FAMOUS THERAPIST ERRORS

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. Albert Ellis, William Glasser, Arnold Lazarus, Gerald Corey, and others disclose their therapy failures for our benefit.

Accreditation
Continuing Psychology Education Inc. is approved by the California Association of Marriage and Family Therapists (CAMFT # 1000067) to sponsor continuing education for LMFTs, LCSWs, LPCCs, and LEPs. Continuing Psychology Education Inc. maintains responsibility for this program/course and its content. This course, Famous Therapist Errors, meets the qualifications for 6 hours of continuing education credit for LMFTs, LCSWs, LPCCs, and/or LEPs as required by the California Board of Behavioral Sciences.

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.

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Outline

Noteworthy practitioners' experience with and learning from therapy failure:
1. Albert Ellis
   a. Recommendations for working with depression
2. William Glasser
   a. Feel commitment toward the client
3. Arnold Lazarus
   a. Strive to maintain empathy and compassion toward client
   b. Validate what client is saying before moving forward to a perceived target
   c. Covering up and denying one's mistakes diminishes learning opportunity
4. Gerald Corey
   a. Under pressure, we sometimes revert to old patterns of behavior
5. Various lessons learned from bad therapy
   a. Have an alternate therapy model if our regular model is ineffective
   b. Keep one foot in the client's world
   c. Bad therapy experiences can become pearls of wisdom
6. The four most pervasive variables in therapy failure
7. Five stages that therapists experience upon therapy-failure awareness
8. Examining our clinical work by asking ourselves key questions
9. Four ways that admitting and learning from our therapy errors can be illuminating

INTRODUCTION

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

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

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

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

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

THE ERRORS OF PROMINENT PRACTITIONERS

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

ALBERT ELLIS

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

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

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

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

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

WILLIAM GLASSER

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

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

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

One day the husband did not show for a scheduled session, out of concern, therapist drove about ten miles to his home. Glasser knew the man was inside but he did not respond so therapist called the police who broke in and found him dead.

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

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

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

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

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

ARNOLD LAZARUS

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

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

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

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

him up in high school – a good example of counter-transference.

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

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

GERALD COREY

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

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

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

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

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

SUSAN JOHNSON

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

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

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

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

you came up with is that he really couldn't be there for you. If indeed that is true, then the relationship really isn't safe for you."

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

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

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

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

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

JON CARLSON

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

Carlson described a client who was hired by his office manager to assist with their office work during the time the client was in therapy with Carlson. The office manager felt this situation would not become a dual relationship problem because the client was not working for Carlson. Client's issue was determining whether to leave a bad marriage. Ultimately, the client's husband suspected his wife of having an affair with Carlson. Therapist asked client what might have led to this absurd suspicion and she disclosed that she was having an affair – with the minister of the church who had recommended client to Carlson.

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

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

Several years later, client called and wrote to therapist revealing he began drinking a glass of wine at dinner for the past year without losing self-control and he no longer viewed

himself as an alcoholic. Soon thereafter, Carlson received a phone call and visit from a police officer informing him of a threat against his life and that the police would patrol his street on a regular basis. The past client had begun drinking heavily leading to the loss of his job and control over his life. Ultimately, client was arrested for being out-of-control and he threatened Carlson's life while in detox. Client's wife wrote therapist declaring him to be a terrible counselor and that he ruined their lives.

Carlson immediately reflected on the experience seeking resolution, he admitted, "It was really upsetting to me that such a spontaneous passing remark could have such a huge negative impact. Again I was right: research supported what I had said but it was totally inappropriate for this individual. I learned after that to be very careful about the things I say to people. At the very least, I might say to him now, "Would you be interested in knowing …?" Or maybe I wouldn't bring it up at all." Therapist learned that he should have given the information in a different way, with greater respect to where the man was coming from. He felt sad that he never talked to client after this experience and that closure was never obtained.

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

PEGGY PAPP

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

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

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

Upon reflection, Papp concluded, "… no matter how long you practice therapy, even in the most stressful of circumstances, you can never really get to the point where you can handle everything deftly that comes your way. There are therapists who think they can, but that is only because they are oblivious to the different ways they could have proceeded." She believes that human behavior is mysterious and unpredictable thus rendering therapists to be humble about their work, otherwise, we can be insensitive to the dilemmas of our clients. Papp contends that "It takes wisdom sometimes, not techniques and approaches to be helpful to people. It takes a kind of real understanding about human suffering." Finally, she stresses the need for therapists to work within the particular cultural context of each client and to respect those beliefs.

VIOLET OAKLANDER

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

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

want to do that, I don't like this stuff. I like the way it was before when I didn't feel anything."

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

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

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

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

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

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

RICHARD SCHWARTZ

Dr. Schwartz pioneered the Internal Family Systems model of psychotherapy which combines family therapy with intra-psychic factors. Clients learn to separate their extreme beliefs and emotions thus liberating a wise and compassionate Self-state capable of creating harmony with self and others. His accomplishments include being associate professor at the University of Illinois at Chicago and Northwestern University and Fellow of the American Association for Marriage and Family Therapy. He authored the book, *Internal Family Systems Therapy* and co-authored *Family Therapy: Concepts and Methods*, a widely-read family therapy textbook; additionally, he has been on the editorial board of four professional journals and he developed the Center for Self Leadership in Oak Park, Illinois, designed to address issues of violence, racism, abuse and oppression.

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

A dislike of clients who are highly dependent, yet demanding is another part of self that Schwartz must be

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

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

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

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

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

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

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

In his therapy model, Schwartz believes in being himself and assuming much responsibility for successful and unsuccessful outcomes instead of blaming client's unresponsiveness or resistance or the therapy model. He has adopted the tendency to look at himself when things did not end well. He admits that "The kind of therapy that I am inviting is a riskier kind of therapy for your ego because you get more involved. It does take more of an investment on the part of the therapist and you do kind of eliminate all those different protective barriers – not all of them but the common protective barriers we have for keeping a kind of distance."

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

STEPHEN LANKTON

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

Lankton believes that bad therapy occurs when therapist does not engage with client and that creative therapeutic techniques will not work given the failure to have developed a solid relationship with client. In sharing a personal therapy failure central to this theme, Lankton described a man attending therapy for back pain referred by a psychiatrist. Therapist saw client in the parking lot leaving his car with the

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

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

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

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

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

Lankton gave the following explanation: "This case illustrates one of those principles that Milton Erickson drilled into my head and that I never should have forgotten for a moment. The most important thing is to speak the client's experience and language. The fact that you build good rapport with the person doesn't mean that you can forget that basic principle. It doesn't mean that you can now speak from your own experience and language and expect them to follow. Rapport doesn't open the doors as wide as you come to think it does."

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

RAYMOND CORSINI

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

When encountering therapeutic difficulties, Corsini recommends flexibility in thought and action. He recalled a case when client-centered therapy led to stagnation but a change to hypnosis brought success, similarly, another case utilizing Adlerian methods led to resistance until

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

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

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

FRANK PITTMAN

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

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

Unexpectedly, the young man stood up, walked off the stage and left the building. The audience became uneasy and the family members began to leave when Pittman urged them to stay and proclaimed, "I suggested to the family that they not follow him. I told them that this was an indication of what good therapy we were doing. I said that what we had been tying to get him to do was to stop collapsing dependently upon them and to get up and go do something. I tried my damnedest to get them to see this, and get the audience to see this. I told them that this was a very therapeutic move, one that I had fully anticipated. This was exactly what I was tying to bring about and that is was a great step toward health." The six women looked at Pittman like he was crazy and he then became concerned for his safety lest the audience might riot in indignation.

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

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

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

of themselves as lacking some sort of power that the therapist has."

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

Counselors may work with people in pain and anguish, but Pittman cautions practitioners to remain objective, otherwise, we could feel as bad and become as paralyzed as they may be. "We have to be there in the midst of that pain while keeping ourselves sufficiently out of it. We have to maintain our ability to have hope, our ability to do reality testing. It's very hard work."

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

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

SAM GLADDING

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

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

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

In evaluating his performance, Gladding assessed that he did not prepare client well enough for the treatment modalities, went too fast instead of letting her talk and then being reflective, and he tried to fix her rather than allowing her to ventilate feelings. Counselor reflected, "Maybe I should have been more self-disclosing and personal with her, especially about my own nervousness. I certainly should have reflected her feelings more often and stayed with her experience. Maybe that would have been more appropriate instead of going with a 'Let's see if I can help you relax' kind of response."

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

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

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

Gladding admitted that he had experienced other bad therapy cases but the one he shared simply haunted him more than the others. A concluding analysis by Gladding led him to say, "I think that bad experiences in therapy are like grains of sand in oysters. At first, they are really irritating. They

can even kill us. But over time, if we live long enough, they can become pearls of wisdom."

LEARNING FROM THERAPY FAILURE

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

CLIENT FACTORS

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

Greenspan & Kulish (1985) found that clients who suddenly end their therapy before work has been completed have a tendency to be young adults, a minority group member, have insurance coverage with maximum benefits, have been referred by another professional in a clinic facility, and have situational, acute, or adjustment reactions that they blame on external factors beyond their control. Colson, Lewis, and Horwitz (1985) determined that individuals in psychoanalytic treatment with higher chronicity of symptoms and degree of disturbance revealed poor prognosis predictors. Clients who display any of these traits are less likely to improve in therapy: poor impulse-control, lack social support systems, are older, lack sense of humor, are impatient, have borderline personality disorder, tend to externalize and lack psychological sophistication (Stone, 1985). It is advised that counselors not be pessimistic when dealing with issues of poor prognosis in the literature because that would contribute to a self-fulfilling prophecy, rather, to remain optimistic while being realistic regarding that which is within our power to change. Therapists need not avoid or fear high-risk cases because often treatment success correlates with client's motivation, personality, and attitude, in turn, client's failure is not automatically the therapist's failure. Despite this information suggesting that there are some people that nobody can help, the preponderance of therapy failure is due to other causes.

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

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

THERAPIST FACTORS

Analysis of treatment failures in family therapy led Coleman (1985) to observe the following most common therapist causal factors:

1) Failure to comprehend the true nature of the presenting problem and the circumstances surrounding the referral.
2) Insufficient bond with family members or a weak therapeutic relationship with client.
3) Theoretical omissions or inconsistent interventions.
4) Waning energy.

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

Within a psychodynamic treatment process, H. S. Strean concludes that failures generally occur when therapist is not

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

With amazing candor, Strean assessed his work with this client and resolved that he made many significant errors resulting from his negative attitude toward client. A case analysis illustrated the following therapist mistakes yielding important learning material:

1. Therapist lost objectivity, thus, he fell prey to client's manipulative ways.
2. Due to feeling threat, jealously, and competition, therapist maintained a continual power struggle.
3. He made "correct" interpretations and used "right" words, but with a hostile and non-empathic tone of voice.
4. He spent excessive time trying to prove to client that he knew what he was doing.
5. Despite his awareness that countertransference feelings were negatively impacting therapy, therapist could not monitor or confront them and did not receive supervision or therapy to resolve them.
6. He hid behind a mask of cold, objective analyst and was punitive instead of being empathic and supportive.

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

Misdiagnosis caused by not identifying a hidden psychopathology or organic dysfunction will often result in premature therapy termination. Straightforward anxiety, for example, can be a sign of hyperthyroidism or a variety of cardiovascular or neurological disorders. Even with an accurate assessment, the ensuing fundamental helping skills can go awry; the following is a list of the most common mistakes and interventions that end therapy prematurely:

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

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

THERAPIST-CLIENT INTERACTIVE EFFECTS

The most common causes of therapist-client therapy process failure are unresolved transference experiences or dependency issues (Herron & Rouslin, 1984). Specifically, separation conflicts are mismanaged or prematurely terminated due to therapist's emotional attachment to a client representing a form of symbiotic interdependence. The counselor's personal and unresolved issues of separation/individuation and parent/child bonding become interwoven with client's ambivalence between the desire for continued intimacy versus freedom. Therapists may terminate therapy prematurely if they feel threatened by these dynamics, contrarily, they may unnecessarily extend therapy if wishing to avoid the sense of loss that results from separation. Premature therapy termination can cause client to feel abandoned leading to regression, isolation, rejection, bitterness, and debilitating anxiety. Lack of confidence and experience together with a desire to punish the "heartless parent/therapist," can cause recurrence of client symptoms and exacerbate them given the new feelings of anger and betrayal. Prolonged therapy can induce client dependency upon therapist and lower probability of personal autonomy. Many therapy failures occur because therapists are not aware of their own dependence or that of their client, therefore, this symbiotic intimacy is not confronted and resolved.

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

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

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

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

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

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

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

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

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

CONFRONTING THERAPY FAILURE

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

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

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

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

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

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

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

CONCLUSION

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

Consensus abounds among these prominent therapists regarding how refinements in technique and theory result from their successes and failures. They respect their failures and personally reflect upon these negative outcomes with improvement as the goal. Other strategies for dealing with failure include Lazarus's belief in working with modest expectations (seeking a first down rather than a touchdown), and Ellis's objective and systematic analysis of his errors for learning purposes. Corey's approach is to remain open to growth after a mistake; he understands occasional errors are inevitable and he cannot control a client's behavior but he

can control the decision to examine his behavior facilitating improved performance. The characteristics of self-honesty and a clear perception of reality are deemed vital for understanding one's therapeutic strengths and weaknesses.

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

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

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

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

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

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

The therapy process may be a process in itself of failure and correction such that even the "prominent figures" in the field are susceptible to making errors in judgment. The question then becomes whether we have the courage to speak more openly about our failures and subsequently make the appropriate modifications.

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TEST - FAMOUS THERAPIST ERRORS

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

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

3. **Peggy Papp learned it is inappropriate to decide ahead of time on a treatment method before even meeting the family and hearing their story.**
   A) True B) False

4. **Violet Oaklander resolved that children cannot manage a lot of expression of feelings all at one time as adults can.**
   A) True B) False

5. **Susan Johnson resolved that being empathic rather than judgmental with the client can facilitate therapy.**
   A) True B) False

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

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

8. **Symptom relief appears to be the most important client reported goal across clinical settings but it is not the most frequently indicated goal.**
   A) True B) False

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

10. **The most common causes of therapist-client therapy process failure are unresolved transference experiences or dependency issues.**
    A) True B) False

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

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

13. **Gerald Corey learned from personal experience how group members often discount their inner reactions and relinquish their power in order to _____.**
    A) be heard in the group
    B) seek justification for a group leader's mistake
    C) criticize other group members
    D) be more assertive

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

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

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

17. **To Richard Schwartz, good therapy essentials include _____.**
    A) being more aware of our inner thoughts, feelings and various parts
    B) monitoring variables that appear to be slowing the therapy process
    C) avoiding placing all the blame on client when the process is not going well
    D) all of the above

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

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

20. **Reflecting upon and understanding therapeutic errors is deemed _____.**
    A) not advised by respected practitioners
    B) relevant because it may lead to improvement
    C) rarely worthwhile
    D) hazardous in the long-term

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