THE TECHNIQUE OF PSYCHOTHERAPY

FAILURES IN PSYCHOTHERAPY

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Failures in Psychotherapy

Psychotherapy was never designed to cure everybody. With present techniques, therapists are able to effectuate symptomatic improvement in almost all patients, behavioral changes in the majority, and complete cure in some. The fact that reconstructive alterations are possible is an encouraging sign, however, since it contradicts the commonly accepted adage that human nature cannot be changed. With continued empirical research the understanding of personality will undoubtedly be advanced, and with more clinical experience therapeutic methods should become enriched. In the meantime, therapists may follow the old Chinese proverb, "It is better to light one candle than to curse the darkness."

Failures in psychotherapy, apart from the employment of improper interventions, are generally the product of mismanagement of the therapeutic relationship. Most commonly, patients are pushed toward reconstructive goals that are beyond their competence and motivation. Also some may seek extensive personality change even though they are incapable of achieving more than symptom relief.

No matter how ambitiously therapists may pursue treatment, they are confronted with limitations in all patients in their potential for growth. Three kinds of patterns may be clinically observed. First, there are promptings so deeply imbedded in the personality matrix that they seem to pursue an autonomous course. No amount of insight or authoritative pressure seems capable of modifying their expression or lessening their force. These tendencies are rooted in conditionings sustained during early childhood, perhaps in the preverbal period before the individuals were able to conceptualize experiences. They may, if sufficiently intense, disorganize adult adjustment. For instance, separation from a mother for extended periods during infancy may sponsor profound feelings of distrust. Apathy, depression, pressing drives for oral gratification, suspicion regarding the motives of people, and a view of the world as menacing may survive in traits that distort the most bountiful reality in later years. The ego, structured on an infirm basis, sustains

disintegrative proclivities. In most people, however, symptomatic residues of early conditionings, though present, are not so pronounced. Minor as the symptoms are, they still defy change and energize maladjustment.

A second group of patternings develops somewhat later, which are remembered, at least in part, and can be verbalized. Serving spurious neurotic functions, they may in execution promote conflict, this group of patternings is subject to some control through willful inhibition once the individuals appreciate the nature and consequences of their inclinations. While these strivings may continue to press for expression, their mastery by patients becomes an important goal. Many of these strivings are rooted in needs and drives that, in promoting anxiety, are repressed. Their recognition, if the individuals are sufficiently motivated, may enable them to bring these forces under control and, in fortunate instances, to eliminate them completely.

For example, a girl whose assertiveness during the second and third years of life was inhibited by parents wedded to the doctrine that children are to be seen and not heard may discover that when she mobilizes sufficient aggression and rage she can get her own way. “Hell-raising” then becomes a pattern essential to the expression of assertiveness. Recognition that her aggression is resented by her colleagues, and insight into the sources of her affiliation of assertiveness with aggression, may enable her to experiment with modes of assertive display dissociated from acting-out. A boy fondled seductively by a parent may become too stimulated sexually and detach from his sexual feelings. Intimate relationships in adult life may precipitate an incestuous association that inhibits sexual expression. Awareness of the roots of his difficulty may enable the individual to experiment sexually with the objective of establishing new habit patterns. A host of pathological conditionings may, as Freud pointed out, invest the sexual and aggressive drives, and the person may develop inhibitions of function or distorted and perverse modes of expression. Burdened by essentially childish needs, he or she may be fixated in activities that survive as outlets for sex or aggression. To gratify these drives, a toll must be paid in currencies of insecurity and

damaged self-esteem. This group of neurotic promptings, with proper therapy—should the individual strongly desire it—may undergo modification. The patient thus either learns to live with handicaps, once they are understood more thoroughly, or is better able to control them. With reconstructive therapy an individual may be able to develop more mature ways of managing sexual and aggressive feeling and behavior.

A third group of patterns present in all people is relatively flexible. This group is not subject to severe repression and does not press for release against all reason. Developing both during early and late childhood and in adult life, the group constitutes the bulk of the individuals' coping maneuvers. These, the most malleable of tendencies, may be influenced most significantly in therapy.

Disappointment in psychotherapy is often registered when, after an ambitious, carefully designed and prolonged program of treatment, patients continue to resist giving up the first set of patterns and must exercise their will power constantly to keep the second group in check. Faulty habit patterns, disorderly study and work activities, conditioned phobias, and many maladaptive attitudes and values are among such tendencies. All human beings are so constituted that no amount of therapy, as practiced today, can alter some personality components, since they have become so firmly entrenched that they function like organic fixtures. Yet, properly designed psychotherapy offers individuals a substantial opportunity to rectify many destructive personality traits and to achieve a measure of happiness that, prior to treatment, was outside their grasp.

UNTOWARD REACTIONS DURING PSYCHOTHERAPY

The bulk of patients in psychotherapy move along well. Obstructions in progress and inimical emotional outbursts are readily handled. There are conditions, however, that pose hazards even for experienced psychotherapists. Personality structures in which emotional instability is ingrained, having existed since early childhood, will in all probability erupt with greater bursts of violence, responding with

insurgency and defying control. Impartial as they may try to be, therapists will be drawn into the patients' onslaught and may be unable to maintain an even tenor, either yielding to unreasonable demands or counterattacking in retaliation. The greatest incidence of untoward reactions in psychotherapy occurs when the relationship between therapists and patients is faulty. Inexperience and improper conduct of treatment, as well as countertransference, account for a large percentage of unfortunate results, although it is unclear how these take place. The work of Bergin (1963, 1971) and Strupp & Hadley (1977) accents the need for further research into deterioration effects and reasons for failures in psychotherapy.

It may not be amiss to mention the virtue of therapists' seeking consultation or supervision for a case that is not going well. This will necessitate courage and honest self-confrontation in facing the fact that they may be acting non-therapeutically with a patient or be employing interventions that do not satisfy the patient's needs. Talking things out with a colleague will often break through the current obstruction and promote satisfactory future movement.

Constituting treatment failure is the emergence during therapy of certain disturbed reactions. These are most apt to erupt when the customary defenses of the individuals are challenged or blocked, as in reeducative and reconstructive therapy; however, they may break loose in certain patients as a consequence of mere contact with the therapists, however supportive therapists may try to be. Thus, borderline patients who are maintaining a delicate balance in holding onto reality are particularly vulnerable to close interpersonal relationships. Even ordinary human encounters stimulate undue tension and conflict. Underlying morbid traits—kept under control by tenuous defenses—may emerge, often with explosive violence. Depressive manifestations may deepen into suicidal attempts; psychopathic aberrations may be acted out in total disregard of consequences; feelings of unreality and depersonalization may spread into an outright psychosis. During any kind of psychotherapy with borderline patients, the course of treatment is customarily stormy, punctuated by fluctuations in the sense of reality. The patients may interpret the relationship as an assault on their integrity, particularly if the

therapists are excessively authoritarian or have unresolved hostile or sexual difficulties that filter through in manner and speech. Borderline patients sensitively divine these from the tiniest cues (Schmideberg, 1959). Emotional crises constitute the usual climate in which therapy is conducted.

Problems are also commonly encountered in the treatment of somatoform disorders, characterized by intensified recrudescence of symptoms. When such eruptions are minor, there is no great danger; however, severe outbreaks of somatic disturbance may occur, such as a thyroid crisis, violent asthmatic attack, or fulminating ulcerative colitis that may lead to death. Suicide is also a possibility. The most disturbing reactions occur in patients who have habitually had a tenuous relationship with other people and a fragile self-image since childhood. "These individuals easily react…with a violent frenzied emotional flood, or with destructive violence at times turned in on themselves, or with a more complete withdrawal and inaccessibility. Any of these reactions may be fused with various disturbances of organ function (oral, excretory, circulatory, and also genital) and may reach the point of abandoning adequate contact with reality" (Mittelman, 1948b).

Patients suffering from brain injuries are apt, during psychotherapy, to manifest outbreaks of euphoric, paranoidal, sexually aggressive, or suicidal behavior (Weinstein and Kahn, 1959). Probing procedures employed in manic-depressive psychosis and involutional psychosis may release great anxiety and resentment and activate latent suicidal drives (Arieti, 1959). A treatment relationship in dependent individuals who mask their hopelessness by a thin overlay of indifference may precipitate a deep depression when the patients realize the realistic limitations in the degree of closeness possible with the therapists. Exploratory activities in reactive depressions, are notorious for exciting intense anxiety (Muncie, 1959).

Paranoid reactions respond adversely to almost any kind of human contact. Thus individuals who are burdened with self-doubt and suspicion may in a relationship of even moderate intensity find themselves responding with strong mechanisms of denial and projection. Ego defenses may then shatter, with

emergence of oversensitivity, estrangement, preoccupation, distrust, suspicion, fears of physical and sexual attack, litigious tendencies, homosexual impulses, delusional jealousies, and grandiose delusions (Cameron N, 1959). Schizophrenics who interpret psychotherapy as an intrusion on their privacy often will be provoked into fearful or aggressive reactions. Personality disorders manifest diverse reactions to therapeutic contacts. Urgent dependency needs may be projected onto the therapists, with excessive clinging, release of intense erotic feelings, and liberation of resentment at the inevitable frustration. Detachment with needs for control may be threatened by the patients' belief that yielding to another person implies a trap from which there is no escape. Masochistic promptings may enjoin the individuals to torture themselves with luxurious symptoms. Homosexual strivings kept in check prior to treatment may suddenly appear, promoting panic. Impulsive characters may exhibit acting-out proclivities without warning, engaging in outlandish and dangerous activities (Michaels, 1959).

Antisocial personalities may when challenged respond with excited and even psychotic behavior. Alcoholics and drug addicts are notoriously treacherous, indulging in defiant and occasionally destructive practices. Some patients with conversion reactions display alarming conduct when an attempt is made to alleviate or reduce their symptoms. A psychotic disorder of a depressive or paranoidal type may supervene (Abse, 1959). In obsessive reactions, frightening extremes of anxiety and rage may from time to time be released, along with guilt feelings and expiatory self-punishment, the therapists being accused of promoting the appearance of these symptoms (Rado, 1959).

RISKS OF PSYCHOTHERAPY

Difficulties will also develop as a consequence of the new adaptations forced on individuals as a result of removal of the problem for which they originally sought help. Sometimes a neurotic disorder constitutes the best compromise individuals can make with life and with themselves. Although they may complain bitterly about the disabling effects of their condition, when they are relieved of it, they may

expose themselves to new circumstances that will or will not terminate happily. This, of course, is something for which practitioners cannot be held responsible. There is no crystal ball with which to predict the ultimate outcome of any problem. The responsibility of therapists is to help patients overcome an illness and to enable them to make a constructive future adjustment.

The end issues, however, may leave much to be desired, under which circumstances therapy may be scored as a failure. Thus a patient with migraine gets insight into the fact that she is complying, with strong internalized rage, to the authoritative demands of a widowed mother who seeks to infantilize her only child as an outlet for her controlling needs. Therapy helps the patient to liberate herself from her mother. The latter, unable to accept her daughter's freedom, commits suicide. The ensuing guilt, recriminations, and depression in the patient make her regret having started psychotherapy. An obese girl, helped to diet by psychological treatments, finds herself attractive to men. Unable to cope with the sexual demands made on her by her admirers, she responds with panic. A patient with frigidity dramatically overcomes her sexual indifference. Responding passionately to a seductive male, her episode terminates in pregnancy and the birth of an illegitimate child, which complicates her life detrimentally.

It is often impossible to foresee and to forestall future calamities that follow even traditional medical and surgical treatments. Thus the relieving of anginal pain, through prescription by an internist of a vasodilator, may encourage a cardiac patient to overtax the heart through physical efforts beyond one's endurance, initiating a massive coronary attack. Plastic surgery often exposes patients to responsibilities that their devalued self-image is unable to countenance, sometimes initiating many adverse reactions.

Another example would be refusing to treat travel phobias by psychotherapy to protect patients from the possibility of an airplane crash; this would constitute a foolish if not irresponsible shirking of therapists' duty. The best course to follow is to attempt to anticipate possible consequences of therapy and to work with patients until a reasonable stabilization is reached in their life situations.

FAILURES IN RECONSTRUCTIVE THERAPY

There are certain patients in whom long-term reconstructive treatment is not only useless but constitutes a definite hazard. Such patients, in good faith, enter into treatment with well-trained psychoanalysts, and after years of futile probing reach a desperate dead end. In many instances the hope of cure enjoins patients to engage a succession of therapists, each espousing a well-documented theoretical system that promises success but ultimately results in failure.

If a hard look is taken at what has been happening, it is often found that the therapists have become incorporated by the patients into their neurotic schemes. It becomes obvious that what the patients are seeking from treatment is not cure, but satisfaction of dependency needs, a relief from the suffering that their conflicts foster, but which they refuse to relinquish, and replacement of amputated aspects of themselves that, with present knowledge, are far beyond the power of science to supply. Freud, astute clinician that he was, recognized that not all people were ready for the long-term pull of psychoanalysis when he advised that only individuals able to develop a transference neurosis be treated with his method. Although the diagnostic boundaries are diffuse, empirically it is possible to designate the kinds of conditions in which failures are common with reconstructive therapy.

The most unacceptable of candidates are patients who seem to be unable to get along on their own. These individuals are possessed of such great fragility in their defenses that they tend to fall apart in the face of even reasonable stress. Often they protect themselves from hurt by restricting needs and circumscribing the zones of their interpersonal operations. Yet their helplessness enjoins them to fasten themselves to some host who, they insist, must supply them with love, support, and other intangible bounties. Such unfortunate individuals have been so damaged in their upbringing that no amount of help, affection, discipline, entreaty, supplication, or castigation seems to repair their hurt. They tend to find and fasten themselves to individuals, movements, and institutions from whom and from which they hope to gain sustenance and strength. They act like exsanguinated people in need of perpetual transfusions.

Diagnostically these individuals spread themselves over a wide nosologic spectrum. They include schizophrenics, borderline patients, alcoholics, drug addicts, and antisocial personalities. They may have obsessive-compulsive, depressive, phobic, and somatoform disorders. Essentially they are characterologically immature, never having achieved inner freedom and independence. It is as if they have become marooned on an island of infantile affect. Outwardly they may present a facade of assurance, but inwardly they are anchored to pitifully dependent moorings.

When such individuals enter psychotherapy, they soon sweep therapists into the orbit of their dependent designs. The grim objective of making therapists idealized parent figures is not diverted in the least by therapists' technical skills, astute observations, lucid interpretations, management of countertransference, encouragement of emotional catharsis, transference revelations, expert unraveling of dream symbolisms, the uncovering of forgotten memories, free association, structured interviews, firm directiveness, punishment, kindness, support and reassurance, suggestion, hypnosis, drugs, or by any other method therapists may exploit or devise. Therapists who are deceived by the earnestness with which patients dedicate themselves to the therapeutic task will credit the patients' lack of progress to the obstinacy of the patients' resistances, which, the therapists imagine, will eventually be resolved. And the patients, coasting along on the premise that time itself brings the cherished gift of unconscious motive or memory, will become increasingly helpless and will then supplicate for greater professions of dedication from the therapists. The liberated hostility serves no purpose other than to make the mutual lives of patients and therapists miserable in a futile tug of war.

With expanded public education and the exciting promises of fulfillment through psychotherapy, more and more individuals—unable to gratify their pathological dependency promptings in their habitual relationships, or through religion, or by affiliation with special movements—have flocked to the office of therapists seeking the elusive pot of gold that never quite materializes. And because hope springs eternal, the therapeutic diggings go on for years in the vain quest of bringing up treasure that somehow, according

to legend, must eventually be exposed. Both patients and therapists enter into this undeliberate deception only marginally aware that the quest is a useless one and that what the patients really seek from therapy is supportive aliment for their emptiness.

The great danger in long-term reconstructive psychotherapy is not only its becoming a never-ending placebo to such characterologically dependent individuals who would otherwise find an object of faith outside of therapy, but, more insidiously, its activation of latent dependency needs in those who have managed their lives, prior to treatment, with a modicum of independence and assertiveness. As treatment continues, the defenses, organized around avoiding dependency, break down and are swept away. This contingency is useful, of course, in patients who have a solid enough core to reconstitute themselves. Indeed, unless the shaky superstructure is removed, the defective underpinnings cannot be strengthened to support more adequate defenses. But what happens in individuals who do not have the materials, let alone the tools, to rebuild their lives? That which once served to carry them through daily chores, albeit not as mature as might be ideal, no longer can be used. The patients have thrown away their crutches, and their legs are now too weak to propel them in any direction. The specter of patients being damaged by prolonged therapy is one that unfortunately haunts every psychotherapist.

Can therapists, by proper diagnosis, select patients for reconstructive therapy more appropriately, eliminating those who are subject to the dependency hazard? Are there ways that poor therapeutic risks can be spotted in advance? Psychotherapists find themselves in a quandary because morally and ethically they are committed to helping people develop and grow no matter how sick. A corollary may, therefore, be appended to the questions: When poor therapeutic risks are detected, are there effective treatments?

Before an attempt is made to answer these questions, the qualities of a good therapeutic risk for protracted reconstructive treatment should be designated. For individuals to benefit from reconstructive therapy, the following conditions should prevail.

1. The presence of a personality disorder serious enough to justify the sacrifices inherent in an extended period of treatment.
2. The presence of symptoms or behavioral difficulties that are intensely annoying to the patient.
3. An ability to accept the conditions related to time and finances, and cooperation to undergo techniques that probe the unconscious.
4. The presence of rigid resistances that cannot be resolved by less ambitious approaches.
5. A level of dependency that is not too high.
6. The ability to tolerate anxiety without severe disintegrative reactions.
7. The presence of some flexible defenses, ample enough to support the patients when anxiety is mobilized.

In advance of starting an actual therapeutic program, there are a few prognostic indicators that may be of value. If the patients have been seriously maladjusted since childhood—have failed to achieve goals ordinary for their age levels; have not had a good relationship with at least one person in the past; are not psychologically minded; are prone to severe acting-out; have been in psychotherapy for a number of years, particularly with a series of therapists without achieving benefits; have been institutionalized in a mental hospital; or manifest symptoms of schizophrenia, manic-depressive psychosis, organic brain disease, severe compulsion neurosis, antisocial personality, alcoholism, drug addiction, severe psychosomatic illness, or obstinate sexual perversion—trouble is likely. Projective psychological testing is helpful diagnostically, but it may not reveal much in relation to the outcome.

The best clues will be supplied by the psychotherapeutic experience itself. If patients show favorable responses to interpretations, evidenced by constructive reactions inside and outside of therapy, and particularly an ability to implement insight in the direction of change, therapists may be encouraged. Material from free associations, dreams, and transference reactions will reveal much that is not apparent on the surface. These are usually good indicators of therapeutic movement. If patients respond

catastrophically to interpretations, or if they do not respond at all, if they manifest few or no transference reactions or the transferences are too violent, if acting-out persists in spite of interpretation, if their associations and dreams consistently reveal no constructive developments—these are warnings that danger may shadow continued intensive explorations.

TREATMENT OF POOR THERAPEUTIC RISKS

When signs indicate patients are poor therapeutic risks, the objective will be to bring them to homeostasis as rapidly as possible with short-term supportive and reeducative approaches. It may be useful to confront patients frankly with the realities of their situation. Remarks may be couched in terms such as these:

> *Th.* You have problems that date way back in your life. It will require some time to reverse these completely. There may be some things we may not be able to alter entirely because they go so far back and are so firmly welded into your personality that they may not budge. But you can still live a comfortable and happy life. Now one of the problems in a situation like yours is that you feel helpless to do things by yourself. You will then get very dependent upon me, and it will set you back. For this reason we will keep our treatment short. Please don't feel that I am neglecting you if I encourage you to do things on your own.

These directives obviously will pass over patients' heads. Even though they may appear to agree intellectually, emotionally they will continue to press for a long-term dependent relationship. In some cases they will really need to be dependent on someone or something the rest of their lives since they cannot get along by themselves. If this is a possibility, therapists may still acquaint patients with the dynamics of their problems in the hope of enlisting their reasonable egos as allies. By showing patients the relationship of their dependency to other elements of their personalities, of how and why they get angry, of what they do with their anger, of how they undermine their self-esteem, of why they detach, they are given a reality explanation for manifestations that they have hitherto considered to be mysteriously ordained.

If patients persist in retaining therapists as their dependency agents—and there are many patients who are able to afford this luxury and some therapists who are willing to play such an exhausting role—therapists may graciously accept the post and inform the patients of willingness to treat them and work with them on their daily problems. The therapist may add, however, that the situation will be very much as in diabetes, where insulin must be taken constantly. There are some emotional problems that are like diabetes and that will require help on a regular basis. Patients need not be ashamed if this is their situation.

There is hardship in working at depth under these circumstances. The patients will merely regurgitate their insights and recite their dynamics like a catechism. The best practice is to settle back with the patients and handle their immediate reactions with logical, persuasive arguments, attempting to inculcate in them a philosophy of living that will help them to accept their limitations and difficulties with grace. At the same time, deep material is interpreted whenever it is propitious to do so. Should the patients rail at the therapist and objurgate him or her for failing to transform them, the therapist must try to control the patients' frustrated feelings. A simple reply is best here: "Maybe it is impossible for you to change." This may have a startling effect on patients for the good, often shaking them out of their therapeutic lethargy.

Recognizing that there are patients who will require aid the rest of their lives and cognizant of the ever-expanding waiting lists, therapists may attempt to provide these sicker patients with a dependency prop that does not require a tie-up of services. For instance 15-, 20-, or 30-minute sessions may be all that is needed. Medications are prescribed intermittently if necessary, and the patients may be encouraged to join groups. Group approaches offer advantages to patients, since they help them to diffuse transference. Within any group, patients generally will select one or two people as their dependency target, but they know they can draw on the group at large when necessary. It is helpful, therefore, to encourage joining various activity groups, such as social and discussion groups. These may eventually replace the therapists as the prime supportive mainstay.