20 Common Mistakes Most Therapists Make — And What You Should Do Instead

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Objectives

- Identify common clinical errors.
- Examine the structure of the therapeutic relationship, and how it can inform our interventions.
- Identify common assumptions therapists make that can lead to clinical errors.
- Consider various elements of effective therapy.

Themes of these mistakes

- The power dynamics in the therapeutic relationship
- The necessity of tolerating patients' discomfort
- Awareness of how our needs affect the therapy
- Confronting cultural pressures & assumptions
- Misunderstanding what our actual job is

20 common clinical errors

Intakes & First Sessions

- Taking cases we shouldn't
- Not having clear, agreed-upon clinical goals
- Doing too much or too little therapy in session #1
- Not finding out about previous therapy
- Letting patients set the rules of therapy, or direct the information-gathering process
- Not consulting a case's other providers

What We Don't Do

- Not encouraging patients' curiosity
- Not challenging narratives of powerlessness
- Not insisting patients refer to their lived experience

What We Do

- Letting patients self-diagnose
- Getting caught up in content
- Disempowering ourselves
- Mollifying patients' guilt or shame
- Reassuring patients they're normal
- Implying our empathy comes from shared experience
- Labelling patients, people they relate to, or behavior

Working With Couples

- Adjudicating a couple's conflict
- Letting the more talkative/upset partner talk too much
- Not interrupting the fight of the week
- Not pointing out couples' values differences or lack of mission consensus

INTAKES & FIRST SESSIONS

Common mistakes:
Intakes & early sessions

- Taking cases we shouldn’t
- Not having clear, agreed-upon clinical goals
- Doing too much or too little therapy in session 1
- Not finding out about previous therapy
- Letting patients set the rules of therapy, or direct the information-gathering process
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Cases we shouldn’t take

- Insufficient expertise
- Too invested in “success”
- Political agenda
- Fear for your safety
- Client pressures you about rules
- Client is too adjacent--unfortunately
- “I hate those cases!”

Goal of the first session:

To have a second session.

How much therapy should we do
in the first session?

People want something:
a takeway or two
hope that their pain can be relieved
confidence that we know something they don’t

But…

They don’t want to be scared away or turned off.

We don’t yet have a therapeutic alliance.

If we activate their defenses, they’ll feel lost.
If we seem arrogant or punitive or weak,
they won’t want to return.

Reminder:

We want to collect information that clients
may not want to discuss,
and may not have thought about for years (or ever).

We also want to demonstrate
our understanding
that this is a difficult process
for clients…

And that we believe they can handle it.

“What would you like
to accomplish
in our work together?”

vs.

“What problems
would you like to fix?”

Clear clinical goals

- Agree on how to parent our kids
- Be able to enjoy sex together
- Decide whether to stay together after her infidelity
- Be able to disagree without being mean to each other
- Understand why he wants to look at porn
- Stop caving in when he bullies me (“Start…”

Unclear clinical goals

- I hate how you spoil our kids
- Are you ever going to initiate sex?
- I’m so angry that you had an affair
- You are so mean when we fight
- I’m sick of how every man is obsessed with porn
- Why won’t my husband listen to me when I say “stop”?

How patients try to control the therapy

- I need to tell my story in my own way
- I’m not comfortable talking about that
- Ask him why, don’t ask me
- I have to have my blanket with me
- Sunglasses helps me deal with my shame
- We want to sit next to each other here
- I’m too busy to do homework
- Would you please summarize our sessions afterwards?
- Refusing to allow consultation with other provider(s)

Meta issue:

How much to let patients
determine our routine

This is one reason the therapeutic alliance
is so important.

Consulting other providers

- When, for how long, and how frequent?
- Goals of previous (or current) therapy?
- Why/how did it end?

- What if client refuses to provide a release of information? It’s typically about power and trust.

Strategies in the early sessions

- Establish therapeutic team
- Clarify goals for therapy
- Clarify major narratives & events
- Establish rules of therapy
- Talk about what we're doing
- Shape their voice ("when infidelity happened…")
- Highlight their cooperative creation of problem
- Underline their strengths
- Highlight parallel process in their relating to us
- Make therapy a valued part of their routine

WHAT WE DON’T DO

Common mistakes:
What we don’t do

- Not encouraging patients’ curiosity
- Not challenging narratives of powerlessness
- Not insisting patients refer to their lived experience

When a patient says:

I don’t know why
I don’t understand
I feel misunderstood
That’s not like me
Of course I take it personally
We have a communication problem…

We can invite them to be curious:

Why don’t you know?
How could your partner feel that way?
What if you decided you could do that?
Why assume it’s about you?

We can direct patients curiosity toward “decisions”

…& teach that these are decisions

- When do you decide to yell at him in front of the kids?
- How do you decide when to initiate sex?
- When do you choose to ignore your chores?
- When do you seem to take your medication?
- How do you decide to sleep in the living room?
- How do you decide when to use a condom?
- When do you decide it’s OK to buy something outside your budget?
- How much were you planning to drink? When did you change your mind?

This is different than criticizing those decisions.

Narratives of powerlessness

- I’m a “nervous flier”
- I am/we are “conflict avoidant”
- We’re both “easily triggered”
- “He’ll get mad” if I do it myself
- She’s “verbally abusive”
- It’s “my culture”
- That’s “not normal”
- My sexual interests make me a “pervert”
- If I set goals that I can reach, “I won’t fulfill my potential”
- He’s a “misogynist”
- “Most guys” don’t like “foreplay” that much
- Talk about feelings? “That’s just not how I’m built”

The opposite of validating these narratives:
Ask patients about their lived experience

Insist they talk about it personally:
This is how I felt
This is what I wanted
This is what I thought
This is what I did

“What was your lived experience?”

- Not speculation (“why”?)
- Focus on decision-making and choice—even if patient wasn’t aware of it
- Motivation: What did you want? What did you hope for? What were you trying to make happen? (What was that like for you?)
- “I don’t know”
- Helps people learn to ask each other
- What is it like to be you? That’s the ultimate intimate question, right?
- “Oh, no wonder you were upset!” “…had difficulty!” “…felt unimportant!”

Asking people about their lived experience

- How did you feel when you decided to call her a slut?
- What were you thinking when you hacked into his phone? What were you hoping to find? What were you planning to do with the information?
- What were you wanting when you demanded he cancel that business trip?
- I understand you were upset when she called you selfish. Exactly what kind of upset? And what were you trying to accomplish when you brought up her affair from 8 years ago?

Patients' lived experience

- I had performance anxiety vs *I felt nervous*
- I have trust issues vs *I'm uncomfortable trusting him*
- I got triggered vs *I felt angry and didn't want to control it*
- When my OCD kicked in vs *when I felt I had no choice*
- I have shame vs *I felt ashamed*
- You can't be trusted vs *I don't trust you*
- When the infidelity happened vs *when I was unfaithful*
- I acted just like a traditional Italian vs *I bullied her*
- I did what any good Indian mother would do vs *I felt protective*

WHAT WE DO

Common mistakes:
What we do

- Letting patients self-diagnose
- Getting caught up in content
- Disempowering ourselves
- Mollifying patients’ guilt or shame
- Reassuring patients they’re normal
- Implying our empathy comes from shared experience
- Needing to label patients or people they relate to

Patients who self-diagnose

- Common themes: ADHD, OCD, panic attacks, eating disorder
- “Oh, that’s a serious problem. Who diagnosed that? When? Has there been any update on this?
- “How are you treating it? Therapy, medication, CBT?”
- Note: loss of self-diagnosis is a loss of identity, dignity, power
- “Reasons” people don’t get diagnosed or treated:
  - Too much trouble
  - What do doctors know?
  - They’ll only medicate me
  - --Too expensive
  - -- What will a diagnosis get me?

Our alternatives:

“I know you feel uncomfortable with X.”

“I understand you never learned to deal with X”

“I know in your family,
you weren’t allowed to say ‘I don’t want to’”

“I want to give you hope and dignity”

Getting caught up in the content

- Kalpana: “So she takes a long relaxing shower. Doesn’t she deserve this occasionally without your permission?”
- Alexis: “Lots of people are nervous flying. Why can’t you be more sympathetic?”
- Nick/Preeta: “No one can predict the future. Why do you have to decide now how many kids you’ll have later?”
- Lizabeth: “Some people don’t want to spend a fortune on an engagement ring. Why can’t you compromise on this?”

How therapists disempower themselves

- Not interrupting unproductive conflict
- Not processing, or challenging undone, HW
- Not challenging missed sessions, lateness, inattentiveness
- Getting involved in power struggles
- Seeing triangulation as a bad thing
- Taking content or criticism personally
- Needing to be liked
- Fearing patients' dissatisfaction
- Needing for couple to stay together
- Needing for therapy to continue

Therapists' discomfort with doing what's needed

- Setting firm treatment conditions
- Making clients uncomfortable
- Dealing with "tangents"
- Facing clients' existential crises

- Allying w/clients by putting things out of bounds
- Wanting to be liked
- Wanting to succeed & feel validated

Our discomfort can encourage us to mollify clients' shame, guilt, & fear, rather than pushing them to examine themselves.

We need to help clients look at their issues before taking them away.

As it is with patients,
shame about our errors
can derail our response to one.

So accepting our imperfection
is an important clinical skill—
just as it is for patients.

Patients struggle with Normality Anxiety.
Let’s help them struggle,
rather than taking the struggle away.

This relieves us of the burden of
knowing everything—
ie, what’s “normal.”

Don’t be too quick to reassure patients
that they’re normal—
as with other things,
interpret their desire to feel normal.

“Is it normal to not want children?
After all, I had a happy childhood.”

“He says everybody has a gun.
Do we have to have a gun?”

The source of our empathy (& expertise)

- Do NOT try to persuade client of your understanding based on your personal experience or struggles. It may relieve them and enable trust, but at a cost.
- Infantile fantasy of perfect patient-therapist attunement.
- Common sense says that shared experiences lead to empathy.
- This limits people's expectations—of others and of self.
- "I understand a lot of things. You're going to teach me exactly what X means to you."

Labelling patients, others, & behaviors

- Passive aggressive
- He sounds like a predator
- Verbal abuse; emotional abuse
- Sex addiction; porn addict
- Trust issues
- Typical male
- Fetish, kinky
- E.D.

WORKING WITH COUPLES

Common mistakes:
Working with couples

- Adjudicating a couple’s conflict
- Letting the more talkative/upset partner talk too much
- Not interrupting the fight of the week
- Not pointing out couples’ values differences or lack of mission consensus

Don’t take sides, even unintentionally.
Is our language neutral?

Is X infidelity?

Wouldn’t any boyfriend object to that?

If someone loves you, is that how they talk?

How would you handle this situation?

Isn’t she being defensive right now?

Isn’t a husband supposed to stand by his wife?

When patients demand answers

- It depends on your contract/understanding/agreement
- Let’s not think about how “other people” might feel or respond
- We don’t need to label feelings or behavior, especially others’
- That’s not exactly a neutral description
- I understand that you’re really upset, and you want answers
- That’s probably not such a helpful question right now
- Words can be ambiguous, so you should clarify your meanings before arguing about them

Letting one partner dominate the session (sometimes the partner prefers that)

- “Did you sort of get dragged here?”
- “What is your partner upset about?”
- “What do they understand pretty well? Not understand so well?”
- “Does talking about things seem mostly like a waste of time?”
- “Do you ever get to say ‘I don’t want to talk about that now?”

- “Let’s make sure he’s listening before you give him more information.”
- “It seems he understands your point. Do you see you’re making it again?”
- “I’m beginning to forget your first point, so I assume she is, too. Let’s let her respond now before continuing.”

Interrupting the fight of the week

- “Interruption” is a valuable intervention
- What are WE queasy about?
- Do we have an alternative for them?

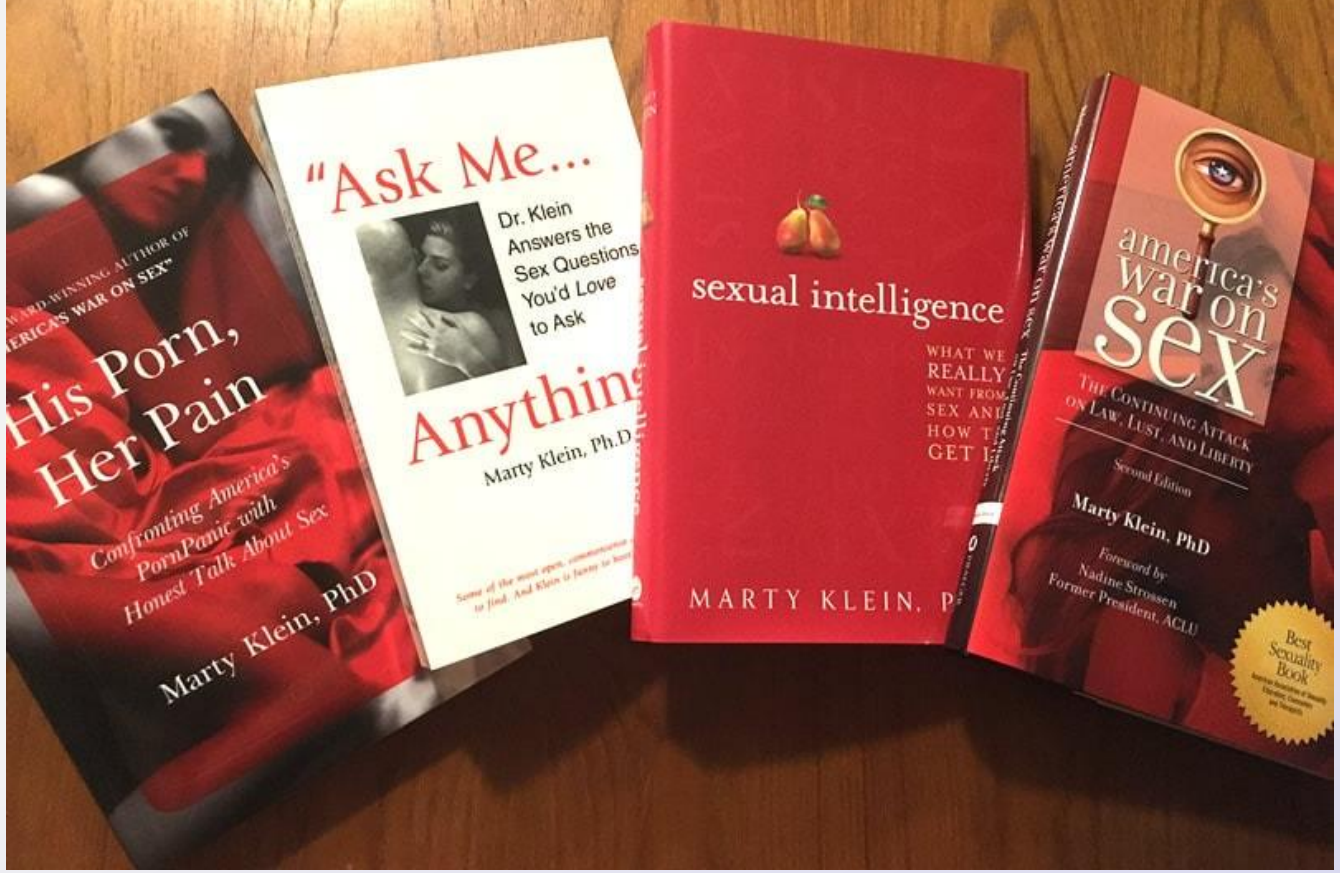
- What’s your goal for this session?
- What do you wish you did differently?
- How well does your partner understand your position?
- What’s your goal for this quarrel?
- What are you curious about?

Working with couples,
point out any big values differences,
or lack of consensus on the couple's mission.

Yes, it can be painful to do so—
because this may not be resolvable.

A BONUS MISTAKE

Starting a session when you need the bathroom, food, or a quick rest.



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