

PREVENTION of MEDICAL ERRORS II

Presented by

CONTINUING PSYCHOLOGY EDUCATION INC.

6 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. James Bugental, Clark Moustakas, John Gray, and others disclose their therapy failures for our benefit.

Accreditation

This course is approved by the Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling (Provider Number 50-446 - Exp. 3/31/2021).

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, Ph.D.
Richard Shuman, MFT

Copyright © 2016 Continuing Psychology Education Inc.

INTRODUCTION

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).

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.

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, Clark Moustakas, John Gray, 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 recalls 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

PREVENTION of MEDICAL ERRORS II

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."

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.

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."

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

PREVENTION of MEDICAL ERRORS II

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 from 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 lose 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 claimed 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."

PREVENTION of MEDICAL ERRORS II

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.”

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

PREVENTION of MEDICAL ERRORS II

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

PREVENTION of MEDICAL ERRORS II

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-therapeutic 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. Moreover, Albert 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.

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).

CONCLUSION

These prominent practitioners essentially agree that making time to constructively process their own therapy failures has significantly contributed to their current level of

competency. Fisch accepts responsibility for negative results, is self-forgiving facilitating the ability to cast off disappointment and enthusiastically move to the next challenge, and he reviews his cases with colleagues to identify what went wrong which motivates him to work even harder for his clientele in the future. 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.

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:

- Not listening to client and alternatively following his or her own agenda.
- Repeating the same errors without end.
- Demonstrating inflexibility and unwillingness to make therapeutic adjustments.
- Having no sense of direction.
- Being arrogant and over-confident.
- Feeling inept.
- Inability to establish solid rapport and alliance with client.
- Utilizing obsolete methods.
- Negative outcomes for client.
- Losing self-control or countertransference issues.
- 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.

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. (1987) *The Art of the Psychotherapist*. New York: Norton.
- Bugental, J.F.T. (1978) *Psychotherapy and Process*. Reading, Mass.: Addison-Wesley.
- 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 psychotherapists. *Professional Psychology*, 15 (6), 833-845.
- 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.
- Guthel, 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.
- Henry, R. (2007). More states weigh “apology” options for doctors leery

PREVENTION of MEDICAL ERRORS II

- of lawsuits. Retrieved August 15, 2007, from <http://www.law.com/jsp/article.jsp?id>.
- 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.
- Koocher, G. P., & Keith-Spiegel, P. (2008). *Ethics in psychology and the mental health professions*. New York: Oxford University Press.
- 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.
- 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.
- 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. (1987). Me get sued -Are you kidding? *Psychiatric Times*, 1-7.
- Rippper, V., & Williams, R. (1985). *Wounded healers: Mental health workers' experience of depression*. New York: Wiley.
- Robbenolt, 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.
- 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 - PREVENTION OF MEDICAL ERRORS II

6 Continuing Education hours

Record your answers on the Answer Sheet (click the "Florida 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. **Robertiello and Schoenwolf did not divide the mistakes of beginning therapists into technical and unconscious errors.**
A) True B) False
2. **Arthur Freeman learned to not miscalculate the power of significant others in a client's life.**
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. **Michele Weiner-Davis believes that there is no such thing as therapy-failure, instead, there is just useful feedback on what to do next.**
A) True B) False
6. **Thinking that a boundary crossing that is helpful for one client is beneficial to all clients is not an example of a potential cognitive error in making boundary-crossing decisions.**
A) True B) False
7. **In Pat Love's bad therapy case, 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.**
A) True B) False
8. **A very common error among beginning therapists is assuming too much responsibility for the client's "cure."**
A) True B) False
9. **Therapy failure can be disturbing to beginning therapists unless it is used as a learning experience and kept in perspective.**
A) True B) False
10. **Albert Ellis advised clinicians to be more forgiving of their mistakes and to use self-talk to combat their irrational beliefs.**
A) True B) False
11. **Deducing the causes of failure in therapy is _____.**
A) difficult
B) too time-consuming to justify
C) generally, not worth the time
D) always easy
12. **Clark Moustakas indicates that therapeutic errors often occur because therapists _____.**
A) offer insufficient paraphrasing and summarizing
B) persist in using a technique that is not helpful to the sensitivities of the client
C) do not establish good eye contact
D) lack self-assertiveness
13. **John Gray believes that bad therapy occurs when anger and pent-up feelings are released at the expense of _____.**
A) good paraphrasing
B) assertiveness skills
C) seeking resolutions and fostering improved communication
D) therapist values
14. **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
15. **Couple's assessments of marital therapy deem the therapy experience as lousy when therapists _____.**
A) are unclear about expectations
B) are not empathic or understanding
C) do not keep things safe
D) all of the above

This course, Prevention of Medical Errors II, is approved for 6 hours of continuing education by the Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling for Florida LCSWs, LMFTs, and LMHCs
(Provider Number 50-446 - Exp. 3/31/2021).

PREVENTION of MEDICAL ERRORS II

16. **John Norcross admitted that his bad therapy case was _____.**
- A) a beginner's mistake of not monitoring his countertransference better
 - B) due to external variables beyond his control
 - C) entirely the fault of client
 - D) not potentially manageable by any therapist
17. **Len Sperry learned to _____.**
- A) avoid difficult clients
 - B) ensure each cotherapist has clear expectations for one another and will support the other if needed
 - C) manage therapy time better
 - D) interpret client non-verbal communication
18. **To Scott Miller, one type of therapy failure occurs when _____.**
- A) therapy sessions conclude before 50 minutes have elapsed
 - B) managed care becomes overly-involved
 - C) client improvement is not a function of the therapy
 - D) fees are not congruent with services
19. **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
20. **Arthur Freeman believes that therapeutic narcissism involves _____.**
- A) overconfidence
 - B) arrogance
 - C) believing we know what others should do
 - D) all of the above

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

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