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BRIEF COMMUNICATIONS

Common Mistakes in Psychotherapy

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To better monitor the psychotherapy training of psychiatric residents and to understand therapist factors involved in a negative outcome to psychotherapy, the authors surveyed 20 supervisors on the frequency of mistakes made by resident therapists. Among the mistakes most commonly made were wanting to be liked by patients, premature interpretations, overuse of intellectualization, inability to tolerate patients' aggression, and avoidance of fee setting. The authors conclude that the mitigation of the most common errors requires open discussion of countertransference issues.

TRAINING IN the practice of psychotherapy occupies a central place in most psychiatric residency programs. Together with didactic seminars, individual supervision of the resident on his or her psychotherapy cases has been the traditional method of conducting this aspect of psychiatric education. Lower (1) commented on the anxiety-provoking situation that faces young therapists as they are forced to learn to deal with the manifestations of patients' instinctual drives while simultaneously learning to become comfortable with, and sensitive to, conflictual emotional responses of their own. As any experienced supervisor can attest, beginning therapists inevitably make mistakes as they begin to learn the difficult and demanding process of actually doing psychotherapy.

The complexity of the supervisory process has often been noted in the literature (2-4), and there is considerable disagreement over whether psychotherapy supervision should be didactic and patient-oriented or should include an exploration of the supervisor-supervisee relationship and be therapist-centered. The mistakes made by individual beginning therapists vary and most likely depend on both the nature of patients' pathology and personality as well as the personality characteristics and ability of the novice therapist. Even though the mitigation of beginning mistakes is a central task for the supervisor, there has been surprisingly little systematic study of the nature of these mistakes.

Deficiencies in therapists' training have been suggested by psychotherapy researchers to be a contributing factor to the problem of negative outcome to psychotherapy. In a review of 52 outcome studies, Bergin (5) contended that psychotherapy outcomes differ significantly as a function of the level of experience of the therapist. He suggested that less experienced therapists may actually cause patient deterioration. In their study of the negative effects of psychotherapy, Hadley and Strupp (6) found that issues relating to the actual technique of psychotherapy were regarded by many experts in the field as the most significant contributors to a negative outcome.

Because "mistakes," i.e., misapplications or deficiencies in technique, in beginning psychotherapy are inevitable, we felt that the identification of the most common mistakes made by inexperienced psychotherapists would help to clarify those areas which need to be more clearly monitored in psychotherapy training. In addition, the delineation of the most common mistakes may add to our understanding of those therapist factors that contribute to a negative outcome of psychotherapy.

METHOD

We developed a 56-item questionnaire based on the literature and our clinical experience. This survey comprised a fairly exhaustive listing of items, includ-

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ing such factors as "wanting to be liked by the patient" and "therapist lack of empathy," as well as specific misapplication of technique, e.g., "premature interpretation" and "assuming a stereotyped 'analytic psychotherapist' stance regardless of the actual treatment situation." The questionnaire was distributed to 26 part-time senior attending and full-time staff supervisors at the outpatient department of psychiatry of the Albert Einstein College of Medicine, Bronx Municipal Hospital Center. A personal memorandum was sent to each supervisor explaining the nature of the survey and requesting that he or she respond anonymously because the data would be presented.

The frequency of occurrence of each item was rated 0 (not at all) to 4 (very often). The supervisors were asked to base their responses on their personal experience in supervision of beginning resident therapists and to include anecdotal material. No prior assumptions were made regarding the relevance of the items, which were placed at random in the questionnaire. An item analysis was performed, and mean ratings and standard deviations were derived for each questionnaire item.

RESULTS

Of the 26 supervisors surveyed, 20 (77%) completed the questionnaire. Inspection of the data revealed 3 natural groupings of responses: 10 items were rated high, 26 items fell in mid-range, and 10 items were rated lowest. The demarcation between these groups was clear, and statistical comparison between them was highly significant. Table 1 presents the 10 items rated as having the greatest frequency of occurrence and the 10 items rated as occurring least.

TABLE 1
Supervisors' Ratings (N=20) of the 10 Most Common and 10 Least Common Mistakes in Psychotherapy Made by Residents

Therapist Mistake	Mean Frequency of Occurrence[a]
Most common	
Wanting to be liked by the patient	3.37
Inability to "tune in" to the unconscious of the patient	3.21
Premature interpretations	3.21
Overuse of intellectualization by the therapist	2.90
Inappropriate transference interpretations	2.89
Assuming a stereotyped "analytic psychotherapist" stance regardless of the actual treatment situation	2.89
Lack of awareness of countertransference feelings	2.84
Therapist's inability to tolerate aggression in the patient	2.84
Therapist's inability to tolerate silence	2.84
Therapist's avoidance of fee setting	2.84
Least common	
Therapist lack of interest	1.44
Excessive voyeurism in the therapist	1.50
Consciously disliking the patient	1.68
Therapist's revealing personal information about himself or herself	1.68
Therapist dissembling	1.68
Therapeutic nihilism on the part of the therapist	1.68
Seductiveness by the therapist	1.84
Therapist's lack of empathy	1.88
Competitiveness with the patient	1.89
Absence of psychological-mindedness in the therapist	1.89

[a]0=not at all; 4=very often. Group mean=2.98; two-tailed t test between means of 10 highest rated and 10 lowest rated items revealed significant difference, $p<.001$.

DISCUSSION

The struggle for a professional identity has been suggested (7) as a central developmental issue for the psychiatric resident. Consonant with this view is our finding that among the most prevalent mistakes of beginning resident psychotherapists, as observed by senior supervisors, are factors related to the residents' self-esteem and professional identity formation. Beginning therapists, faced with new, complex, and frequently anxiety-provoking treatment situations, may feel ineffectual and attempt to prove themselves to patients. This is reflected in our findings that "wanting to be liked by the patient," "overuse of intellectualization," "premature interpretations," and "inappropriate transference interpretations" were the most commonly noted mistakes. The beginning therapists supervised by our respondents seem to be frequently preoccupied with impressing patients and obtaining reassurance about their competence and skill from them. These well-meaning therapists, struggling with establishing their own identity in their new role and attempting to enhance their own personal professional self-esteem, may thus inadvertently influence the therapy adversely.

Ford (8), in his study of supervisees over an extended period, noted that as the student psychotherapist begins to acquire competence as a therapist interference from his or her personal and therapeutic identity strivings decreases. These errors may be an inevitable part of beginning development as a psychotherapist, but the supervisor should be alert to them and attempt to use them in the teaching situation to facilitate the therapist's self-awareness.

"Inability to tolerate aggression," "inability to tolerate silence," "avoidance of fee setting," and "lack of awareness of countertransference feelings" reflect difficulties with the special nature of the therapeutic situation and may be attempts to avoid anxiety on the part of the therapist. Feeling comfortable in the therapeutic setting appears to be an overriding concern of beginning therapists, but such comfort, if it is obtained by devices such as ignoring the patient's aggression, may lead to a distortion of the treatment and a collusion between patient and therapist to avoid emotionally charged issues. The ability to tolerate the inevitable emotional tension inherent in the therapeutic situation

is an essential attribute for an effective therapist and is critical to the establishment of a therapeutic alliance. The need to use one's own responses, especially countertransference to the patient, as a window into the therapeutic situation is also an issue for the supervisor to emphasize.

Dealing with negative transference is clearly a highly charged issue for beginning psychotherapists. If they do not acquire the ability to withstand the patient's aggression, or even sadism, it is likely that aggression on the part of the therapist will be evoked and the therapist may unconsciously collude with the patient in acting out within the session. Kernberg (9) pointed out the harmful consequences of the therapist's stimulating the release of primitive aggression in the borderline patient without quite knowing how to deal with it.

It is noteworthy that our respondents found truly destructive factors such as lack of interest, lack of empathy, and therapeutic nihilism to be uncommon among beginning resident therapists. These factors are therapist deficiencies rather than mistakes in technique, and the relatively rare appearance of these frankly antitherapeutic factors was encouraging, since it is doubtful whether they would be amenable to change.

The mitigation of the most common mistakes made by beginning therapists requires an open discussion of countertransference issues. Goin and Kline (10) found that many supervisors are reluctant to address this issue because they tend to view discussions of countertransference as equivalent to therapy. We agree with Goin and Kline that encouraging an awareness of how a therapist's reaction affects therapy does not inevitably turn the supervisor into the supervisee's therapist, since the origin of these feelings is not an issue for supervision.

Chessick (11) suggested substantial changes in psychiatric education to further improve the practice of psychotherapy. He stated that of the various factors which cause failure in psychotherapy the one which can be remedied most easily is the psychic field of the psychotherapist. In his view, an optimal psychic field consists of a "humane attitude on the part of the therapist as well as an understanding of what he can accomplish and clarity of assumptions about his own therapeutic work" (11, p. 19). Chessick stated that the best hope for preventing failure in psychotherapy lies in improving psychotherapists. One approach toward making such improvements is through the elucidation and rectification of mistakes by beginning student psychotherapists.

Becoming an effective therapist necessitates an awareness of one's responses to the patient, and the development of such a capacity should be seen as a central function of psychotherapy supervision. The failure to develop such an awareness inevitably leads to an inadequately trained therapist whose efficacy is limited and who may contribute to a negative outcome of psychotherapy.

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