FAMOUS THERAPIST ERRORS

Presented by

CONTINUING PSYCHOLOGY EDUCATION INC.

4 CONTINUING EDUCATION HOURS

"Such self-honesty and internal clarity are prerequisites for a serious analysis of therapists' flaws and imperfections."

Kottler and Blau (1989, p. 127)

Course Objective
This course examines the prevalence of therapeutic errors and how we may learn from the process. A number of prominent practitioners disclose their counseling mistakes allowing the reader to gain from their experience. Albert Ellis, William Glasser, Arnold Lazarus, Gerald Corey, John Gray, James Bugental, Clark Moustakas, Richard Fisch, and others disclose their therapy failures for our benefit.

Accreditation
Continuing Psychology Education Inc. has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6084. Programs that do not qualify for NBCC credit are clearly identified. Continuing Psychology Education Inc. is solely responsible for all aspects of the programs. Continuing Psychology Education Inc. will award NBCC-approved continuing education clock hours for all of its listed programs.

Mission Statement
Continuing Psychology Education Inc. provides the highest quality continuing education designed to fulfill the professional needs and interests of mental health professionals. Resources are offered to improve professional competency, maintain knowledge of the latest advancements, and meet continuing education requirements mandated by the profession.

Learning Objectives
Upon completion, the participant will understand the nature and prevalence of therapeutic errors and the learning potential inherent in examining one's mistakes. A number of influential psychotherapists-theorists examine the concept of therapeutic errors facilitating the reader to integrate these principles into his or her own practice.

Faculty
Neil Eddington, PhD, obtained his doctorate from the University of California, Berkeley. He was a research associate and assistant professor at Harvard University within the department of psychiatry, adjunct professor at Tulane University, and associate professor and coordinator of graduate studies at the University of New Orleans. He co-authored the book, "Urbanman: The psychology of urban survival."

Richard Shuman, LMFT, is a private practitioner in San Diego, CA and was selected as a court-appointed therapist. He was a psychology professor at Phillips College in New Orleans, LA and currently is the director of Continuing Psychology Education Inc.

INTRODUCTION

Understanding therapeutic errors may lead to improved future performance through refinement of our strategies and the necessary implementation. Therapists grow by demonstrating what works and by identifying what does not work. Lapses in judgment, mistakes in timing and pace, and mis-use of techniques and interventions are instructive because they are fundamental errors suggesting the need to utilize basic therapeutic strategies.

Deducing the causes of failure in therapy is difficult for several reasons. First, clients often do not inform therapists of the true reasons for leaving treatment – it could be as trivial as our style of dress, the way we addressed them on a particular occasion or something we said which was understood out of context. Second, clients may not be aware of why they felt dissatisfied with the process as it was unfolding. Third, therapists may lack inner courage or objectivity to admit errors or poor judgment thus maintaining self-evaluation in a favorable light. Additionally, therapeutic encounters are generally too complex to discover a single reason causing failure, rather, a combination of factors is probably at work.

Kottler and Blau (1989) believe that determining good versus bad therapy is based on a subjective assessment of one or both participants such that relative meaning and value are attributed to the outcome. Bad therapy occurs when personal issues and counter-transference processes negatively affect sound judgment (Robertiello & Schoenewolf, 1987). It is understood that committing therapeutic errors is a product of being human and that constructive processing of our mistakes leads to mastery of a profession (Conyne, 1999).

A good indication of therapy failure is "when both parties agree there has been no apparent change" (Kottler & Blau, 1989, p. 13). Uncertainty of therapy effectiveness may still occur though given clients not disclosing truthfully about their satisfaction level. Further, Kottler (2001) reminds us that we may receive completely different feedback from the client's significant others compared to the client him/herself. Keith and Whitaker (1985) indicate that therapy may appear worthless in the short-term but can result in long-term benefits. Defining bad therapy is difficult, in fact, Bugental (1988) believes that every session includes elements that are both good and bad.

Hill, Nutt-Williams, Heaton, Thompson, and Rhodes (1996) examined factors that lead to impasses in therapy by interviewing twelve experienced therapists who were working with relatively severe cases in long-term treatment. Variables most associated with impasses included client characteristics (severity of pathology, history of interpersonal conflict), therapist characteristics (therapist mistakes, counter-transference), and problems with the therapeutic contract yielding disagreement about treatment goals. Stiles, Gordon, and Lani (2002) reviewed empirical studies differentiating good from bad therapy and found the following two most significant factors: the depth or power of the therapy, and how smoothly things proceed. These researchers note that often therapists and clients do not agree about how smoothly or deeply the therapy is proceeding which may result from different treatment expectations.

Estrada and Holmes (1999) examined couple's assessments of marital therapy and determined that clients deemed the therapy experience lousy when therapists were passive, unclear about their expectations, not empathic or understanding, and when they did not keep things safe or wasted time. Clients find therapy less than helpful when therapists do not do what they want and expect; therapists gauge the therapy as bad when clients are not cooperative. Poor therapy outcomes tend to result from contributions by therapist, client, the situation and external forces.

Hollon (1995) suggests that insight regarding therapy impasses may be attained not only from a supervisor but also from the client. Whether accurate or not, Hollon believes that client feedback is the perception most influencing the result.

The following section examines the self-admitted therapeutic errors of prominent practitioners. The goal is for all of us to learn from their mistakes and to confront our own.

THE ERRORS OF PROMINENT PRACTITIONERS

Kottler and Blau (1989) and Kottler and Carlson (2003) interviewed noteworthy practitioners and asked them to describe an experience with therapy failure due to their own error, what they learned from the experience and how it has impacted their life. James Bugental, Richard Fisch, Albert Ellis, Arnold Lazarus, Gerald Corey, Clark Moustakas, John Gray, William Glasser and others shared some of their imperfections allowing us to learn from their mistakes and to be more disclosing of our own.

JAMES BUGENTAL

Bugental has been a dominant force in existential-humanistic psychotherapy and his books, including *The Art of the Psychotherapist* (1987), and *Psychotherapy and Process* (1978) highlight the importance of sensitivity, love and intuition within the therapeutic encounter.

He disclosed his therapy failure with a client named Nina, a wife and mother who experienced periods of despondency all her life and when in this mood would become argumentative. There was no significant change in her emotional issues after more than three years of therapy. "I failed Nina, although I'm not sure how. My best guess is that I misread the depth of her depressive character and therefore didn't help her come to an adequate accommodation to it…" Bugental confirmed that client progress did occur in several areas, hence, the therapy had successful aspects as well.

Bugental felt strongly of the need to provide a situation which clients can use to implement life changes. He understood that this is not always possible, acknowledging that he is very human, thus limited. The common

denominator for therapy failure, in his perspective, is the therapist's hesitation to invest as completely and to be as present-oriented as the client needs.

Successful therapy requires therapists to confront client despite our fear of their anger, disappointment or of losing client. We must not divert their emotional outbursts, transference, or "messiness;" we must allow client to face the "ultimate insolubility of life" and we are better served to be responsible for our own neurotic distortions. Moreover, Bugental believed that at least some benefits resulted given sincere effort of therapist and client but these benefits may be less than desired. He stated, "…there is merit both in trying to approach that ideal more frequently and in accepting that we will always fall short of it."

RICHARD FISCH

Fisch, a psychiatry professor at Stanford, has pioneered research in problem-solving therapy and has co-authored many books, including *Change: Principles of Problem Formation and Problem Resolution* (1974) and *The Tactics of Change: Doing Therapy Briefly* (1982). In 1965, he founded the Brief Therapy Center at the Mental Research Institute in Palo Alto, California. It was the first such institute in the world established for the purpose of researching ways to make therapy more effective and efficient. In doing so, Dr. Fisch and his colleagues created time-proven methods of therapy in use today.

He admits that some failure cases leave him puzzled as to the cause – even after reviewing case notes and pondering intervention taken. In such instances, "I can't say I learned anything and I had to shrug my shoulders and go on to the next case and give it my best shot." To Fisch, the therapist assumes much of the responsibility for treatment and outcome and the outcome is easily measured by whether client's issue is resolved or not.

Fisch recollects that generally he did learn from his errors, including having intervened too quickly or with insufficient planning and having argued with client while attempting to offer a different perspective on a situation. "You can usually tell when you're arguing because you're talking too much. You can sense you're working too hard."

Disclosure of a therapy error by Fisch involved working with the parents of a 10 year-old boy who had a kidney condition requiring dialysis several times a week. The parents indicated their son was socially withdrawn and having peer difficulties at school and in the neighborhood. They felt the medical condition was causing the boy to feel inferior to peers which they attempted to combat by reassuring him that he was like the other kids. Unfortunately, this was not the case and the "reassurances" reinforced that he was so different that it could not even be acknowledged. Fisch recommended parents to deal with the situation in a more honest and matter-of-fact manner which they did and found to be effective. The error arose when Fisch attempted to reassure the parents by lightening the tone. He suggested that despite their worries, the boy would

be alright in school and with peers but during this discourse he innocently stated, "Our kids grow up and we lose them." Naturally, Fisch meant that children grow older and become independent of the nuclear family but the parents' fear of the boy's expected shorter life was triggered. The therapist noticed the affect of the statement on the parents' faces but the session was about to end so they walked out "stonily." The parents did not return for their next scheduled session nor did they return therapist's phone calls.

Fisch learned that he failed to comment on the parents' fundamental fear, additionally, "…to pay attention to people's sensibilities, values ,and frames of reference, not to take those things for granted, and to carefully match my phrasing to people's positions."

ALBERT ELLIS

Ellis is known for developing Rational Emotive Therapy (RET), an action-oriented therapy designed to make emotional and behavioral change through challenging self-defeating thoughts. He died on July 24, 2007, at age 93. The American Psychological Association, in 2003, named Dr. Ellis the second-most influential psychologist of the 20th century, second to Carl Rogers. In 2005, his 78th book, *The Myth of Self-Esteem*, was published.

He remembered working with Jeff, a young man who was very depressed. Client had responded well to active-directive therapy with Ellis in the past but after a number of years he returned to therapy with severe depression. Therapist disputed client irrational beliefs and used a variety of behavioral imagery and RET interventions.

Client depression occasionally improved but as business slowed down he regressed into severe despair and self-downing. After 23 RET sessions client's wife insisted that something other than his desire to succeed was troubling him; she became upset with therapist for not helping her husband and coerced him to attend psychoanalysis. Eight months later he attempted suicide and was hospitalized for several weeks. Since that time he has maintained a marginal existence. Client would like to return to RET but wife prevents this and she encourages him to take antidepressants, which help moderately.

Ellis concludes that he made at least the following three errors: 1) He diagnosed Jeff as a severe depressive but he did not rule out endogenous depression. He knew client's father experienced depression but he did not investigate other close relatives. "I now think that endogenous depression probably runs in the family." 2) During the second round of therapy, Ellis did not urge client strongly enough to try antidepressant medication concomitant with the therapy. "I misled myself by remembering the good results we had obtained without medication. I now believe that Jeff could have profited most from psychotherapy and pharmacotherapy combined."
3) He did not urge client to bring his wife fully into the therapy, in fact, she attended only one session. "Instead, I probably should have arranged continuing sessions with her and with both of them."

Ellis concluded by stating, "As a result of my failing with Jeff and with several similar cases of severe depression, I now take greater care to look for evidence of endogenous depression, to enlist other family members in the therapeutic process, and to ferret out and actively dispute – and teach my clients to dispute – their dogmatic shoulds, oughts, and musts."

ARNOLD LAZARUS

Lazarus, a Rutgers University faculty member, coined the term "behavior therapy" then combined cognitive therapy and other interventions with his behavioral approach to become the founder of multimodal therapy. He has written numerous books, including *The Practice of Multimodal Therapy*, *Brief but Comprehensive Psychotherapy: The Multimodal Way*, *I Can If I Want to*, and *The 60 Second Shrink: 101 Strategies for Staying Sane in a Crazy World*. He has won many honors, including the Distinguished Service Award of the American Board of Professional Psychology in 1982 and the Distinguished Psychologist Award of the Division of Psychotherapy of the American Psychological Association in 1992.

When asked what constitutes bad therapy, Lazarus offered a list of errors such as the therapist who lacks empathy and compassion. He admitted that it is possible to be less engaged or concerned than what is required, for example, "…when we have seen 8, 9, or even 10 clients in a day, it is even more difficult to concentrate on remaining caring; under such circumstances we have sometimes found ourselves functioning on autopilot." Ineffective therapy also occurs when therapists: do not hear their client, constantly answer questions with other questions, engage in labeling, misread the client, utilize malignant interpretations, ridicule, insult, or offer destructive criticism, and do not employ empirically supported techniques when relevant.

Lazarus described one of his bad therapy sessions which involved a man in his 40's who had lost three jobs in eight months and agreed to therapy per his wife's request. Client presented as skeptical, hostile and attacking which began to irritate Lazarus. During one session client verbally attacked therapist and then his own wife which led to therapist losing self-control and telling client that he was "a really reprehensibly guy" and stating to client's wife, "I don't know why you put up with this guy. I mean he is the most royal pain in the neck." Therapist never saw client or his wife again.

Lazarus admitted that this was not a therapeutic intervention, rather, "I stopped being a therapist at that point and I came across purely as a crazy fellow going for this guy's jugular." After deliberation through the years, Lazarus concluded that client's putdowns, criticism and the way he treated his wife bothered him. Referring client to another therapist was an option in therapist's mind, "But I couldn't think of anyone I hated enough to refer this guy to." When asked why he was so affected by this client, Lazarus responded, "Perhaps there are just times, for whatever reason,

that our own life problems place us in a vulnerable state." He also admitted that client reminded him of a bully who beat him up in high school – a good example of counter-transference.

Another insight gained from past mistakes led Lazarus to state, "One of the tendencies that I used to have was to move in too quickly without getting the full picture." He learned that the therapist must validate what client is truly indicating before moving forward toward a perceived target. "Many times I've seen some of these people jump to conclusions after less than a minute, and they almost always miss the point. They hadn't heard their clients. They hadn't asked the relevant questions. They didn't even realize they were way off base."

In reflection, Lazarus observed that he has become less patient over the years; moreover, he believes that therapists often try to cover up and deny their mistakes which diminishes learning opportunity.

GERALD COREY

Corey is a premier textbook writer specializing in the training of therapists. His numerous books include the classic, *Theory and Practice of Counseling and Psychotherapy*.

The error that Corey disclosed occurred when he was co-leading a training group. A former student and trainee in the group asked Corey how he viewed her. The other co-leader intervened and asked the student to verbalize why this information was important to her and she responded that she respected Corey but she feels insignificant in his eyes. Corey did not respond to her. When asked by the co-leader during the break why he had not responded Corey stated that he felt uncomfortable, put on the spot and he did not know what to say. The co-leader suggested he could have stated these true feelings along with the observation that the student did not assert herself by requiring a response.

This issue was raised in a subsequent group session whereby some thought Corey's non-response was a technique while others thought it was insensitive. Corey admitted, "… I felt put on the spot and was somewhat at a loss for words. I let the group know that I do struggle at times with giving my immediate here-and-now reactions when I am confronted, and that I become evasive or sometimes say nothing at all. I acknowledged that I made a mistake. She did deserve a response from me, and I regretted holding back my perceptions."

Corey and the co-leader were intrigued how group members often discount their inner reactions, relinquish their power and seek justification for a group leader's mistake.

Corey realized that " … it isn't easy to do what one knows is appropriate, and that under pressure we sometimes revert to old patterns of behavior. In my eyes, although I did make a mistake, the situation did not turn into a failure because I was willing to explore what happened with my co-leader and

the group members. In this particular case, all of us learned something from my mistake."

CLARK MOUSTAKAS

Moustakas is one of the founders of the humanistic psychology movement as evidenced by establishing a graduate institute and writing numerous books on the subject.

He shared an early experience in his career of a client who had problems with women and wanted advice. Therapist utilized his previous specialized training in nondirective therapy by listening, reflecting thoughts, feelings and content and sharing his concerns with client. Client became dissatisfied with this therapeutic style and demanded advice. Therapist indicated that offering advice was not compatible with his helping style and that a solution would arise if client continued to explore the issue. Client ended the session early, said it was a waste of time and did not return.

Moustakas realized that his nondirective approach did not suit this particular client but he did not view the case as a failure. This experience opened Moustakas to experimenting with his own presence to facilitate change and growth. "If I saw this man today, I would be more interactive, more confrontive; still I would not give him advice, but I probably would be more directive, more interpretive, and more self-disclosing. My interactions with him were on an 'I-it' basis; I feel certain that faced with a similar situation today, I would be more responsive as a self, entering into an 'I-thou' relationship."

Therapeutic errors, according to Moustakas, often occur because therapists persist in using a technique or methodology that is not helpful or amenable to the sensitivities of the client.

WILLIAM GLASSER

Glasser is the creator of reality therapy and has written numerous books, including the classics, *Reality Therapy*, *Choice Theory*, and *Reality Therapy in Action*.

He described a case regarding a woman in therapy who eventually decided to leave her husband. The husband, a wealthy man used to getting his way, convincingly threatened to kill himself if she left him unless his wife agreed to live with him for two months a year. Glasser noted, "I just didn't know what to do, or whom to call. I mean the man was not insane. In those days, there was no chance whatsoever of getting someone committed who was reasonably sane. I thought of calling the police. I didn't even know what to say to him."

Therapist confronted the man, tried to negotiate a suicide contract and attempted to convince him to check into a hospital – but unsuccessfully. He then asked the wife to write a letter stating that she was aware of the situation but chose to leave her husband.

One day the husband did not show for a scheduled session, out of concern, therapist drove about ten miles to his home.

Glasser knew the man was inside but he did not respond so therapist called the police who broke in and found him dead.

Glasser still wondered if he had done something wrong. "What I could have done – I did this with a few other people – is sat with him for a long period of time. Maybe I could have shown him how much I cared. In all my years of practice, this was the most disturbing thing I faced."

After some deliberation, Glasser confided of another case in which he saw a wealthy woman from Beverly Hills who was the mother of several daughters he was seeing in therapy for some time. He could not remember her reason for seeing him but he recollected that she was highly obnoxious. As the session was about to end, therapist told the mother how he felt about her. "I told her that I felt uncomfortable talking to her. I didn't like the way she presented herself. I felt antagonistic toward her. Then I said to her, 'I can't wait until you leave.'"

Upon reflection, Glasser realized that this may have been bad therapy because he did not help the mother or daughters by this action. He let her get under his skin but he learned from the experience and expressed "… I can't recall a time when I ever lost my cool like that again."

Glasser believes that bad therapy occurs "when you tell people that they need help, and that only I can fix you. You've got something wrong that you can't figure out and you need me to do it for you." Additionally, he admits that having his therapeutic theory already in mind guides him but "Sometimes I think I've gone a little bit too far with this and too fast. Sometimes I'm not careful enough to build a relationship with the client before pointing out that he or she may have made some bad choices."

In assessing his career, Glasser realized that it was not his theoretical contributions or therapeutic techniques that came to mind but instead his relationships with people – the commitment he felt toward the people he helped. When asked about his weaknesses, he revealed that sometimes his impatience led to pushing someone faster than expected, fortunately, he learned from his mistakes, was quick to apologize once awareness set in and then he moved at an appropriate pace.

JOHN GRAY

Initially trained as a family therapist, Gray became an author of relationship books, including his best-seller, *Men Are From Mars, Women Are From Venus*. He was frustrated with the therapeutic style that highlighted expressing feelings over seeking mutual understanding between partners, hence, his writing focuses upon gender differences within communication styles.

Gray and his wife had experienced marriage counseling to resolve some marital challenges and he thought it was worthy when the therapist asked appropriate questions and listened well. Contrarily, he did not appreciate therapist intrusiveness or when the practitioner would observe a faint hint of emotion during the communication and then over-probe the feelings. He found that therapists enjoy probing feelings and

they can push clients to express themselves too much. His therapist kept pushing him to express feelings, which he did, but this led to his wife becoming more upset which further impaired their communication. He felt therapy only made the relationship more problematic. In his words, "Once you are more balanced you can talk about your issues. But it doesn't serve any purpose to go back and forth, venting, accusing, misinterpreting, and correcting, and so forth. All we were doing was an exaggerated form of what was going on at home."

Gray believes that bad therapy occurs when anger and pent-up feelings are released at the expense of seeking resolutions and fostering improved communication between the partners. He feels that venting should be a means to an end rather than the end itself.

When performing marital counseling himself, Gray periodically perceived the ill-effects of expressive therapy in his clientele such that they could express sadness or anger fluently but could not find forgiveness or self-responsibility for their behavior. He concluded that "the act of venting feelings could be as addictive as taking drugs."

Gray believes that therapists who have experienced the issues for which their clients present are in a better position to be of help as illustrated by his statement, "You are a much better guide if you have been there and you got through."

JEFFREY KOTTLER

This best-selling author of over 75 books in psychology, counseling, and education is considered an expert on human relationships. Several of his notable books include: *Compassionate Therapy: Working with Difficult Clients*; *On Being a Therapist*; and *The Client Who Changed Me*. Kottler has been professor and chair of the counseling department at California State University, Fullerton.

Kottler revealed his bad therapy experience involving an older lady named Frances who verbalized and vented a lot but did not listen well. Therapist felt his responses were not being heard or heeded, rather, client rambled as though he was not in the room. He disclosed, "I'd interrupt her with some brilliant interpretation, she'd ignore me. This really hurt my feelings, not to mention my sense of competence." Initially, he assessed the client as being uncooperative and difficult but upon deeper inspection over time he concluded that he was being a bad therapist.

After a handful of sessions, Kottler concluded that Frances was not meeting his expectations as a good client; she was not interesting, entertaining or in noticeable pain. Further, she was not changing and then being grateful for the rapid change.

During one session, Frances was speaking for some time about how she felt her daughter was an inadequate mother because she did not do things as Frances would. This theme touched a nerve within therapist (he felt as though he was being scolded by his own parent in raising his own son) who then proceeded to gather his courage and stated, "It's really hard for me to listen to you." He confronted her by stating

that she rambled without listening, was self-absorbed, and exhibited poor social skills and fears of intimacy. He used here-and-now statements indicating that he felt pushed away from her and how it was impossible to get close; therapist also reflected her anger toward him at that moment. Therapist then said he was done saying that which he had wanted to for weeks and he asked client, "Go on, what do you think?" She replied, "I think that daughter of mine better change her ways or there's gonna be serious trouble in that house" and she continued to go on and on about this topic. Therapist admitted to feeling unappreciated and frustrated and that he retreated into his own fantasy world.

After reflection over time, Kottler realized that to have helped this client all he had to do was compassionately listen, give her respect and empathy, and make her feel cared for. Instead, therapist acknowledged that he surrendered his compassion and refused to remain present with her. Granted, she rambled a lot but he assessed that she was simply afraid and this was her method of keeping things together.

Within a constructively positive manner, Kottler concluded that he was disrespectful and judgmental to his client by blaming her for being the way she was rather than understanding her. He became lazy, gave up, yielded to his boredom by not staying present, and he "punished" her for not entertaining him rather than accepting who she was.

Kottler suspects that therapists periodically "leave their sessions for a period of time" and they escape into this fantasy world for reasons such as boredom, laziness, feeling threatened by client issues, and their own personal issues. He advises therapists to avoid client neglect and to be forgiving of our therapy mistakes while being self-reflective and self-critical of our sessions. Regardless of the amount of training and practice, Kottler believes that we won't have the ability to give our clients as much as they need or deserve and that we will not meet our standards of perfection. He professes that "We will do good therapy and, at times, bad therapy. The thing is: Just hope you can tell the difference."

JON CARLSON

Carlson has authored 40 books and 150 journal articles and has been professor of psychology and counseling at Governors State University in Illinois. He received Distinguished Services awards from the American Psychological Association, American Counseling Association, International Association of Marriage and Family Counselors and the North American Society of Adlerian Psychology. Dr. Carlson was named one of five "Living Legends in Counseling" in 2004 by the American Counseling Association.

Carlson described a client who was hired by his office manager to assist with their office work during the time the client was in therapy with Carlson. The office manager felt this situation would not become a dual relationship problem because the client was not working for Carlson. Client's issue was determining whether to leave a bad marriage.

Ultimately, the client's husband suspected his wife of having an affair with Carlson. Therapist asked client what might have led to this absurd suspicion and she disclosed that she was having an affair – with the minister of the church who had recommended client to Carlson.

Therapist received a phone call from the attorney of the client's husband, after client filed for divorce, because husband was threatening a lawsuit and registering a complaint with the Licensing Board for unethical conduct based on therapist having sex with his wife. Resolution occurred when husband sought his own therapist and Carlson's client arranged for Carlson to attend one of husband's sessions; she gave him permission to reveal her extra-marital affair to the husband's therapist but not to husband. Carlson recollects, "The other therapist did some good mediation and was able to calm the husband down and try to get him to look at why their relationship didn't work. I wasn't defrocked of my license and I wasn't accused of improprieties, but I still have to take responsibility of creating a big part of this mess."

A second case was disclosed by Carlson which involved a man in his early 30s seeking help with relationship issues and who also acknowledged being in recovery from drug and alcohol abuse. Client stated that he would be in recovery for the rest of his life but in therapist's view this way of thinking is a liability, consequently, therapist mentioned some evidence that people can train themselves to be social drinkers. Client's immediate response was to nod his head and not respond verbally but several days later client wrote therapist a letter terminating therapy stating that therapist was unprofessional, did not understand that alcoholism was for life and such people cannot be taught to drink socially. Carlson sought closure by sending client a termination letter along with literature supporting feasibility of social drinking and wrote the information was controversial and client would have to reach his own conclusion.

Several years later, client called and wrote to therapist revealing he began drinking a glass of wine at dinner for the past year without losing self-control and he no longer viewed himself as an alcoholic. Soon thereafter, Carlson received a phone call and visit from a police officer informing him of a threat against his life and that the police would patrol his street on a regular basis. The past client had begun drinking heavily leading to the loss of his job and control over his life. Ultimately, client was arrested for being out-of-control and he threatened Carlson's life while in detox. Client's wife wrote therapist declaring him to be a terrible counselor and that he ruined their lives.

Carlson immediately reflected on the experience seeking resolution, he admitted, "It was really upsetting to me that such a spontaneous passing remark could have such a huge negative impact. Again I was right: research supported what I had said but it was totally inappropriate for this individual. I learned after that to be very careful about the things I say to people. At the very least, I might say to him now, "Would you be interested in knowing …?" Or maybe I wouldn't bring it up at all." Therapist learned that he should have

given the information in a different way, with greater respect to where the man was coming from. He felt sad that he never talked to client after this experience and that closure was never obtained.

Carlson noted, "I have a lot of regret and sadness about the blessedly few failures I have encountered. They are stories without endings, and I have to live with that." His current belief is that therapists do make mistakes but it's important to not continue making the same mistakes.

PEGGY PAPP

This therapist is known for her innovative work exploring gender differences in the practice of family therapy. In her acclaimed book, *The Process of Change and Family Therapy: Full Length Case Studies,* she was one of the first to trace family belief systems that affect core values of individual members. Other noteworthy books include, *The Invisible Web: Gender Patterns in Family Relationships*, and *Couples on the Fault Line: New Directions for Therapists*. She has been a supervising faculty member of the Ackerman Institute for the Family and founder/director of Ackerman's Depression and Gender project. Papp received the American Association for Marriage and Family Therapy's Lifetime Achievement Award, and she was honored by the American Family Therapy Academy for her ground-breaking work on The Women's Project for Family Therapy. She has been in private practice in New York while supervising therapists at North General Hospital.

In recollecting a past therapy failure, Papp described working with a couple utilizing the technique of sculpting in front of a large crowd for demonstration purposes. Each member is asked to have a fantasy about their relationship and then act out the fantasy together; the fantasies offer a metaphorical view of the way each member experiences the relationship and the metaphors are then used as a guide for bettering the relationship. Therapist recalled how the wife could not derive a fantasy and the husband's fantasy was about a rock which was difficult to sculpt. To make matters worse, therapist intentionally did not have background information on this couple – her therapeutic style is to form her own opinion rather than be potentially biased by a referring therapist – and this lack of information militated against this demonstration as well. Ultimately, therapist could only muster a "flimsy kind of message" back to the couple and she felt it was the worst session she ever did.

Papp felt that she ignored her intuition and continued to work within a structure that was not working. She learned that it is "unrealistic and inappropriate to decide ahead of time on a treatment method before even meeting the family and hearing their story. Such a structure was eventually bound to fail." Certainly, it is important to not remain focused on a specific treatment or plan when the flow of information suggests a different approach.

Upon reflection, Papp concluded, "… no matter how long you practice therapy, even in the most stressful of circumstances, you can never really get to the point where

you can handle everything deftly that comes your way. There are therapists who think they can, but that is only because they are oblivious to the different ways they could have proceeded." She believes that human behavior is mysterious and unpredictable thus rendering therapists to be humble about their work, otherwise, we can be insensitive to the dilemmas of our clients. Papp contends that "It takes wisdom sometimes, not techniques and approaches to be helpful to people. It takes a kind of real understanding about human suffering." Finally, she stresses the need for therapists to work within the particular cultural context of each client and to respect those beliefs.

VIOLET OAKLANDER

This pioneer of child and adolescent therapy has attained international recognition and has received several awards for contributions to the mental health field. Her books, *Windows to Our Children: A Gestalt Therapy Approach to Children and Adolescents*, and *Hidden Treasure: A Map to the Child's Inner Self* reveal her unique Gestalt and Expressive Therapy techniques.

In sharing an example of her bad therapy, Oaklander described a 16 year-old boy who was reluctantly attending therapy at his father's request and whose mother was an alcoholic. The youth disclosed many physical complaints, including chronic stomach aches which eventually led to ulcers. He was passive, quiet, restricted in self-expression, and admitted to skipping a lot of school. Client became emotional several times upon admitting he could not invite friends to the house because his mother was drunk. Therapist felt progress was occurring and that client would perhaps experience a catharsis soon, however, after six sessions client refused to continue attending therapy because, in his words, "I feel things. And I don't like it. I don't want to feel what I am feeling." Further probing revealed that he recently cried in the classroom when criticized by his teacher and he yelled at an acquaintance who made him mad. He said, "I don't want to do that, I don't like this stuff. I like the way it was before when I didn't feel anything."

Therapist told client that releasing feelings hurts at first but later if feels better and that his physical problems were caused by keeping his feelings inside. Nonetheless, client discontinued therapy which left therapist with an uncomfortable feeling. Oaklander assessed the case and concluded that she hurried the pace of therapy, "I had gone much too fast with him and I just hadn't paced the sessions. I had just pushed him – it didn't feel like I pushed him – but that's really what I did. I just kept going further and further and pushing him and all these things would come out. It was like he lost control over himself and I certainly didn't help him feel any control over anything. I thought a lot about this. I learned a lot about pacing sessions and being careful, particularly with a child with his background." Therapist resolved that children cannot manage a lot of expression of feelings all at one time as adults can due to a lack of ego strength. She stated, "Often children will take care of

themselves by breaking contact. They say they don't want to do it anymore. With a child with his background, I needed to be more alert about not pushing him too hard. Ever since that case, I have handled this differently."

Another unsettling concern for Oaklander is that she never learned what happened to client which left her with a feeling of uncertainty as expressed by, "I try to comfort myself that whatever we did together might have been helpful to him, but I am really not sure about that."

In a second case, Oaklander described a 13 year-old boy who was often truant from school and was failing academically. His mother brought him in and she was angry with his behavior.

Therapist observed that client was not emotionally expressive and would not be motivated for projective work but he did show enthusiasm toward fishing which was his favorite activity during his school truancy time. Therapist advised the mother to notify the school of her intention to allow her son periodic mental health days to go fishing which might heighten desire to attend school. Therapist also recommended to mother to seek professional help for some learning disabilities that she observed in client and such improvement could make a big difference. The mother said she could not possibly do that then she got angry with therapist and immediately terminated her son's therapy. Sadly, the mother called therapist about a month later and said that her son had hanged himself and she wished she had listened to therapist. Oaklander recounted, "Since then, I've always wondered about what I could have done or said so that she would have listened to me. I don't know if it would have helped him or not, but I always wondered about what I had missed."

Upon reflection, Oaklander realized that she may have given ample attention to client but not enough to mother. "I know sometimes I will be so much the child's advocate that I might forget to listen to the parent, to honor the parent." In hindsight, therapist would have been more empathetic with mother's feelings and frustration, in her words, "It is not helpful to the child if we antagonize the parents, or if we criticize them. Some parents are not ready to hear things that we tell them. And I think where I went wrong is that his mother felt criticized by me."

Each of Oaklander's cases illustrates that failure may occur despite good rapport with child or adolescent if parent is ignored or not valued; contrarily, she admits, "Parents take their kids out of therapy when it's not time, or it's too soon" resulting in a sense of futility over lack of control of parental action.

RICHARD SCHWARTZ

Dr. Schwartz pioneered the Internal Family Systems model of psychotherapy which combines family therapy with intra-psychic factors. Clients learn to separate their extreme beliefs and emotions thus liberating a wise and compassionate Self-state capable of creating harmony with self and others. His accomplishments include being associate

professor at the University of Illinois at Chicago and Northwestern University and Fellow of the American Association for Marriage and Family Therapy. He authored the book, *Internal Family Systems Therapy* and co-authored *Family Therapy: Concepts and Methods*, a widely-read family therapy textbook; additionally, he has been on the editorial board of four professional journals and he developed the Center for Self Leadership in Oak Park, Illinois, designed to address issues of violence, racism, abuse and oppression.

Schwartz notes that some therapists pathologize their clients by using the DSM (Diagnostic and Statistical Manual) as a Bible, hence, only perceiving the individuals through that scope of vision. This view can lead to therapy becoming mere self-fulfilling expectations and the therapist's self-protectiveness can trigger unhealthy aspects within client. Schwartz pleasantly admits, "I don't have these struggles because I don't make those presumptions about people when they come in." His therapeutic method avoids traditional diagnostic labels and focuses instead on labeling important parts of the self. People, including therapists, have many different parts along with a "core" self; the concern is that one part, for example, having extreme reactions to people, may take charge of the therapy session and lead to non-productivity. This therapist discloses, "My goal when I am working is to try to maintain what I call "self-leadership" most of the time. I have my parts around, but I won't have them taking over… It's a different take on countertransference. The parts of me that have gotten me in trouble would include parts that can be very impatient and think that therapy is taking too long." The "impatient self," Schwartz admitted, may encourage him to rush clients into doing things before they are ready and the part within him desiring to be entertained can attempt to rush the pace of therapy to the detriment of the client.

A dislike of clients who are highly dependent, yet demanding is another part of self that Schwartz must be cognizant of. His cold side could take over when confronted by a client being needy or entering into a childlike state as illustrated in his words, "I might say all the right words but there would just not be any heart in them at all. That again would make my clients' needy parts just that much more needy. They might feel abandoned by me and panic even more." Schwartz is aware that many of our clients exhibit a presenting style of feeling helpless and lost and seek direction from the therapist so we must balance this awareness with the urge to simply state "do something and stop complaining."

In recounting a past therapy failure, Schwartz described a female survivor of abuse who displayed neediness thus triggering coldness in therapist leading to rageful and demanding client behavior. Client rage elicited a critical part of therapist skewing his perception that client was manipulative and tapping into a part of him that was afraid of her. Client sensed therapist negative feelings and critical judgment resulting in her feeling more worthless. Things escalated such that therapist secretly wished client would discontinue the therapy; this desire came to fruition when client was ultimately hospitalized and another therapist took over.

After deliberation, Schwartz concluded that this case represented bad therapy because he did not seek consultation. He noted that "When parts of you take over, as was true for me, you don't even know that you are out of line." This therapist admitted that practitioners sometimes look to justify their own actions rather than exploring alternative therapeutic methods when clients act in unexpected ways, in his own words, "As I got more experience I realized my own role in things, I felt righteous until I saw how much differently I could have handled things. It does still haunt me."

Schwartz learned from this case that he needed to continue evolving an awareness of the parts within him that prevented his best work, to control those parts so they do not prevent client from full emotion-expression, and "to trust in me more and let myself keep my heart open even in the face of the rage, dependency, the neediness, or whatever parts of my clients that are coming at me."

In offering advice to therapists, Schwartz encourages awareness of countertransference and self-protective thoughts and behaviors that get triggered by our clients. He believes that we may not notice when we lose focus of client's needs in the context of becoming oblivious to our own issues surfacing. Essential for good therapy, according to Schwartz, includes: 1) being more aware of our inner thoughts, feelings, and various parts, 2) monitoring the variables that appear to be slowing the therapy process, and 3) avoiding placing all the blame on client when the process is not going well or clients display resistance.

Schwartz feels that managed care and brief therapy modalities can generate pressure on therapist to produce quick results yielding insecurity and anxiety in both therapist and client. He also has observed that beginning therapists may feel insecure about their performance which can lead to client becoming resistant thus scaring therapist even more. For beginning therapists, "I try to help them with those very anxious parts that make them either push too hard or become totally passive and let clients do whatever they want;" he encourages self-patience for beginners as well as the ability to apologize to client if the process is not unfolding perfectly or not going smoothly. Regarding apologizing to client, this therapist shared, "My experience is that clients really appreciate it. They feel like their perceptions are finally validated. Here is somebody who is not going to try and pretend they are right and the client is wrong, which is what their family usually did."

In managing client resistance, Schwartz recommends therapists to respect these protective parts that disallow access to momentarily weak areas and that ensure client that therapist is competent enough to maneuver within them. He urges therapists to listen to client fears rather than pushing past them and then resistance will lessen.

In his therapy model, Schwartz believes in being himself and assuming much responsibility for successful and unsuccessful outcomes instead of blaming client's unresponsiveness or resistance or the therapy model. He has

adopted the tendency to look at himself when things did not end well. He admits that "The kind of therapy that I am inviting is a riskier kind of therapy for your ego because you get more involved. It does take more of an investment on the part of the therapist and you do kind of eliminate all those different protective barriers – not all of them but the common protective barriers we have for keeping a kind of distance."

Schwartz reiterated that if he can maintain a self-leadership place then therapy failures will be rare, specifically, he reveals, "When I have been able to make a self-to-self connection with someone and have been able to respectfully handle their protective parts and get to some of their very wounded parts, we generally don't fail."

STEPHEN LANKTON

This therapist's accomplishments include being director of the Phoenix Institute of Ericksonian Therapy, faculty associate at Arizona State University and editor of the American Journal of Clinical Hypnosis. Lankton studied with Milton Erickson for five years then combined this work with neurolinguistic programming into a practical, relationship-oriented approach. He is a recipient of the Lifetime Achievement Award for outstanding contribution to the field of psychotherapy and the Irving Secter Award for advancement in clinical hypnosis. His books include *Practical Magic*, *The Answer Within*, *Enchantment and Intervention*, and *Tales of Enchantment*.

Lankton believes that bad therapy occurs when therapist does not engage with client and that creative therapeutic techniques will not work given the failure to have developed a solid relationship with client. In sharing a personal therapy failure central to this theme, Lankton described a man attending therapy for back pain referred by a psychiatrist. Therapist saw client in the parking lot leaving his car with the aid of his wife helping him walk every step of the way. Client appeared to not meet his wife's assistance half-way, in fact, his body language was perceived as uncooperative and resistant. Upon therapy beginning, client often responded in a condescending manner with the phrase, "Let me tell you something, Sonny" despite client being of the same age as therapist. Lankton asked client if he had ever tried self-hypnosis for his back pain, which was the purpose of the psychiatrist referral, and client replied, "Let me tell you something, Sonny. I never tried hypnosis and I'm never gonna try hypnosis." Therapist changed tact with an indirect approach of reporting past successes he had by using self-hypnosis on chronic pain but client retorted, "Let me tell you something, Sonny. I don't think it happens like that." Therapist felt client was calling him a liar and answered, "Okay, then I'd like to just call it a day. If you ever get to thinking about this in a way that would make you want to give it a shot, then you call back." Therapist walked the couple to the door and as they reached the waiting room client turned back and offered Lankton his hand. Therapist responded by saying, "Tell you what, I'll shake your hand next time I see you."

As the man slowly hobbled out the door, therapist immediately reflected on his own strong negative reaction to the event. He heard Milton Erickson's voice in his mind saying, "You know how you could have engaged that client, Steve?" After reflection, Lankton concluded that he could have engaged this man by speaking his language rather than demanding client mirror his speaking-style and he felt frustrated that he was not willing to "invest the hard work involved in meeting the man on his terms."

A second failed case disclosed by Lankton illustrated more than just a waste of time, instead, a negative outcome. Client was a young woman with self-doubt, social anxiety, she kept many problems to herself, and she was the victim of sexual abuse in a satanic cult. Client refused to discuss the sexual abuse, only reporting that she addressed the issues in previous therapy; her goal was only to overcome social anxiety. Therapist resolved not to confront her past but to focus on alleviating her social avoidance, as she requested, since the past may not have been relevant to the presenting concern. Client made progress over the next eight weeks and each person felt the therapy was successful, but the story did not end here.

Lankton decided to continue the therapy; in a later session client revealed becoming more social but her fears of sexual contact were surfacing. She asserted her inability to have orgasm and her embarrassment to bring this up to her dates. Therapist felt comfortable to transition from social anxiety to this issue and he stated to her, "I can help you learn to have an orgasm." Client showed horror and shock but counselor clarified his awkward statement and true intention by explaining his previous success with sensate focus and how she would perform such exercises in the privacy of her own bedroom. He educated her on the success rate for this difficulty and how his only interest was to help her, unfortunately, his attempts to convince her only led to increased agitation – there was an apparent irreversible breach of trust.

Counselor revealed, "What I had felt was that my relationship with her had built such trust that I could speak to her with an ease that I should not have felt. I was truly saddened by her reactions. I even had tears in my eyes as I explained to her that I would never do anything to hurt her. I was so sorry that this had taken away from her other success." Lankton asked her to think things through before reaching a conclusion, that she return when feeling more comfortable and to come back with a third party if necessary. The young woman chose to report to the referring agent that therapist was inappropriate and unethical leading to an interview to clarify the complaint. Though no evidence of misconduct was found, rather, just a misunderstanding, Lankton felt bad about the outcome.

Lankton gave the following explanation: "This case illustrates one of those principles that Milton Erickson drilled into my head and that I never should have forgotten for a moment. The most important thing is to speak the client's experience and language. The fact that you build good rapport with the person doesn't mean that you can forget that

basic principle. It doesn't mean that you can now speak from your own experience and language and expect them to follow. Rapport doesn't open the doors as wide as you come to think it does."

Therapist relied upon his intuition and empathy but these senses failed him in this particular case, as he admitted, "My core understanding of the world was shaken. My intuition was slapped." Lankton learned that "we must always keep one foot in the client's world."

RAYMOND CORSINI

The Biographical Dictionary of Psychology lists Corsini as one of the most important psychologists of the past 150 years. He is known to scholars and students in counseling and psychotherapy as first editor of the classic text, *Current Psychotherapies*, which was the major introduction to theory in the profession and currently, in its sixth edition, is still widely popular and has sold more copies than any other in the field. His scholarly production in the fields of prison, industrial/organizational, educational psychology, and psychotherapy is significant. His 4-volume *Encyclopedia of Psychology* is widely acclaimed as one of the best in its genre and along with his *The Dictionary of Psychology*, Corsini developed comprehensive resources for practitioners. Corsini studied with Carl Rogers and Rudolf Dreikers, demonstrating his diverse training; this interest in synthesizing different viewpoints is manifested in his books, *Case Studies in Psychotherapy*, *Six Therapists and One Client*, and *Handbook of Innovative Therapy*.

When encountering therapeutic difficulties, Corsini recommends flexibility in thought and action. He recalled a case when client-centered therapy led to stagnation but a change to hypnosis brought success, similarly, another case utilizing Adlerian methods led to resistance until psychodrama was integrated into treatment. This adaptive approach is reflected in his own words, "The ideal therapist knows everything, knows every technique and every method available. You shouldn't be stuck with any particular method." Employing medicine as an example, he acknowledged that it is impossible for a physician to know everything in the profession, but more mastery of knowledge leads to more treatment options. "In therapy, we are free to be ourselves and we are not stuck with anything, whether it's psychoanalysis or Adlerian or cognitive behavior and so on. The ideal therapist, I think, is a person who has a working knowledge of many systems." Upon reflection of past clients, Corsini was proud of his willingness to try so many different methods because when feeling stuck, he simply reached out for a different approach until the right combination of modalities worked.

Corsini reflected on a case occurring when he was Chief Psychologist at San Quentin Prison in California. The inmate wanted to know why he had acted as a criminal in the past despite his not feeling or thinking as a criminal. Therapist used Rogerian therapy over a course of three months but without resolution, however, ninety minutes of hypnosis culminated in client realizing a childhood experience was a significant contributor to his present situation. Corsini referred to this example of flexibility that helped throughout his career; he admitted that he did not think in terms of success and failure, rather, sometimes it merely took him a while to uncover the right treatment. He was confident that if therapy would "go bad" it was mandatory to use that data to make adjustments and switch gears. Contrarily, Corsini felt bad for therapists (and their clients) who are stuck operating with only one model because they have fewer options when things do not go well.

Corsini's views are summarized in the following message: "As I think I have already mentioned, the more you know about psychotherapy the more likely you are to be good at it. Learn all these systems, all of them, and try to learn as many as possible because all have something to offer."

FRANK PITTMAN

Dr. Pittman, psychiatrist, author, faculty member of Georgia State University, and bimonthly writer of columns in *Psychology Today* and *Psychotherapy Networker* has been a family therapist with specialization in couples in crisis. He is a widely quoted author with books including, *Turning Points: Treating Families in Transition and Crisis*; *Man Enough: Fathers, Sons, and the Search for Masculinity*; *Grow Up: How Taking Responsibility Can Make You a Happy Adult*; and *Private Lies: Infidelity and the Betrayal of Intimacy*. Both of his daughters are psychologists.

This therapist recalled a case of bad therapy involving a therapy demonstration before an audience with a young man, apparently depressed, his grandmother, mother, aunt, and sisters who he was living with and who were always pitying him. Pittman recounted that client would cry and report feeling bad but he did not specify any reasons. Counselor assessed the situation as an individual being irresponsible and refusing to display independence, choosing instead to blame others for his misfortune. The more intense the session became then the more nurturing and protective the women became but therapist wanted them to back off and inform client that he could take care of himself, get a job, and be independent. As client began to cry, therapist asked family members of the best way to respond to client when he acted so pitiful and when he tried to get control of them in this unhealthy way. As usual, they tried to rescue client rather than encouraging him to work things out on his own. The young man then complained that everyone was so mean to him, to which Pittman responded with, "If I were you and I was unappreciated this much, I think I would leave home and go find people who would not complain so much about taking care of me while I sit around and don't do crap. Show them you don't need them."

Unexpectedly, the young man stood up, walked off the stage and left the building. The audience became uneasy and the family members began to leave when Pittman urged them to stay and proclaimed, "I suggested to the family that they

not follow him. I told them that this was an indication of what good therapy we were doing. I said that what we had been tying to get him to do was to stop collapsing dependently upon them and to get up and go do something. I tried my damnedest to get them to see this, and get the audience to see this. I told them that this was a very therapeutic move, one that I had fully anticipated. This was exactly what I was tying to bring about and that is was a great step toward health." The six women looked at Pittman like he was crazy and he then became concerned for his safety lest the audience might riot in indignation.

Upon assessment, Pittman concluded that therapists risk people getting mad at them whenever they do something therapeutic: "You are shaking them from their usual pattern and you are making them aware of the fact that they have more power than they thought they had. You are telling them that they can do things that they had not been doing before. Empowerment can be terrifying. Naturally, when you scare people this much, you have to expect a certain amount of anger toward you for this."

In this case, Pittman resolved that he made a mistake and it surfaced in other cases as well – he thought clients really did want to change. "You have to avoid making the assumption that these people have already figured out that what they are doing doesn't work and they are asking you to correct the error of their ways."

To Pittman, bad therapy increases people's emotional expression and intensity without increasing their sense of power and good therapy does not necessarily inform client of a right answer or a recommended course of action. He advises therapists to be caring toward client but not to the point of instilling dependency upon counselor as expressed in the following, "A good therapeutic relationship creates more bad therapy than anything else a therapists can do. It gets people dependent upon the therapist. It gets people thinking of themselves as lacking some sort of power that the therapist has."

In the above case, Pittman admitted that his mistake was playing for the audience instead of responding to the family's needs. In such settings, there can be a conflict of interest in the needs of therapist and client, specifically, "If you are doing therapy right, it's not very showy. It's very warm, it is very comforting, yet at the same time it is quite confrontive. You put new information into the system but it does not make a spectacular show and it doesn't wow a crowd. When you try to make it a great show, you run the risk of alienating the people you are trying to help." On a positive note, Pittman deduced that client left the session knowing what was expected of him and that there was at least one other person who believed he had the ability to do it. Therapist admitted to not knowing client's outcome because many variables are involved that are out of therapist's control; Pittman addressed this issue by saying, "I try my hardest not to take responsibility for things over which I have no control – that would really paralyze me as a therapist."

Counselors may work with people in pain and anguish, but Pittman cautions practitioners to remain objective, otherwise,

we could feel as bad and become as paralyzed as they may be. "We have to be there in the midst of that pain while keeping ourselves sufficiently out of it. We have to maintain our ability to have hope, our ability to do reality testing. It's very hard work."

Relieving client pain is one goal for therapists, but Pittman believes that within this honorable intention therapy errors may be concealed, in turn, he suggests vigilance and also cognizance that sometimes we must inflict pain by enlightening clients that they are doing something wrong and that they can do things differently. Despite his vigilance, Pittman disclosed that "In every interview I am hitting something too hard or not hard enough. I'm hitting the wrong thing or my reality testing is faulty, but even then my caring comes through, and more importantly, my optimism for change."

When asked how he would like others to perceive him, Pittman modestly said, "I've been around about as long as anyone in family therapy. Because I have been doing private practice most of that time, and because I am rather a terminal workaholic, I've done a lot of family therapy. I figured recently I had logged more than 75,000 hours. And I'm still not doing it right."

SAM GLADDING

Gladding has written some of the major texts in the counseling field, including *Community and Agency Counseling*; *The Counseling Dictionary*; *Counseling: A Comprehensive Profession*; *Family Therapy: History Theory, and Practice*; *Group Work: A Counseling Specialty*; *Ethical, Legal, Professional Issues in the Practice of Marriage and Family Therapy*; and *Becoming a Counselor: The Light, the Bright, and the Serious*. In 1999, he was cited as being in the top 1% of authors in the counseling field. He has been a counseling professor at Wake Forest University, and he has been President of the American Counseling Association and the Association for Counselor Education and Supervision.

Ineffective therapy, to Gladding, is when therapist or client exhibits less than desirable behavior culminating in a bad situation, or therapist says or does something that does not succeed.

This counselor described a personal therapy failure concerning a middle-aged woman presenting with the issue of being nervous all the time. Therapist tried to help her relax allowing exploration into the issue but she actually became more agitated and ultimately ran out of the office. He tried systematic desensitization, deep breathing, attempted to work through her irrational thinking, and asked client to try meditation but the situation simply worsened.

In evaluating his performance, Gladding assessed that he did not prepare client well enough for the treatment modalities, went too fast instead of letting her talk and then being reflective, and he tried to fix her rather than allowing her to ventilate feelings. Counselor reflected, "Maybe I should have been more self-disclosing and personal with her, especially about my own nervousness. I certainly should

have reflected her feelings more often and stayed with her experience. Maybe that would have been more appropriate instead of going with a 'Let's see if I can help you relax' kind of response."

Gladding felt bad because client walked out on him resulting in no closure so he never learned what happened to her. He learned to sense when to go slowly with a client as indicated by his evaluation, "I thought here is a situation that is maybe teaching me that there is much more to human life than what I thought I knew. Instead of addressing matters as quickly as I had before, I've been more cautious and more humble in working with people."

This case reminded Gladding that one must be prepared for the unexpected even when presenting issues appear simple and predictable. A potential hazard for veteran counselors is to treat new cases as if they are familiar because our assumptions can distort the unfolding of actual events. Gladding believes that therapists must be lifelong learners, in fact, "It's being somebody who's constantly trying to understand the human condition. It is about realizing that people sometimes don't fit our theories."

When asked why counselors are reluctant to divulge their therapy failures, Gladding mentioned two factors: therapists are trained to uphold confidentiality so we do not disclose all events occurring during a session, and admitting mistakes can cause us to lose some status. Further, there may be even more to lose for well-known practitioners who have attained a certain status in the field – these individuals may have superhuman expectations leading to belief in their own myths.

Gladding admitted that he had experienced other bad therapy cases but the one he shared simply haunted him more than the others. A concluding analysis by Gladding led him to say, "I think that bad experiences in therapy are like grains of sand in oysters. At first, they are really irritating. They can even kill us. But over time, if we live long enough, they can become pearls of wisdom."

SUSAN JOHNSON

Integrating components of humanistic and systemic constructs, Johnson is one of the originators of Emotionally Focused Therapy (EFT) which assists couples to emotionally express themselves constructively. She has been a professor of Clinical Psychology at The University of Ottawa and a member of the editorial board of the Journal of Marital and Family Therapy, Journal of Couple and Relationship Therapy, and Journal of Family Psychology. Her books offer practitioners a guide to dealing effectively with conflicted couples, evidenced by *Emotionally Focused Therapy for Couples*; *The Practice of Emotionally Focused Therapy: Creating Connection*; and *The Heart of the Matter: Perspectives on Emotion in Psychotherapy*. Her approach is premised upon the idea that expression of significant attachment-related emotions can elicit new, healthy responses in partners and facilitate improved bonding. Johnson received the Outstanding Contribution to the Field of Marriage and Family Therapy Award given by the American Association of Marriage and Family Therapy in 2000.

Administering therapy is an ongoing learning process to Johnson, who reasons that therapists are mentors who have gone through their own learning which gives others permission to learn from us and permission for therapists themselves to continue learning. She notes, "I feel like one of the reasons I do couples therapy is because I learn from every couple."

When considering a personal case of bad therapy, Johnson recalled an intimidating and difficult woman who would interrupt and even yell at her coupled with therapist feeling tired and depleted. Client divulged a personal experience of testing whether she could count on her husband (whom she felt was callous and incompetent) by pretending to hang herself in the basement of their home, making all the persuasive noises to convince the husband and waiting to see his reaction. Ten minutes elapsed before husband went to the basement which convinced client that her husband was useless. Therapist disapproved of this extreme test and began saying blaming remarks to client such as "You really felt like you needed to go to this extreme measure" and "You were trying to prove him wrong." Johnson knew her responses were not helpful and later felt uneasy because she lost perspective and the capacity to put herself in client's shoes.

While spontaneously processing the session that evening, Johnson suddenly could hear client's voice in an objective manner without therapist becoming reactive or negative and she sensed how their alliance was damaged but how she could restore the connection. Counselor told client the next session, "What I didn't understand until I put myself in your shoes was what incredible courage it must have taken to test out your worst fears. You were so afraid and you were saying to your husband, 'I can't count on you in the most basic ways. I believe that you would abandon me if I was dying.' That is a huge thing to say… I can't imagine how much pain you must have been in and also how much courage it must have taken to really test it. The conclusion you came up with is that he really couldn't be there for you. If indeed that is true, then the relationship really isn't safe for you."

Once Johnson stopped judging the woman and began to understand and validate her then the therapy flourished. The woman became logical and coherent with her struggle that she married a man who could not be her spouse. She admitted that he did not want a partner and that she captured him. Therapist was amazed by client's transformation due to an empathic approach and shared, "I still keep that in my head as a lesson."

Counselor acknowledged that trouble with her clients could ensue if she labeled, blamed, or judged them. "Bad therapy for me involves times when I get caught in a reactive cycle with clients and start to pathologize them and not give them the benefit of the doubt. If I had then started to do some sort of superficial coaching, trying to teach her not to be so aggressive, I think it would have been even worse."

In another case, Johnson recollected a couple in which the husband was highly verbally abusive to his wife. Counselor tried to contain the man's negative emotion, place it in the context of his attachment, needs, fears and their interactional cycles, increase his self-responsibility and transcend the anger. It wasn't working, instead, he would blame his wife and justify his behavior; he even began to become hostile with therapist when confronted. The man began to storm out of the session leaving Johnson worried about the wife because it looked like she would not leave him. Therapist asked wife if she could talk to her individual therapist but the wife politely refused and wept. Johnson concluded that this was not a case for couples therapy, alternatively, he needed to examine his rage in a safe environment. Though therapist felt nothing more could have been done, she still pondered if there were other ways to have reached him. She felt the couple's helplessness but could not join successfully with them to implement change in their interactions. "The bottom line is that I couldn't make an alliance with him and the therapy never got off the ground."

In reflection, Johnson wished she could have helped the husband realize he had a problem because that would have been a first step. Given clients refusing to make a change, Johnson's method is to step back to where they are, stay with them, recognize their being stuck and their need to self-protect and validate them until they are ready to take a first step. She has experienced a client stating "I can't move at all" which fosters therapeutic movement in itself – in this case, she would have liked the man to have looked at his wife and said, 'I can't let you in. I don't think I can ever let you in. Perhaps, I'm never going to let anyone in.' Unfortunately, this case did not move as such.

The lesson for Susan Johnson is that "bad therapy takes place not only when your model doesn't work, but when you don't have another model that you can reach for. You see that clients need something other than what you are offering them, but you can't figure out what that might be. You remain stuck with what you already know how to do."

PAT LOVE

This individual, for more than twenty-five years, has contributed to relationship education and personal development through her books, articles, training programs, speaking and media appearances. She has taught marriage and family therapy at Texas A&M and has written several successful books for couples, including *Hot Monogamy*, *The Intimate Couple*, *Handbook for the Soul*, and *The Truth About Love*. Love has appeared many times on Oprah, The Today Show and CNN, has been a regular contributor to magazines such as Cosmopolitan, Men's Health, Good Housekeeping, Men's Magazine and Woman's World and is a past president of the International Association for Marriage and Family Counseling.

When considering bad therapy, the type that is not very helpful to client, Love recollected a 21 year-old young woman referred by a university counseling center who took a leave of absence from school after a suicide attempt. Client presented with several family-of-origin issues so therapist recommended the family be present. This notion frightened client, especially if her father attended as he was described as being controlling and dogmatic. The father-daughter relationship was complex and ambivalent as daughter was terrified of him but also irresistibly attracted to him; "It was almost like a traumatic bonding between them."

Therapist analysis revealed an individual attempting to differentiate herself from a dysfunctional home environment; father wanted to hold onto her while mother was weak, passive and absorbed with the younger children who were also acting out. Counselor sensed a need for the entire family to attend therapy but only the father agreed to do so.

Father displayed as highly angry and controlling with his daughter and therapist alike as he expressed fright, embarrassment and disappointment over his daughter. Upon returning home after the first session, father and daughter vehemently argued as he became very controlling and client felt the need to escape to her boyfriend's home. Father called therapist and instructed her to fix the mess that she had created, Love described, "He actually wanted me to go to the boyfriend's house, retrieve his daughter, and bring her home. Well, I explained to him that this wasn't part of my job." Father became more enraged by her refusal and "He called me every name he could think of. He maligned me as a woman, and as a professional – I don't know which hurt worse. He threatened to sue me. I was just stunned. And I was scared." Counselor reflected back to father his powerful feelings, tried to deflect the anger and understand the source of his helplessness. With each counselor attempt to establish rapport with father, he uttered, "I am not your client. Don't speak to me that way." Love became frustrated and did not know how to proceed with the man but she resolved to keep him away from therapy sessions.

Looking back on the case, Love felt she did not handle the matter well, "In truth, I felt like I had lost all my effectiveness." Having been warned by client that father was controlling and enraged with anger, counselor was overconfident her therapeutic skills would suffice in managing the situation but she ultimately did not anticipate and manage his outbursts. "I neither protected my client very well, nor defended myself constructively. It became so important for me to stand up to him, to be a model for my client who was so terrified of the guy. Ultimately, he scared me as well." She realized that the outcome may have been different had she taken time to have developed rapport with father, additionally and significantly, Love disclosed that she was experiencing countertransference in relation to her own stepfather.

Once Love felt afraid of the father and allowed herself to be put on the defensive, she lost control of the situation. "I didn't help my client. I didn't help the family. And I fell deep into my own issues." Eventually, client did make some progress, was referred back to the campus counseling center and resumed her studies, however, therapist could not take credit for such. Love processed the experience as, "Well, for

one thing, if you have posttraumatic stress yourself you should be careful about getting into similar territory with clients. Second, I realize now that I made a big mistake by not getting the whole family involved in the therapy. I could have diluted the man's anger with others present. Instead, it ended up a struggle for power, one that I lost."

Deeper analysis revealed that therapist did not listen to her intuition that whispered to see the whole family and not just the father and daughter. Further, she could have recognized that her own stepfather issues might distort this case in which she was overidentifying with her client, suggesting a need for receiving supervision. As this was the first time she had confronted such a case, Love was unprepared to manage all the variables – her intuition may have been advising but she did not know how to fully respond. Counselor became triangulated between father and daughter as she reflected, "This was just another piece of the drama that they enacted continuously. They already knew the rules and the steps of the dance. I was the naive bystander who let herself get sucked into it."

ARTHUR FREEMAN

Author of over 25 books that apply cognitive behavioral therapy to various areas such as pain management, personality disorders, suicidal behaviors and children and adolescents along with over 60 book chapters, reviews and journal articles, Freeman has been a clinical professor and Chair in the Department of Psychology at the Philadelphia College of Osteopathic Medicine. His two popular books for the public are: *Woulda, Coulda, Shoulda: Overcoming Regrets, Mistakes, and Missed Opportunities*, and *The 10 Dumbest Mistakes Smart People Make and How to Avoid Them*. He studied at the Alfred Adler Institute in New York, the Institute for Rational Living under Albert Ellis, and completed a Postdoctoral Fellowship at the Center for Cognitive Therapy at the University of Pennsylvania under Aaron Beck. This accomplished individual has served on the editorial boards of several national and international journals, was a past president of the Association for Advancement of Behavior Therapy, and in 2000, the Pennsylvania Psychological Association granted him its award for Outstanding Contribution to the Science and Practice of Psychology.

Failed therapy, to Freeman, represents significant impediments to the therapeutic process that counselor did not account for. His bad therapy case involved a 16 year-old boy referred by his school for a significant motor tic relating to head shaking and being isolated from peers at school and home. The parents of the boy were reluctant toward therapy for their son while the mother displayed as being intrusive and controlling and the father was indifferent. Individual sessions with client revealed a lonely and isolated youth trying to meet his mother's expectation of being a good student heading to college and law school and believing that time to socialize with peers would come later in life. The boy had two younger teenage sisters and all three siblings had to share one bedroom because the mother said it would be easier to clean and make the beds; client admitted this arrangement offered no privacy. Therapist noticed that the youth's head-shaking increased as he revealed that sometimes he sees the naked backside of a sister.

Therapist assessed the situation as an anxiety problem being perpetuated due to lack of physical and social outlets to release anxiety. Given client's school already having ruled out a medical explanation for the tic, Freeman noted, "My conceptualization was he had no way of releasing the anxiety. He did not play sports, he did not exercise, and he did not masturbate. I saw this muscle twitch as a manifestation of severe anxiety. He had no more cognitive ways of relieving his anxiety, so he just suffered with it."

Therapy evolved around ways the boy could release his nervous energy and creating some privacy at home. The boy ultimately got his own room and began releasing pent-up energy which led to marked symptom decrease as therapist evaluated, "The progress was remarkable and dramatic." Unfortunately, the parents were not paying the session fees, thus, Freeman informed them that without payment he would have to refer the boy to a community mental health center.

Client attended the next session with his tic back to pretherapy level and explained that his mother had just taken him to the bank to withdraw the $600 therapy fee and she said to him, "I have to pay your therapist. This is money that will never be replaced. This is money for your college." The youth was so afraid that he would lose the family money that he told therapist that he had nothing to talk about and he left abruptly never to return.

In reviewing the case, Freeman acknowledged that he underestimated the mother's power and, "Most simply, I did not get her to join the effort." He admitted to being annoyed and angry with her controlling parental style and with her manipulation of the fee payment. "I was just angry with her and that really clouded what I did with the kid. I was just so pleased I was able to help this kid so quickly I didn't pay enough attention to his environment."

Freeman believes that therapeutic resistance stems from four main areas: 1) from the client which is termed resistance; 2) from the environment which can be labeled sabotage; 3) from the pathology itself, for example, we expect depressed people not to smile and laugh a lot; and 4) from the therapist, which usually results from therapeutic errors or countertransference. Despite awareness of this paradigm, Freeman overlooked his own negative personal reactions. "I was aware that the mother was a powerful character but I underestimated her power. At the same time, I overestimated my own power because client responded so well to me." This case taught Freeman to not miscalculate the power of significant others in a client's life. "I think this particular example made it clear enough to me that when working with adolescents I should bend over backwards to get more voice form the parents. So what I have learned from that is not be so taken with myself that I think I am that powerful, there are other people that are more powerful than me and they were there before I was on the scene."

Citing a recent case reinforcing this idea, Freeman noted a 42 year-old man living with his mother who attempted suicide. Counselor enlisted mother's help by saying, "I need your help. I need you to be my cotherapist," and she responded that she could be counted on.

When examining knowledge to be gained from the first case, Freeman explained, "We are not as smart as we think we are. No matter how many years we have been doing therapy, and no matter how sensitive we are to our own therapeutic narcissism, we still do things that may not help, and even may hurt." He used interpreting clients' feelings as an example by suggesting we not say 'You seem angry' but instead to say, 'There is a look on your face. What does it mean? How would you put that into words?' The look of anger could be expression of, for example, being upset with therapist, hence, nuances exist that require deeper investigation. "Therapists love to interpret because it makes us feel as if we are really doing something useful… it really does stem from the therapeutic narcissism that says, 'I know what you are thinking.' Then, if the client says, 'No, that's not it,' we then label it resistance."

Evidence of therapeutic narcissism is illustrated in this list by Freeman:
1. We think we are smarter than we are.
2. We think we are more skilled than we really are.
3. We think that charisma is an adequate substitute for skill.
4. A strong theoretical grounding is unnecessary. That you don't have to learn any theory, you can take a little bit of this and a little bit of that.
5. Interpretations to the patient must be totally accepted by the patient or they are labeled as resistant.
6. One's theoretical model cannot or should not ever be challenged.
7. The model must be accepted as applicable to all patients without question or modification.
8. Calls for empirical support of what we do should be resisted as unnecessary.
9. Therapists believe themselves to have some sort of shamanistic function.
10. Whatever therapy we practice is the only true religion.
11. Technical approaches are to be avoided in favor of the intrinsic beauty of purely theoretical models.
12. Long-term therapy is the only "real" type of therapy.

Therapeutic narcissism, including overconfidence, arrogance, and believing we know what others should do can lead to trouble and bad therapy.

JOHN NORCROSS

In addition to being a psychology professor at the University of Scranton, Pennsylvania, Norcross has authored over 300 publications and co-written or edited 16 books in the areas of psychotherapy, clinical training, and self-change. His known works include the reference books, *Authoritative Guide to Self-Help Resources in Mental Health*, and *Psychologists' Desk Reference*; he has been a leader in the integrative therapy movement which attempts to combine the best, empirically-based aspects of therapeutic practice into a synthesized model conducive to individual and cultural differences, spawning the books, *Psychotherapy Relationships That Work*, and *Handbook of Psychotherapy Integration*; and his book, *Changing For Good*, reveals functional methods for self-initiated change. He is past-president of the International Society of Clinical Psychology, and of the APA Division of Psychotherapy, editor of *Journal of Clinical Psychology: In Session* and has been on the editorial boards of 12 journals. Norcross has received professional awards, including APA's Distinguished Contributions to Education and Training Award, Pennsylvania Professor of the Year from the Carnegie Foundation, the Rosalee Weiss Award from the American Psychological Foundation, and election to the National Academies of Practice.

When asked to define bad therapy, Norcross stated it is treatment that does not lead to attaining declared goals or that worsens client issues; this can cause client deterioration or premature termination. He described one bungled case in which he served as an expert witness involving a client displaying major depression and possibly also narcissistic personality disorder. Client was seeing a psychoanalytic therapist but without much success and he requested from therapist a consultation for antidepressant medication. Counselor told client and wrote in his case notes that he interpreted client's medication requests as a form of narcissistic pleading and avoiding the difficult work of therapy. Unfortunately, client was deteriorating, experiencing vegetative symptoms and ultimately went into the hospital.

To Norcross, this case is inexcusable as it exposes a clinician so vested in his theoretical orientation and personal agenda that he did not understand client's special needs and respond appropriately; he did not consider the possibility that a different therapeutical model may have been needed. Therapist insisted client was exhibiting resistance and must continue with the original plan.

The client did respond well upon being placed on antidepressant medication and later sued therapist for breach of practice standards. The case settled out of court in favor of client. Norcross summarized, "The patient's health was trumped by the therapist's theory."

In sharing a personal case of failure, Norcross spoke of a 50 year-old man, recently divorced, who was court-ordered to undergo psychotherapy as a condition of his divorce; he was so narcissistic and hostile that the judge refused child visitation rights until he showed improvement. Client was referred to Norcross by an office associate and that therapist warned Norcross that client was very difficult. Therapy with Norcross only lasted one 50-minute session due to extreme hostility by client which ended in therapist and client negativity.

Client's self-centered and acrimonious character was displayed toward his wife, children and colleagues. He had a past history of substance abuse but refused to discuss this topic. Counselor reflected onto client the difficulty of his

present situation, including how he felt cheated in his divorce, having to attend therapy, and how there must be anger pent-up. Client responses were negative which triggered counselor to loses objectivity. "I engaged in some pejorative interpretations which, even as I speak about it now, I feel ashamed. Surely I know better. Although his narcissism and anger were masking his depression and insecurity, nonetheless, I was brought right into it." Upon reflection, Norcross admitted, "It was a beginner's mistake; not monitoring my countertransference better… I should have… found a different way of reaching him." This therapist admitted to rarely feeling this frustrated with a client and he could not manage to take the session to a higher level. He never saw client again. Interestingly, at a later date, client called therapist to ask for a referral of someone living in the new area he had moved to. He called Norcross because client felt he was honest despite the difficult time client gave therapist. Counselor was pleased client gained something useful from the session and pondered how bad therapy in the short-term can have a good outcome in the long-run.

Several fundamentals were relearned by Norcross, specifically; 1) therapists need to set and uphold boundaries on referrals, 2) we need to be more aware of pervasive countertransference, 3) "Strongly resistant or oppositional patients require a form of psychotherapy and a therapist stance that is quite different from most patients. It should involve low therapist directiveness, emphasizing client self-control procedures, I didn't do that well early on," and 4) … "virtually all of us have similar sessions. But due to confidentiality, or isolation, most of us overpersonalize our own failures, when in reality they seem to be part and parcel of our common world." In other words, Norcross concluded, "Appreciating the universality of the struggles of psychotherapy might lead to corrective actions in the sense that we are not alone."

LEN SPERRY

Trained as both a psychologist and physician, Sperry's clinical practice and authorship have been diverse. His books include *Spirituality in Clinical Practice*; *Counseling and Psychotherapy: An Integrated, Individual Psychology Approach*; *Adlerian Counseling and Therapy*; *Cognitive Behavior Therapy of DSM IV Personality Disorders*; *Handbook of Diagnosis and Treatment*; *Treatment Outcomes in Psychotherapy*; *Marital Therapy: Integrating Theory and Technique*; *The Disordered Couple*; *The Intimate Couple*; *Brief Therapy With Individuals and Couples*; *Health Counseling*; and *Aging in the 21st Century*. He has been on the faculty at Barry University in Miami, Florida.

Negative therapy outcomes, to Sperry, result when either client or therapist is diminished by the experience, therefore, the partnership outcome is determined by the perceptions of both participants. Moreover, using a treatment without a sound basis resulting in client harm, for example, utilizing regressive therapies with individuals lacking in a cohesive

self, Sperry terms bad therapy. "I think there are some kinds of therapy that are particularly ill-advised, especially in situations when clients are vulnerable and not able to make informed choices about their participation." He believes that specific treatment modalities should not be used with identity disorders whereas other types are more likely to be favorable. This therapist strongly feels that practitioners should only use treatments that are clinically sound or scientifically supported because, above all, we should do no harm. "Let's say that someone is in the midst of trauma and I'm using an exploratory, regressive therapy where we're processing very primitive dynamics, to the point where the client decompensates. These individuals might not have very good defenses and boundaries. If things go wrong, they could take a long time to recover from that sort of treatment." This shows how making poor clinical judgments can lead to trouble.

The personal case of flawed therapy for Sperry occurred during his psychiatric residency with a male borderline individual in an inpatient group. Patient became enraged over a father-figure type of statement by Sperry and he stood up and acted in a threatening manner toward Sperry. Therapist hoped his cotherapist would intervene to neutralize the transference, deflect the aggression and refocus the group but she was frozen as was Sperry. He recalled, "I felt frozen as well. I couldn't do anything. I couldn't think what to say. Until this guy clamed down, I felt helpless. And it took a very long time for his anger to run its course." This constituted bad therapy for Sperry because it was not therapeutic for patient and both therapists felt traumatized by the encounter. "It seemed that all my inexperience was showing. I let the client down because I didn't know how to handle the situation and how to be helpful."

Due to lack of therapist control, Sperry realized that group members were not protected from the abuse of unsafe situations that they routinely see in their lives; … "it was our job to protect them from further abuse. We let them down."

Reflectively, Sperry viewed this humbling event as a significant formative training experience. "After this situation, it only heightened my interest in working with these people. So that was my adaptive response to feeling helpless." Instead of avoiding such difficult cases, Sperry was motivated to learn from the setbacks, strengthen his resolve and deal more effectively in the future with similar situations.

When asked what he could do differently in future sessions, Sperry professed that he would ensure each cotherapist has clear expectations for one another and will support the other if needed. He said, "One of the basic rules of cotherapy is when you are doing a group or family together, if one of the therapists gets pinned against the wall, or gets in trouble, it is important to offer support as needed. The cotherapist's role is to somehow redirect, to refocus, and to allow the situation to clam down so that you can process it. That allows it to be therapeutic. And, of course, you try to keep situations from escalating."

The mistake Sperry admits is that he did not coordinate his plans or review respective roles with his partner. Learning from this experience, and whether working alone or with a cotherapist, Sperry prepares for sessions by gathering information such as the status of each participant, previous staff reports, known concerns, and potential acute problems that could arise. Above all, Len Sperry manifests the trait of willingness to examine and acknowledge his mistakes through honest self-reflection.

SCOTT MILLER

Miller is co-founder of the Institute for the Study of Therapeutic Change, a private group that studies "what works" in mental health and substance abuse treatment; this research led to his book, *The Heart and Soul of Change* which informs practitioners of effective treatment options. The vital role that clients play in their own treatment is explored in his books, *The Heroic Client*; *Escape From Babel*; and *Psychotherapy With Impossible Cases*. He examines solution-focused therapy in his books, *Handbook of Solution-Focused Brief Therapy*; *The Miracle Method*; and *Working With the Problem Drinker*. Miller also co-directed Problems to Solutions, Inc., a clinic specializing in treatment for the homeless and other traditionally underserved populations.

When asked what represents failure in therapy, Miller defined two types: First, when client improvement is not a function of the therapy, instead, maturation of the individual, passage of time, chance, or error yielded the progress and the therapy added nothing. Second, when client "reliably" deteriorates in the presence of therapist more than what would have transpired by chance alone. "Something I did, or didn't do, ended up making the client worse."

The failed therapy case depicted by Miller centered around a woman in her mid-30s, with a polysubstance abuse history, who was feeling hurt and traumatized after having sex with her previous therapist. Additional issues surfaced including abuse by her father when younger, her mother was an active alcoholic who was emotionally abusive to her, she experienced chronic feelings of emptiness, depression, difficult interpersonal relationships and risky sexual and other personal behavior such as taking drugs. Weekly sessions were increased as more personal material was unveiled.

Constructive change was not occurring so therapist tried different approaches then settled on allowing client to lead the process but lack of success led to Miller seeking consultation and supervision from two colleagues. One supervisor assessed client was showing signs of borderline personality disorder and recommended setting appropriate boundaries while gently confronting her presenting issues. The second supervisor suggested to continue the therapy as it was currently unfolding, reinforce strengths and resources, and stay focused upon the original trauma with her past therapist. Miller resolved, "So maybe I should externalize all of this angst and trauma and talk about how the client was

going to 'stand up' to that trauma instead of allowing it to engulf and swallow her."

Eventually, two years elapsed with therapist maintaining the same therapeutic approach without success. Reflectively, counselor concluded this case was outside his scope of practice, "I went beyond what I knew how to do," hence, Miller sought to end the therapy and allow continuation with a different counselor and perhaps better alternatives. Client received this plan as a personal rejection, a breach of the trust she developed for therapist, and began to act self-destructively through anonymous sexual encounters and drug usage.

Admitting discomfort over this case, Miller stated, "… I hate not succeeding. I hate it when people leave and feel dissatisfied with me. That plays into all my own personal issues and probably is one of the reasons I became a therapist." Worse yet, client called therapist and said she was going to 'tell on him,' further, she began receiving therapy from a colleague of Miller's thus opening up the failed case for another to see and creating a sense of triangulation. Counselor expressed, "I guess I'm trying to say that I don't think that having failures is the problem per se. But to allow a failure to continue over a long period of time, much beyond where you are usually successful with people, that is troubling."

When asked what he gained from this experience, Miller shared, "I learned that I needed to be attentive to patterns of nonsuccess and failure. I needed to be more sensitive to knowing at what point my knowledge, or my ability, or my connection with the client, was not likely to lead to any better results." This case stimulated therapist to measure and predict intervention effects, "That led me to this whole business of measuring outcomes and trying to use outcome scores to predict the likely trajectory of change of clients in an individual therapeutic relationship with me." Miller expressed the need for therapists to know their limits and to be brutally honest with themselves when not being successful. "I think the main thing to take away is that my doggedness and my reliance on techniques were not enough, could never have been enough. I should have seen this earlier and made my failure a success by helping connect this client to something or someone else."

Several years later, Miller received a few emails and a phone call from this client acknowledging that his perception of her was correct in that she needed to feel okay and not be tortured by past memories, "So I feel that my fundamental experience of this person was accurate, I personally was just not able to be of help to her the way I would have liked, and I wish I had been aware of that earlier."

MICHAEL HOYT

Having worked at Kaiser Permanente Medical Center, San Rafael, California, and at the University of California School of Medicine, San Francisco, Hoyt has been one of the leaders in the brief therapy movement. His writings and teachings about ways therapy may be practiced more efficiently and

effectively are published in the following works: *Brief Therapy and Managed Care*, *Constructive Therapies*, *The Handbook of Constructive Therapies*, *The First Session in Brief Therapy*, *Some Stories Are Better Than Others*, and *Interviews with Brief Therapy Experts*.

Hoyt's definition of bad therapy is "that which is injurious or harmful or that fails through incompetence or is way below standard performance," moreover, when you realize that you should not have done that, you should have known better, and it leaves a bad taste in your mouth.

A bad therapy case for Hoyt involved a woman in her mid-30s who was nervous, dependent, neurotic with obsessive-compulsive personality features and he thought probably a diagnosis of generalized anxiety disorder or depression not otherwise specified. Therapist tried to teach client cognitive-behavioral strategies designed to stop her worrying, challenge her premises and assumptions, lower anxiety and stress levels, utilize problem-solving skills and relaxation techniques with hopes of making her aware that her issues were self-created. After several sessions, these methods were not working. During one meeting, client incessantly deflected and ignored counselor's therapeutic remarks and repeatedly responded with, "But what if…: What if my children get sick? What if my car won't work? What if my mother won't help? What if… what if… what if." Counselor was losing patience but he maintained self-control and asked client to recognize times she controlled the urge to worry. She ignored his questions and continued to repeat her questions despite Hoyt already having addressed them. Counselor asked her to ponder the effect on her family members of repeating questions without responding to their feedback. " I shared with her my frustrations. I asked if she wanted to learn some other ways of thinking and responding." Client smiled at therapist and then resumed her series of questions. Hoyt recalled, "Finally, after the umpteenth time I gently snapped. I stood up and announced that I would no longer be her therapist. I asked her to follow me to the front desk where she could sign up to see somebody else if she so desired. I remember her looking tearfully at me with a little glimmer of recognition in her eye that she had pushed me too far."

Upon reflection, Hoyt felt bad about his frustration and loss of self-control and how client left feeling hurt and rejected, "That certainly wasn't therapeutic at all." Therapist realized that he did not have an effective therapeutic alliance with client and that he made a mistake by becoming aggravated instead of understanding her anxious responses as part of the problem. He remembered a past supervisor saying, "Therapy would be easy if the patients weren't neurotic!" He wished he had been more graceful in terminating the therapy rather than being humiliating. Counselor learned that if someone is being difficult or pushing his buttons and therapy is not being useful then he needs to regroup, try something different or perhaps seek consultation. Further, he learned that he and most therapists have triggers that can lead to failed therapy, "I can certainly see things in my own personal history and personality that made me more vulnerable to doing poorly

with a highly anxious and dependant female patient." Hoyt advises counselors to note if there is a pattern to their impasses or failures and then take responsibility for the required improvement. "This term 'resistance' is too easily applied to patients. I think we should first look at our contribution as therapists, and then look at the interpersonal process, and then, only then, look at the client."

In examining his most recurrent weakness as a therapist throughout his career, Hoyt mentioned that sometimes he would cross the boundary of being empathic and then become totally absorbed in the client's world. "I see their logic and join with them, sometimes to the point that I get stuck." His resolution to this dilemma is to remain objective, keep a balance between self and other, and maintain a different perspective from client. He articulated, "If you only have one perspective – the client's – then you may not be able to help them to see things that they don't already see." Additionally, Hoyt recognizes the need for therapists to not project their issues onto the client.

Hoyt understands the marked difference between being impassioned versus feeling unmotivated to work on a specific issue. "So I think sometimes we may have blind spots but sometimes we may have special vision where we are really lit up or excited about something and we can go farther with it." He recalls enjoying grief work, for example, when he was younger whereas now, "I still have some interest but I have moved on."

With compassion, Hoyt notes that even good therapists make mistakes and we should not overgeneralize one bad session or case with being a bad therapist. He concludes, "I think if you are having lots of bad therapy sessions then you had better take a look at what is going on because there is some problem there. But I think if you are having bad ones on rare occasions, hey, that's what we all do."

RICHARD STUART

With over forty years of teaching and research experience in psychology, psychiatry, and social work, Stuart has been Professor of Psychiatry at the University of Washington and has also taught and directed the program in respecialization in Clinical Psychology at the Fielding Graduate Institute. Behavioral marital therapy techniques including utilizing "homework assignments" were revealed in his book, *Helping Couples Change*. Through applying behavioral methods to treat obesity, he wrote, *Slim Chance in a Fat World*; *Act Thin, Stay Thin*, and *Weight, Sex, and Marriage*. His other books include, *Trick or Treatment*; *Adherence, Compliance, and Generalization in Behavioral Medicine*; *Second Marriage*; and *Violent Behavior: Social Learning Approaches to Prediction, Management, and Treatment*.

To Stuart, a distinction exists between unsuccessful and bad therapy. Unsuccessful therapy does not attain all goals or the stated goal at the desired level of change. Despite some positive changes, more effective planning and execution would have yielded more positive results. The onset of change is delayed resulting in wasted time and

money for client and possibly a negative attitude toward the therapy process. Bad therapy can worsen client functionality by over-burdening coping skills and perhaps eliciting latent pathology; it can create maladaptive behavior and may adversely affect family and social relationships that otherwise might have been client resources.

The evaluation of whether therapy was good or bad is sometimes in question because therapists and clients may value different criteria. Stuart reflects, "It amazes me that sometimes I get referrals of friends and relatives from clients whose therapy I thought was quite unsuccessful, yet these supposed failures told laudatory stories to others about my work." This therapist uses at least the following three assessment measures when evaluating the quality of therapy. First, he asks whether a connection was made resulting in client open disclosure and therapist understanding client's world. "In other words, could I enter their system?" Were they relaxed enough, and forthcoming enough, to let me in?" He divulged that his therapy at times was unsuccessful because an alliance with client was not established due to inability to accept, relate to, or understand client's view. Second, ensuring his morals are somewhat congruent with client's goals and the actions needed for attainment. He believes therapists should not impose their own values on their clients, likewise, counselors must not distort their own values in order for client to pursue objectionable goals. Third, therapists must acknowledge their limits of competency and not attempt to "provide every service sought by clients." Stuart judges this practice to be the main cause of bad therapy.

Upon examination, Stuart suggests his previous therapy failures fall into several categories. Being too parental or directive led to clients inability to set their own goals. Next, clients entering therapy with little motivation to change because they were trying to please someone else; their presence may have been deceptive from the start. Additionally, clients who lacked self-control to move beyond emotional ventilation into problem-solving. "It always frustrates me when I can't help clients move beyond thinking about how bad they feel into discussing what they can do to change their feelings."

In contrast to practitioners who attribute therapy success or failure to client's dedication and motivation, Stuart takes self-responsibility for his work outcomes and does not only blame client if the process fails. He resolves, "I fail if couples leave without being willing to try and work things out. I also fail if they stay in the relationship even though they are still very unhappy. I succeed if they make an attempt to change and decide that while better, their relationship is still not good enough to be preserved. And I succeed if the partners stay together because they have found a new level of satisfaction."

A personal case of bad therapy for Stuart centered on a couple seeking marital counseling. The night before the second session ended in an argument when wife stayed on the phone for thirty minutes after husband came home from work – she was talking to one of her friends whose mother

had died. Husband got angry, swore at her, slammed the door and left for several hours only to return after heavy drinking. During the session, wife briefly explained the two had argued the night before and she was then interrupted by husband who said "It's hopeless and I just want out." Counselor asked husband what he meant by "out" but husband continued to scold and verbally abuse wife. Stuart attempted to act as a referee as wife indicated that she wanted to work through the issues but husband adamantly refused and stated, "I just don't want anything to do with her." Therapist asked wife how she and their two children would cope if husband moved out; the couple talked about their options for about two minutes then husband said he didn't want to listen anymore and he walked out of the office.

Husband called therapist at least twelve times over the next three or four days saying his wife was throwing him out of the house but that he really loved her and he needed Stuart's help to change her mind. Counselor responded that he could not speak for client and that wife already heard his intentions during the last session.

Looking back, Stuart acknowledged that he overlooked the husband's Axis II features and that he should have seen each member individually before as a couple. He wished he had said to them, "… there were goals that should be accomplished by each one individually as a precursor to being able to change as a couple. And I would say it's best to talk about those separately and not together." Therapist realized that he did not connect with husband during the first session and this fact should have been a signal but it was ignored. Stuart admitted, "I have such confidence in what I can do that it sometimes overwhelms the facts."

When asked about his career regrets, Stuart said during the first twenty years, he began as a Sullivanian analyst and then became a radical behaviorist, both of which he feels were narrow positions. "I wish that I had started thinking more pragmatically and integratively. I would have done better therapy over the years."

A general philosophy of therapy and life is expressed by Stuart in these words: "I believe that people can change much more radically than they ever thought possible, but I now realize that change is easiest to accomplish if the efforts to achieve it blend an understanding of personal vulnerabilities, personal skills, and environmental situations that bring out the worst and best in people. My goal then becomes helping them challenge internal reactions that cause problems, develop a repertoire that allows them to create the relationships that work best for them, and then empower them to create and maintain these relationships."

MICHELE WEINER-DAVIS

This therapist and accomplished author has applied solution-focused therapy to working with troubled couples. Beyond her first book for therapists, *In Search of Solutions*, Weiner-Davis has written a series of books coupling brief therapy with marital issues, including *Change Your Life and Everyone In It*; *Getting Through to the Man You Love*; *The*

Divorce Remedy, and the best-selling books, *Divorce Busting*; and *The Sex-Starved Marriage*. She received the American Association of Marriage and Family Therapy's Outstanding Contribution to the Field of Marriage and Therapy Award and has made many media appearances on programs such as Oprah, 20/20, The Today Show, CBS Evening News, and CNN.

After each session, Weiner-Davis reflects on the therapy process and evaluates if anything went wrong and plans on adjustments for the next session. She tries to do something different the next time and to not repeat the same mistakes, "I guess I believe that the only real failure in therapy is when you don't keep your eyes and heart open so that you continue to make the same kind of mistakes over and over again. I truly learn from each session."

She advises therapists to avoid over-valuing therapy techniques at the exclusion of listening and watching the clients. Moreover, Weiner-Davis understands the need to have the ability to competently exercise therapy techniques and to comprehend the essentials of being a therapist because only then can counselor transcend these concrete elements and "…become what more seasoned therapists often talk about as the 'art' of doing therapy." Playing the piano with feeling by applying softer and louder notes and using the pedals as contrasted to simply placing your fingers on the correct keys to ensure not hitting wrong notes is an analogy Weiner-Davis uses when comparing an experienced therapist who utilizes intuition and connection as compared to one who has not taken time to learn the basics.

The case of bad therapy that Weiner-Davis shared involved a married couple whereby the wife was positive in nature and the husband generally responded to his wife's remarks with negativity. Therapist tried to get husband to focus on positive things in the marriage by asking questions such as, "What was different about your marriage when things were working?" and "I hear that things aren't working, but there must have been a time in your marriage when things were better?" Husband responded with, "Yeah, they weren't some of the things that I just mentioned but…" and he then went on to list other things not working in the marriage. Therapist assessed the situation as a man who refused to answer her questions and refused to be positive rather than someone who had a story to tell but was not being understood or heard. After several more sessions of this process, counselor changed tact and used a paradoxical directive explaining she was concerned that this couple may not have the ability to successfully move through their issues. The next session reflected a loving husband who had done wonderful things for his wife since the last session.

Initially, Weiner-Davis felt this was a great example of the potential of a strategic intervention, however, over time, she concluded that she was not listening to the husband and that the content of her paradoxical intervention were things the husband was saying to her all along but that therapist was not attending to. "I finally realized that this man had felt ganged up on because his wife was so positive by nature and then I was so single-minded about focusing on all the positive stuff

as well. I really missed the boat. For years I was showing this tape as an example of dealing with resistance in therapy and I finally figured out that I was the one being resistant."

Upon reflection, Weiner-Davis expressed that mistakes do happen in therapy but she chooses to focus on the positive that she brings to the experience. When asked her recommendation to therapists of how to process their failures and mistakes, Weiner-Davis stated, "There is no such thing as failure, just useful feedback as to what to do next. I think it is pretty self-indulgent to sit around feeling really bad about yourself for mistakes that you have made rather than trying to figure out how you can do better the next time."

LEARNING FROM THERAPY FAILURE

Literature on the subject of therapy failure suggests that rarely does one specific reason to which we attribute unsuccessful therapy explain the entire truth. Deducing causes of failure is difficult because clients may not know why they felt dissatisfied or given such awareness they often keep reticent over the reason for leaving treatment. Further, therapists may lower their own cognitive dissonance over losing a client by clouding the issue in order to appear competent, denying mistakes, and avoiding self-responsibility for negative outcomes. Finally, the many complexities of the therapeutic encounter itself imply that a number of variables are involved rather than just one factor. The most pervasive variables in therapy failure, whether alone or in combination, are categorized into factors attributed to client, therapist behavior, interactive effects between therapist and client, and sabotaging influences outside of therapy.

CLIENT FACTORS

Most often, clients terminate therapy because of therapist actions or inactions, but in some cases, regardless of counselor competency, clients may be determined to avoid improvement. They may unconsciously be driven to sabotage progress or to defy efforts of the most skilled counselor, hence, some people may never succeed in therapy. Certain personality and mood disorders, various defense mechanisms, and people with impaired judgment or insight are concerns limiting treatment potential – progress in these situations may be measured in decades rather than weeks.

Greenspan & Kulish (1985) found that clients who suddenly end their therapy before work has been completed have a tendency to be young adults, a minority group member, have insurance coverage with maximum benefits, have been referred by another professional in a clinic facility, and have situational, acute, or adjustment reactions that they blame on external factors beyond their control. Colson, Lewis, and Horwitz (1985) determined that individuals in psychoanalytic treatment with higher chronicity of symptoms and degree of disturbance revealed poor prognosis predictors. Clients who display any of these traits are less likely to improve in therapy: poor impulse-control, lack social support

systems, are older, lack sense of humor, are impatient, have borderline personality disorder, tend to externalize and lack psychological sophistication (Stone, 1985). It is advised that counselors not be pessimistic when dealing with issues of poor prognosis in the literature because that would contribute to a self-fulfilling prophecy, rather, to remain optimistic while being realistic regarding that which is within our power to change. Therapists need not avoid or fear high-risk cases because often treatment success correlates with client's motivation, personality, and attitude, in turn, client's failure is not automatically the therapist's failure. Despite this information suggesting that there are some people that nobody can help, the preponderance of therapy failure is due to other causes.

Research indicates that clients present with a broad range of combinations of goals, instead of single or isolated goals, of which symptom relief represents only a small percentage of all possible goals (Connolly & Strupp, 1996; Grosse-Holtforth & Grawe, 2002; Grosse-Holtforth et al., 2004; Hasler et al., 2004; Uebelacker et al., 2005). These studies also reveal that treatment goals are only partly associated with client diagnosis, hence, therapists cannot assume they know client's treatment goals solely based on diagnosis. Symptom relief appears to be the most important client reported goal across clinical settings but it is not the most frequently indicated goal. Other commonly reported client goals include interpersonal problems, personal growth, and existential issues (Hasler et al., 2004; Holtforth et al., 2004). Hasler et al. (2004), for example, found that clients with personality disorders and adjustment disorders did not include symptom relief as their most important desired change, and Uebelacker et al. (2005) determined that depressed clients indicated psychosocial functioning was equally important a goal as symptom relief. Further, certain client variables, such as employment status, affect preferred client goals. Hasler et al. (2004) discovered that unemployed clients reported more social support goals than employed clients. These studies infer that various client characteristics influence their treatment goal preferences.

Gross-Holtforth & Grawe (2002, p. 79) define treatment goals as "intended changes of behavior and experience that patient and therapist agree on at the beginning of psychotherapy and on which successful psychotherapy should be instrumental." Establishing realistic and beneficial treatment goals is deemed clinically important because they direct patient participation and therapist interventions (Long, 2001; Tryon & Winograd, 2002). Eliciting active client participation in the development of treatment goals has been found to increase commitment to goals and the probability of goal-attainment (Locke & Latham, 2002).

THERAPIST FACTORS

Analysis of treatment failures in family therapy led Coleman (1985) to observe the following most common therapist causal factors:
1) Failure to comprehend the true nature of the presenting problem and the circumstances surrounding the referral.
2) Insufficient bond with family members or a weak therapeutic relationship with client.
3) Theoretical omissions or inconsistent interventions.
4) Waning energy.

Coleman concluded that failures were not caused by conscious or unconscious errors as much as therapists being surprised by "unforeseen entanglements."

Within a psychodynamic treatment process, H. S. Strean concludes that failures generally occur when therapist is not motivated due to negative feelings toward the client (Strean and Freeman, 1988). Interestingly, he cites one of his own cases as an example involving a philosophy professor, named Albert, who after two years of therapy became more impaired. Strean recalled, "Usually after a first interview, I feel an eager and interested anticipation of the next session, much like the feeling of getting ready to go on a journey. This time, however, I found myself obsessing about Albert after he left. I knew from my analytic training that obsessing is a sign of mixed feelings. After my first interview with Albert, and after a number of succeeding sessions, I engaged in fantasied arguments in which I was trying to ward off a bully who made me feel weak and vulnerable. Obviously, Albert threatened me, and it was difficult for me to acknowledge this truth, so I argued with him in fantasy. In hindsight, I have to admit my work with him was a failure in that I could not give him the help he was entitled to receive and was, I believe, capable of using" (pp. 186-187).

With amazing candor, Strean assessed his work with this client and resolved that he made many significant errors resulting from his negative attitude toward client. A case analysis illustrated the following therapist mistakes yielding important learning material:
1. Therapist lost objectivity, thus, he fell prey to client's manipulative ways.
2. Due to feeling threat, jealously, and competition, therapist maintained a continual power struggle.
3. He made "correct" interpretations and used "right" words, but with a hostile and non-empathic tone of voice.
4. He spent excessive time trying to prove to client that he knew what he was doing.
5. Despite his awareness that countertransference feelings were negatively impacting therapy, therapist could not monitor or confront them and did not receive supervision or therapy to resolve them.
6. He hid behind a mask of cold, objective analyst and was punitive instead of being empathic and supportive.

Strean evaluated this case: "Actually my work with him should not really be called psychoanalytic treatment. It was more of an interpersonal struggle between two men who felt uncomfortable with each other, each one trying to prove his potency to the other and to himself" (p. 191).

Misdiagnosis caused by not identifying a hidden psychopathology or organic dysfunction will often result in premature therapy termination. Straightforward anxiety, for example, can be a sign of hyperthyroidism or a variety of

cardiovascular or neurological disorders. Even with an accurate assessment, the ensuing fundamental helping skills can go awry; the following is a list of the most common mistakes and interventions that end therapy prematurely:

1. Confronting client in a style received as overly aggressive.
2. Making an interpretation viewed as too threatening for client at that particular time.
3. Establishing unrealistic goals or that are inconsistent with client values.
4. Acting too passively or failing to respond adequately.
5. Showing a lack of care, respect, and acceptance toward client.
6. Not creating a strong alliance with client.
7. Over-stepping a boundary that violates client's privacy or security.
8. Enacting paradoxical strategies, psychodramatic methods, or other techniques that fail.
9. Inquiring by using a series of close-ended questions that are felt as interrogative.
10. Acting evasively or mysteriously leaving client to feel manipulated.
11. Offering poor empathic responses that resemble parroting.
12. Mismanaging silence by allowing it to continue beyond reason.

Therapist-induced failures can be minimized if issues are detected early given counselor honest and objective self-analysis; if necessary, consultation may be sought. Additionally, since clients often present with an array of treatment goals rather than a single theme evolving around symptom relief, therapists are encouraged to develop a wide range of clinical skills affording the opportunity to competently work with a greater number of clients (San Martin, 2007). Given that clients often express a combination of goals only partially elucidated by their diagnosis, Grosse-Holtforth & Grawe (2002) suggest that specializing in only one thematic area increases the risk of disregarding client's various issues and they recommend clinicians to engage in broad training covering areas beyond symptomatic change.

THERAPIST-CLIENT INTERACTIVE EFFECTS

The most common causes of therapist-client therapy process failure are unresolved transference experiences or dependency issues (Herron & Rouslin, 1984). Specifically, separation conflicts are mismanaged or prematurely terminated due to therapist's emotional attachment to a client representing a form of symbiotic interdependence. The counselor's personal and unresolved issues of separation/individuation and parent/child bonding become interwoven with client's ambivalence between the desire for continued intimacy versus freedom. Therapists may terminate therapy prematurely if they feel threatened by these dynamics, contrarily, they may unnecessarily extend therapy if wishing to avoid the sense of loss that results from

separation. Premature therapy termination can cause client to feel abandoned leading to regression, isolation, rejection, bitterness, and debilitating anxiety. Lack of confidence and experience together with a desire to punish the "heartless parent/therapist," can cause recurrence of client symptoms and exacerbate them given the new feelings of anger and betrayal. Prolonged therapy can induce client dependency upon therapist and lower probability of personal autonomy. Many therapy failures occur because therapists are not aware of their own dependence or that of their client, therefore, this symbiotic intimacy is not confronted and resolved.

Transference is a potential cause of unrealistic perception in relationships and may be defined as "the client's experience of the therapist that is shaped by the client's own psychological structures and past and involves displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully in earlier relationships" (Gelso & Hayes, 1998, p. 51). Being aware of transference in therapy is relevant because it is believed that the therapeutic relationship evolves into a replication of other relationships in the client's life (Teyber, 2000).

The therapist's own unresolved issues and character defenses can create countertransference suggesting that there may be a pattern in each of us regarding the typical errors we make, situations we misperceive, and the failed therapy cases we encounter. Our own feelings of anger, fear, or love may sabotage progress with certain clients or may compel us to work overtime with other clients. Fortunately, therapist resistance, countertransference, and blockages are manageable through self-awareness, self-monitoring, supervision, and if needed, personal counseling – often, it is undiagnosed concerns and disguised feelings that perpetuate our therapy failures. Many therapist issues are recognizable but many are still beyond our awareness at any given time, thus highlighting the need to know how to avoid failure as well as the need to learn from it.

Mohr (1995) indicates that therapist lack of empathy, under-estimation of the severity of client's problems, and negative countertransference are related to negative therapy outcome; additionally, disagreement with client regarding the process and content of therapy may yield poor results. Mohr professes, "Certainly, it cannot be too much to ask that we do what we ask of our patients – to examine our failings with an open mind and with a view toward change." Unfortunately, this researcher believes that the field of psychotherapy has chosen to avoid looking at negative outcomes and seldom reports them. He contends, "To the extent that the field avoids examining when psychotherapy fails, the field succeeds only in limiting its own potential" (p. 24).

Case studies and surveys on sexual involvement with therapists and other therapeutic errors have been correlated with client deterioration. Pope and Tabachnick (1994) surveyed psychologists who were in therapy and found that 22% felt the therapy was harmful due to the following reasons: sexual acts or attempted sexual acts, therapist incompetence, therapist emotional abuse, therapist failure to understand them, and boundary violations.

Another common therapist-client interactive variable leading to failure is counselor's attitude of "I've seen it all before." Experienced practitioners can become jaded into thinking that most new clients present with only a few scenarios that are routinely repeated. For example, client anger toward counselor may be automatically deemed "transference reaction" or shyness always means "poor self-esteem and fear of rejection." These assumptions based on past experience can be faulty as each individual is unique and presents with a different history, personality, and perception of the world, regardless of symptoms appearing similar. We may then see a culmination of past events rather than what is really there. Beginning therapists may fail with a particular client due to lack of experience, whereas, if not cautious, veterans may do so through neglect and a waning energy level.

Excessive therapist self-disclosure can cause the client to feel bored, ignored, and minimized and lead to client terminating therapy. Effective usage of self-disclosure may produce bonding, modeling, empathic understanding, sincerity, authenticity, and can assist in moving through client resistance, denial, and aloofness. Concern arises when therapist offers long and tedious self-revelations that may negate client's worth by implying who is really the important one in the process, in fact, self-disclosure is one of the most abused interventions. Therapists can also lose their value as a neutral transference figure through talking too much about themselves because client may conclude "this therapist is just like me" and they may then question the value of attending therapy. Revealing too much of one's life story, trying to convince clients of their next step and to view things the way we do can overwhelm them into thinking that they must conform to only one option which might stifle their personal growth and self-exploration.

Failed therapy often occurs when clinician underestimates the psychopathology, which slows progress, and when excessive patience and tolerance is granted toward client who violates basics of the treatment contract such as lateness, no-shows, noncompliance, late payments, and continued drug use. Additionally, Lambert and Bergin (1994) determined that severely disturbed clients treated with techniques that rely upon breaking down defenses and challenging typical patterns of behavior or coping strategies are more likely to experience negative outcomes. They also suggest that intense groups with coercive group norms that promote brutal honesty and quick fixes have been related to client deterioration.

Contrarily, research has proposed that goal agreement between therapist and client can significantly assist in developing a positive working alliance and is associated with positive treatment outcome, treatment engagement and treatment compliance (Horvath & Symonds, 1991; Krupnick et al., 1996; Martin et al., 2000; Tryon & Winograd, 2002). Definition and agreement on treatment goals is also associated with client satisfaction, which, in turn, correlates with greater treatment gains (Eisenthal et al., 1983; Holcomb et al., 1998). The working alliance between therapist and client as related to positive therapeutic outcome has received significant empirical support (Martin, Garske, & Davis, 2000), whereas, disagreement on therapeutic aims between counselor and client can significantly hinder client progress (Tryon & Winograd, 2002). These studies collectively emphasize the importance of defining and negotiating treatment goals with clients at the beginning of therapy; this process may assist therapists to articulate the relevance of various treatments and to tailor treatments as needed (Uebelacker et al., 2005).

San Martin (2007) notes that clients present with numerous goals that are only partially associated with their diagnosis, therefore, the potential for failure exists among many treatments not designed to resolve issues beyond those of presenting symptoms. She recommends that clinicians assess client treatment goals early in therapy and then actively discuss with client any treatment limitations that could impede progress. This open discussion might "strengthen the working alliance, increase satisfaction, and reduce early drop-outs."

COMMON BOUNDARY-DECISION ERRORS

Therapists periodically encounter boundary issues with clientele such as dual relationships, bartering, nonsexual touch, social contact, and acceptance of gifts and services. Boundary-decision mistakes can and do occur as practitioners may disregard important information, maintain a narrow focus, infer wrong conclusions, or encourage unrealistic expectations. Gutheil and Gabbard (1993) note that crossing boundaries "may at times be salutary, at times neutral, and at times harmful" and that the ultimate worth of a given crossing "can only be assessed by a careful attention to the clinical context" (pp. 188-189).

Koocher & Keith-Spiegel (2008) and Pope & Vasquez (2007a,b) report that therapists are vulnerable to the following seven most common cognitive errors in making boundary-crossing decisions:

Mistake 1. *Events outside of the therapy session have no effect on the therapy process.* For example, a counselor who teaches a course in which client is enrolled or being a member of an association that client just joined are potentially impactful situations on the therapeutic relationship.

Mistake 2. *Crossing a boundary with a client imposes the same meaning and effect as doing so with a non-client.* Everyday acts as helping someone remove a coat, offering a ride, lending money or playing golf together are natural and customary with non-clients but they may have significantly different connotations for the client. Humanistic therapists often maintain different opinions than psychodynamic or cognitive therapists regarding the appropriateness of various boundary crossings and they enact them more frequently (Borys & Pope, 1989). This more open perspective can be discussed during therapy onset.

Mistake 3. *A therapist's understanding of a boundary crossing is the same as the client's.* Despite our best

intentions of touching a previously untouched client after hearing of a loss in the family, for example, the client may feel stunned or confused due to a different interpretation of the heart-felt action.

Mistake 4. *A boundary crossing that is helpful for one client is beneficial to all clients*. Utilizing therapeutic touch with one client may increase self-disclosure about a previously closed matter, for instance, but may create a fear response in another.

Mistake 5. *Boundary crossings are fixed and isolated events*. This error in thinking ignores the possibility that client's or therapist's perception and feeling of a particular boundary crossing will change over time leading to future concerns.

Mistake 6. *If therapist does not foresee any potential risk or harm to crossing a particular boundary then there is no risk or harm*. Anyone can fall prey to self-deception and rationalization, in turn, judging the potential downside of crossing a boundary can be incorrect. Engaging in peer consultation or supervision to acquire an objective view may be recommended.

Mistake 7. *Self-disclosure is always therapeutic because it reveals transparency and trust*. When congruent with client's needs, nature of the therapy, and other situation-specific factors, self-disclosure can be productive, however, it is not always appropriate and is the cause of many boundary errors, including monologue that is unwanted, mistimed, or disruptive. Clients sometimes complain that therapists spend too much time talking about self and do not pay enough attention to their distress.

Koocher & Keith-Spiegel (2008) and Pope & Vasquez (2007a,b) recommend the following steps to assess whether a boundary crossing will be beneficial or harmful:

1. Ponder the best and worst possible outcomes for crossing and not crossing the boundary.
2. Consider the research and other published literature on the boundary crossing.
3. Examine information on the boundary crossing presented in professional guidelines, ethics codes, legislation, case law and other resources.
4. Discuss the boundary crossing questions with a trusted colleague.
5. Reflect on any doubts or uneasy feelings you have rather then ignoring your intuition.
6. During informed consent at the beginning of therapy, describe to client your therapeutic orientation and how you work; assess any client discomfort then explore further, if necessary, refer to someone else.
7. If you feel you would be uncomfortable or ineffective with a client then refer to a colleague.
8. Use the informed-consent process to address planned boundary crossings (i.e., walking outdoors with an agoraphobic).
9. Include boundary crossing plans and justifying rationale in session notes.

These authors also suggest that counselors take the following steps when boundary crossing issues become a dilemma:

1. Monitor the situation carefully.
2. Remain open and non-defensive.
3. Consult with a colleague to gain objective feedback.
4. Listen thoughtfully to what client is saying rather than making assumptions.
5. See the situation from the client's perspective.
6. Respond to a formal complaint with due diligence and seek legal counsel, if necessary.
7. Maintain comprehensive records as the situation evolves (this can also foster understanding and required response).
8. Consider apologizing to client. An apology can help in healing the effects of purposeful or inadvertent professional mistakes (Robbennolt, 2003). "I'm sorry" laws exist in over half of the states encouraging doctors to apologize without delay, and inform patients of mistakes, and other states are considering the same (Henry, 2007). The Veteran's Affairs Medical Center in Lexington, Kentucky, saw malpractice costs and settlements significantly drop after initiating a policy of admitting mistakes and apologizing when warranted (Kraman & Hamm, 1999). A sincere and personal apology is suggested because an insincere apology may be worse than no apology (Robbennolt, 2003). Therapists are wise to consider the client, the situation, and the nature of the boundary crossing when deliberating whether to make an apology.

BEGINNING THERAPIST MISTAKES

Through analysis of the mistakes by beginners, experienced therapists may recollect their path of development and the obstacles confronted along the way. Examining our errors as beginners affords us the realization of our professional evolution, a heightened awareness, and an opportunity to evoke the passion of our work.

Robertiello and Schoenwolf (1987) divide the mistakes of beginners into two types: 1) technical errors occur during early years of practice and involve wrong choice of techniques, misdiagnosis, failure to decipher latent from manifest content, and a less than optimal attitude, and 2) unconscious mistakes entailing therapist countertransference and counter-resistance. Van Hoose and Kottler (1985) highlight the beginner's unintentional actions promoting client dependency due to underestimating their power and influence within the therapeutic relationship.

A very common error among beginners is assuming too much responsibility for the client's "cure." After hearing client's concerns, beginners may believe that they know what client should do and therapist then initiates all the required action rather than allowing clients to help themselves. Therapist may make phone calls to community resources, and give a list of contacts and books to client. Beginners can feel they must persuade client to act in a certain way but this perspective can lead to creating a dependent relationship and it establishes a sense of therapist over-importance. Beginners may find themselves working harder than their clients because they are assuming too many responsibilities resulting

from their own need to succeed and lack of faith the clients can resolve their issues. This concern with responsibility for outcome also affects veteran therapists who overlook what lies beyond their power to control.

While experienced therapists comfortably enact interventions, beginners can be unsophisticated in their execution of techniques given lack of trust in their intuition and inexperience in basic helping skills. Even veterans, though, may forget the value of basic active listening skills and reflection of feelings in an effort to evolve more sophisticated strategies. The following list of common basic skills errors in beginners may assist all practitioners in monitoring elementary behavior and exercising vigilance over counter-productive actions:

1. Distracting mannerisms or facial expressions
2. Poor eye contact and attending skills
3. Not focusing on client's statements
4. Using close-ended questions and an interrogative style thus putting client on the defensive
5. Interrupting client's natural flow of expression
6. Observing surface rather than deeper client messages
7. Focusing only on content of communication while ignoring affect or process
8. Over-indulgence in self-disclosure and placing the focus on oneself
9. An overly passive therapeutic style
10. Uncomfortable in tolerating silence
11. Appearing cold and aloof in appearance
12. Appearing overly friendly, seductive and informal
13. Being aggressive or disciplinary during confrontation

Errors in timing including insensitivity to rhythm and pace of the therapeutic process can cause beginners to intervene too soon or too late. Poor listening skills, such as interrupting, not attending to client's communication, and being certain of a supposed diagnosis leading to distorted perception of client may foster mistimed interventions. For beginners and veterans, often it is not what to say but when to say it.

New therapists frequently desire to be liked by the client but this approval-need can culminate in not setting limits and confronting client when necessary. This concern of potentially upsetting and losing client can become non-therapeutical and may interrelate with therapist's own issues, hence, caution is advised in selfishly doing our own psychological work or protecting our ego at client's expense.

Early in their careers and due to insecurity, new therapists regularly seek supervision and advice on the best practice but this tendency sometimes leads to not listening to their own intuition. Many beginners later resolve, "I fail when I'm not true to myself." Given an interest to please others, for example, the referring individual, client's family, colleagues, or the court, therapists may not consult with their inner wisdom. As self-confidence develops so may our motivation to listen to our inner voice, however, beginners may have too little confidence resulting in weak decision-making or too much confidence potentially ending in unnecessary risk and failed outcomes.

Desire to see quick results and evidence of success often ends in beginners acting impatiently and hindering client's natural growth process. Therapists may believe they know more than client or they may not trust in client's capacity for self-discovery. This impatience may result in counselor disclosing information pre-maturely to clients who are not ready; presenting a solution before client has had time to consider options; or racing ahead when client requires a slower pace.

Fear may be induced in beginners when presented with a threatening label or diagnosis such as "paranoid personality" or "borderline." Their reaction may be to recall everything they learned about this pathology as though to arm themselves against a powerful enemy. Perceiving the client as a negative force disallows accepting the person with positive regard and establishes a pre-determined treatment program. The practitioner's fear may have been addressed but fear may be aroused in the unsuspecting client and the therapeutic relationship can become a power struggle rather than a health-inducing partnership.

Therapy failure can be disturbing to beginners unless it is used as a learning experience and kept in perspective. Observing how experienced therapists confront their therapy failures and earn self-acceptance and improved therapeutic skills through self-examination can be beneficial. All of us had much to learn as beginners, hopefully, we are not repeating our early mistakes. As seasoned veterans, we may need to fight the complacency of our relative success and the challenge of admitting our failures as they occur. Revisiting the mistakes of beginners may remind us of our own vulnerabilities and of the vast levels of therapeutic competency.

ON BEING A REFLECTIVE THERAPIST

It appears that failure is pervasive in therapeutic practice, fortunately, it also serves as a meaningful tool for learning and growth. Rippere and Williams (1985, p. 19) describe a psychiatrist's phenomenological description of his own emotional breakdown that he attributed to his self-critical and perfectionist nature. The experience evolved into the doctor feeling cleansed, improved and a better therapist. He expressed, "It seems to me that from depression itself one learns nothing. Rather it is from what one makes of depression that benefit derives. Depression is depression. It lays waste and may prove, too, a total waste of time unless one uses the experience, and all its consequences, to build anew." The interpretation of failure may be substituted for the psychiatrist's understanding of depression – it can be harmful or helpful. Creative reflection on the experience can expand options for the future.

The field of psychotherapy has seen an increase in the technology of eclecticism, instead of using one theoretical model, many clinicians draw upon several orientations. Psychoanalysts may also use behavioral interventions and behavioral therapists, who concentrate on symptoms, may establish a client-centered rapport or explore hidden

psychodynamics. This diverse approach allows therapists to confront and overcome failures due to a more flexible treatment style and the willingness to experiment with proven alternative strategies. Rubin (1986, p. 385) recommends "to use the common factors in psychotherapy as effectively as possible with all patients, while applying specific techniques to individual patients selectively, depending on the needs of the patient, the most appropriate techniques available, and the personality of the therapist." This open and fluid attitude might prevent practitioner from feeling trapped, helpless, or without options because freedom abounds to act in a multitude of ways.

In dealing with therapeutic failure, counselors may choose to endlessly and regretfully re-experience the event and consider the potential negative implications and outcomes or, more positively, they can adjust their thinking and behavior by concentrating pragmatically on options possibly generating more accurate predictions and future success. Feelings of incompetence and insecurity would have to be managed while recognizing obstacles impeding success.

Jenkins, Hildebrand, and Lask (1982) propose an approach for overcoming failure through reformulating the problem based on new information attained from the previous dead-end:

Step 1: Identify cues indicating failure is occurring and precisely what is not working.

Step 2: Assesses the reasons why therapy is not moving forward by asking these questions:

a) Is client experiencing secondary gains by therapy failure, if so, what are they?

b) Has the problem been defined such that it is not soluble?

c) Which interventions have been productive and not productive?

d) When did progress begin to decline?

e) Who can gain from sabotaging the therapy?

f) How have I been negligent?

g) What matters did I overlook?

Step 3: Adjust initial treatment goals so they are more attainable.

This type of reflection offers the potential to transform unsuccessful treatments into information yielding better future predictions and interventions.

Opportunity to employ different intervention strategies in an eclectic, reflective, and pragmatic manner is contingent upon client's patience and lenience. Therapy failures may best be processed or prevented, therefore, given a mutually caring and trusting therapeutic relationship. Trust can produce the time, incentive, and opportunity to work through errors or setbacks and may minimize likelihood of one mistake destroying previous progress. In contrast, if the therapeutic atmosphere is perceived solely as a business or contractual arrangement instead of an authentic human encounter then client is more likely to react negatively to failure. Coincidence alone may not be the reason certain practitioners lose clients or get sued.

A self-proclaimed concerned and careful psychiatrist shared his learning experience after being sued by a client:

"Thus far, this experience has taught me how omnipotently I have practiced, and how I have clung to the belief that 'good' physicians can practice without making errors when they're careful enough. But the events of the last few months have made it clear to me that I have engaged in, and supported, the myth of physician infallibility. I'm learning that making mistakes is not equivalent to incompetence but is an expected condition of functioning as a sentient being…" "Without trust, the contact becomes idled with anxiety, thereby increasing the potential for anger, followed by blame and guilt. When trust does occur, we practice with less stress and are more inclined to spontaneously extend ourselves. In turn, our patients will reciprocate by working with us in a positive, cooperative manner" (Powles, 1987, pp. 6-7).

Reframing a negative outcome as an "apparent failure," meaning that the final evaluation is yet to be determined, is another tool for the reflective therapist. Without reverting to various defense mechanisms such as denial, suppression or rationalizing away disagreeable outcomes, many apparent failures culminate in great successes. Many experiences, for instance, divorce, unemployment, rejection, and embarrassment encourage personal growth and motivation for future positive outcomes such as an improved marriage or job, enhanced self-awareness and personal efficacy. Essentially, for therapist and client alike, our interpretation of an event determines the perception of failure versus success. Moreover, progress may occur with the passage of time after therapy finished unsatisfactorily – information or a technique may take time to evolve into positive change.

Accepting and integrating therapy failures, and moving forward appears essential for practitioners because mistakes seem inevitable and success itself frequently depends on many random factors beyond our control. This means not becoming frozen or stuck with an error, alternatively, reflective therapists learn from mistakes, fluidly move onward and do not look back. A common denominator among the previously discussed prominent therapists is the belief and ability to cast off disappointment. Lazarus acknowledges his frustration and discomfort but later is self-forgiving for his imperfection. Ellis takes self-responsibility for his role but ultimately performs self-talk to eliminate the concept of "total" failure from his work. Irrational beliefs, to Ellis, such as "a failure with my client meant my personal failure as a therapist" or "with every client I must put myself on the line" produces needless performance anxiety. He believes that unrealistically demanding perfection from ourselves with every client, at all times, can set us up for a fall. Ellis advised clinicians to be more forgiving of their mistakes and to use self-talk to combat their irrational beliefs: "When you ferret out the absolutistic philosophies and perfectionistic demands that seem to underlie your difficulties, ask yourself – yes, strongly ask yourself – these trenchant questions: 1) Why do I have to be an indubitably great and unconditionally loved therapist? 2) Where is it written that my clients must follow my teachings and absolutely should do what I advise? 3) Where is the evidence

that therapy must be easy and that I have to enjoy every minute of it?" (Ellis, 1985, p. 171).

Deutsch (1984, p. 839) illustrated the following irrational beliefs that reinforce the therapist's stress and feelings of failure:

- I should be able to help every client.
- When a client does not progress, it is my fault.
- I should always work at my peak level of competency.
- I am responsible for my client's behavior.

Other strategies for dealing with failure include Lazarus's belief in working with modest expectations (seeking a first down rather than a touchdown), Ellis's and Fisch's objective and systematic analysis of their errors for learning purposes, and Fisch's reviewing of his cases with colleagues to identify what went wrong which motivates him to work even harder for his clientele in the future. Corey's approach is to remain open to growth after a mistake; he understands occasional errors are inevitable and he cannot control a client's behavior but he can control the decision to examine his behavior facilitating improved performance.

Processing our negative feelings and examining our countertransference reactions assists reflective therapists in dealing with failure. Corey and Corey (1988) recommend therapists to become aware of their strong feelings toward the client, including biases, fears and attitudes along with their own present life conflicts and issues that may be impeding therapeutic progress; secondly, they advise identifying client's projections and defense mechanisms that are interfacing with our own negative feelings.

Client resistance may surface for many reasons: they may display habitual helplessness and self-defeating behavior, there may be reluctance to sacrifice secondary gains from their symptoms, and they may try to overwhelm the therapist or avoid making changes. This resistance may be viewed as normal and can beneficially offer more needed processing time for client and signals to therapist that they might be on the right track. At this point, therapy can focus on increasing client awareness of blind spots and working through unfinished business.

Stone (1985) resolves that within the realm of psychotherapy, success is seductive and failure is instructive (p. 145). Living productively with failure means we are seeking the instructive qualities inherent in our errors through self-examination and willingness to change. Evidently, many therapists are performing this self-corrective process as there is substantial agreement among practitioners and researchers that psychotherapy is beneficial in general (Lambert & Ogles, 2004).

CONFRONTING THERAPY FAILURE

Though therapy failures are generally viewed with disgust, they simultaneously present creative opportunities for personal and professional development given an open mind-set. An accepting and probing attitude toward our therapeutic failures can foster:

> Enlightening reflection

> Positive change
> Beneficial information
> Useful feedback on the effect of taking action
> Broadened flexibility
> Learning to be humble
> Heightened motivation
> Enhanced frustration-tolerance
> Improved creativity and experimentation

Kottler and Blau (1989) suggest five stages that therapists experience upon therapy-failure awareness: illusion, self-confrontation, the search, resolution, and application. The practitioner's experience level and how a negative outcome is defined are two variables affecting movement through these stages. During illusion, therapists live in denial and seek something or someone to blame other than themselves. The emotions of fear, anxiety, and guilt that an unexpectedly negative outcome is occurring fuel the search. The ego pursues protection through distorting reality such as claiming "I'm not at fault, it's the client." Next, self-confrontation involves self-anger/blame/doubt while therapist takes self-responsibility for the error and stops blaming others. The third stage, the search, is driven by a desire to determine what truly happened, leading to information-seeking and a careful study of the event and its causes. Similar to the data collection phase during scientific research, therapists explore and analyze various possibilities though self-study and utilization of all resources. This research facilitates understanding the multi-dimensionality of the experience culminating in a broader and healthier perspective increasing likelihood of resolution. The next stage, resolution, focuses on attaining new insights and direction allowing therapists to process causes of the negative event within a manageable perspective. Although therapists may never know precisely what went awry, they understand and accept their role in the process. The last stage is application of new learning in future work. Therapist feels more determined to work competently and more interested in ongoing learning. Confronting failure breeds confidence, professional growth, and an appreciation of our vulnerability, which is often the compelling force for change and growth.

Kottler and Blau (1989) recommend practitioners to ask themselves the following questions in honestly assessing their work:

- What are my expectations of the client? Of myself?
- What does the client expect of me? Of him-or herself?
- Are my expectations congruent with the client's expectations?
- What is my investment in this case? What do I need from the client?
- How aware am I of the timing necessary for the process to unfold?
- What reaction is triggered in me by this client?
- What am I doing that is helpful?
- What am I doing that is not helpful?
- How may I be getting in the client's way?
- What changes can I make?

– What outside resources can I tap? Colleagues? Experts? Literature?

Examining our clinical work by asking such questions can engender greater receptiveness to new information and discovery.

Veteran practitioners accept shortcomings and imperfections of others and themselves. Through self-study, they learn of their limitations, mistakes, and misjudgments and they work diligently to not repeat them. Certainly, by examining our mistakes and forgiving ourselves we can transform therapy failures into opportunities for enhanced personal and professional efficacy.

CONCLUSION

These practitioners agree that therapists are human and thereby susceptible to error of many types, including misperceiving client response, using inappropriate techniques, not responding to client frame of reference, and having neurotic lapses themselves. Such mistakes often yield discomfort but also, hopefully, a desire to examine the flawed situation, take self-responsibility, gain insight and move on. Lazarus echoes these thoughts by suggesting therapists benefit by maintaining a balanced view of therapy with realistic expectations allowing them to take failure in stride. Fisch accepts responsibility for negative results and is self-forgiving facilitating the ability to cast off disappointment and enthusiastically move to the next challenge.

Consensus abounds among these prominent therapists regarding how refinements in technique and theory result from their successes and failures. They respect their failures and personally reflect upon these negative outcomes with improvement as the goal. The characteristics of self-honesty and a clear perception of reality are deemed vital for understanding one's therapeutic strengths and weaknesses.

These prominent practitioners essentially agree that making time to constructively process their own therapy failures has significantly contributed to their current level of competency. Though they may not disclose their errors before a public audience expecting to hear amazing success stories, such reflection may occur within the confines of safe company.

Admitting and learning from our therapy errors can assist us in numerous ways:

Promotes reflective thought – Processing mistakes leads to healthy reflective action that can foster growth toward being the best we can be in this role. Desire to improve suggests the need to identify our weaknesses and build on our strengths.

Imparts valuable information – Therapy errors can be viewed as simply feedback en route to a successful outcome rather than the end in itself. Generally, given trust, clients will be patient as therapist seeks a combination of methods that work.

Enhances flexibility – Awareness that a specific therapeutic approach is not working with a given client ideally will lead to utilization of a different strategy. Often, greater flexibility can decrease the likelihood of bad therapy.

Increases patience – If therapist and client are patient with one another while maintaining realistic goals and expectations, and forgive one another's miscalculations then successful outcomes are more likely.

Reinforces humility – Listening carefully and responding to client's needs is vital whereas therapist need to be right, to win power struggles, and to prove his or her way is the right way can lead to ineffective therapy. Confronting our errors and failures teaches us to accept and ultimately turn weaknesses into strengths.

Most of the practitioners discussed were able to let go of their bad therapy, be self-forgiving for their errors, and accept their mistakes as "the inevitable result of doing their jobs." They identified the following most common therapist-induced causes for therapy failure:

1. Not listening to client and alternatively following his or her own agenda.
2. Repeating the same errors without end.
3. Demonstrating inflexibility and unwillingness to make therapeutic adjustments.
4. Having no sense of direction.
5. Being arrogant and over-confident.
6. Feeling inept.
7. Inability to establish solid rapport and alliance with client.
8. Utilizing obsolete methods.
9. Negative outcomes for client.
10. Losing self-control or countertransference issues.
11. Making and relying upon invalid assumptions.

In essence, therapy failure abounds when client or therapist is dissatisfied with the result and that negative outcome is due to therapist miscalculations, misjudgments or errors. Disclosing our mistakes and failures to others can enhance our learning from these experiences in growth-oriented and constructive ways rather than internalizing them in secrecy and shame. The therapy process may be a process in itself of failure and correction such that even the "prominent figures" in the field are susceptible to making errors in judgment. The question then becomes whether we have the courage to speak more openly about our failures and subsequently make the appropriate modifications.

REFERENCES

Borys, D.S., & Pope, K.S. (1989). Dual relationships between therapist and client: A national study of psychologists, psychiatrists, and social workers. *Professional Psychology: Research and Practice*, 20, 283-293. Retrieved August 27, 2007, from http://kspope.com/dual/research2.php.

Bugental, J.F.T. (1988). What is failure in psychotherapy? *Psychotherapy*, 25, 532-535.

Bugental, J.F.T. (1987) *The Art of the Psychotherapist*. New York: Norton.

Bugental, J.F.T. (1978) *Psychotherapy and Process*. Reading, Mass.: Addison-Wesley.

Coleman, S. (ed.). (1985). *Failures in Family Therapy*. New York: Guilford.

Colson, D., Lewis, L., and Horwitz, L. Negative Outcome in Psycho-therapy and Psychoanalysis. In D. T. Mays and C. M. Franks (eds.), *Negative Outcome in Psychotherapy and What to Do About It*. New York: Springer, 1985.

Connolly, M. B., & Strupp, H. H. (1996). A cluster analysis of client reported psychotherapy outcomes. *Psychotherapy Research*, (6), 30-42.

Conyne, R.K. (1999). *Failures in group work*. Thousand Oaks, CA: Sage.

Corey, G. (2005). *Theory and Practice of Counseling and Psychotherapy*. (7th ed.) Monterey, Calif.: Brooks/Cole.

Corey, G., & Corey, M. S. (1988). *Helping the Helper*. Monterey, CA.: Brooks/Cole.

Deutsch, C. J. (1984) Self-reported sources of stress among psycho-therapists. *Professional Psychology*, 15 (6), 833-845.

Eisenthal, S., Koopman, C., & Lazare, A. (1983). Process analysis of two dimensions of the negotiated approach in relation to satisfaction in the initial interview. *The Journal of Nervous and Mental Disease*, 171, 49-54.

Ellis, A. (1985). *Overcoming Resistance*. New York: Springer.

Estrada, A.U., & Homes, J.M. (1999). Couples' perception of effective and ineffective ingredients in marital therapy. *Journal of Sex and Marital Therapy*, 25, 151-162.

Fisch, R., Weakland, J.H., and Segal, L. *The Tactics of Change: Doing Therapy Briefly*. San Francisco: Josey-Blass, 1982.

Gelso, C. J. & Hayes, J. A. (1998). *The psychotherapy relationship: Theory, research, and practice*. New York: Wiley.

Greenspan, M., & Kulish, N. M. (1985). Factors in premature termination in long-term psychotherapy. *Psychotherapy: Theory, Research, and Practice*, 1985, 22 (1), 75-82.

Grosse-Holtforth, M., & Grawe, M. (2002). Bern inventory of treatment goals: Part 1. Development and first application of a taxonomy of treatment goal themes. *Psychotherapy Research*, 12, 79-99.

Grosse-Holtforth, M., Ruebi, I., Ruckstuhl, L., Berking, M., & Grawe, K. (2004). The value of treatment-goal themes for treatment planning and outcome evaluation of psychiatric inpatients. *International Journal of Social Psychiatry*, 50, 80-91.

Gutheil, T. G. & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *American Journal of Psychiatry*, 150, 188-196.

Hasler, G., Moergeli, H., Schnyder, U. (2004). Outcome of psychiatric treatments: What is relevant for our patients? *Comprehensive Psychiatry*, 45, 199-205.

Henry, R. (2007). More states weigh "apology' options for doctors leery of lawsuits. Retrieved August 15, 2007, from http://www.law.com/jsp/article.jsp/id.

Herron, W. G., and Rouslin, S. (1984). *Issues in Psychotherapy*. Washington, D.C.: Oryn Publications.

Hill, C.E., Nutt,-Williams, E., Heaton, K.J., Thompson, B.J., & Rhodes, R.H. (1996). Therapist retrospective recall of impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology*, 43, 207-217.

Holcomb, W. R., Parker, J. C., Leong, G. B., Thiele, J., & Higdon, J. (1998). Customer satisfaction and self-reported treatment outcomes among psychiatric inpatients. *Psychiatric Services*, 49, 929-934.

Hollon, S.D. (1995). Failure in psychotherapy. *Journal of Psychotherapy Integration*, 5(2), 171-175.

Holtforth, M. G., Reubi, I., Ruckstuhl, L., Berking, M., & Grawe, K. (2004). The value of treatment-goal themes for treatment planning and outcome evaluation of psychiatric inpatients. *International Journal of Social Psychiatry*, vol. 50 (1), 80-91.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, 38, 139-149.

Jenkins, J., Hildebrand, J., & Lask, B. (1982). Failure: An exploration and survival kit. *Journal of Family Therapy*, 4, 307-320.

Kantor, M. *Problems and Solutions: A guide to psychotherapy for the beginning psychotherapist*. New York: Praeger Publications, 1990.

Keith, D.V., & Whitaker, C.A. (1985). Failure; Our bold companion. In S.B. Coleman (Ed.), *Failures in family therapy* (pp.8-23). New York: Guilford.

Koocher, G. P., & Keith-Spiegel, P. (2008). *Ethics in psychology and the mental health professions*. New York: Oxford University Press.

Kottler, J.A. (2001). *Making changes last*. New York: Brunner/Routledge.

Kottler, J.A., & Blau, D.S. (1989). *The imperfect therapist: Learning from failure in therapeutic practice*. San Francisco: Jossey-Bass.

Kottler, J.A. & Carlson, J. *Bad therapy: Master therapists share their worst failures*. New York: Brunner-Routledge, 2003.

Kraman, S. S., & Hamm, J. (1999). Risk management: Extreme honesty may be the best policy. *Annals of Internal Medicine*, 131, 963-967.

Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P. A. (1996). The role of the therapeutic alliance in psychotherapy pharmacotherapy outcome: Findings in the National Institute of Mental Health treatment of depression collaborative research program. *Journal of Consulting and Clinical psychology*, 64, 532-539.

Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psycho-therapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 143-189). New York: Wiley.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (pp. 139-193). New York, NY: John Wiley & Sons.

Locke, E. A., & Latham, G. P. (2002). Building a practically useful theory of goal setting and task motivation: A 35-year odyssey. *American Psychologist*, 57, 705-717.

Long, J. R. (2001). Goal agreement and early therapeutic change. *Psychotherapy*, 38, 219-232.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68, 438-450.

Mohr, D C. (1995). Negative outcome in psychotherapy: A critical review. *Clinical Psychology*, 2, 1-27.

Pope, K. S., & Tabachnik, B. G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems and beliefs. *Professional Psychology: Research and Practice*, 25, 247-258.

Pope, K. S., & Vasquez, M. J. T. (2007a). 18 basic steps in ethical decision-making. Retrieved August 20, 2007, from http://kspope.com/memory/ethics.php.

Pope, K. S., & Vasquez, M. J. T. (2007b). Ethics in psychotherapy and counseling: A practical guide (3rd ed.). San Francisco: Jossey-Bass/Wiley.

Pope, K. S., & Keith-Spiegel, P. (2008). A practical approach to boundaries in psychotherapy: Making decisions, bypassing blunders, and mending fences. *Journal of Clinical Psychology: In Session*, 64 (5), 638-652.

Powles, D. E. (1987). Me get sued … Are you kidding? *Psychiatric Times*, 1-7.

Rippere, V., & Williams, R. (1985). *Wounded healers: Mental health workers' experience of depression*. New York: Wiley.

Robbennolt, J. (2003). Apologies and legal settlement: An empirical examination. *Michigan Law Review*, 102, 460-516.

Robertiello, R.C., & Schoenewolf, G. (1987). *101 common therapeutic blunders: Countertransference and counterresistance in psychotherapy*. Northvale, NJ: Jason Aronson.

Rubin, S. S. (1986). Ego-focused psychotherapy: A psychodynamic framework for technical eclecticism. *Psychotherapy*, 23 (3), 385-389.

San Martin, D. (2007). Treatment goals of adult mental health patients: A literature review. *Dissertation Abstracts International*, 68 (4-B), 2670.

Stiles, W.B., Gordon, L.E., & Lani, J.A. (2002). Session evaluation and the session evaluation questionnaire. In G.S. Tryon (Ed.), *Counseling based on process research: Applying what we know* (pp. 325-343). Boston: Allyn and Bacon.

Stone, M. (1985). Negative outcome in borderline states. In D. T. Mays & C. M. Franks (eds.), *Negative outcome in psychotherapy and what to do about it*. New York: Springer.

Strean, H. S., & Freeman, L. (1988). *Behind the couch: Revelations of a psychoanalyst*. New York: Wiley.

Teyber, E. (2000). *Interpersonal process in psychotherapy* (4th ed.). Belmont, CA: Wadsworth/Thompson Learning.

Tryon, G. S., & Winograd, G. (2002). Goal consensus and collaboration. In J. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patient needs*, 109-125. New York: Oxford University Press.

Uebelacker, L. A., Battle, C. L., Friedman, M A., Cardemil, E V., Beevers, C. G., & Miller, I. W. (2005). *Treatment goals of depressed inpatients and outpatients*. Unpublished.

Van Hoose, W. H., & Kottler, J. A. (1985). *Ethical and legal issues in counseling and psychotherapy: A comprehensive guide*. (2nd ed.). San Francisco: Jossey-Bass.

Watzlawick, P., Weakland, J. H., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution*. New York: Norton.

TEST - FAMOUS THERAPIST ERRORS

4 Continuing Education hours
Record your answers on the Answer Sheet (click
the "NCC Answer Sheet" link on Home Page
and click your answers).
Passing is 70% or better.
For True/False questions: A = True and B = False.

1. **Arthur Freeman learned to not miscalculate the power of significant others in a client's life.**
    A) True   B) False

2. **Almost always, one specific reason to which we attribute unsuccessful therapy explains the entire truth.**
    A) True   B) False

3. **Scott Miller learned to be sensitive of when his knowledge, ability, or connection with client was not likely to lead to better results.**
    A) True   B) False

4. **Michael Hoyt advises counselors to note if there is a pattern to their impasses or failures and then take responsibility for the required improvement.**
    A) True   B) False

5. **Therapist-induced failures can be minimized if issues are detected early given counselor honest and objective self-analysis.**
    A) True   B) False

6. **A very common error among beginning therapists is assuming too much responsibility for the client's "cure."**
    A) True   B) False

7. **Eliciting active client participation in the development of treatment goals has not been found to increase commitment to goals and the probability of goal-attainment.**
    A) True   B) False

8. **A common therapist-client interactive variable leading to therapy-failure is the practitioner's attitude of "I've seen it all before."**
    A) True   B) False

9. **Excessive therapist self-disclosure can cause the client to feel bored, ignored, and minimized and lead to client terminating therapy.**
    A) True   B) False

10. **Thinking that a boundary crossing that is helpful for one client is beneficial to all clients is one example of a potential cognitive error in making boundary-crossing decisions.**
    A) True   B) False

11. **Deducing the causes of failure in therapy is _____.**
    A) too time-consuming to justify
    B) difficult
    C) generally, not worth the time
    D) always easy

12. **An indication of _____ is highly suggested when both therapist and client agree that there has not been an apparent change.**
    A) counterresistance
    B) countertransference
    C) therapy failure
    D) poor anger-control

13. **Studies have shown that the two most significant factors in differentiating good from bad therapy are _____.**
    A) the fee and client punctuality
    B) depth or power of the therapy and how smoothly things proceed
    C) therapist assertiveness and utilization of humor
    D) confrontation and mirroring

14. **William Glasser disclosed that one of his therapeutic weaknesses was _____.**
    A) to not listen effectively
    B) to avoid confrontation
    C) to be impatient and push client faster than expected
    D) to lack empathy

15. **Arnold Lazarus believes that bad or ineffective therapy occurs when therapists _____.**
    A) lack empathy and compassion
    B) do not hear their client
    C) do not employ empirically supported techniques when relevant
    D) all of the above

Continuing Psychology Education Inc. has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6084. Programs that do not qualify for NBCC credit are clearly identified. Continuing Psychology Education Inc. is solely responsible for all aspects of the programs.
Continuing Psychology Education Inc. will award NBCC-approved continuing education clock hours for all of its listed programs.

16. **Raymond Corsini believes that the ideal therapist _____.**
    A) utilizes only one therapeutic method
    B) maintains a fair sliding fee scale
    C) has a working knowledge of many therapeutic systems
    D) limits confrontational communication

17. **Jeffrey Kottler suspects that therapists periodically "leave their sessions for a period of time" and escape into a fantasy world due to**
    A) boredom
    B) laziness
    C) their own personal issues
    D) all of the above

18. **To Richard Stuart, the main cause of bad therapy is _____.**
    A) poor client listening-skills
    B) lack of therapist empathy
    C) therapist not acknowledging limits of competency and attempting to "provide every service sought by clients"
    D) excessive client anxiety

19. **Admitting and learning from therapy errors can assist therapists in _____.**
    A) promoting reflective thought
    B) enhancing flexibility
    C) reinforcing humility
    D) all of the above

20. **Therapist resistance, countertransference, and blockages are manageable through _____.**
    A) avoidance behavior
    B) self-awareness, self-monitoring, personal counseling, and supervision
    C) relaxation procedure
    D) stress reduction techniques

Please transfer your answers to the Answer Sheet (click the "NCC Answer Sheet" link on Home Page and click your answers).

Press "Back" to return to "NCC Courses" page.