Failure and Success in the Psychotherapy of the Severer Adult Disorders
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While the limiting elements of psychotherapy have been noted by psychologists (Barlow, 2010; Dimidjian and Hollon, 2010), their studies have usually concerned short-term treatment using behavioral techniques, not lengthy interventions which seek to reconstruct the adult personality. Here the issue is more complex, its conclusions deriving from who is making the determination and the measures used. The resolution of unconscious conflicts or the improvement of ego capacities are not ordinarily tracked for brief psychotherapy lasting months rather than years. More easily charted indicators are considered satisfactory: whether a person still fears airline travel, or argues less at work.

Though therapists dislike admitting failure, some is inevitable. For even if they behave ideally, the therapist's role can be only secondary, analogous to adoptive parents since they enter their patients' lives long after mental structures have formed and emotional difficulties develop. Still, if their patient fails to achieve the hallmarks of adult development, autonomy and intimacy, they may consider the treatment to have failed though these are difficult goals and perhaps unattainable for some.

While considering this painful conclusion, I remembered a former patient, Sharon. I thought of what she achieved and failed to and how her treatment might have been more successful. Though the recommendations which follow must be judged tentative since they lack evidence.

I treated Sharon in one session weekly, individual psychotherapy over more than twenty years, from her college days through her early forties. There were long gaps in her treatment, once of five years when she lived far from my office. She came from a troubled family: her older sister was hospitalized during adolescence and later made a suicide attempt which left her partially disabled. Sharon's mother died when Sharon was a teenager and her father died ten years later. Sharon's mother was overly involved with her older daughter, largely ignored Sharon, and her husband neglected both

children, having received his wife's message that the children were to be parented by her alone. The parents' communication was minimal and venomous.

Sharon was a bright child, gained a scholarship to an Ivy League school and later earned a graduate degree. But problems on her jobs soon arose because of her difficulties in relating, the prejudice against women in her largely male vocation, and jealousy of her ability by co-workers. Though advancing in her job at a major corporation, her social life remained barren: she had no friends and had sex only once, while on a business trip in Argentina. She returned to treatment after her failure to gain a promotion left her profoundly depressed. She had worked long hours for this manager and been left with unfulfilled promises.

Sharon's final period of treatment lasted less than two months. During it I reminded her of her past intense desire for marriage and added that she was still young enough to have children; both these hopes had been forgotten. She ended psychotherapy when her depression lifted and she began making plans to seek a new job. A goal which would not be difficult for her skills would make her a valued employee at many government and private organizations. She didn't keep her last appointment and I have not heard from her since.

Sharon's treatment can be considered successful from several viewpoints. After dropping out of one college she entered and graduated from another and thereafter had a successful career though with considerable anxiety along the way. She traveled widely (on business) and enjoyed a high income. But her life lacked balance and joy. During her five year absence from therapy she rarely left her apartment except for shopping or work, the TV being her only companion.

Though Sharon's difficulty in tolerating feelings and emotional conflicts were central to her social isolation, other factors appear significant. She, and perhaps others who experienced a similarly destructive parenting had never gained the comfort from human relationships which makes intimacy

desirable to seek and maintain, Nor did they learn how intimate relationships operate: through sharing and healthy dependency.

Can such severe deficits be repaired through psychotherapy? If not, must the treatment be regarded as a failure? Or can later life itself provide the additional necessary healing? Enable the patient to discover their more authentic self—after experiencing the catalytic effects of psychotherapy but long after the artificiality of the treatment session has ended.

Change during psychotherapy can occur through various means: the gaining of insight during which self-defeating impulsive behaviors lose their strength; the construction of a coherent life story, one which need be only reasonably accurate so long as it provides meaning to existence; a healthy interpersonal interaction which provides the essential nurturing which was earlier absent; the experiencing of closeness through the therapeutic alliance where the patient is valued for themselves, accepted as they are—an emotional experience similar to the religious transformation of gaining Grace from an all accepting God; suggestions in the hushed therapy office which have a hypnotic-like potency through the power of the transference; gaining a changed view of reality and optimism about overcoming difficulties and the psychological mechanisms for doing so.

Yet even with all these therapeutic tools the goals of autonomy and intimacy may not be achievable: structural change is difficult, the unconscious is powerful, and life is finite.

If one considers Sharon's intimacy difficulties as reflecting social phobia, would a cognitive-behavioral approach as suggested by Heimberg, et.al. (1985) have been helpful? But there were such elements in her psychotherapy: I remember our long discussions about dating possibilities. At one point, after losing much weight which greatly increased her attractiveness, men tried to pick her up as she walked to work and she had continual contact with others in her large corporate environment.

Could Sharon's difficulties have reflected a biological limitation deriving from lack of parenting? There is research that children brought up in orphanages have lower levels of certain

hormones, vasopressin and oxytocin, which interferes with the comfort normally developing between children and their caregivers (University of Wisconsin-Madison, 2005).

Or perhaps there were other factors of greatest importance. The fear and rage from her childhood which caused her to regard intimacy as dangerous with she being a danger to others and they to her. Or the shame of being truly known and found wanting (Miller, 1985), exacerbated by her lack of basic trust: the sense that despite having limitations one is acceptable to others.

I recently considered another possibility: that Sharon could not even grasp the possibility of intimacy much as snow is completely foreign to a child of the tropics. This limitation, the inability to conceive oneself in a desirable adult position, is not exclusive to social difficulties. Those recovering from long-term psychoses may suffer this regarding independent living and employment.

Throughout the seven years in which I ran a psychotherapy group in a day hospital program, I was continually moved by the poignancy of the patient experiences: visits to their old neighborhoods during which they viewed childhood friends having families and jobs while they remained mired in the "mental health system." The popularity of this group was, I think, because I explored symptoms in a way which made sense and gave hope. Thus "hearing voices" was not explained as evidence of a "brain dysfunction," "chemical imbalance," or another vague and impressive but frightening and unhelpful bit of medical jargon. Rather, it reflected talking to oneself about something important, in the manner of dreams which require interpretation. Persistent indecisiveness or moodiness reflected other equally understandable symptoms: ego limitations caused by inadequate parenting when the basic psychological capacities were formed. I also detailed how goals which seem impossible are attainable.

For their limitations and those like Sharon's, providing long accepted developmental information (Balint, 1968; Bowlby, 1960; Grotstein, 1985; Kohut, 1977; Winnicott, 1965) may be the key, helping to bridge the gap in their lives when they sense a door which remains unopened. This

technique is well within the tradition of psychoanalytic psychotherapy for its ultimate goal has always been the gaining of intellectual control over unconscious forces.

This confrontation with factual reality during psychoanalytic psychotherapy will partially dissolve the transference, causing the patient's separation from the therapeutic alliance and their increased maturity. But though intermittently helpful throughout the entire course of treatment, these interventions should be carefully timed lest the mind's basic conservatism, its deep-rooted resistance to change, overwhelm.

To summarize: the goals of autonomy and intimacy may more likely be achieved when the patient's symbolic re-experiencing of merging and separateness during treatment is accompanied by their psychotherapist's detailed theoretical explanation of the psychological damage which the patient unknowingly experienced during their deficient early development. For example, by explaining that their tendency to be easily swayed by others reflects their inadequate sense of self. This being a condition which results from the lack of healthy emotional reciprocity/interaction with parents during the earliest years when the basic sense of who one is, the personality, is formed (Kernberg, 1976)..

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