASJA, a variety of individual Institutes in the U.S., and several individual, anonymous donors. We are deeply grateful.

Psychology, are analyzed by the co-investigators. The history of research at the San Francisco Jung Institute is presented, followed by an overlay of the process leading to the SFPRP. The main approaches for yielding outcome information were consultation in the Clinic of the C.G. Jung Institute of San Francisco with the Clinic director, coordinators, and interns to refine research instruments and procedures toward meaningful data collection, and the administration of surveys to the entire analyst membership of the Institute to learn about how analysts actually practiced and how willing they were to participate in research studying their practices. The results of the surveys are presented, followed by the final version of the SFPRP data collection forms and procedures that emerged after a study of how well the instruments were yielding meaningful data. The SFPRP design is a prospective psychotherapy outcome study with 4 measurement occasions: intake, termination, 1-year follow-up, and 5-year follow-up. There were two major failings in the execution of the original design: 1. A woefully inadequate number of analysts and candidates volunteered to participate in the research, and 2. Follow-up proved to be very difficult to conduct on a meaningful basis. In lieu of the planned data analyses, which could be supported on statistical grounds, the faults in the study are described in detail and analyzed in depth. The most positive outcome turned out to be the bridge built between the SFPRP and the Wallerstein research on Psychological Capacities. The Wallerstein research continues in the Institute's Clinic in the wake of the SFPRP.

***Key Words:*** psychotherapy research outcomes empirical validation Jungian analysis

*Word Count:* 7270

### *History*

The San Francisco Psychotherapy Research Project (SFPRP) emerged out of a long tradition of empirical research at the C.G. Jung Institute of San Francisco. The earliest documented reference about research occurred in 1957 during the seminal discussions about the formation of the Institute out of its preexisting Society of Jungian Analysts. In 1963, an already existing Research Committee merged with the original Clinic Committee. It began working to develop a longitudinal study similar to the one at the Institute of Human Development at the University of California at Berkeley.. Even though the Clinic Committee eventually separated its functions from the Research Committee, the Clinic continued to be an active venue for empirical research as well as a center for training pre-doctoral psychology interns in Jungian psychotherapy and serving low-fee, long-term psychotherapy patients.

In 1990, the Clinic's first line of research investigation came to an end. In 1992, Seth Rubin presented a paper at the IAAP Congress in Chicago in which he made a case for conducting psychotherapy outcome research on Jungian analysis. After moving to San Francisco and becoming a member of the Institute in 1993, he set about translating his ideas into practice in a slow, step-by-step process. In 1995 he made presentations at the Society for Psychotherapy Research and the IAAP Congress in Zürich. In 1996, he conducted a Professional Membership Survey of the Institute so as to ascertain current

practices of analysts conducting psychotherapy as well as the interest of Institute analysts in participating in the SFPRP. In 1997, he replicated the survey in order to determine the reliability of the original results. In 1998, he prepared a research proposal for submission to the IAAP. At that point, the Committee for the Protection of Human Research Participants, the first IRB at the Institute, was formed. The research proposal was vetted by this committee as well as the Research Committee before it was reviewed by the Institute's Executive Committee and approved as a project of the Institute.

### *Membership Surveys*

In earlier papers, e.g., those presented to the 1997 California Conference of Jungian Analysts and Control Stage Candidates and the 1998 IAAP Congress in Zürich, Seth Rubin has presented the results of the Professional Membership Surveys. The results of the second survey, given in 1997, essentially replicated the results of the 1996 survey, so only the results of the initial 1996 survey will be presented in detail here.. Most of the questions the analysts were invited to answer in this survey survive nearly entirely in one of the instruments generated by the SFPRP, the Portrait of my Practice form (POMP), which is appended at the end of this article. In addition to the questions contained in the POMP, however, there were three open ended questions asked of the analysts in the 1996 survey and its 1997 follow-up: 1. How do you differentiate between therapy and analysis (or, do you?)? 2. What is your position on the distinction between clinical and symbolic work? 3. Can you have somebody in analysis who is on psychiatric medication? Following these queries, there was a brief description of the SFPRP

followed by what for the future of this research was the operative question: Would you be willing to participate?

Sixty analysts out of about 100 responded, 32 male and 28 female. (Ten additional members returned written statements only, which are not included in the quantitative analyses.) The ages of the respondents ranged from 45 to 81 in a positively skewed distribution with a mode of 52 years. The year each of these respondents were certified as Jungian analysts ranged from 1963 to 1994. The largest number of respondents were physicians, followed by psychologists, social workers and MFCCs. (This was skewed from OR this followed the percentages within the total membership that received the invitation to participate.)

The following information pertained to "your analysand who most recently finished therapy." The most frequently cited referral source for this analysand had been another analyst followed by another professional, with other analysands trailing behind as a distant third referral source. This pattern of referral source was typical of the other analysands in these respondents' practices. Therapy with the most recently terminated analysand had usually begun on a once-a-week basis (in one case, more than 4 times a week), but could change during the course of therapy. Forty nine of these most recently terminated patients identified by this question had paid for their therapy out of pocket, in 40 of the cases paying the analyst's full fee. Telephone sessions were used for only 10 of the patients, and even among them, the percent of therapy time conducted by phone sessions was 10 per cent or less. The couch was use in 11 cases, and never at the

beginning of therapy. Alternating between the couch and the chair was reported in about half of these cases. The length of therapy ranged from less than one year up to 29 years! Only 10 cases were in therapy for 10 or more years, however. The analysands initiated the termination in 42 cases; the initiative for termination was reported as "shared" in x cases; and in only one case did the analyst take the lead as the sole terminator. For 29 of these patients, the respondents felt that the therapy was terminated because the work was done. The other reasons for termination were evenly distributed over a range of reasons, as follows. After 31 of the "terminations," there was further analytical contact between the analyst and the analysand.

So far as willingness to participate in the prospective research project using Clinic analysands, eleven analysts agreed to participate in the research and 16 additional analysts were open to the possibility. (This figure increased only slightly in the second membership survey.)

There were fewer, but thoughtful, answers to the open-ended questions. Most of the respondents felt they could distinguish between analysis and therapy, though they did so not on the basis of the number of sessions per week or any other "objective" factor, but rather in terms of the presence of a symbolic process making use of dreams, active imagination, and the transference-countertransference in the therapy. Almost all of the respondents said they saw the dichotomy between clinical and symbolic work as not useful, in that they viewed both modalities of analytic treatment as inextricably intertwined in the work. Only one of the analysts said he was unwilling to use

psychiatric medication with analysands (and he has since changed his mind); the common view was that when indicated, psychiatric medication could enable patients to be more accessible to the analytical process. These results facilitated the development of the research proposal that followed.

### ***Research Project***

In designing a research protocol for research in Jungian analysis that would be conducted using the willing and interested analysts identified through the two membership surveys, the Principal Investigator encountered an obvious limitation at the outset. He had little precedent for conducting such research. Even within the relatively sparse literature on long term psychotherapy research, there was a notable paucity of systematic scientific evaluation of the efficacy of Jungian analysis. One excellent retrospective study had just been completed (Keller et al, 1995) but no previous study of Jungian psychotherapy had been of a *prospective* nature. There was therefore no precedent for what to pursue and what to avoid when doing this kind of research. On the other hand, the absence of a precedent was highly motivating to the Principal Investigator, because the lack of the kind of information a prospective study could have yielded raised a concern that needed to be answered to preserve the credibility of the field itself. Bluntly stated, this concern was: How can Jungian analysis hold itself out as a bona fide clinical science without meeting the fundamental requirement of therapeutic science, some evidence of the efficacy of the method of treatment? The intent of the prospective research investigation was therefore clear from the beginning: it was to

assess as systematically and thoroughly as possible the outcomes of Jungian therapy and analysis.

In pursuing this goal, one of the aims that surfaced early in the mind of the Principal Investigator was to determine whether the degree of experience of the therapist had any relation to a psychotherapy's outcomes. The hypothesis, generated as far back as the investigator's own training as an analyst, was that the more extensive the experience of the therapist, the better the outcomes of a therapy or analysis conducted by that therapist would be. A secondary aim was to measure different kinds of therapeutic change. The research design needed to enable someone to examine the time course of personal change in analysis as it ranges from the surface level of symptom reduction to the deeper level of character transformation. This long term arc of personal change in analysis is highly relevant to treatment planning in this era of managed care, under which focus on brief psychotherapy or upon psychopharmacology, aimed exclusively at symptom reduction, may be a short-sighted efficiency, if it leads to "the revolving door syndrome," with the highly cost-ineffective side effect of having to manage difficulties rooted in the deeper characterological problems of the patients, which the treatment plans never address.

## 2. BACKGROUND

The only completed empirical study of Jungian analysis and psychotherapy is "Efficacy and Cost Effectiveness Aspects of Outpatient Jungian Psychoanalysis and

Psychotherapy - A Catamnestic Study” by W. Keller, G. Westhoff, R. Dilg, R. Rohner, H.H. Studt and the study group on empirical psychotherapy research in analytical psychology, Department of Psychosomatics and Psychotherapy, University Medical Center Benjamin Franklin, Free University of Berlin. This 1995 research is an elegantly designed and conducted retrospective study. It makes use of the thinking and methods of D.T. Campbell and J.C. Stanley (*Experimental and Quasi-Experimental Designs for Research*, 1963) to control and compensate for some of the inherent weaknesses of the retrospective approach, a variety of biases and threats to internal validity.

In 1994, the Principal Investigator of this proposal initiated a prospective research study in the James Goodrich Clinic of the San Francisco Jung Institute (the Clinic) involving the Clinic’s psychology interns and their patients. Their willingness to share their work with us enabled the authors of the present paper to “pilot test” the methods and instruments we will be discussing later on in this paper.. The results of these two research projects were presented at a panel of the 1995 international meetings of the Society for Psychotherapy Research. More recently, the IAAP has recently funded several studies at various centers in Germany and Switzerland that have also mounted prospective research studies with the comparison of psychotherapy vs. analysis as the independent variable. The Principal Investigator did not choose to examine that particular independent variable for two reasons: 1. The distinction between analysis and psychotherapy is blurred in most Jungian communities, and in Jung’s own writings, where the generic term for dynamic, long term treatment using his methods, including dream analysis and attention to transference projections and countertransference

responses, is usually “psychotherapy.” 2. The psychoanalytic research comparing outcomes of analysis and psychotherapy has not demonstrated a significant difference between the two. (See, for example, *Forty Two Lives in Treatment: A Study of Psychoanalysis and Psychotherapy* by Robert S. Wallerstein, 1986, New York: The Guilford Press.) The terms “psychotherapy” and “analysis” in this proposal are therefore used interchangeably; the treatments, when not conducted by certified Jungian analysts, were supervised by them, but the significant factor as we see it was less the analytic stance that were brought to the treatment situation than the personality and style of the therapist who was conducting the therapy.)

### 3. METHODS

a.) General Study Design: In lieu of a true clinical trial that would require randomization -- an insurmountable obstacle for this research study -- the Principal Investigator decided upon a comparative study design involving two groups: 1. Institute candidates, and 2. Institute analysts. (Psychology interns could not be included formally in the design because their time at the Institute was limited to one or two years. Their data continued to be collected, however, and was going to be informally compared to the data generated by candidates and analysts.) In distinguishing analysts as clinic therapists from candidates the thinking was that the status of the therapist in terms of analytical standing and experience would affect the conduct of therapy in some way. For the purposes of statistical analysis, each therapist-patient pair had to be completely independent of each other therapist-patient pair, i.e. they would have to be without

overlap, so that a single therapist could only have one Clinic patient in the research study, even if the therapist had several suitable patients in treatment. Measurements were taken at the following occasions: 1. Beginning of analysis, 2. Termination of analysis, 3. One-year follow-up, and 4. Five-year follow-up. Unlike other studies that have attempted to dictate how the therapy under study would be done, this study allowed the therapists to tailor the therapies to the needs of the patients and to provide a description of the therapy (via the Portrait of My Practice [POMP] below) to the principal investigator only at the end of therapy. The following instruments (see Table below) were used at different points in the therapies studied:

---

#### SFPRP DESIGN

	Intake	Termination	1-Year F-U	5-Year F-U
Patient:	Consent PDS SCL-90 IIP	PDS-Update SCL-90 IIP	PDS-Update SCL-90 IIP	PDS-Update SCL-90 IIP
Therapist:	Consent GAF (Axis V)	GAF (Axis V) POMP		

SCL-90 is the Symptom Checklist 90.

IIP is the Inventory of Interpersonal Problems.

PDS is the Personal Data Summary which is found at the end of this paper.

POMP is the Portrait of My Practice which is also found at the end of this paper.

---



---

b.) Study Procedures: The first step was to get the therapists as well as the patients who would be participating formally to consent to do so. This was accomplished by having them sign a form (see later in text). At the time the therapists gave their consent, the protocol was explained to them. At Measurement Occasion #1 (see Table above) analysands would be asked to complete the: 1. Personal Data Summary, 2. Symptom Checklist-90 (SCL-90), and 3. Inventory of Interpersonal Problems (IIP) (see Appendix for copies of each). The patient would be expected to complete this task at home in the range of 30 to 45 minutes and return the materials to the Principal Investigator in a stamped, addressed envelope. It was made clear that this envelope would be provided by the patient's therapist. After the end of the first session, the therapists would be asked to perform a Global Assessment of Functioning (GAF), or Axis V of the DSM IV (current and highest level in past year), probably the most reliable of all measures in psychotherapy and pharmacotherapy outcome research (see Appendix). This would take about 10 minutes. For the remaining three measurement occasions, the analysands would be asked to complete the PDS, SCL-90 and the IIP. At termination, the therapist was to notify the Principal Investigator, who would then contact the former patient by mail with the requisite instrumentation and an addressed stamped return envelope. Also immediately after termination, Measurement Occasion #2, the therapists would be asked to perform another GAF. The participating therapists would be asked then to complete a version of the POMP, which had previously been used under the guise of the Professional Membership Survey in the San Francisco Jung Institute professional community on two other occasions, (see Appendix). Therapists would provide the Principal Investigator with the POMP as well as the GAFs in separate stamped, addressed

return envelopes. The primary focus, however, was on data about and from the analysands.

c.) Data Analysis: Because of the limitations of our sample size, formal data analysis was not appropriate. We were, however, able to achieve some meaningful descriptive analyses, and these were be presented in earlier papers.

#### 4. HUMAN PARTICIPANTS

a.) 1.)Participant Population: All participants were drawn from the Clinic. The participants were patients who present themselves for reduced-fee psychotherapy or analysis conducted by the Institute's psychology interns, candidates and analysts. At the time of the study, over 100 patients were receiving treatment through the clinic. The breakdown was approximately as follows: 31 patients were being seen by 23 analysts, 19 patients were being seen by 17 candidates, and the remaining patients were being seen by 7 psychology interns or by an International Analytical Psychology Student working in the Clinic (there were four such students during the period of the study).

2.)Therapist Population: All therapists who consented to participate had formal connections to the Institute, whether as Psychology Interns, International Students, Candidates, or Analysts and all were bound by the Ethics Code of the Institute as well as by any regulations that applied to psychotherapists and students in their various professional disciplines. The Clinic policy at the outset of the study was that psychotherapists who were not analysts or candidates (who were already licensed mental

health professionals) were also required to be in psychotherapy supervision; during the course of the study a requirement for analytic supervision as a condition of working in the Clinic was also applied to Candidates.

b.) 1.) Participant Selection -- Inclusion / Exclusion Criteria: The Clinic was chosen as the source of therapists and patients for two reasons. First, it represented a common source of patients for the various categories of therapists included in this study. Second, we knew that each potential Clinic patient would be screened to ensure that those with florid psychoses or serious ongoing drug and alcohol abuse would be directed to a more appropriate mental health setting. This meant that the patients participating in this study would be less likely to be in a chronically impaired mental state during the period of psychotherapy evaluation and less likely to find the tasks involved in evaluating their psychotherapies unduly burdening. This screening of patients was conducted by the Clinic Director, a well-seasoned clinical psychologist.

2.) Therapist Selection -- Inclusion / Exclusion Criteria: All therapists who were interns, International Students, candidates and analysts in good standing at the San Francisco Jung Institute and who consent to participate were considered eligible for inclusion in the study.

c.) Participant Recruitment:

1.) Source (s): Although the Clinic was the ultimate source of all the patients whose psychotherapies were studied, the individual therapists participating in the

study were asked to recruit one their Clinic patients to participate from the outset of therapy.

2.) Initial Contact: At the time of intake into the Clinic, every patient was informed about the San Francisco Jung Institute Psychotherapy Research Project, and provided with a Letter of Introduction which explained the research project and asked for a tentative agreement to participate. After being assigned to a psychotherapist, at the beginning of therapy, they were again reminded by their therapists of the research project and once again asked whether or not they wished to participate.

3.) Recruitment of Therapists: Therapists were recruited by the Principal Investigator, who made the case for participating in the project at Analyst and Candidate Dinner Meetings as well as individually. The process of recruiting therapists had already been initiated by the two Professional Membership Surveys that were conducted by the Principal Investigator over the preceding two years. Moreover, the President of the San Francisco Jung Institute was asked to inform Institute Analysts and Candidates about the opportunity to participate in the Clinic as well as this research study. Finally, members of the Research Committee were active in promoting the research within the Jung Institute community.

## 5. CONSENT PROCESS AND DOCUMENTATION

The process of ensuring that those participating in the research were properly prepared to do so required a number of steps and procedures. At intake, we would first get a tentative verbal agreement from a patient entering the clinic indicating that they would be willing to have their therapy studied by the research team. (If a new patient declined to participate in the research, the therapy would simply proceed un-researched.) Then the therapist assigned to any patient who had given an initial affirmative response to the question of research participation would be contacted. At this point, the therapist would also be asked to consent to participate in the research study. To make sure this was informed consent, we explained to every therapist invited to participate what the research was about, allowing the therapist to ask questions and make a determination whether his or her participation could in any way be harmful to the patient whose therapy would be assessed if the therapist agreed. Again, some therapists declined to participate.

However, clinic interns were required to participate as part of their internship, with the reasoning that close evaluation would be a useful part of their training. Once therapists other than clinic interns had made their decision to participate, they would then be required to confirm that their patients whose therapy process would be followed by the research team were still willing to participate; this meant in practice that a therapist would have to discuss the research project with any patient who had indicated willingness to participate in the research at intake. If the patient continued to express a willingness to participate, at this point the therapist would hand the prospective participant a packet consisting of the Patient Consent Form (see p 11), Personal Data Summary, SCL-90, IIP, and a stamped, addressed return envelope and asked the prospective subject to briefly review the materials. (The clinic interns, since both they and their patients had been

oriented to the possibility of the research would only hand the packet to their patients, not asking them one more time before doing so if they really wanted to participate.

Nevertheless, clinic interns' patients also had the right to refuse to participate and even to accept the packet.) Once the packet had been received from the therapist, the prospective participant was instructed to mark, not sign (!), the Letter of Introduction before taking the packet home along with a copy of the Letter of Introduction for further consideration. The prospective participant who agreed to participate would indicate the decision to do so by signing the Patient Consent Form and filling out the other forms, which included an instruction to mail them to the Principal Investigator within two weeks. The patient was told in writing that any questions could be directed to the Principal Investigator.

## 6. POTENTIAL RISKS / DISCOMFORTS TO SUBJECTS

Of course, there is always a sacrifice of privacy for both therapists and patients who must share some of their process with a research team beginning with the first session of therapy. Some schools of psychotherapeutic thought believe that any infringement on absolute confidentiality compromises a therapy. The pilot test, involving over 70 Clinic patients in our study to date, has not, however, revealed any serious risks or discomforts from exposure of the research subjects to its particular methods and instruments. The only reported problem was with one question on the IIP which presupposes a heterosexual orientation; we found that a few participants left it blank, and that a few left the Principal

investigator a note of serious concern about the mindset communicated by such a question.. (The principal investigator has informed the IIP's creator, Len Horowitz, of this problem and has decided, in future, to mark the item and leaving a note for the research subjects.) The methods and instruments used have been chosen to minimize intrusiveness, time and effort for the participants, therapists as well as patients. These instruments may, nevertheless, interfere with the natural style of some patient, and therapists may experience discomfort in having to objectify what they do for the purpose of objective description.

#### 7. POTENTIAL BENEFITS TO SUBJECTS AND / OR GENERAL BENEFITS TO OTHERS

Therapists were shown scale scores of the PDS, SCL-90 and the IIP, not the patient responses to individual items. For some patients, a systematic review of their symptoms and problems may well have facilitated the therapeutic process, though we did not collect any data about this. The researchers would let the therapists know the scale scores of their patients' some therapists would make use of this data to guide their conduct of therapy; others made no use of it, according at least to what they directly told us. A study of how therapists use objective feedback as to how a case is going would be of great interest.

#### 8. CONFIDENTIALITY OF RECORDS

Preserving confidentiality while research was being conducted was of highest priority throughout the project. It has to be recognized that research records could not be entirely anonymous because of the need of the Principal Investigator and the Clinic Coordinator to conduct follow-up at Measurement Occasions #2, #3 and #4. The non-anonymous research records, however, were converted into anonymous research records by the Principal Investigator as soon as he received them, by placing code number stickers over the name of the patient and other identifying patient information and by otherwise obliterating this information. This way, the Research Assistant was able to work with research records that were anonymous during the processes of data entry and data management. The research records were kept by the Principal Investigator in a locked file cabinet along with a directory linking code number and name and other identifying information. (Intern-patient codes would be handled by the Clinic Coordinator.) This meant that the Research Assistant would have no contact at all with the therapists and patients who participated in the research study and no knowledge of who they were. At the end of the study, moreover, the directory and all of these research records were destroyed by the Principal Investigator. The signed Therapist and Patient Consent forms were kept in the same locked cabinet and will not be destroyed for at least ten years following the completion of the research study. (This is for legal purposes and observes the ethical standard set by the American Psychological Association for the maintenance of such documents.)

Before the data were entered into any data base, computerized or manual, a coded sequence number was substituted for each participant's name. The Principal Investigator

was the only member of the research team knowing how to match name and code number. (A protocol was established such that in the event of the death of the Principal Investigator prior to completion of the study, his Professional Will would direct the code to be transmitted to another a research investigator designated by the C.G. Jung Institute of San Francisco to complete the research.)

The Principal Investigator was aware that even with anonymous data there would be the possibility that certain of the research evaluative interventions and procedures might have the unwitting effect of compromising the confidentiality of the research participants. He made the determination early in the course of the research, integrating it into the research design, that when any exposure of a patient's identity occurred, the research findings about that patient would not be published. This even extended to an entire group of patients, if for instance a research evaluation depended on knowing that these patients were all at the same school: in such cases where it would be relatively easy to determine which students at that school were also clinic patients, all evaluations depending upon that knowledge would not be reported, i.e. were excluded from the results of the study. Naturally, this was one more limitation on what could finally be recorded as an outcome.

### *Vagaries and Vicissitudes of the Clinic, the Site of the SFPRP*

As it turned out, the fates of the Clinic and the SFPRP were inextricably intertwined. Shortly after the correspondence with Dr. Moretti, a variety of problems developed in the Clinic that affected the research project directly. Suffice it to say, after the unexpected departure of one key administrative staff member, the Clinic Co-ordinator and the firing

not long after of the person hired to replace her, the analyst who had been heading the Clinic as its Director for 33 years, by now a beloved figure throughout the Institute, resigned abruptly, only to become seriously ill and die a few months later. The Principal Investigator of this research was selected to replace him by an Institute search committee, and though at first the choice was met with joy, he too was not able to hold the replacement position tenably for very long and chose, with regret, to resign shortly after the Memorial Service for his predecessor, just four months after he had begun to replace him. All of this disruption of the holding environment of the Clinic, understandably, was a shock to the interns, the Clinic, and the analytic community. The Clinic occupies a position of psychological importance within this extended community that is exceeded only by the candidate training program, so it was predictable that the Clinic would find a new director and continue to operate once the stir over the many changes of personnel in such a short period had subsided. The same level of concern for eventual continuity was not present, however, in relation to the San Francisco Psychotherapy Research Project, which had always been viewed with a measure of skepticism as at best a necessary incursion of the analytic terrain protected by the Institute. Moreover, its Principal Investigator was now the person who had not been able to fill the beloved initial Clinic Director's shoes. This posed a serious political problem for the viability of research that depended upon the cooperation of the Institute community for its continuation.

As early as the December, 2003 Executive Committee meeting at which Dr. Batt's retirement was first announced, Dr. Rubin, the Principal Investigator, went through

an agonizing decision-making process about how best he might further the research mission. His choices, as he saw them were to:

1. Compete for the Clinic Director position by applying for it to the Executive Director of the Institute (who would be doing the actual hiring) and an ad hoc Hiring Committee of Institute analysts that had been set up to advise him;
2. Pursue the position of Chair of the Clinic Committee, which would now be split off from the Clinic Director position to ensure better oversight of the Clinic operation;
3. Continue simply as the Principal Investigator and as a member of the Clinic Committee without attempting to lead either the Clinic or its steering Committee.

After a variety of consultations, Dr. Rubin decided that being the Clinic Director, something that with his own clinical psychology work background he felt qualified to assume, would not only best serve the research mission, but might also serve the Clinic in its time of need. He applied for the position and was hired as Clinic Director, starting on February 1, 2004. Although he was able to identify administrative issues in the Clinic that had needed attention, and he was able to leave the Clinic in better financial and administrative shape than he had found it, his dual role as Principal Investigator at the same time he was helping to reorganize the Clinic was not well tolerated by many of his colleagues, particularly on the new Clinic Committee, which was seeking, appropriately, to establish its own influence over future Clinic operations. Inevitably, his role as director of a research project in the same clinic became a target of the tension. Although

the Principal Investigator eventually neither chaired nor retained membership in the Clinic Committee, as his predecessor as Clinic Director had always done, it was noted that he was still wearing three hats, that of conducting the research project in the Clinic, that of directing the Clinic, and that of chairing the Research Committee . The consensus of other analysts was that too much power should not be concentrated in one person, and it was suggested that he give up one of his hats. Dr. Rubin decided to stop being the Principal Investigator of the Psychotherapy Research Project, but would offer to remain as Chair of the Research Committee. In time, however, it seemed that it would better serve the needs of the Institute, if he were to continue to advocate for psychotherapy research in the Institute, that he resign the Clinic Directorship as well. In making this series of moves, he believed at first that the SFPRP might continue, led by others to whom he could consult as needed. Eventually, however, it became clear that the SFPRP could not continue with even this much involvement by him without being seen as an intrusion on the Clinic's new administration and so it had to be brought, prematurely from the standpoint of what could still be learned from it, to an end.

Fortunately, these recognitions, in time shared by all, and the decisions that stemmed from them, though at times painful, were made with equal portions of grace and resignation by all concerned, so that by the time Dr. Rubin's decision to step down from his post as Clinic Director was announced to the community, a spirit of generosity prevailed all around. The President and Executive Director of the Institute sent the following message to the Institute community:

We are writing to let you know of another change in the Clinic. Seth Rubin has tendered his resignation as Clinic Director, effective November 1<sup>st</sup>.

For over three decades, the Clinic was shaped by Hal's single voice. With his departure, this program, so central to the Institute, is becoming like our other programs: a place of many voices in conversation, some smooth, some contending. Despite the great care we invested in the hiring process, it has become apparent that we seriously underestimated the complexities and the passions that this transition has provoked. Many of us care deeply about the Clinic, but our visions differ significantly. In this new context, it became clear to Seth and to us that Seth's gifts and values made him better suited to an interim role rather than a longer term role as Clinic Director. Seth has brought his skill and energy to the Clinic and the community at a time of sudden uncertainty and for taking on that daunting task with such focus and dedication, we are grateful to him.

And, as part of the exit agreement between Dr. Rubin and the Clinic Committee, the Wallerstein research was allowed to continue in the Clinic unscathed, even though the SFPRP would have to come to an end.

This administrative and political history is necessary to relate here, because it may be one of the most important legacies of the SFPRP experience to future psychotherapy research. Such research is by its very nature intrusive, and those conducting it must be extremely careful not to seem to wield too much power, i.e. be intrusive themselves on the processes of the psychotherapy association in which the research must be conducted. The continuation of the Wallerstein research at the C. G. Jung Institute of San Francisco was possible because the research was largely being done by mostly anonymous outsiders, without power in the governance of the Clinic or elsewhere in the Institute. Rather, the Institute exerted a measure of influence over the research. One of the happiest

developments from the standpoint of developing a Jungian contribution to psychotherapy research was that to Wallerstein's seventeen emerging Psychological Capacities that he had come to use to measure effective outcome of psychotherapy, we were able to suggest four new ones, derived from what a Jungian analyst regularly attends to: 1. Capacity to Symbolize, 2. Capacity to Imagine, 3. Capacity to Not Know, and 4. Capacity for Complexity. It is hoped (and there is a very good chance) that these capacities will be measured as part of future Wallerstein research in our Clinic. And Dr. Rubin remains Chair of the Institute's Research Committee..

With this background, we will now look at what was actually found by the SFPRP.

### ***Results of the SFPRP***

There were 101 Clinic patients enrolled in the SFPRP, 91 being patients of Clinic interns. Because only 5 analysts and 5 candidates and their Clinic patients volunteered to participate in the research, it was not possible to fulfill the ambitions of the research design, which had called for data from analytical psychotherapies conducted by at least 20 analysts and 20 candidates. Equally disappointing was the fact that though there were 39 patients at Termination, only 7 gave data at 1-year Follow-up, and only 5 at 5-year Follow-up. We believe that the numbers at Termination and at the times of the two

Follow-ups would have improved substantially had the SFPRP been able to continue for another three years in the Clinic.

The fundamental problem of recruiting analysts and candidates on a volunteer basis is one future studies of Jungian psychotherapy in America will have to solve. The German and Swiss research projects mandated analyst and candidate participation, with the result that their research designs were adequately fulfilled. Such an approach to data collection would be much harder to impose upon American depth psychologists.

It is customary to scrutinize research to see if it has internal validity, i.e., that there is no confounding of variables in the design of the study itself, and external validity, i.e., that the findings, even if they are true outcomes, not merely artifacts of a confounded design, can be generalized beyond the sample from which the research findings or outcomes emerge. Had the original design of the SFPRP been realized, there would have been ways of addressing threats to both internal and external validity. The collapsed design, however, magnified these threats.. For the purpose of statistical analysis, there is really only one aggregated group of all therapists in place of the three separate groups we had originally hoped to study and compare, interns, candidates and analysts.

Because of follow-up problems, moreover, the only comparisons that make any sense to study with respect to the hypotheses of the SFPRP are changes between Intake and Termination for the 39 aggregated patients. Unfortunately, even these comparisons are very shaky and can be presented as findings only with the strictest qualifications.

Campbell and Stanley (1963) refer to this type of collapsed design as a One-Group Pretest-Posttest Design, naming among others the following threats to internal validity that must be taken into account when proceeding with analysis of results from such a design: History, Maturation, Testing, Instrumentation, and Interaction of Selection and Maturation. History refers to change-producing external events (such as the Sept 11, 2001 terrorist attacks in the United States) that may have impacted the treatment. Maturation means biological or psychological processes that are likely to develop with time independent of the treatment. (Some borderline personalities, for example, are said in the literature to be outgrown independently of any actual treatment.) There are similar challenges to external validity. (See pages 7 to 9 of Campbell and Stanley for a more complete discussion.) We are thus faced with the dilemma of possessing a large amount of data for which statistical analyses related to the original SFPRP hypotheses are highly suspect because they are not sufficiently grounded in all the conditions the original research design had proposed to allow for.

For the purposes of this research report, which the reader must therefore take with a large grain of salt, we can state that the gains for both the SCL-90 and the IIP from Intake to Termination are "statistically significant." In earlier reports, we have addressed on a descriptive basis other analyses of interest, even though these were not directly connected with the hypothesis-testing of the SFPRP. On balance, the most interesting finding, however, is a qualitative, not a quantitative one. It is that research continues to be a hard sell among depth psychotherapists, and until this problem is solved, we cannot really access the practical results of our endeavors in a scientific way.

## REFERENCES

Campbell, D.T., & Stanley, J.C. Experimental and quasi-experimental designs for research. Chicago: Rand McNally College Publishing Company, 1963.

Keller, W., Westhoff, R., Dilg, R., Rohner, H.H., Studt, and the study group on empirical psychotherapy research in analytical psychology. Research and Jungian psychotherapy - Outcome studies, part II. In, Matton, M.A. (ed) Open Questions in Analytical Psychology. Proceedings of the Thirteenth International Congress for Analytical Psychology, Zürich, 1995 Einsiedeln: Daimon, pp 641-645. \*\*\*\*

Wallerstein, R.S. Forty-two lives in treatment: a study of psychoanalysis and psychotherapy. New York: The Guilford Press, 1986.

\*\*\*\*In the text, I have provided the actual title, which is also produced on the internet version of the research report. The title in the references is connected to a panel on which I also presented, as Outcome studies, part III.

Analyzing the San Francisco Psychotherapy Research Project: Appendix

Word Count: 1413

PERSONAL DATA SUMMARY

Today's date: \_\_\_\_\_

CLINIC CODE NUMBER: \_\_\_\_\_

DEMOGRAPHICS: Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_

EDUCATION:

Dates Major Minors Degrees and honors

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRESENT EMPLOYMENT:

Title Nature of work Duties Dates

_____	_____	_____	_____
_____	_____	_____	_____

PRIOR POSITIONS:

Title Dates Nature of work Duties

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MARITAL STATUS: (Please Check)

Important \_\_\_\_\_  
People \_\_\_\_\_  
In Your \_\_\_\_\_  
Life \_\_\_\_\_

Place "N" beside the name of person(s) who live at the same place that you do now.  
Show the date of death of any deceased.

**MILITARY:**

Service \_\_\_\_\_ Branch: \_\_\_\_\_ Rank \_\_\_\_\_ Dates: \_\_\_\_\_

Overseas Service? Area: \_\_\_\_\_ Dates: \_\_\_\_\_

Combat? Yes ( ) No ( )

Hospitalized? Yes ( ) No ( )

**CHILDHOOD:**

Were your parents ever separated? \_\_\_\_\_ If so, for how long? \_\_\_\_\_

How old were you at the time? \_\_\_\_\_ With whom did you stay? \_\_\_\_\_

Did you ever live with anyone other than your  
parents while a child? \_\_\_\_\_ With whom? \_\_\_\_\_ How old were you? \_\_\_\_\_

**MEDICAL:**

What current medications? \_\_\_\_\_  
\_\_\_\_\_

Major life illnesses or injuries: \_\_\_\_\_  
\_\_\_\_\_

**RELIGIOUS** affiliation: \_\_\_\_\_ Observant? \_\_\_\_\_

**PREVIOUS COUNSELING OR PSYCHOTHERAPY:**

Profession	City, State	Dates	Frequency	Indiv./Gr.
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

---

**What are the main concerns that bring you to the therapy?**

---

---

---

---

**By whom were you referred?** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Do you want to go to the North Pole?** \_\_\_\_\_

**(Termination and follow-up only)**

**How valuable was the psychotherapy/ analysis for you?**

**[Mark with an "X"]**

_____	_____	_____	_____	_____
+2	+1	0	-1	-2
<b>Very Helpful</b>	<b>Somewhat Helpful</b>	<b>No Value</b>	<b>Somewhat Harmful</b>	<b>Very Harmful</b>

**Please amplify:** \_\_\_\_\_

---

---

---

---

---

**C. G. Jung Institute of San Francisco**

**PATIENT CONSENT FORM**

**STUDY TITLE:**

**The San Francisco Jung Institute Psychotherapy Research Project:  
Outcomes as a Function of Therapist Experience**

You are being asked to be included as a participant in a research study being conducted at the James Goodrich Clinic of the San Francisco Jung Institute by Seth Isaiah Rubin, Ph.D., FPPR, Principal Investigator.

**A. WHAT IS THE PURPOSE OF THIS STUDY?**

The purpose of this study is to assess the outcomes systematically of Jungian therapy and analysis, in terms of experience of therapists, changes in symptoms and character transformation over time.

**B. WHAT WILL HAPPEN TO YOU AND OTHER STUDY PARTICIPANTS?**

You would become a research subject by signing this Patient Consent Form and filling out the Personal Data Summary, the Symptom Checklist 90 (SCL-90), and the Inventory of Interpersonal Problems (IIP) within two weeks and mailing these to the principal investigator. The principal investigator would contact you by mail at termination, one-year follow-up, and five-year follow-up. You would keep the principal investigator informed of your mailing address from termination through the five-year follow-up.

**C. WHAT ARE THE RISKS OF THIS STUDY?**

The methods and instruments have been chosen to minimize intrusiveness, time, and effort. The investigators have collected data using these methods and instruments on over 70 patients in the Clinic. They are also used in many other psychodynamically-oriented psychotherapy research. There may be some inconvenience in participating.

**D. WHAT ARE THE POTENTIAL BENEFITS TO YOU AND OTHERS?**

Your Personal Data Summary and scored results of the SCL-90 and the IIP would be available to your therapist in a form he or she can make use of clinically. The results of this research can serve not only to establish further the scientific credibility of Jungian analysis and therapy, but to enhance the understanding and efficacy of the Jungian approach.

**E. ARE ALTERNATIVES AVAILABLE?**

You are free to choose not to participate in this study.

**F. HOW CONFIDENTIAL ARE YOUR RECORDS?**

The principal investigator is the only member of the Research Project to have access to your research records which he would keep locked securely in a cabinet. The Clinic Coordinator also has access to this information. Any data entered into a database, computerized or manual, would be coded to assure your confidentiality. The principal investigator would be careful not to violate your confidentiality even in analyses with anonymous data. At the end of the study, the principal investigator would destroy all the research records. He would keep the signed Consent Forms for another ten years before destroying them, too.

**G. STATEMENT OF VOLUNTARY PARTICIPATION**

You recognize that your participation in this study is voluntary. Without any prejudice, you are free to take part in, or withdraw from the study at any time.

**H. WOULD YOU BE TOLD WHAT WAS LEARNED FROM THIS STUDY?**

Yes. You would be provided with a written report about general results at the conclusion of the research study, should you so desire.

**I. PRINCIPAL INVESTIGATOR'S NAME AND NUMBER**

Seth Isaiah Rubin, Ph.D., FPPR  
Voice/Fax: 415-331-5013  
Office: 415-771-5115  
e-mail : sirseth@well.com

**J. COMMITTEE HOURS AND NUMBER**

Should you have any questions about your rights as a research participant, you may call the Committee For The Protection Of Human Research Participants at the C.G. Jung Institute of San Francisco between the hours of 9:00 a.m. and 5:00 p.m at 415-771-8055.

**Signature:**

\_\_\_\_\_  
**Participant (client) signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Therapist**

\_\_\_\_\_  
**Date**

San Francisco Jung Institute Psychotherapy Research Project  
Outcomes as a Function of Therapist Experience  
Seth Isaiah Rubin, Ph.D., Principal Investigator

## PORTRAIT OF MY PRACTICE

---

Please provide answers to the following questions about yourself and your clinic patient who is a research participant in the San Francisco Jung Institute Psychotherapy Project and is terminating therapy with you. Please mail this to the Principal Investigator at your convenience.

---

CHECK LICENSE: MFCC  MD  SOCIAL WORKER  PSYCHOLOGIST

YEAR LICENSED \_\_\_\_\_

MALE  FEMALE  (CHECK) AGE \_\_\_\_\_

YEAR CERTIFIED AS A JUNGIAN ANALYST \_\_\_\_\_ (If applicable)

YEAR BEGAN JUNGIAN-ORIENTED CONSULTATION OR TRAINING  
\_\_\_\_\_

MARK THE FREQUENCY OF VISITS AT THERAPY'S:

	BEGINNING	MIDDLE	END
LESS THAN ONCE A WEEK? _____	_____	_____	
ONCE A WEEK? _____	_____	_____	
TWICE A WEEK? _____	_____	_____	
THREE TIMES A WEEK? _____	_____	_____	
FOUR TIMES A WEEK? _____	_____	_____	

MORE THAN 4 TIMES A WEEK? \_\_\_\_\_  
\_\_\_\_\_

WAS THIS PATTERN OF FREQUENCY OF VISITS TYPICAL  
FOR YOUR PRACTICE? \_\_\_\_\_

DID THE ANALYSAND MAKE USE OF TELEPHONE SESSIONS? \_\_\_\_\_

IF YES, PLEASE ESTIMATE THE % OF TELEPHONE SESSIONS? \_\_\_\_\_

IF YES, IS THE USE OF TELEPHONE SESSIONS TYPICAL? \_\_\_\_\_

DID THE ANALYSAND DO DEEP INNER SYMBOLIC WORK?  
(e.g., DREAMS, ACTIVE IMAGINATION, SANDPLAY)

NONE \_\_\_\_\_ SOME \_\_\_\_\_ A LOT \_\_\_\_\_

WAS SANDTRAY USED? \_\_\_\_\_

IF YES, IN APPROXIMATELY HOW MANY SESSIONS WITH THIS  
PATIENT

WAS SANDTRAY USE? \_\_\_\_\_

DID THE ANALYSAND USE THE COUCH? \_\_\_\_\_

IF YES, DID THE ANALYSAND START ON THE COUCH? \_\_\_\_\_

IF YES, DID THE ANALYSAND ALTERNATE BETWEEN THE COUCH AND  
THE

AND THE CHAIR? \_\_\_\_\_

IF YES, IS THE COUCH TYPICAL FOR YOUR PRACTICE? \_\_\_\_\_

WHAT WAS THE LENGTH OF THE THERAPY IN YEARS? \_\_\_\_\_ TYPICAL? \_\_\_\_\_

WHO WAS THE SOURCE OF TERMINATION?

ANALYST \_\_\_\_\_ ANALYSAND \_\_\_\_\_ MUTUAL \_\_\_\_\_

WAS THIS SOURCE OF TERMINATION TYPICAL? \_\_\_\_\_

WHAT WAS THE REASON FOR TERMINATION?

WORK COMPLETED \_\_\_\_\_  
FINANCIAL \_\_\_\_\_  
CHANGE OF LOCALE \_\_\_\_\_  
NEED TO WORK WITH ANOTHER ANALYST \_\_\_\_\_  
OTHER \_\_\_\_\_ PLEASE SPECIFY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WAS THIS REASON TYPICAL? \_\_\_\_\_

DO YOU EXPECT THIS TERMINATION TO EVENTUATE IN:

NO FURTHER CONTACT? \_\_\_\_\_  
FUTURE ANALYTICAL CONTACT? \_\_\_\_\_  
FUTURE PROFESSIONAL CONTACT? \_\_\_\_\_  
SOCIAL CONTACT OF SOME FORM? \_\_\_\_\_  
OTHER? \_\_\_\_\_

PLEASE SPECIFY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHAT IS THE LENGTH OF YOUR LONGEST THERAPY  
THAT YOU AS ANALYST CONDUCTED? \_\_\_\_\_

HOW VALUABLE WAS THE PSYCHOTHERAPY/ANALYSIS FOR YOUR  
CLIENT/ANALYSAND?

[Mark with an "X"]

_____	_____	_____	_____	_____
+2	+1	0	-1	-2
Very Helpful	Somewhat Helpful	No Value	Somewhat Helpful	Very Helpful

Please amplify: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_