

THERAPISTS' EXPERIENCES OF THERAPEUTIC MISTAKES

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The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others.

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## Abstract

*Introduction:* In contrast to the extensive literature on related areas such as therapeutic boundaries, alliance and ruptures, little empirical research has been conducted on therapeutic mistakes. Existing research based predominantly on case studies and observations have focused on systems for categorising mistakes. Empirical research on therapeutic mistakes has focused on supervisors' and clients' perspectives. This study is the first to explore therapists' experiences of therapeutic mistakes.

*Method:* Seven psychological therapists were interviewed using semi-structured interviews on their experience of therapeutic mistakes in therapy sessions. Interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA). Initially, individual transcripts were analysed separately, resulting in a number of themes for each participant. A group analysis was then conducted across participants, yielding super-ordinate themes and sub-themes, based on their psychological relatedness.

*Results:* A seven-stage process was identified across participants' accounts (including participants' experience of *before the session, in the session, the emergence of a problem, in the midst of the problem, 'The aftermath', making sense* and *'How I'm left'*), detailing the experiential themes for participants at each stage. Some of the main themes that emerged were a sense of *'something brewing'*, *feeling criticised by their client or self-criticism, relief and recovery, reflecting on roles and responsibility* and *pre-occupation* with the mistake. Four key findings were presented including *participants' complex constitution of mistakes, the role of emotion in participants' experiences of mistakes, participants' on-going meaning making process and participants' experience of mistakes as an interpersonal negotiation*. The findings also suggested a difference between how participants constituted mistakes in principle (more aligned with the literature on boundary transgressions and categorisations of mistakes) and the mistakes they shared in their accounts (which reflected more *ordinary* and *minor* mistakes, e.g. administrative errors or sharing an interpretation that was not well received).

*Discussion:* The findings were examined in relation to existing literature. An evaluation of the methodology was presented, resulting in suggestions for future research. Finally the clinical implications of the study for therapists, supervisors, clients and services were discussed, including recommendations for clinical practice.

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## **Abbreviations**

BPS: British Psychological Society

HPC: Health Professions Council

BACP: British Association for Counselling & Psychotherapy

UKCP: The United Kingdom Council for Psychotherapy

EI: Exploitation Index

NHS: National Health Service

IPA: Interpretative Phenomenological Analysis

FANI: Free Association Narrative Interview

CBT: Cognitive Behaviour Therapy

CAT: Cognitive Analytic Therapy

PA: Psychoanalytic

PD: Psychodynamic

## CHAPTER ONE

### **Introduction to the study**

This study into therapists' experiences of therapeutic mistakes is positioned alongside my own personal and professional development throughout clinical training. In particular, it resonates with my exploration of the phenomenon of mistakes and my shifting perspective from viewing mistakes as undesirable and avoidable to viewing them as often helpful. I remember moments in my early clinical placements where I placed a strong emphasis on whether I was doing things right or wrong and often wondered if my struggles with clients in therapy would have not been so much an issue for another therapist with more experience. This reflected my sense of insecurity and self-criticism. I therefore became interested in how other therapists might experience therapeutic mistakes. The idea for this research culminated through exploring possible ideas in a number of other areas such as therapists' use of humour, experience of ending sessions, and experience of self-disclosure. Connecting these ideas was both a link to therapeutic boundaries and thus connotations of therapeutic error or therapeutic mistakes.

### **Literature review**

'Anyone who is afraid of making mistakes may end up not making anything' (Casement, 2002, p.17). This quote highlights the inevitability of mistakes in psychotherapy as well as the need to act with courage. In order to set the context for my study, I will review key areas of the research and literature relating to mistakes; namely ethical guidelines, decision making, therapeutic boundaries, therapeutic alliance and ruptures and therapists' experience of difficult sessions. Much of the literature is not research-based. I shall examine a mixture of non-research literature (including clinical, anecdotal and theoretical papers and texts) as well as empirical research relating to therapeutic mistakes.

### ***Process of conducting the initial literature review***

The following strategy was developed: The areas of literature for review were defined by their relevance and relatedness to the main topic area. The following

key terms for the literature search (and their variations, e.g. therapy/psychotherapy) were entered into the psychological electronic databases 'PSYCINFO' and 'Medline' in various combinations: 'therapy', 'therapist', 'boundaries', 'crossing', 'violation', 'transgression', 'alliance', 'ruptures', 'impasse', 'decision', 'dilemma', 'competence', 'mistake', 'error' and 'failure'. Research papers which related to failures associated with therapeutic models or approaches and not discrete mistakes within therapy were excluded. In addition, those relating to clinical practice with children as well as families were also excluded as the current study focused on psychological therapists working with adults on a one-to-one basis.

### ***Ethical guidelines and codes of conduct***

It has long been established that the key to a sound and ethical treatment is the presence of a protective and predictable 'holding environment' (Winnicott, 1958), in which clients can feel secure. There are a number of factors involved in maintaining such a holding environment, including the existence of professional and ethical guidelines and codes of conduct, to which therapists are required to adhere. They reflect the minimum standard of ethical and competent treatment that clients can expect when entering into a therapy. These are significant in the context of the current study, as they provide a set of 'rules of behaviour' for therapists (BPS, 2009, p.6). In turn, they also highlight a number of potential pitfalls for therapists and provide a lens through which therapeutic mistakes could be viewed.

Guidelines for therapists working psychologically on a one-to-one basis with individuals exist in order to govern clinical practice and to protect both client and therapist. The British Psychological Society (BPS) Code of Ethics and Conduct (2009), UK Council for Psychotherapy (UKCP) Ethical Principles and Code of Professional Conduct (2009), Health Professions Council (HPC) Standards of conduct, performance and ethics (2008) and British Association for Counselling & Psychotherapy (BACP) Ethical Framework for Good Practice in Counselling & Psychotherapy (2010) outlined a number of ethical principles to promote ethical behaviour, attitudes and judgement for therapists. These guidelines address common issues such as client respect, confidentiality, high

levels of competence, acting in clients' best interests, recognising professional and personal limitations and preventing harm. The various guidelines (See Table 1) provide an outline of what constitutes ethical practice. The guidelines do differ in some aspects of clinical practice, for example in relation to responsibility; whilst the BPS suggests therapists should assume responsibility, monitor and address negative outcomes in therapy, the BACP and UKCP promote the discussion of joint responsibility between therapist and client. Moreover, codes of conduct offer guidance for therapists and do not dictate required action for all eventualities in therapy. Thus, they can represent a source of uncertainty for therapists, which may contribute towards therapeutic mistakes.

Table 1. Summary of ethical principles applicable to psychological therapy with clients based on BPS, HPC, BACP & UKCP guidelines.

Principle	Professional Code of Conduct			
	BPS	HPC	BACP	UKCP
Act in best interest of client		✓		✓
Respect confidentiality	✓	✓	✓	✓
Do no harm	✓		✓	✓
Informed consent	✓	✓	✓	✓
Accurate record keeping		✓		✓
Recognise limitations of practice	✓	✓	✓	✓
Recognise impact of own physical and mental health	✓	✓	✓	✓
Maintain personal boundaries	✓			✓
Consider use and impact of dual relationships	✓		✓	✓
Report breaches of ethical practice	✓	✓	✓	✓
Effective communication		✓		✓
Update professional knowledge and skills	✓	✓	✓	✓
Use supervision to explore situation and reactions	✓		✓	✓
Assume responsibility	✓		✓	✓
Maintain competent practice	✓	✓	✓	✓
Respect client	✓			✓

Whilst the purpose of the guidelines is to promote ethical practice, they also guard against unethical practice, or indeed malpractice, the most severe of which is seen as sexual misconduct. Whilst this could be viewed as the most extreme form of unethical behaviour, Simon (1995, p.90) used the term, 'a road much travelled' to

illustrate the notion of sexual misconduct as a result of the progression of increasingly unethical behaviour, rather than it representing a discrete incident. Similarly, Strasburger, Jorgenson & Sutherland (1992) highlighted important factors involved in the development of sexual misconduct, namely those surrounding the therapeutic relationship, including power imbalance, patient vulnerability and transference and countertransference reactions. Martin, Godfrey, Meekums & Madill (2011), in their study on managing boundary pressures when therapists are sexually attracted to their client, provided support for the presence of early non-sexual boundary crossings by therapists, which were interpreted by participants as early warning signs for the potential for something more severe. Be that as it may, this study will not focus on either sexual misconduct, nor specifically on severe and unethical behaviour that could be viewed as part of a 'slippery slope' towards sexual misconduct (Simon, 1995 p.90). This is in part due to the methodological and ethical complexities that may arise from interviewing therapists on their experience of making therapeutic mistakes in this domain, as well as the pursuit of interests in other related areas of psychotherapy; these will be discussed later in more detail.

In order to protect those receiving psychotherapy, ethical codes include items relating to clinical competence and decision making.

### ***Clinical competence***

Overholser & Fine (1990) adapted a healthcare categorisation schema (Norman, 1985) to describe 5 domains of activities in psychotherapy necessary for competent practice by therapists: knowledge and understanding, generic clinical skills, orientation-specific technical skills, interpersonal attributes and clinical judgement. They examined these domains in relation to managing subtle cases of clinical incompetence. Overholser & Fine (1990) suggested that clinical incompetence occurs when therapists apply therapeutic technique rigidly and overzealously, obtain inadequate or uninformed consent, offer excessive advice or self-disclosure, maintain inaccurate perceptions of client problems and continue to practice when unable to function. Whilst the pursuit of clinical competence in therapists is expected and promoted, there is a risk of evaluating therapists exclusively in black and white terms; competent or incompetent, ethical or

unethical. Instead, it could be argued, that therapy is an on-going process incorporating a number of situations and junctures that require sound decision making.

### *Decision making*

Various models for clinical and ethical decision making exist, including general models (e.g. Kitchener, 1984; Haas & Malouf, 1989; Sileo & Kopala, 1993) and those specific to particular issues in therapy (e.g. Gottlieb, 1993). Forester-Miller & Davis (1996) incorporated much of their work into a seven-step ethical decision making model. This model suggests a number of decision making factors to consider when faced with difficult decisions. Whilst it recommends a definition of the problem and seeking relevant professional guidelines (see above), it also provides a strategy for thinking about and generating a number of potential solutions (including evaluating potential consequences, costs and benefits). Gottlieb (1993) proposed a five-step ethical decision making model for considering the impact of a potential dual relationship through assessing the current relationship on the basis of power, duration and termination within the therapeutic relationship. Gottlieb argues that this model can be used for all possible dual relationships. A limitation of these decision making models lies in their lack of consideration for situational factors, such as the frequent need for an immediate response in psychotherapy. It is often not possible to refer to guidelines, consult with colleagues and evaluate the consequences of actions when faced with dilemmas or difficult decisions in therapy. The time between therapists' immediate reaction and required response is often short. Many guidelines do not account for these considerations. A further criticism of these models is the lack of consideration paid to individual clinical judgement. Clinical judgement is implicit in decision making (Garb, 2005) and is important to consider in the way people make decisions and thus potential mistakes. The BPS code of ethics and conduct (BPS, 2009, p.4) is the only guideline which focuses explicitly on decision making, stating that professional judgement should not be sacrificed for guidelines. It recommends that:



‘In making decisions on what constitutes ethical practice, psychologists will need to consider the application of technical competence and the use of their professional skill and judgement. They should also be mindful of the importance of fostering and maintaining good professional relationships with clients and others as a primary element of good practice’

This highlights the frequency and requirement for in-the-moment clinical judgement and decision making in therapy. Whilst ethical guidelines and codes of conduct can be helpful in guarding against unethical practice, it is inevitable that in the heat of the moment, clinicians will sometimes make mistakes. As such, mistakes may reflect a misjudgement about ethical issues or technique. They may also result from a quick decision, made without sufficient time for reflection.

Whilst ethical guidelines and codes of conducts distinguish between ethical and unethical practice, they cannot account for every conceivable eventuality or the individual circumstances within every therapeutic relationship. As such, there exist a number of grey areas in clinical practice subject to therapists’ clinical judgement and decision making, giving rise to the potential for therapeutic mistakes. These may not necessarily reflect a sense of unethical or incompetent practice, but instead an inevitable part of the therapeutic encounter. These grey areas in ethical practice can be brought to light through the examination of therapists’ negotiations with various types of boundary transgressions.

### ***Boundaries***

Boundary issues are a universal feature of psychotherapy (Pope & Keith-Spiegel, 2008). Before proceeding with a discussion of boundaries, it is useful to note the various types of boundaries as well as the definitions and terminologies used in the literature to describe the transgression of such boundaries. Langs (1979) described boundaries as the parameters to appropriate behaviour and part of what is referred to as the therapeutic frame. Therapists work with clients within the context of multiple boundaries, for which therapists are mostly responsible (Spruiell, 1983). Gutheil & Gabbard (1993) outlined several types of boundaries

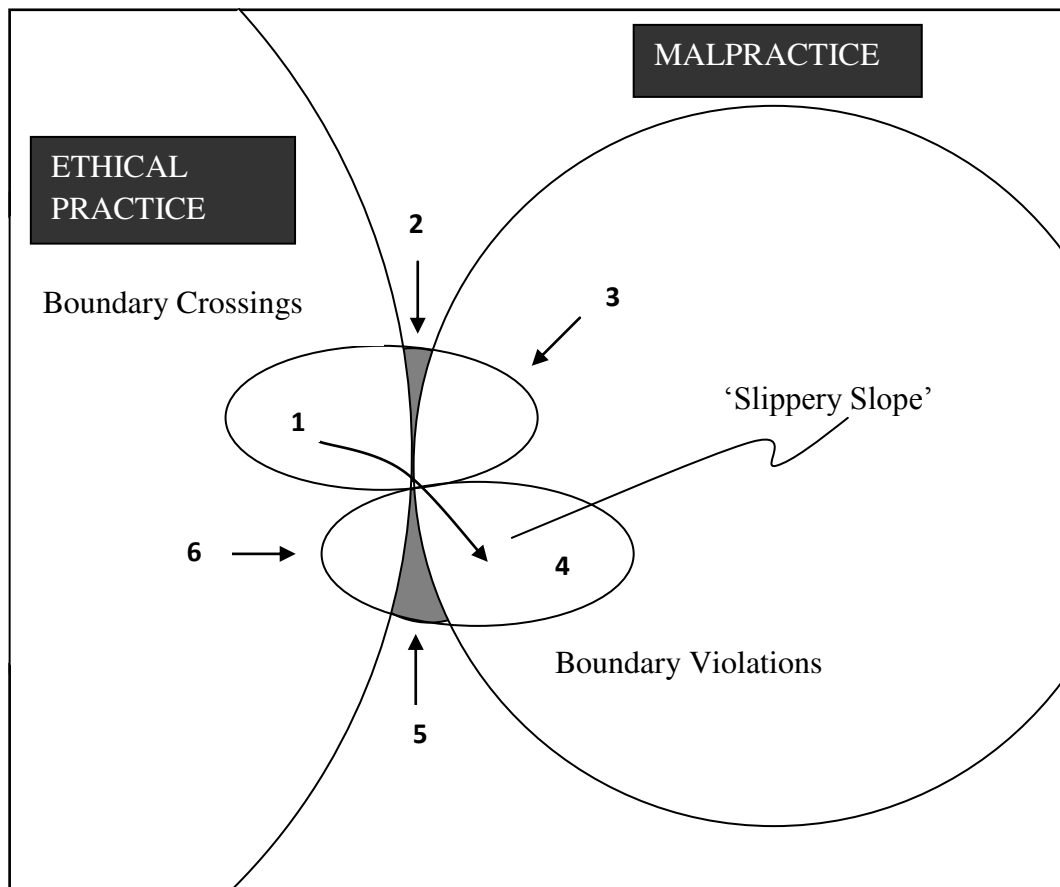
in therapy such as role, time, place and space, money, gifts, services, clothing, language, self-disclosure and physical contact.

*Boundary crossings* are viewed predominantly as minor transgressions from the aforementioned boundaries, which are seen as ‘neither laudatory nor pejorative’ (Gutheil & Gabbard, 1993, p.190). As such, they are seen as ‘non-progressive and discussable’ (Glass (2003, p.430) and associated with constructive processes in therapy, which do not ultimately lead to harm (e.g. running slightly over time in a session). *Boundary violations*, however, are associated with harm to the client through unethical and potentially illegal actions, including sexual misconduct, deriving from the misuse of power and exploitation (Zur, 2004).

The term *boundary transgression* is commonly used as an overarching term to describe both boundary crossings and violations (e.g. Gutheil & Gabbard, 1998). I will adopt this term when referring globally to boundary crossings and violations, but will otherwise refer to these individually when reflecting the associated literature.

Glass (2003, p.430) proposed a model (See Figure 1) to help us understand some of the complexities involved in boundary transgressions in therapy, and differentiated between ethical and unethical transgressions as well as those situated in grey areas that are not as easily defined in terms of their ethical status. Zur (2007) supported this notion by suggesting boundary transgressions exist on a continuum of ethical behaviour. The model features a number of assumptions, which are visually represented. The model demonstrates that most boundary *crossings* exist as part of ethical practice (1), seen as appropriate attempts by the therapist to promote therapeutic alliance and a *real* relationship; this supports previous assumptions about their potential therapeutic benefits. It also assumes that most boundary *violations* represent forms of malpractice (4), with benefits only to therapists (e.g. exploitation and misuses of power). An important assumption in this model is that boundary *transgressions* exist on a continuum in regards to ethical practice; some therapist actions typically viewed as boundary crossings can reflect malpractice (3), whilst some typically viewed as boundary violations can be viewed as ethical (6).

Figure 1. A model of boundary transgressions within clinical practice (Glass, 2003).



\* 1= Ethical boundary crossings, 2= Ethical 'grey area' of boundary crossings, 3= Unethical boundary crossings, 4= Unethical boundary violations, 5= Ethical 'grey area' of boundary violations, 6= Ethical boundary violations.

Glass proposes that only when boundary crossings occur frequently, unquestioned and unconnected to the development of a therapeutic relationship, do they risk being considered malpractice. In contrast, some boundary violations can be seen as ethical. For example, whilst hospitalisation by a therapist for client suicidal intent may be perceived as an intrusion and violation of a client's boundaries, it might actually reflect an attempt to act in the client's best interest and provide a similar function to the boundaries themselves – a safe and predictable environment. The implication here is that the subjective experiences of boundary transgressions may be vastly different between therapist and client. Glass thus referred to these as 'grey' areas (2&5). For example a breach in confidentiality for a student case conference whilst typically constituting a boundary violation, does not necessarily directly impinge on the therapeutic relationship, and indeed may

provide indirect benefit to the client, through suggestion, reflection and advice from colleagues. Glass provides a useful dynamic model for exploring boundary transgressions, in contrast to more dichotomous conceptualisations, presented in ethical guidelines. Viewing boundary transgressions in the context of ethical or unethical practice allows us to consider the possibility that not all boundary crossings or even violations necessarily may lead to mistakes. The constitution of therapeutic mistakes therefore not only depends on the transgression from boundaries and misjudgements of ethical practice, but is subject to contextual and subjective factors.

Contextual factors surrounding boundary transgressions include the therapists' theoretical orientation (Williams, 1997). For example, a session in a car would be seen as a boundary transgression regarding place and space from many therapeutic orientations, yet may be constituted as part of a constructive therapeutic treatment plan within a behavioural model. Other factors include variations of boundary agreements across different clients (Mitchell, 1993) and the timing of boundary transgressions (Pinkerton, 2008). Humanistic approaches such as Gestalt, Person-centred and Existential therapy actually promote the *pulling down* of boundaries rather than maintaining them, in order for the construction of a real relationship whereby client and therapist are *equals*; clients see that therapists have failings too. To this end, Bugental (1987, p.143) claimed that, '...first and foremost: strict honesty is required'. Korchin (1976) argued that boundaries, rather than protecting the therapeutic relationship, cause interference. However, other humanistic therapists describe a more considered use of boundaries, suggesting variability both between and within therapeutic orientations. For example Rogers (1951) promoted the use of disclosure of feelings in response to clients' situations, aligned with *empathic attunement*, without the use of personal disclosure. Both these approaches are in contrast to classical psychoanalytic approaches that suggest any deviation from interpretation is viewed as a boundary violation (Lazarus & Zur, 2002). As such, there are inconsistencies in the literature as to whether boundary transgressions are examples of a positive therapeutic tool or a mistake (Hanson, 2005; Guistolise, 1996).

Moreover, there may be a distinction to be drawn between overt and covert boundary transgressions and whether boundary transgressions are necessarily recognised as such by therapists. Luchner, Moser, Mirsalimi & Jones (2008) used psychodynamic theory to highlight how therapist characteristics can complicate the maintenance of boundaries in psychotherapy. Luchner et al. (2008) examined the influence of therapist covert narcissism in therapy, suggesting that whilst it can be a healthy aspect for both therapist and client, it may also contribute to an unsafe, controlling and confusing environment for clients. Covert narcissism in therapy may represent a therapist's desire to be seen as good and admired. Potential difficulties may arise when therapists prevent clients from being able to express negative reactions towards them. Luchner et al. also suggested that an unhealthy renegotiation with boundaries might follow, leading the therapist to cross and violate boundaries (e.g. extending sessions, pleasing the client, providing unconditional love, engaging in dual relationships and avoiding termination of therapy) to protect their own narcissism.

Epstein & Simon (1990) devised The Exploitation Index (EI), a self-assessment questionnaire to identify early warning indications of boundary *violations*. Epstein & Simon claimed that the EI is more likely to be of use for therapists whose exploitative behaviour or attitudes, '...may seriously interfere with the efficacy of treatment but that has not yet (and may never) become gross abuse' (Epstein & Simon, 1990, p.455). Such cases of boundary violations are difficult to explore in isolation due to their association with self-deception. Therapists rate the frequency of a number of behaviours or attitudes (occurring in the last two years) across domains of generalised boundary violations, eroticism, exhibitionism, dependency, power seeking, greed and enabling. The EI addresses ethical attitudes as well as ethical behaviour, providing therapists with an opportunity to reflect on their practice and raise awareness of the potential for exploitation and serious boundary violations. The strength of this model is that it allows therapists to learn from therapeutic mistakes, providing beneficial content for client and therapist, rather than being destructive and abusive. Epstein, Simon & Kay (1992) evaluated the clinical utility of the EI through a survey. Whilst this study provided support for self-assessment of ethical attitudes and behaviour, it is worth noting some possible limitations. Firstly Simon & Kay found that whilst

43% of therapists identified an item which alerted them to behaviour which could have been harmful in their clinical practice, only 29% of therapists were encouraged to make changes to their practice as a result. Secondly, this index may be subject to the same difficulties that it attempts to address, in that unethical attitudes and behaviour might not be in therapists' conscious awareness and if they are brought to light, therapists may engage in self-deception. As such, this index alone may not be sufficient to explore potentially useful content for therapists. These limitations nonetheless do not detract from the potential value that this index could provide in the promotion of self-examination and reflection of therapist attitudes and behaviour in relation to therapeutic practice, error and boundaries. Furthermore, this index supports the exploration of therapists' experiences of therapeutic mistakes in the current study, which whilst furthering our understanding of therapeutic mistakes may also provide some experiential benefit.

Another important contextual factor relates to whether boundary transgressions are avoidable or unavoidable. A prime example is drawn from literature on self-disclosure. Zur (2010) distinguished between three types of therapist self-disclosure; deliberate, unavoidable and unintentional. Deliberate self-disclosure involves intentional verbal or non-verbal disclosures of personal information through self-revealing or self-involving communication. Unavoidable self-disclosure refers to unhidden characteristics of the therapist, including tone of voice, accent and clothes style. Gutheil & Gabbard (1998, p.412) highlighted the difficulty with unavoidable self-disclosure, referring to 'the impossibility of avoiding being known'. Unintentional self-disclosure refers to incidental and unplanned events, such as chance meetings outside therapy or countertransference reactions, which provide information about the therapist to the client. Deliberate boundary transgressions are therefore subject to clinical judgement, and may therefore be a juncture at which a mistake could be made, whereas unavoidable boundary transgressions are not subject to a therapist action. It could therefore be questioned as to whether unavoidable boundary transgressions could be viewed as a mistake, given that they do not arise from an intentional therapist action involving clinical judgement. Moreover, there may be further complexity in

relation to whether an unintentional boundary transgression could be viewed as a mistake or not.

This serves to raise a key ethical and philosophical distinction between intentions and consequences. Seedhouse (1988) distinguished between deontology and consequentialism i.e. viewing an action by its intention or by its outcome. For the purpose of exploring therapeutic mistakes, it would not be unreasonable to suggest that unless therapists are committing gross violations, generally therapist actions are likely to have good intentions. Thus, it is important to examine mistakes in the context of their outcome in the therapeutic encounter.

### ***The therapeutic relationship: therapeutic alliance and ruptures***

An important implication of mistakes is the potential impact on the therapeutic relationship and associated therapeutic ruptures. A consensus in the therapeutic alliance literature points to the association between a strong or improving therapeutic alliance and a positive outcome in therapy (Lambert, 1992; Johansson & Jansson, 2010). Conversely, Samstag, Batchelder, Muran, Safran & Winston (1998) found a correlation between weakened alliances and unilateral termination in therapy. Whilst this research linking the strength of the therapeutic alliance to therapy outcome is well evidenced, examining the consequence or outcome of actions in sessions is perhaps more relevant in the context of the current study. This serves to introduce therapeutic ruptures. Ruptures are common in therapy (Leiper, 2001) and can result as a product of client or therapist action, or both. Pinkerton (2008) described a number of discourteous behaviours that therapists can fall into inadvertently, reflecting a sense of thoughtlessness or fatigue. These included: tardiness, falling asleep in sessions, neglecting to inform clients of urgent expected phone calls and checking the time. Pinkerton suggests that these therapist actions can produce anything from minor tensions or major ruptures. The implication is that therapeutic mistakes of this nature could be seen in terms of their negative consequence or outcome for the therapeutic relationship, regardless of how they were intended.

However, the consequences of therapists' mistakes may not only negatively impact the therapeutic relationship. Zur (2004) claimed that careful and justified boundary transgressions can aid therapeutic alliance, if therapists

consider the client's welfare (e.g. escorting a client to a gravesite to help facilitate their grief process). This demonstrates a well-intentioned transgression aimed at a positive outcome. Indeed, Gutheil & Gabbard (1993) claimed that clinical exploration of therapeutic ruptures, caused by boundary transgressions, might positively influence therapeutic alliance and outcome. Conversely, therapeutic ruptures can result from the strict use of boundaries (e.g. Martin et al., 2011). Zur (2004) suggested that rigid adherence to boundaries (adherence to boundaries being a well-intended action) can threaten clinical judgement and result in a therapeutic rupture.

Safran, Muran, Samstag & Stevens (2001) highlighted the importance of recognising and addressing alliance ruptures for successful outcome. Furthermore, Mays & Franks (1985) highlighted the responsibility of therapists in preventing further deterioration. A difficulty with ruptures is that they are often hidden and unrecognised (Nathanson, 1992). Moreover, research also suggests clients withhold negative feelings towards therapists due to their fear of offence or perceived implications for their therapy (Safran & Muran, 1996). This suggests the recognition of mistakes is the therapist's responsibility, and as such, questions whether a lack of such recognition by the therapist is itself a therapeutic mistake. The following empirical studies illustrate the link between therapeutic ruptures and therapist mistakes.

Hill, Nutt-Williams, Heaton, Thompson & Rhodes (1996) conducted a qualitative study using questionnaires and interviews to explore the recollections of therapists regarding impasses that led to termination. Hill et al. (1996) used a consensual qualitative research method and identified a common theme relating to therapist mistakes, including being excessively cautious or pressuring, misdiagnosing and being inconsistent in their approach due to being unclear of the intervention. Whilst these findings provide some examples of what therapists themselves constitute as mistakes, they do not further our understanding of the experience and meaning of mistakes.

Dalenberg's (2000; 2004) Trauma Countertransference Study elicited client's retrospective critiques of their therapists. 132 clients were interviewed about their experiences of their therapist (working either in a psychoanalytical, cognitive-behavioural or humanistic model), including topics around therapist



disclosure, boundary crossings, rigidity, intrusiveness and reactions to client anger. The most frequent sources of client anger were interpretations perceived as blaming, therapist shifts in boundary agreements, therapist disbelief or minimisation of problems and therapist manipulation. Clients also reacted badly to neutral or 'blank' therapist responses to client anger within trauma work, suggesting this represented a non-caring attitude towards clients. Whilst this study addressed the problem of therapist self-reports of mistakes and elicited what is important for clients, the way clients constitute mistakes is likely to differ from therapists. For example client's anger at a neutral therapist response may well represent their transference reaction, rather than an inappropriate therapist response (viewed within a psychoanalytic model). Moreover, it is unclear whether attributions of client anger represented therapist mistakes, even from clients' perspectives. This study nonetheless highlights the role of clients in identifying therapeutic mistakes.

Having explored what clients should expect from therapy, in the context of ethical guidelines and therapeutic boundaries and having reviewed the relevant literature regarding the therapeutic relationship, I will now consider the literature which holds more direct relevance to the current study.

### ***Therapeutic Mistakes***

A number of studies have attempted to classify and categorise common mistakes made by psychotherapists. Altshuler (1989) proposed four common types of mistakes made by beginning psychoanalytic psychotherapists, based on case studies of trainee therapists' supervision: pushing transference, inappropriate support, premature overinterpretation and pressing the past. Altshuler claimed that these mistakes reflect an anxiety to know and be effective and suggests that prevention of such mistakes requires a shift in the therapist's stance to that of being able to accept not knowing. Altshuler's model also highlights the influence of character and experience on the frequency of therapist error; the eager and well-intended inexperienced therapist may be more prone to such mistakes. Most significantly, Altshuler suggested that 'few behaviours categorically and always imply a mistake' (Altshuler, 1989, p.79). This study has some important limitations, given its focus purely on psychiatrically trained psychotherapists,

whose background is in action, cure and helping. As such, Altshuler's typology of mistakes may not apply to all types of psychotherapist.

Mordecai (1991) proposed a classification for six types of specific mistakes in therapy called *empathic failures*. Mordecai distinguished between obvious and hidden empathic failures, the latter having the potential to disrupt therapy if unnoticed. Obvious failures are those expressed verbally or affectively by the patient, whilst hidden failures are obscured by factors such as transference and countertransference. The study outlined a system for detecting hidden empathic failures and reducing their impact through the recognition of obscuring factors, possible response failures and remediation strategies for each of the six types of empathic failure. This classification system has its merit in providing a tool to encourage therapists to consider their role in therapeutic mistakes, yet it lacks an empirical basis and the evidence to support its use in clinical practice.

Thompson & Sherman (1989) explored therapist errors in treating clients with eating disorders. In relation to difficult therapeutic relationships, they distinguished between client transference experiences and feelings versus *iatrogenic therapist errors*, defined as those that arise inadvertently and inappropriately through a lack of sensitivity to clients' situations, which in turn may reinforce unhelpful behaviours and beliefs in clients. This supports the need for self-awareness and self-questioning in therapists when dealing with difficult cases.

Greaves (1988) attempted to classify common errors that can occur in working with clients with multiple personality disorders, as well as suggesting some unique errors related to this client group. This paper, based on Greaves' own clinical experiences as well as those he consulted, highlighted the impact of departures from the use of the therapeutic frame (Langs, 1979) and consistent use of therapeutic boundaries. Greaves (1988, p.62) suggested that therapists seem '...to repeat the same mistakes over and over'. Common errors identified included dual relationships with patients and the inability of therapists to tolerate 'patient productions', characterised by avoidance of distressing material or acting out of countertransference feelings. It is possible that the same departures from such frames are more visible and consequential for working with those with multiple

personality disorders than other adults and thus the potential for the appraisal of mistakes is vastly increased.

These papers outlining classification models of therapeutic mistakes provide some insight into the types of mistakes that are common in therapy; however, they are predominantly informed by case studies, reflections and theory.

Buckley, Karasu & Charles (1979) conducted an empirical study surveying supervisors of resident psychotherapists as to the frequency and typology of mistakes witnessed through monitoring their practice. They defined mistakes to be ‘misapplications or deficiencies in technique’ (Buckley et al., 1979, p. 1578). Examples of common mistakes from their study included a wish to be liked by their patient, overuse of intellectualisation and premature interpretations (See Table 2).

Table 2. Common errors made in psychotherapy (Buckley, 1979).

Therapist Mistake	Mean Frequency of Occurrence*
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 intellectualisation 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

\* 0= not at all, 4= very often

Hence it provides no understanding, for example, of how therapists experienced silences, whether they constituted it as a mistake or how they dealt with it. Methodologically, responses were derived from a questionnaire using a predefined list of *mistakes*, based on clinical experience of the researchers. As such, the validity of the study is questionable in a number of ways. Firstly, it limited supervisors' responses to a defined number of mistakes, creating potential for an oversight of other meaningful processes, not previously defined. Secondly, supervisors were asked to use their own experiences of being a trainee therapist to inform their responses to current trainees, which may have biased their judgements.

Whilst empirical research relating explicitly to mistakes in therapy is sparse, research has examined areas typically constituted as mistakes, such as acting out in the countertransference (Waska, 1999) and neglecting the discussion of a missed session (Gans & Counselman, 1996). Waska (1999) highlighted the frequent and often unavoidable nature of acting out by the therapist in response to powerful countertransference feelings, yet claims this error is often required to fully understand the client's unconscious fantasies. Gans & Counselman (1996, p.45) studied the missed session in psychotherapy suggesting, 'it is a clinical mistake to consider a missed session as a time and space where therapy does not take place'. Moreover they feel the neglected missed session reflects a lack of attention by the therapist to any 'thoughts, feelings and fantasies' that the session might represent. Whilst these studies illustrate some processes involved in particular difficulties in therapy which could be seen as a mistake, there was not an explicit focus on this aspect. As such, they provide little insight into therapists' experiences of difficulties in therapy.

#### *Therapists' experiences of difficult sessions*

I will now review the empirical research most closely related to the current research study; that which has explored therapists' experiences of difficult and upsetting sessions. Much of the research into therapists' experiences in therapy relates to areas that cause therapists difficulties in their work with clients, such as feelings of incompetence (Thériault & Gazzola, 2005), client suicide (Knox, Burkard, Jackson & Schaack, 2006), being the target of client anger and hostility

(Hill, Kellems, Kolchakian, Wonnell, Davis & Nakayama, 2003) and deciding whether to disclose personal information to a client (Bottrill, Pistrang, Barker & Worrell, 2010).

Thériault & Gazzola (2005) used a grounded theory approach to explore feelings of incompetence amongst eight therapists, with between 10 and 29 years of experience. Thériault & Gazzola's study resulted in a continuum model for feelings of incompetence, which they claimed was qualitatively different as a function of experience. According to the three-stage model, therapists are initially preoccupied with feelings of inadequacy questioning whether they are right or wrong and doubting their effectiveness (stage 1), before an increased emphasis on insecurity (together with a reduction in the intensity of stage 1 doubts), encompassing confidence and faith in the therapeutic process (stage 2). Deeper levels of insecurity relate to deeper doubts about therapist identity and ability (stage 3). The implications from this study in relation to therapeutic mistakes are significant. Therapists' general feelings of incompetence and self-doubt may influence the way they appraise difficult sessions, with the potential for them to be unnecessarily self-critical. Also, whilst variations of feelings of incompetence may vary between therapists of differing levels of experience, they may also apply within the same therapist across time. Thus therapist current appraisal and actual experience of therapeutic mistakes may vary as a result. However, these findings should be interpreted cautiously due to a potential limitation of the study. The criterion-based sampling (ability to provide insight into the area) resulted in the majority of participants having current or historical professional relationships with the researchers, which may have influenced the material they shared (e.g. through social desirability), although their motivation to speak more openly may also have represented a strength.

Smith, Kleijn & Hutschemaekers (2007) explored therapists' reactions in difficult sessions with traumatised clients using a grounded theory approach and multiple correspondence analysis. Therapist reactions had some common features including feelings of shock, anxiety, a sense of being overwhelmed, somatic feelings and the need to talk about their experience. This study highlights the importance of sharing difficult experiences with colleagues as a supportive factor.

de Oliveira & Vandenberghe (2009) explored upsetting in-session experiences of four psychotherapists (two behavioural and two psychoanalytical) in therapy with clients. Grounded theory analysis of therapists' experiences yielded some key themes, in particular a sense of helplessness and insecurity relating to therapist effectiveness. Difficulties in dealing with these feelings led to self-doubt and anger, which were sources for therapeutic stress and error. The difficult and emotionally distressing experiences of participants in this study were therefore seen as pre-cursors to therapeutic mistakes and thus linked to the experience of therapeutic mistakes. Furthermore, despite distinct differences in therapeutic orientation, therapists shared qualitatively similar upsetting experiences.

Knox et al. (2006) explored the experiences of therapists-in-training who had a client who committed suicide. In addition to participants' affective responses, including sadness and anger, a common theme in their reaction to the suicide was questioning of their clinical skills and role as a therapist. Interestingly, this was not only introspective, but from others. Some participants described being questioned as to what they may have done wrong, leaving participants feeling that they were processing the suicide alone. Participants' subsequent therapeutic work was affected, with an increased emphasis on risk assessment and increased sensitivity to client pain and distress. It is not clear whether these changes impacted positively or negatively on their work. An important limitation is that these findings only reflect the experience of participants who chose to discuss their experiences.

Hill et al.'s (2003) qualitative study examined therapists' experiences of being the target of client anger and hostility. Common to these experiences were therapist anxiety, feelings of incompetence, frustration and thoughts that they had made mistakes. Such mistakes were related to tangible events (e.g. lateness), yet therapists still felt client anger was disproportionate to their mistakes. Therapists often rationalised their part in sources of client anger due to facets of their therapeutic modality (e.g. not being able to offer them an extended session).

Bottrill et al. (2010) used interpretative phenomenological analysis (IPA) to explore 14 clinical psychology trainees' experiences of self-disclosure with clients. Trainees' experiences were characterised by struggles with decision

making related to self-disclosure, including feelings of being caught off guard, entering into an unknown zone, a focus on rules and boundaries and protecting themselves and the therapeutic relationship. Participants' experience of self-disclosure reflected their development as clinical psychology trainees; these experiences were a part of their therapist identity formation. This study highlights some key processes involved when faced with difficult decisions and suggests some ways in which therapists evaluate their practice within moment-to-moment decisions. These studies into therapists' experiences of difficult sessions yield some interesting and pertinent findings. For example, they provide understanding of therapeutic processes involved in such situations and in some cases suggest links to the appraisal and prevention of therapeutic mistakes. They are also particularly relevant to the current study in the way that therapeutic mistakes in therapy sessions may well be characterised by a difficult session. However, whilst difficult situations evoke uncomfortable feelings for therapists, they do not necessarily lead to inevitable therapeutic mistakes, nor might all mistakes necessarily result from situations which are experienced as difficult by therapists. Despite this, there exists no research that examines therapists' experiences of therapeutic mistakes, which may explore these potential paradoxes.

Chused & Raphling (1992), in a review of psychoanalytic theory, vignettes, teaching and supervision, highlighted the importance of technical procedure, the fantasy of perfection in case studies and the teaching of a flawless technique contributing to the avoidance of recognising therapeutic mistakes. As such, there is a need to examine this phenomenon more closely.

### ***A gap in the literature***

Pope & Keith-Spiegel (2008) offered an explanation for this gap in the literature through highlighting the difficulty therapists face when consulting colleagues about mistakes, relating to openness, honesty and defensiveness. They raised an important question. 'What sorts of feelings do we experience when we think of disclosing our blunders or instances in which we need help because we are not sure what to do?' (Pope & Keith-Spiegel, 2008, p.649). Dalenberg (2004) recognised the difficulties in asking therapists about their own mistakes through self-reports, particularly in situations evoking strong emotional reactions, such as

*countertransference explosions*. Dalenberg identified a reluctance in therapists to disclose hostile, passive-aggressive or defensive practice. Yourman & Farber (1996) explored disclosure in supervision by 93 psychotherapy trainees. Supervision questionnaires suggested that 30-40% of supervisees withheld or distorted aspects of therapy cases including therapist errors at moderate to high frequencies. Yourman (2003) explored an association between non-disclosure and therapist shame, suggesting a positive correlation, based only on case studies however. Yourman concluded that the exploration of material that may lead therapists to view themselves or appear to others as less competent is likely to produce a sense of shame and in turn less disclosure to supervisors. This has important implications for the empirical exploration of therapeutic mistakes with therapists; however it is not clear whether the same factors for disclosure in supervision will necessarily apply to disclosure in research focusing on therapists' experiences in therapy.

A study eliciting therapists' subjective experiences of therapeutic mistakes will supplement the literature to improve our insight and understanding of such a complex and amorphous area as well as providing real life value (Mason, 1996). Given the differing severities of boundary transgressions and associated mistakes, it is important to develop our understanding of how mistakes are encountered and managed, with implications for raised awareness and prevention of therapeutic mistakes in clinical practice. A qualitative study of therapists' experiences of mistakes will aim to elicit what is important and salient for therapists themselves – those making decisions and dealing with mistakes. As such, this will help us to understand what it is like to experience therapeutic mistakes, rather than its conceptualisation.

### ***Summary of current literature***

The literature relevant to the current study comprises a variety of key areas within psychotherapy. Therapeutic boundaries are seen as the parameters to appropriate behaviour in therapy and part of the therapeutic frame (Langs, 1979). As such, much of the responsibility for the management of boundaries lies with therapists. It follows that boundary transgressions are often viewed as signs of inappropriate therapist behaviour, which could in turn be viewed as constituting a mistake.



Context has been viewed as an important consideration in boundary literature, sometimes being the difference between whether a boundary transgression is seen as harmful or not (e.g. Mitchell, 1993; Williams, 1997; Gutheil & Gabbard, 1998). This implies the presence of a number of grey areas (Glass, 2003). The role of the therapeutic alliance is instrumental in determining how boundary transgressions are viewed and managed. Therapeutic alliance literature views this in terms of therapeutic ruptures and highlights the importance of the recovery from ruptures for positive outcome in therapy (e.g. Safran et al., 2001). There is also an emphasis on therapists' awareness of ruptures and responsibility in facilitating their recovery. Although these areas of literature have been examined separately, it is helpful to advance the literature by bringing them together based on a common concept, namely the notion that therapists' responsibility for boundary transgression and therapeutic ruptures may reflect therapeutic mistakes.

There is a dearth of literature on therapeutic mistakes. Existing literature has focused largely on mistake classifications (e.g. Buckley et al., 1979; Greaves, 1988; Altshuler, 1989; Mordecai, 1991), based on case studies and observations of others. Other research has focused implicitly on therapeutic activity that could be classified as mistakes (e.g. Gans & Counselman, 1996; Waska, 1999). There exists a gap in the literature relating to therapists' experience of therapeutic mistakes, perhaps due in part to some of the difficulties in asking therapists to disclose mistakes (e.g. Dalenberg, 2004). The closest research relates to therapists' experiences of difficult and upsetting sessions (de Oliveira & Vandenberghe, 2009), feelings of incompetence (Thériault & Gazzola, 2005), and working with traumatised clients (Smith, Kleijn & Hutschemaekers, 2007).

### ***Research questions***

Due to the lack of any focused empirical research on therapists' experiences of therapeutic mistakes in therapy, the aim of this study is to address the following questions:

1. How do therapists constitute therapeutic mistakes?
2. How do therapists experience therapeutic mistakes?
3. How do therapists respond to and deal with therapeutic mistakes?
4. How do therapists understand the consequences of therapeutic mistakes?

## CHAPTER TWO

### **Methodological approach**

This section briefly outlines the methodological approach used in this study, its theoretical roots and issues and the rationale for its use in the current study. In order to elicit the experiences of therapists in relation to therapeutic mistakes, this study will utilise a qualitative design, given its capacity to describe, understand and explain social phenomena, through obtaining rich descriptive accounts (Geertz, 1973). Much qualitative research has its theoretical foundations in phenomenology, concerned with how individuals perceive and talk about objects and events (Mason, 1996). Qualitative designs often utilise data to develop concepts and theories, working from the idiographic to the nomothetic (Smith & Eatough, 2006).

### ***Interpretative Phenomenological Analysis***

This study will utilise Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009) to explore therapists' experiences of therapeutic mistakes. IPA is an inductive qualitative approach to analysing data, which allows for an in-depth exploration of the subjective experiences of individuals. IPA involves the active, dynamic and reflective role of the researcher in making sense of individuals' experiences, through interpretation (Smith, Jarman & Osborn, 1999). This involves what is referred to as a double hermeneutic (Smith, 2008), whereby the researcher interprets an individual's interpretation of an event or experience. Smith & Osborn (2003) stated that, 'the participants are trying to make sense of their world, the researcher is trying to make sense of the participants trying to make sense of their world' (Smith & Osborn, 2003, p.51). Reid, Flowers & Larkin (2005, p.23) suggested that, 'IPA is particularly suited to research in unexplored territory', which makes it appropriate to the area of therapeutic mistakes. In addition, an IPA method is commonly used in investigations concerned with process (Smith & Osborn, 2003, p.53).

IPA is informed by some key philosophical concepts; phenomenology, hermeneutics and idiography. Phenomenology refers to the philosophical study of being and 'what the experience of being human is *like*' (Smith et al., 2009, p. 11).

Moran (2000, p.61) described phenomenology as ‘an attempt to bring philosophy back from abstract metaphysical speculation...in order to come into contact with the matters themselves, with concrete lived experiences’. As such, IPA focuses on understanding individuals’ rich experiences in terms of what is important to them. Husserl (1927) developed a transcendental approach to phenomenology in which enquirers bracket off their assumptions and pre-conceptions in order to explore the essence of phenomena through experience. With regards to psychological research, this would imply a separation of the researcher’s theoretical assumptions from the exploration of the participant’s lived experience. Heidegger (1962/1927) proposed a different approach to phenomenology. His hermeneutic-existential approach suggested that as enquirers of experience, we must take into account our own beliefs and assumptions as subjective beings and accept that it is not possible to bracket off these from enquiry into the subjective experiences of others. Heidegger’s approach resulted in the inception of the interpretative phenomenological method, in contrast to the descriptive phenomenological method based on Husserl’s approach.

Hermeneutics is a theory of interpretation. Heidegger (1962/1927) suggested that interpretation is what makes us human; we are always actively attempting to make sense of the world. This is reflected in the hermeneutic cycle in which our fore-understanding – what makes us *who we are* – is constantly revised due to new experiences. The implication for IPA is that the researcher is involved in their own hermeneutic cycle whilst also exploring that of research participants. Both are making sense of and reflecting upon experiences both during and after the research interview.

Idiography focuses on the particular examination of individuals. As such, idiographic approaches to research promote the exploration of detailed, rich accounts of experiences. In IPA, this requires both a thorough enquiry as well as analysis on such accounts. Idiography focuses not only on subjective experiences but also their place within a context, with an appreciation that individuals and thus their experiences are not separate from the world; rather they are experienced in relation to the world.

Using IPA will best help answer research questions 2-4 through exploring how participants make sense of their experiences, including how they understand

and find meaning in their experiences. The benefit of IPA is that it involves detailed exploration of individuals' rich accounts.

### ***Alternative methodological approaches***

*Grounded Theory* (Glaser & Strauss, 1967) is the closest method to IPA, given its emphasis on meaning using *codes*, *concepts* and *categories*. A Grounded Theory approach to exploring therapists' therapeutic mistakes would have used participant data to inductively derive a conceptualisation or theory of therapeutic mistakes. However, as the focus of this study was to examine participants' experiences of therapeutic mistakes, a Grounded Theory approach was not considered appropriate for addressing the research questions.

*Free Association Narrative Interview (FANI)* (Hollway & Jefferson, 2000) focuses on participants as defended subjects, using psychoanalytic principles to explore anxieties and defences that affect participants' recollection and meaning of events or memories. However, the aim of the study was to understand therapists' experiences of mistakes which are consciously accessed, rather than understanding unconscious processes that influence therapists' access to such material. As such, whilst this approach seemed initially to be an attractive method to utilise, it was not deemed appropriate for use in the current study. Another rationale for not utilising this approach was the fact that the researcher was not psychoanalytically trained.

### ***Sampling***

The use of IPA is associated with purposive sampling methods. Smith et al. (2009) described purposive samples as relatively small, consisting of participants who share similar experiences and/or perspectives relating to a particular phenomenon. Due to the data collection and analysis, a relatively small sample size is required (between 7-9 participants), with an emphasis on depth, not breadth of data. As such, Smith & Osborn (2003, p.56) recommended finding, 'a more closely defined group for whom the research question will be significant'. This alludes to homogeneity, another associated construct when using purposive sampling methods. A homogeneous sample is one that is alike; this sample can be selected based on one or many factors. In this regard, homogeneity is flexible and

can be broad or focused. For example, a homogeneous sample may be defined on the basis of either age, gender, social status, occupation alone, or upon all these factors together (i.e. young, middle class, male therapists *or* all therapists). The homogeneous sample in this study is based on a number of factors, but allows for the recruitment of a broad range of therapists; psychological therapists working one-to-one with adults using talking therapies in consultation rooms.

### ***Data collection***

Semi-structured interviews enable participants to describe their experiences and meaning of therapeutic mistakes through the use of flexible questions, guided by the narrative of the participant. Questions for the semi-structured interviews were developed with feedback from supervisors. A flexible interview schedule allowed for the researcher to engage with participants in a dialogue, whereby key areas are explored and supplemented with prompts, in response to participants' answers, should further avenues of exploration be identified or existing avenues require more detailed exploration. Semi-structured interviews were informed by ideas from Free Association Narrative Interview Method (Hollway & Jefferson, 2000), in particular its utility in eliciting detailed accounts of experience (e.g. "Tell me about a time when...").

Other approaches to data collection that were considered included personal accounts, diaries, recorded sessions and focus groups, however the advantage of using a semi-structured interview is that, 'it facilitates rapport, allows a greater flexibility of coverage and allows the interview to go into novel areas, and it tends to produce richer data' (Smith & Osborn, 2003, p.59). Recorded sessions and diary accounts lack the flexibility and collaborative engagement between researcher and participant, which enable the exploration of a wide range of areas and experience. As such, they may miss mistakes that are significant. Focus groups, while providing breadth of data, do not allow for the exploration of deeper individual accounts, thus omitting the opportunity for participants to discuss sensitive or personal experiences. Shame feelings may also be more likely to affect participants' accounts of mistakes in groups. When exploring therapeutic mistakes, a very specific area in therapy, semi-structured interviews provide the opportunity for participants to talk about a broad range of experiences, which they

determine to be a mistake. These may cover areas in the existing research literature or uncover concepts previously not encountered.

### ***Interpretative Phenomenological Analysis: The process***

Interpretative Phenomenological Analysis involves a number of steps. An initial encounter with each transcript allows for a familiarisation with the data, in which reflections are noted and a summary of the whole transcript is produced. Transcripts are then read again and initial comments and observations are noted in the left-hand margin. This process is referred to as phenomenological coding, whereby sections of text are summarised. Subsequently, themes are noted in the right-hand margin. Themes are ascribed to sections of the text ranging from one word to a few sentences in order to explore the transcript for meaning, with particular attention to patterns, contradictions, metaphors and imagery. This process is called interpretative coding. Once themes are identified, they are arranged into clusters on the basis of similarity and psychological relatedness. The clusters are then assigned master theme category titles. The master themes are cross-referenced with the associated data. This analytic process is conducted for each participant, before group master themes (super-ordinate themes) are developed. These are defined as themes that apply to most participants and their individual narratives as well as those producing rich and meaningful data relevant to the broader research question. Thus both convergent (shared, common) and divergent (unshared, outlying) themes are identified. This integrative analysis stage will result in themes that represent the group.

## **Method**

### ***Research Design***

As outlined above, this study utilised a qualitative design. IPA was used as the methodological framework for approaching the research and analysing the experiential data.

### ***Sampling and recruitment***

It was decided that participants be recruited from two large NHS trusts. At the time of applying, the ethical approval pathway for these trusts had transformed from a joint process to two separate processes. As such, the research & development departments were contacted separately. In parallel to the ethical approval pathways, the heads of Adult Psychological Therapy Services were contacted in order to both discuss the research proposal and request preliminary approval to recruit psychological therapists from their services, following full ethical approval. Department staff lists were subjected to a number of inclusion and exclusion criteria before participants were invited to take part.

Participants were excluded if any of the following criteria were not met; practicing psychological therapist, working one-to-one with adults, in consultation rooms, using talking therapies. As such, group, family, art and drama therapists were not contacted. Therapists working primarily with specialist client groups (e.g. eating disorders, personality disorders, dementia) were also not contacted. Subsequently, 97 psychological therapists were sent an invitation to participate by e-mail (See Appendix I). Four therapists agreed to take part. Two therapists discussed their potential involvement but decided not to participate. Reasons for this related to their confidence in their ability to provide useful accounts and their limited availability. Those who had not replied to the initial e-mail were sent a reminder by e-mail with another opportunity to take part. A further two therapists agreed to take part at this point. The final participant was approached by the field supervisor and was keen to take part. Due to their working relationship, it was negotiated with this participant that the field supervisor would have no access to his data; only the researcher and research supervisor would look at the transcript. It was explained that the field supervisor would only be consulted with regards to group themes, further protecting his anonymity.

### ***Information & Consent***

Participants were sent a detailed information sheet (See Appendix II) shortly after their interview was arranged (1-4 weeks before the interview). The information sheet outlined a number of details including: the purpose and context of this study; the background literature; why they had been invited to take part; brief

information about design & methodology and what taking part would require; ethical considerations and how they would be addressed, as well as a protocol for withdrawing from the interview or withdrawing consent for their data to be used subsequent to the study. Finally, details of the dissemination of the study were outlined. A consent form (See Appendix III) was produced which outlined the main principles of the research study. Participants were asked to confirm their understanding of the study before consenting to take part.

### *Ethical issues*

Full ethical clearance was obtained from the Leeds Central Research Ethics Committee and the project was registered with the Research and Development departments for the two NHS trusts from which participants were recruited. Ethical issues in this study were participant distress, disclosure of unethical practice and confidentiality. The exploration of therapeutic mistakes had the potential to evoke distressing feelings. Participants were offered the opportunity to terminate the interview at any point, take a comfort break or withdraw from the study if they felt uncomfortable with discussing any material. A conversation was also held after the interview to check with participants about their interview experience. This protocol was also included in the detailed information sheet, given to participants prior to the interview.

Participants' accounts of therapeutic mistakes also had the potential to elicit potentially unethical conduct (such as sexual misconduct, inappropriate personal disclosure or extra-therapeutic relationships). A number of strategies were in place to minimise this. Firstly, the information sheet included a paragraph which stated that the researcher was not interested in grossly unethical practice. Instead it was stated that the researcher was interested in therapists' experience of mistakes (e.g. boundary transgressions). This information was reiterated in the consent process, immediately prior to the interview. Participants were also told what measures would be taken should they disclose such mistakes, so that they were aware of the consequences (e.g. informing my supervisor, contacting their line manager or contacting safeguarding departments).

It was likely that participants would disclose specific details in relation to themselves, their clients or colleagues, when describing examples of mistakes.



Confidentiality was protected in a number of ways. Participants were allocated a pseudonym in order to protect their anonymity. Names of clients, colleagues and places were replaced with '(client)', '(colleague)', '(e.g. psychology department)'. Upon participant request, a copy of the transcript was sent so that they could read the interview and either approve the document for analysis or request changes be made. Participants were also given the opportunity to declare that certain sections be removed from the transcript, if they felt it contained or alluded to any information they felt was identifiable. All data, including audio recordings and transcripts were stored in a combination of lockable units, password protected computers and encrypted pen-drives (for the transfer of material).

### ***Procedure***

#### *Interviews*

Interviews were held at the participants' workplace, in either their own clinic room or another consultation room. Interviews lasted between 45-90 minutes, including a review of the study information and consent procedure. A semi-structured interview was used to elicit participants' experiences of therapeutic mistakes. (See Appendix IV). Semi-structured interview questions were printed on an interview schedule for use by the researcher.

#### *Interview schedule*

The interview schedule comprised of several pre-determined questions and prompts in order to elicit participants' accounts of therapeutic mistakes. The construction of the interview schedule was informed by a number of principles outlined by Smith et al. (2009) as part of their suggested sequence for the development of a semi-structured interview schedule. Firstly, interview questions were designed to elicit different types of data (e.g. participant information, experiential data and general opinions of mistakes) in order to best answer the primary research questions.

There was a rationale for some order in the types of questions asked. For example, questions aimed at gathering participant demographic and job information (e.g. experience, typical client caseload) were asked at the start in

order to ease participants into the interview before asking them to talk about times they feel they made a mistake. It was hoped that asking these questions first would help building rapport and trust between participant and researcher and help participants feel more comfortable to explore experiences thereafter. Likewise, questions gauging participants' general opinions about mistakes were asked at the end of the interview. This both allowed participants time to speak about less emotive material and also to remember any material they felt they had not mentioned during the main section of the interview.

The main section of the interview used questions intended to elicit participant's experience of therapeutic mistakes. A 'funnelling technique' (Smith et al., 2009, p.61) for asking these questions was used, in that broad questions were asked first (e.g. 'could you tell me about a session where you felt you made a therapeutic mistake'), followed by more specific questions (e.g. 'When did you first realise you'd made a mistake?'). The rationale for this technique was to first allow participants to interpret and answer the questions in the way that was most meaningful for them without restricting their account, before focusing more specifically on their experience of mistakes, addressing any gaps in their account and/or enquiring in greater depth. The interview questions were designed to follow a logical order; for this study questions were ordered in a temporal sequence to address participants' experiences at different points across the mistake (i.e. before, during and after the session). As participants may have addressed some aspects of the mistake more than others, more specific questions along a timeline were not always necessarily asked in order or in equal detail.

Despite the logical order to the design of the schedule, it was used flexibly, in that not all the questions were asked, those that were asked were not in the exact order as they appeared on the schedule, and other questions were asked which were not on the schedule. The flexible use of the schedule allowed the interview to be guided by the participants' accounts. Other types of questions and prompts were used in order to elicit further information from the participants or to clarify their responses. These techniques allowed for the interview to flow, for participants to feel listened to and engaged in a conversation and also to further develop a rapport. This was particularly important given the potentially sensitive nature of participants' accounts. Consideration was also given to mirroring the

language and phrases participants used when describing their accounts, particularly the words they used to refer to mistakes; some participants chose not to refer to them as mistakes, but instead errors or getting things wrong. As suggested by Smith et al. (2009), the Interview schedule was developed using a number of resources, including discussions with both research and field thesis supervisors and feedback from the Qualitative Research Support Group within the Leeds Doctorate in Clinical Psychology course. In addition, two pilot participants were used to practice using draft interview schedules at different points along its development. The pilot participants, fellow Psychologists in Clinical Training, provided feedback on how they experienced the interviews and how they felt the interview questions guided their accounts of their experience. These pilot participants also provided an opportunity for the researcher to reflect on the effectiveness of the questions as well as becoming accustomed to using the interview schedule flexibly. All these processes influenced the modification of the interview schedule towards its final state.

Interviews were recorded using a digital recording device. The first three interview recordings were transcribed by an external transcriber and the final four recordings were transcribed by the researcher. Recordings were transcribed verbatim, including notations of any non-verbal communications (e.g. laughter, pauses, hesitations, crying, sighing). The decision to split the interview transcriptions between an external transcriber and the researcher reflected the need for a balance between time management and pragmatics and depth of understanding of interviews. Direct transcription allowed for a greater familiarisation with the interview recordings and thus a more thorough understanding of the data prior to detailed analysis. It also evoked some initial thoughts about the data and secondary reflections on the experience of the interview. Transcripts done by the external transcriber were quality checked by the researcher, due to the presence of potentially unfamiliar psychological concepts that were key to participants' accounts. Transcripts were also checked for common errors, which may have affected the context of a sentence and thus how the researcher understood the data. These quality checks also allowed for a re-familiarisation with the data, similar to the direct transcription.

## *Data Analysis*

### *Organising different types of data*

In line with Smith et al. (2009), transcripts were read several times in order to gain familiarity with the interview. Subsequently, annotations were made in the left-hand margin of the transcript next to any sections of the text which seemed important, interesting or unclear. This included highlighting participants' use of language (including use of humour, abrupt departures from their accounts, hesitation and extreme language). Initial annotations included general comments, words and questions. Questions about the data alluded to gaps in participants' accounts and a lack of clarity relating to the context of sections of data. Some of these questions were made clear by re-visiting the audio recordings (in particular listening to the tone participants used or the way in which they talked about their experiences).

A subsequent examination of the transcript required the researcher to distinguish between sections of the text which were descriptive (i.e. their description of what happened or what the client did or felt) and those which were experiential (i.e. they referred to the participant's experience of therapeutic mistakes). In order to aid the distinction between different characteristics of the data, sections of participants' transcripts were identified using different coloured highlighter pens. Other types of highlighted text were those which referred to the description of the mistake, participants' use of language to describe their experiences, participants' more general opinions of therapeutic mistakes (including other examples of what they constituted to be a therapeutic mistake) that were separate to their provided accounts, and information about the participant and their job. The following colour coding system was utilised:

Participants' demographics and job information

Participants' description of the mistake

Participants' experience

Participants' use of language

Participants' general opinions of therapeutic mistakes

A sample of a transcript analysis is displayed in Appendix XI.

In addition to analysing participants' experiential data through IPA, there were several other processes involved in order to organise the data for discussion. Data alluding to participants' job roles, length of experience and therapeutic orientations were summarised and placed in each participant's *Pen Portrait*. Participants' general opinions about therapeutic mistakes and summaries of their shared accounts were also summarised and placed under the same heading in the results section.

In order to answer Research Question 1 (How do therapists constitute therapeutic mistakes), a number of processes were undertaken. Firstly, each participant's mistakes were summarised and placed in the results section. In order to understand the qualities of the participants' mistakes as a group, each mistake was examined in terms of their characteristics and displayed in a table (See Table 4), illuminating the common and contrasting features of participants' mistakes across the group.

#### *IPA Procedure*

IPA was used to analyse sections of the data with regard to participants' experiential data (i.e. sections of the data highlighted in green). Subsequent examinations of the transcript involved ascribing psychological themes to these data. Annotations were placed in the right-hand margin alongside individual words, phrases or sections of the transcript, paying particular attention to participants' thoughts and feelings at different stages in their accounts of mistakes. Each transcript was analysed in turn, before moving on to the next transcript. The rationale for this was so that making sense of a participant's transcript was not compromised or influenced by a concurrent examination of another transcript. A number of experiential themes arose from examining each transcript. This process was repeated for each participant.

As each participant described at least one therapeutic mistake, it was important to organise the resultant themes in relation to the mistake they were associated with, so that separate experiences were not merged into one another. This resulted in a separate set of themes based on their experience of each mistake. In order to further make sense of each participant's experience of their

mistakes, each mistakes' set of themes was displayed in a table, highlighting each theme and the supporting extract in the transcript. Added to this table was a timeline of each mistake, highlighting the key stages and details of what happened (e.g. before the session – participant was re-reading last week's notes). The aim of this was to provide context to the participant's experience of their mistakes. Finally, each participant's themes for their mistakes were allocated to the stage of the timeline at which they occurred in the process. Where necessary and appropriate, themes in the same section were organised based on their psychological relatedness. Less importance was placed on organising themes in this way for each individual at this stage, as this was seen as more integral to the later stages of the group analysis. A reason for organising themes in this way at this early stage, however, was to begin to make sense of emerging patterns within the data. In summary, themes were organised firstly by participant, then by their mistakes, and finally by the stage of the mistake (and psychological relatedness, where necessary).

At the group analysis stage, themes from each participant's mistakes were organised based on the stage of the mistake to which they were attached. For example, all the themes associated with participants' experiences *before the session* were examined separately from those associated with participants' experiences of the *consequences* of their mistakes. Subsequently, there were seven separate group analyses: *Before the session*, *In the session*, *The emergence of a problem*, *In the midst of the problem*, *'The aftermath'*, *Making sense* and *'How I'm left'*. The rationale for separating participants' themes into different categories was to determine where participants' themes occurred in the process of making mistakes. For example, it would have been important to distinguish therapists' anxiety prior to making a mistake from that occurring afterwards. Moreover, participants' experiential themes would have lost meaning in isolation of context, had this stage of analysis not existed.

Once all seven participants' themes were grouped together based on the categories outlined above, each group category was analysed separately by examining emerging patterns and psychological relatedness between the themes. These patterns and relatedness between themes formed the basis for clusters of themes. Each cluster was allocated a super-ordinate theme title. This title either

used a common psychological concept as a label to connect the themes or ‘abstraction’ (Smith et al., 2009, p.96) or used one of the sub-themes as a label to describe the cluster, referred to as ‘subsumption’ (Smith et al., 2009, p.97). For some super-ordinate themes, often the most suitable cluster label emerged through a sub-theme, where a new label was not appropriate or useful. Alongside each stage’s set of super-ordinate themes, the process was depicted using flowchart diagrams to reflect the convergence and divergence among the psychological processes involved across the sample, and as such the complexities across participants’ accounts. The separate flowchart diagrams were then amalgamated, resulting in a diagrammatic representation of participants’ experience of therapeutic mistakes.

### ***Quality checks: reliability and credibility***

The applicability of reliability and validity in assessing qualitative research is widely contested. Glaser & Strauss (1967) promoted the use of the terms ‘credibility’, ‘usefulness’ and ‘trustworthiness’ to refer to the quality of qualitative research. Reliability typically refers to how reliable and accurate the data collection and analysis are for producing the most consistent findings. However, this assumes that such processes can be standardised in qualitative research (Mason, 1996). Mason instead outlines the importance of data collection and analysis being, ‘thorough, careful, honest and accurate’ (Mason, 1996, p.146). Elliott, Fischer & Rennie (1999) outlined 7 detailed quality criteria for qualitative research including specification of the researcher’s orientation and anticipations, contextual situation of participants, grounding of data in examples, providing credibility checks, coherence, accomplishment of general and specific tasks and resonance with the reader.

In order to increase the quality and credibility of this study, I undertook the following procedures:

- A thorough description of the data collection and analysis to reflect the complexities in the data; results of the analysis were supplemented with participant extracts in order to add transparency to the data.
- Research supervision involving on-going communications and meetings throughout, particularly during the process of analysis. The research

supervisor provided credibility checks on sections of transcripts in order to verify the analytic coding framework and provide constructive feedback for subsequent analyses of transcripts.

- On one occasion, the research supervisor read a large section of a transcript and made some preliminary notes relating to observations and emerging themes. These were compared with those of the researcher as part of a double-coding exercise (Miles & Huberman, 1994).
- Use of supervision with the field supervisor, which differed from the more regular research supervision (above), in that it focussed on broader discussion of the research, including linking the emerging research findings to the wider literature and reflecting on the researcher's use of self throughout the process.
- Use of a reflective research journal to enhance self-reflection. This included tracking my own responses, biases and ideas to help separate my responses from those of the participants.
- A detailed analysis accounting for the variation in perspectives, resulting in divergent as well as convergent themes.

### ***Reflexivity***

A key characteristic in qualitative research is the active engagement of the researcher in all elements of the research process, including the development of the research interest, questions, data collection and analysis. Reflexivity (Henwood & Pidgeon, 1992) refers to the process by which the researcher is able to engage with the data whilst being aware of their own biases and assumptions. In the context of the methodological approach in the current study, a reflexive position represents the researcher engaging in a 'double hermeneutic' with an appreciation of the ways in which their own experiences and perspectives might impact on their interpretation of participants' accounts. In order to reflect my attempts to account for my own biases, assumptions and pre-conceptions relating to the topic area, I have included a number of reflexive paragraphs at different points throughout the text (e.g. introduction to the study, participant interview reflections, reflexive summary following analysis, closing reflections) as well as the following personal reflexive statement:



It is important to acknowledge my own experiences of therapy, both as a psychologist in clinical training and a patient of a psychoanalytic psychotherapist for two years (alongside my clinical training experience). My attitude towards my own mistakes has developed since progressing throughout clinical training. I began with a level of insecurity about my own competence and ability to deliver therapy to clients without making too many mistakes. As such, I expected that I was much more likely to make mistakes than more experienced colleagues, reflecting a sense of self-criticism. A mistake I remember well was allowing a session to run 20 minutes over, due to a client's level of distress; I recall my internal conflict between a desire to maintain therapeutic boundaries and a desire to help contain the client's distress. Other examples of my own mistakes include premature interpretations, addressing a client by the wrong name and not fully explaining homework tasks, resulting in client anxiety. My experiences of being a therapy patient were that I felt both a sense of responsibility for saying the right things but also questioned, at times, the fallibility of my therapist. These perspectives on therapy reflected dichotomous thinking and perhaps a judgmental perspective towards therapeutic mistakes. Thus these experiences and pre-conceptions of therapy have the potential to bias my evaluation of others' accounts of mistakes.

## CHAPTER THREE

### **Results**

The findings from the analysis will be presented in a number of separate sections. Firstly, pen portraits will provide contextual information about each participant. This section will also include a reflexive paragraph outlining my sense and experience of each interview. The results chapter will also contain a section on the characteristics of the mistakes described by the group of participants. The group analysis will then be described: a summary of the main themes representative of the group of psychological therapists. These will initially be presented in a table, before being examined in more detail stage-by-stage, with the use of supporting extracts from participants, to illustrate the themes' connection to participants' lived experiences.

### ***Participants***

Seven early to mid-career psychological therapists were interviewed about their experiences of therapeutic mistakes in therapy (See Table 3). Six therapists were recruited across several Adult Psychological Therapy Services and one therapist was recruited from an Older People's Psychology Service. Each participant was given a pseudonym. Four therapists were recently qualified (within the last 5 years), whilst the other three therapists were experienced, having been qualified for at least 10 years.

Table 3. Participant information.

Pseudonym	Gender	Role	Years qualified	Orientation, models used			
				CBT	CAT	PA	PD
Alex	M	Clinical Psychologist	More than 15 years				✓
Linda	F	Clinical Psychologist	More than 15 years	✓			
Elaine	F	Clinical Psychologist	Less than 5 years	✓			✓
Simon	M	Clinical Psychologist	Less than 5 years	✓	✓		
Michael	M	Psychoanalytic Psychotherapist	Between 10-15 years			✓	✓
Ruth	F	Clinical Psychologist	Less than 5 years	✓			
Margaret	F	Clinical Psychologist	Less than 5 years	✓	✓		

\*CBT = cognitive behavioural therapy, CAT = cognitive analytic therapy, PA = psychoanalytic, PD = psychodynamic

### ***Pen Portraits***

Pen portraits for each participant include a description of the type of work they do, the models they use and the client presentations typically seen, as well as a paragraph outlining their general opinions of and attitudes towards therapeutic mistakes. A summary of participants' accounts of mistakes are also provided. Whenever participants' quotes from interviews are used to support their pen portraits, these will be highlighted in *italics*.

#### *Alex*

Alex has worked psychotherapeutically with adults for 17 years, working psychodynamically for the most part; in particular his focus is on transference and

countertransference. Prior to identifying himself as working psychodynamically, he used models such as CBT and considered himself an eclectic therapist. He described seeing clients with a range of presentations, including personality disorders, childhood traumas, but excluding OCD, anxiety and PTSD. Alex described the type of clients he sees as being challenging to work with.

Alex described himself as someone who makes mistakes in every session with clients, in the sense that mistakes are a normal part of conversations with clients. He distinguished these '*ordinary mistakes*' from the more gross mistakes such as inappropriate self-disclosure and aggressive outbursts towards clients; the types of mistakes Alex recognised in general practice included inappropriate self-disclosure, saying something in an aggressive tone and engaging in a sexual relationship with a client. Alex felt that he makes more mistakes with clients with whom he has not spent as much time, for example in first sessions or one-off assessment sessions. He described that mistakes are either felt by therapists or identified by clients. He mentioned that he can feel very awkward when challenged directly by clients. Alex felt that therapeutic mistakes are a product of an inevitable and necessary emotional investment in therapy and '*getting drawn into something*'; this is when '*the real therapy starts*'. Conversely, he claimed that being tactful and attempting to avoid making mistakes represents a weak, ineffective therapist and therefore a '*sham therapy*'. He argued that there is a harsh and blaming attitude towards making mistakes within clinical practice. Alex felt that supervision and personal therapy are helpful structures for understanding oneself and thus exploring existing or potential therapeutic mistakes. Despite this, he felt therapists can think too deeply about mistakes and become too doubting of themselves, when the majority of therapeutic mistakes are '*grist for the mill*'.

This was my first interview and as such, I was keen to capture as full an account of Alex's experience as possible. At times I needed to consider when to stay on topic and probe further, and when to move on. This was a fine balance throughout. I wondered how my general anxiety and desire to do my best impacted on my ability to really listen to Alex's account and respond appropriately with prompts and probes. Alex gave some feedback towards the end that he felt he was repeating himself in regards to some points, which felt like an indication of saturation.

*'she made me feel like I'd made a horrible mistake'*

Alex described a session in which he responded to a client's comment in a way which overlooked a subtle change in her presentation. Alex recalled a feeling of being *'told off'* by the client and been made to feel like he had made a mistake.

*'I had not even remembered having done this'*

Alex described another session in which he felt *'told off'* by a client after he had shared an interpretation in which he suggested the client didn't fully believe what she was saying. The client insisted that Alex not challenge her again. Alex did not feel his comment was a mistake at the time, but felt bad when he was reprimanded.

*Linda*

Linda has offered psychotherapy for over almost 20 years. She described her as split between management, supervision and clinical work. In terms of her therapeutic approach, Linda's dominant model is CBT, although she acknowledged the influence of ideas from attachment theory and a compassionate mind approach in her thinking. Prior to qualifying as a Clinical Psychologist, Linda worked as a CBT therapist. Linda mentioned that she typically sees clients who either require specialist CBT or have had difficulties with previous therapy within the service.

Linda felt mistakes are inevitable in therapy and part of being human, where one puts themselves into their job. One reason Linda described mistakes as inevitable is that it is hard to determine how any one decision will affect a client. For example, an action with a good intention does not always produce a good outcome. Linda felt that mistakes can be *'turned into good stuff'*, both by exploring mistakes with clients and simply by clients noticing that therapists do not always get things right. Linda feels she is someone who goes out of her way to help people; however has realised through her experiences that this does not always work. As such, she felt therapists learn about themselves through their clients. She was aware that despite her efforts, she will continue to make mistakes in the future and acknowledged the importance of being as aware as possible about her potential to make mistakes, through utilising supervision. Linda recited

a quote which she felt summarised her attitude towards mistakes: ‘I learn so much from my mistakes, I think I’ll make some more’. Despite having a strong belief in her ability to help people, she felt she could be hard on herself when she gets things wrong. She also acknowledged the potential for emotive client material to affect her personally and invade her private life.

Linda had clearly prepared some examples of mistakes to share before the interview. Linda had much to say about the cases she described and she mentioned that she had not had the chance to reflect upon one of her cases in much depth due to a lack of supervision. It felt as though Linda was using the interview to reflect further on some difficult situations. She told me that one of her mistakes had the potential to make her emotional and warned me in advance. Following the interview, Linda contacted me to request that certain parts of the interview transcript not be used as quotes in my results section, due to her anxiety that they may compromise the anonymity of the case. Subsequently, we negotiated that whilst such sections of text would not be used as direct quotes, they could be used in order to elicit themes in the analysis. Linda was thankful for this consideration and wanted to feedback how useful the interview had been for her thinking; she had not thought as much about this case following the interview.

*‘I gave her too much information basically’*

Linda described a session in which she provided a client with some self-help material to read before the next session. In the previous session, the client had told Linda that she didn’t understand the content of the first readings Linda had suggested she read. Despite this, Linda had provided the client with more self-help material. Linda felt that her mistake was in giving the client too much information too soon despite the client’s previous feedback and attributed this to her *‘eagerness to help’* her client. The client did not attend the next session, and in a phone call to the client, it emerged that she had felt overwhelmed, worried and low in mood, as a result of her difficulties in understanding the self-help material. Linda mentioned that the client was encouraged to return by other professionals involved in her care and that she and the client were able to talk about the situation and use it to work effectively in the future. Linda felt the client made significant progress as a result of this resolution. Despite initially describing this

as a mistake, Linda has since questioned the extent to which this was a mistake, following its positive impact on therapy.

*'In working harder, I probably actually made it worse'*

Linda spoke about a whole therapy with a client in which she felt she did too much and did not maintain her therapeutic boundaries. Linda identified several instances where she felt she made mistakes across the course of the therapy. The client was referred to her as she had been seen by two previous therapists and needed specialist help for complex mental health problems. Linda felt her first mistake was in agreeing to work with the client without questioning her suitability for therapy. The client often presented in a state of crisis and was difficult to engage, demanding lots of time and resources from Linda. Linda felt her overall mistake was in responding to the client's unrealistic demands by trying harder and putting more energy into thinking about her and working with her. This approach was born from Linda's attitude that she might be able to do more than other therapists and work effectively with the client – offering her something she had not received before. However, Linda felt that initially, doing more for the client helped develop a strong working alliance with the client. It was only when the demands became more frequent and more demanding that she felt she made a number of mistakes. These included loosening boundaries (e.g. extending sessions, changing locations) and not taking the case to supervision. Linda felt she should have been able to recognise the process that she was being drawn into and that more regular supervision would have enabled her to reflect upon this. Instead, Linda sought help from her colleagues, who advised that they would have not worked with this client and that she had done too much. Linda recalled the client regularly criticising her for not helping her. Both Linda and her client agreed to end therapy after their agreed number of sessions. Linda felt that she had failed her client, whilst also recognising factors that were beyond her control. Despite sending a therapeutic discharge letter, Linda mentioned that she still thinks about the therapy and that it bothers her to this day.

*Elaine*

Elaine recently qualified as a Clinical Psychologist and has worked in adult psychological service for approximately one year. Elaine has been working with clients with a range of complex mental health problems. She identified her theoretical approaches as being informed by CBT and psychodynamic ideas, depending on the client. She described a particular interest in working with clients with early childhood trauma. Prior to working as a psychologist, she had non-psychological roles in learning disabilities and older adults. Elaine shared two examples; one which she described as a mistake and another on-going case in which she has yet to reach such a conclusion.

Elaine described making mistakes in therapy as like walking a tightrope. This is because she feels mistakes are situated in the context of each therapeutic relationship; what might be a mistake in one therapy may not in another; the types of mistakes Elaine recognised in general practice included meeting up outside of therapy, inappropriate self-disclosure and other boundary crossings. She referred to the role of therapists' feelings in making mistakes, in that they act as a measure of a mistake's severity. Elaine described some benefits to mistakes: they allow scope for reflection, help therapists learn, illuminate areas of clinical difficulty and reflect important interpersonal dynamics requiring exploration. Elaine also discussed the importance of a compassionate attitude within therapists towards their therapeutic mistakes, suggesting '*you can't get it right all the time*'.

I found that this interview seemed to last longer than it did. At times it felt as though Elaine found it difficult to elaborate on her answers. I was not sure how much of this was due to a patchy memory of the cases or instead representative of a reluctance to share a fuller account of her experience. At one point she alluded to her ambivalence towards the interview, mentioning that she didn't know me. I felt that Elaine needed prompts to expand upon her answers. As such, it felt slightly awkward at times. There were other times in the interview where Elaine opened up and used the interview to further reflect on her experiences. Towards the end of the interview, Elaine reflected on the fact that she had overlooked some emotional aspects relating to her mistakes. It felt as though Elaine had gained some personal insight through live thinking in the interview.



*'How did this all get a bit messy?'*

Elaine described a session towards the end of a therapy, in which she and the client were discussing what might happen if they were to meet outside of therapy. The client suggested they might meet up socially. Elaine described becoming anxious that the client would maintain this view following the end of therapy and made an unplanned comment which closed down this conversation. Elaine realised the power of this comment and the shame that it caused for this client, appraising it as a mistake. She then described the period after this mistake where *'it sat for a bit'*, before they went on to talk about *'ordinary things'*. Following the session, Elaine attempted to make sense of the situation and weigh up her contribution, through re-assurance seeking with colleagues, self-blame, weighing who was responsible and self-compassion. She received a message from the client who said he did not intend to return to therapy to complete the ending. This confirmed to Elaine that her comment was a mistake. She used supervision to decide that she would write the client a therapeutic letter. The client did return to therapy and they spoke about the session. An ending to therapy was completed and Elaine concluded that *'everything turned out OK in the end'*.

*'Time will tell whether that was a mistake or not'*

Elaine described an initial assessment session where a client with physical difficulties, who she felt was able to come upstairs, said they couldn't. She described having conflicting thoughts about what to do: whether to maintain therapeutic boundaries relating to the room, or to turn the client away (due to lack of rooms downstairs). Elaine decided to turn the client away and re-arrange another session downstairs. Elaine spoke about the uncertainty following her actions, concluding that time (and their subsequent therapy work) would determine whether her decision was a mistake or not.

*Simon*

Simon has worked in an adult psychological therapies service since he qualified recently. Simon described using a range of therapeutic approaches including CBT, mindfulness, interpersonal therapy and gestalt therapy, but identified CAT as his preferred modality. Simon described working with a wide range of client

presentations, including depression, anxiety, OCD, PTSD and personality disorders.

Simon viewed therapeutic mistakes as inevitable due to the '*human endeavour*' of therapy; the types of mistakes Simon recognised in general practice included empathy failures, poor decision making, saying the wrong thing, acting out irritation and cancelling therapy sessions without notice. He also suggested that a therapy without mistakes may reflect an ineffectual therapy. Simon's attitude towards mistakes has changed across the course of his career. As a trainee Simon saw mistakes as an indication of a deficit in his therapeutic skills, whereas he now views them as opportunities for exploring important issues and providing the potential for breakthroughs in therapy. Simon confessed that he used to strive to be '*the perfect therapist*' and would often feel '*demolished*' when he got things wrong. He realised that this was an unrealistic expectation. He now accepted that mistakes are a part of normal practice. As such, Simon now felt more resilient in dealing with mistakes and feels like a more effective therapist. Simon felt that therapists should be able to explore their own fallibility if they expect that of their clients.

Simon distinguished between mistakes attributed to active or passive processes (i.e. saying or doing something vs. omitting or missing something). He believed therapists were more likely to notice an active mistake themselves. Simon described reflecting upon mistakes as almost more crucial than the mistakes themselves. Simon also mentioned the importance of supervision in reflecting upon mistakes in conjunction with an open attitude to exploring mistakes in supervision.

Before the interview began, Simon mentioned that he might not be at his best as he had felt to have had a difficult and busy week. He expressed a sense of exhaustion and demonstrated it throughout. This perhaps accounted for a difficult start to the interview, where Simon found it difficult at times to articulate and remember details. When exploring his first mistake, he took long periods to think and appeared to struggle to answer my questions. I recall feeling a mixture of frustration and anxiety at that point, as Simon had chosen to tell me about a case about which he had limited information. I wondered whether this interview would be fruitful. I also wonder whether this might have affected the way I interviewed

from that point onwards. Prior to discussing his experiences of mistake, Simon was anxious to understand what I meant by a therapeutic mistake; I remember feeling taken aback, but I asked him what he thought it meant. This was one of a few occasions where it felt like Simon was seeking my approval and re-assurance. For example, he asked me whether I felt his account was relevant and useful. Simon appeared more comfortable as the interview progressed to exploring his second mistake. It felt here as though Simon was engaging in some uncharted reflection, supported by his telling me he had not yet had supervision on this case, constructing a narrative around this session being a mistake. Whilst he described it in response to ‘tell me about a mistake’, it did not yet seem clear to him why it was. Simon had yet to discuss this case in supervision.

*‘There was a lot going on in my head at the time’*

Simon described an experience in which he was told by a client that he had not been listening to her in a session. Whilst Simon appraised this as a mistake in retrospect, he described feeling distracted at the time by thoughts of future session plans. As such, Simon was not present in the moment or connected to what the client was saying. As he described it, this mistake was a ‘failure in receptiveness’.

*‘It’s the doubt that creeps in isn’t it’*

Simon described another session in which he was criticised by a client. In this session, Simon asked a question that the client felt to be a repetition. Simon recognised its difference from other questions he had asked and felt it was a reasonable one, yet he remembered immediately questioning whether he had made a mistake, with some doubt as to his contribution towards the client’s reaction, raising an awareness of his own fallibility. Simon mentioned that this was the first client that he had ever felt anger towards. Simon wondered whether his negative feelings towards the client contributed to the situation in an unhelpful way. Simon mentioned that this case had not yet been brought up in supervision, so had some more thinking and reflecting to do.

*Michael*

Michael has worked as a psychoanalytic psychotherapist in an adult psychological therapy service for many years. He described working using a psychodynamically informed exploratory approach with most of his clients, yet working psychoanalytically with some. Michael described working with clients for between 20 sessions and 2 years, depending on his approach; he distinguished between working with clients in exploratory therapies which have no contracted length from those which were brief and time-limited. Michael described working with clients with a range of common psychological presentations, including depression and anxiety, however identified specific issues around personality, relationships and loss, as characteristic in those he sees.

Michael's view of mistakes was that they are an inevitable part of therapy. He distinguished between mistakes that can be reflected upon, rectified and used as a helpful part of therapy and those which are unethical and an abuse of a boundary or power (to be avoided). Michael viewed mistakes as either process or setting related. He believed that therapists should have more control over *setting* related mistakes (practical mistakes such as incorrect details in reports, double bookings), whereas process mistakes in therapy are not always in a therapist's control. He felt that despite this, therapists can help prevent process mistakes from happening through implementing clear therapeutic boundaries at the start of therapy.

Michael felt that there is a sense of shame attached to making mistakes, which can draw therapists in to self-criticism. Whilst he felt it is important not to *'beat yourself up'* about making mistakes, he thought therapists should not run away from them either. Instead, Michael felt therapists should have an open, honest attitude to exploring mistakes. He also identifies the importance of humour (with colleagues) in dealing with mistakes. Michael has gained confidence in talking to other therapists about mistakes and sharing stories. Michael reflected on his experience of making mistakes across his career. He has realised that through making mistakes, he can handle them. He identified that he can be hard on himself and not give himself credit. Michael now saw mistakes as opportunities in therapy, yet felt that bringing about mistakes in therapy would in itself represent a *'big mistake'*. He felt that it is important to notice mistakes, acknowledge them

and address them in therapy. Michael spoke about the importance of support networks such as supervision and personal therapy in understanding himself and in relation to making mistakes, for example in acknowledging his ‘buttons’, which can be pressed by clients.

This interview was my last and perhaps most probing. It is pertinent that I had worked in the same service as Michael on a clinical placement but had never worked with him and had limited contact. Nonetheless we were familiar with each other prior to the interview and it is worth considering the impact of this on Michael’s account of his experiences of making mistakes in therapy. Michael reflected upon his experience of the interview process on a number of occasions. In particular, he commented on the fact that he was sat in the room and chair that his client sat in. He linked his occasional discomfort to his client’s discomfort when he felt challenged by a question or made to think and joked at one point, *‘maybe I want this to end...(like my client did)’*. He also commented at the end, when I asked if there was anything he felt I had not asked, *‘I think you’ve been quite thorough’*. Furthermore, Michael often took time to consider his answers, and said that he found that the interview had enabled him to reflect on his experiences. Following the interview, he said that whilst he felt challenged to think, he never felt too uncomfortable, acknowledging the balancing act in research questioning.

*‘I hadn’t been attentive to the ending’*

Michael described a whole case in which he had not brought up the ending with the client with only a few months to go in their 12 month therapy. Michael mentioned that he would normally have discussed the ending much earlier in a therapy. As Michael described his account of the therapy, he identified several mistakes he made. Firstly, he felt that the therapy lacked focus and that he should have taken a briefer, more focused approach to therapy. Michael spoke about his frustration at his client’s presentation and that he often ‘wanted to get rid of him’. Michael also thought that he extended the therapy to compensate for his negative feelings towards the client. He also kept the case from supervision. He finally realised that he had not brought up the ending when there was a break in the therapy. Michael then brought up the ending and discussed its significance with

the client. He felt that a resolution was reached and that the therapy came to a natural but speedy ending as a result.

### *Ruth*

Ruth recently qualified as a Clinical Psychologist and has worked in an older adult psychological service since. She described her split role between consultation work with services staff and working psychotherapeutically with older adults. Ruth described predominantly using CBT in structured time-focused therapy with older adults with complex issues. She also described using ideas based on systemic, attachment and psychodynamic theory to reflect upon client cases in supervision. Ruth described typically seeing clients who present with depression and anxiety; however there are often other underlying problems such as relationship problems, histories of abuse and low self-esteem.

Ruth confessed to making lots of mistakes in therapy, as she believes all therapists do. As relatively newly qualified, she finds it re-assuring to hear her colleagues talking about their mistakes, especially her supervisor. This has led her to appreciate that no therapist is perfect. She also finds it helpful to share experiences of making mistakes. Despite this, Ruth feels that no therapist wants to make mistakes, due to their potential to be harmful. Ruth believes that therapists learn more from getting things wrong as they require more thought and reflection. She also thought that whilst they are not pleasant to think about, they make for better therapists. This highlighted the importance, for Ruth, of facing up to mistakes. Ruth spoke about how each mistake is different so that whilst learning is helpful to prevent further mistakes, there is potential for lots of new types of mistakes to happen, so that therapists need to keep learning. Whilst Ruth acknowledged the benefits of making mistakes, she is aware of the potential to get things dangerously wrong, In other words, therapists *'can't just do what they want and learn from it'*. Ruth also feels that the right conditions have to be in place (e.g. supervision) so that learning from mistakes is possible. Ruth spends a lot of time thinking about all her cases both in supervision and outside of therapy, particularly on her way home from work.

This interview was the shortest interview but felt like one of the richest. I didn't feel as though I asked many questions. On reflection, Ruth was a recently

qualified clinical psychologist, speaking about a recent therapy case, perhaps one of her first in her new job. I had the sense that the interview allowed her to productively reflect on this piece of work. As such, Ruth did a lot of live thinking when she spoke about it. I decided to stop the interview when Ruth began to talk about a second mistake, as I felt it related more to a service/system issue, rather than an interpersonal therapeutic one. I explained to Ruth why I had done this and she seemed relieved, as she was unsure whether it ‘counted’.

*‘It’s like some of the things you hear happening to other therapists and now that they’re actually happening to you’*

Ruth described a therapy case in which she felt she did ‘certain things that weren’t helpful’. When asked for one session in particular, she described sessions as all ‘jumbled into one’. As she spoke about the case, Ruth highlighted two separate mistakes within this case. Ruth felt her first mistake was her being punitive towards her client, who regularly asked her to provide solutions to her problems, yet rarely carried out her suggestions. Whilst Ruth felt justified in challenging the client’s perceived inability to solve her own problems, she felt she inadvertently communicated her frustration in the way that she told the client. Ruth realised this was a mistake much later in therapy, when she reflected upon her general struggle with the client, so this mistake was not addressed directly with the client. The other mistake was when she shared an interpretation about the client’s anger that Ruth felt was both premature and intolerable for the client. The client questioned Ruth’s competency as a therapist, asking whether her supervisor had told her to say that. Ruth felt her client’s reaction influenced her appraisal of her mistake. Ruth used supervision to reflect upon these mistakes. Ruth also used supervision in order to arrive at a more realistic expectation of what could be achieved with her client, based on her complex history as a mental health patient.

### *Margaret*

Margaret qualified as a Clinical Psychologist relatively recently. She predominantly mentioned working with individuals for one-to-one therapy, but occasionally saw couples, families and groups. Margaret described herself as an integrative therapist, using a range of models dependent upon each client, yet

identified herself as working mostly from a cognitive analytic perspective, but using some CBT. Margaret spoke about working with a range of clients presenting with depression and anxiety, but specialised in trauma, seeing many clients with early childhood trauma and PTSD.

Margaret does not commonly use the word mistake in her clinical practice. Instead, she prefers to think about '*things that you get wrong, but that are part of the work*'; the types of such activity that Margaret recognised in general practice included poor formulations and technique. She felt that the work of a therapist is to interact with people and deal with strong feelings, and so it is about being a fallible human. Furthermore, Margaret thought it is important for clients to see that whilst therapists try their best, they do get things wrong. Also, if therapists are not open about getting things wrong, she feels this is indicative of something very shameful. She feels it is unrealistic and ultimately less effective to be a perfect therapist. Margaret spoke about feeling unsettled when things go wrong in therapy, as it goes against her desire to help people and do a good job. She mentioned using intellectualisation, in particular formulation, to defend against difficult feelings such as being unsettled, confused and put on the spot in order to not become overwhelmed. Margaret also referred to her '*internal supervisor*', which can help her to guard against getting things wrong or help her to question difficult situations.

Her reaction to '*getting things wrong*' has changed since qualifying from clinical training. She felt she is now more likely to reflect upon difficult situations and try to understand what's going on, as opposed to her previous tendency to panic. Margaret felt that being more comfortable with getting things wrong helps a therapist to detect them early and help address them. Margaret also felt that developing as a therapist is a process and that each client helps refine a therapist's technique. She values supervision and felt she is a better therapist when she receives regular supervision.

This interview felt productive. Margaret provided examples of two mistakes and spoke at length about them, responding to prompts and further questions. What I noticed during this interview was that I identified with much of her experiences. I wonder whether this was because she often referred to her



recent experiences in clinical training and some of her insecurities about getting things wrong.

*'All hell broke loose because of that!'*

Margaret described a session in which a client brought a copy of an assessment report that she had written complaining that Margaret had got a detail wrong. Margaret recalled the client being extremely angry and waving the report at her exclaiming, 'this is wrong, this detail!' Whilst Margaret was initially taken aback by the client's reaction, she described how this was explored and worked on in the session constructively. Margaret could not deny she made a technical mistake, but felt that it illuminated other difficulties for the client.

*'My technique wasn't as good as it could have been'*

Margaret described a case with a client in which she felt she could have done more, in particular placing more emphasis on process issues within therapy. She worked using a CAT framework and felt she worked *'too cognitively'*. Margaret could not identify a particular session in which this happened; instead she regrets her whole approach and wishes she had done it differently. Margaret mentioned that she only appraised her approach as *'a mistake'* in the months following therapy; the client had showed no improvement and had disengaged with therapy. Margaret described this mistake as *'still bugging me to this day'*. Margaret mentioned that this therapy happened at a time where she was not receiving regular supervision, due to staffing levels, meaning she didn't have a space in which to consider what was going on; instead she just *'got on with it'*.

### ***Mistake Characteristics***

The following table (Table 4) displays a group overview of the types of mistakes described by each participant, in terms of a number of characteristics. The aim of this table is to highlight some common and disparate features of the mistakes between participants, in relation to how they constitute therapeutic mistakes.

Table 4. Characteristics of participants' mistakes.

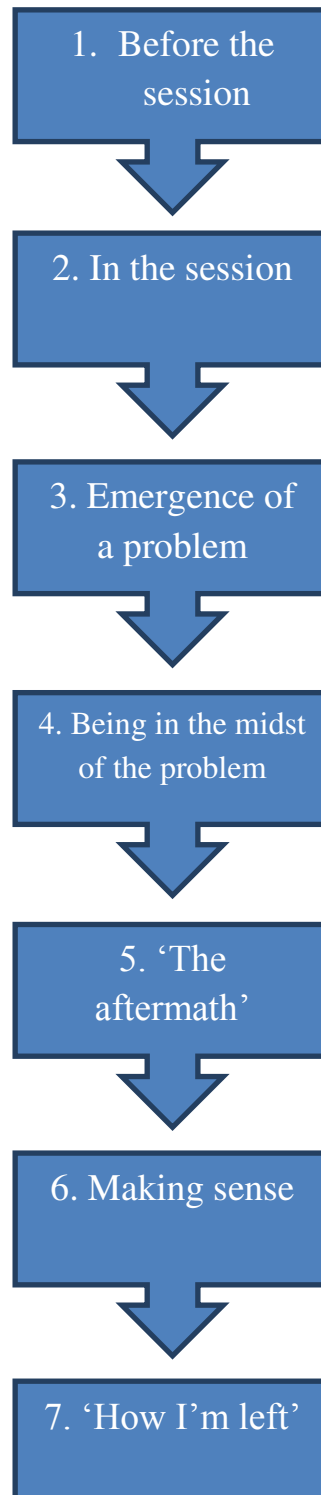
Participant	Mistake	Mistake characteristics							
		Told by client	Technique	Administrative error	Boundary issues	Conscious decision making error	Acting out on difficult emotions towards client	Not listening to client	Not taking mistake to supervision
Alex	Mistake 1	✓						✓	
	Mistake 2	✓	✓						✓
Linda	Mistake 1	✓				✓			
	Mistake 2				✓		✓	✓	✓
Elaine	Mistake 1	✓					✓		
	Mistake 2				✓	✓			✓
Simon	Mistake 1	✓						✓	
	Mistake 2	✓							✓
Michael	Mistake 1		✓		✓			✓	✓
Ruth	Mistake 1	✓					✓		
	Mistake 2	✓	✓						
Margaret	Mistake 1	✓		✓					✓
	Mistake 2		✓					✓	✓

There are a number of shared and distinct characteristics of participants' mistakes. The majority of mistakes were ones which were brought to the attention of therapists by their client (8 out of 13 accounts). The types of mistakes made belonged to four categories: mistakes relating to *technique* (4 accounts), *boundary issues* (3 accounts), *acting on difficult feelings towards a client* (5 accounts) and *conscious decision making* (2 accounts). One mistake related to an *administrative error*. Some mistakes were characterised by belonging to more than one category. In 3 accounts, mistakes were not reflected upon in supervision. On reflection, 7 participant accounts were characterised by doubts as to whether their mistake was a mistake or not, despite all participants being invited to discuss a session where they felt they made a mistake.

### ***Group analysis***

Participants' experiences of making mistakes will be presented stage-by-stage. Figure 2 (below) provides a summary of the separate stages as they occur in a process. Tables 5-11 display the super-ordinate themes and subthemes for each stage of the mistake, which will be explored in more detail and supported by participant extracts throughout the narrative. Figures 3-9 provide a graphical representation of these themes in support of the text. Where extracts are provided, the participant's pseudonym is displayed, in addition to the page and line number of the extract within the participant's transcript. Figure 10 displays full and detailed overview of all the stages, including the main themes within each stage as well as how they connect to each other). Appendix V displays a 'Who said what' table illustrating the prevalence of each theme across the group for all stages of mistake experiences.

Figure 2. Participants' stages of experiencing a therapeutic mistake.



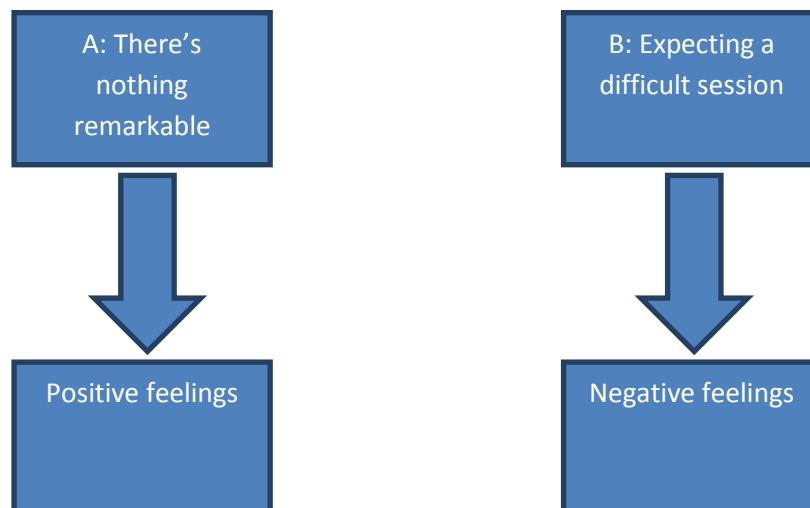
1. *Before the session*

Table 5. Participants' themes relating to their experience before the session.

Super-ordinate theme	Sub-themes	
<b>A: 'There's nothing remarkable'</b>	Positive feelings	Everything's going well Enthusiasm
<b>B: 'I'm expecting a difficult session, which is no different to usual'</b>	Negative feelings	Preparing to suffer Feeling stuck Frustration Anxiety

Participants recalled their experience before the session in which they encountered a therapeutic mistake. This stage of the process encapsulated their thoughts and feelings going into the session. The group analysis reflected a split between participants who entered the session with positive feelings and those with negative feelings (See Figure 3 below).

Figure 3. The split between participants' before session experiences.



*A: 'There's nothing remarkable'*

Two participants recalled going into the session with no expectation of anything remarkable, in particular no concerns regarding any difficulties. In fact, one participant described their *enthusiasm* for working with a potentially challenging and intriguing client.

'I thought, "Yeah, I'm gonna really try and we're gonna manage to get somewhere"' (Linda, 9.405)

*B: I'm expecting a difficult session that's no different to usual*

The majority of participants' accounts of mistakes alluded to the presence of a number of difficult feelings before going into sessions. These participants *expected the session would be difficult*, or described feeling *wary of a 'difficult client'*. An important aspect to these experiences is that they were viewed as usual; in that they were a regular feature of a difficult therapy. Characteristic of these common experiences was a sense of *anxiety* and *dread*.

'I was probably quite apprehensive about the fact we were coming towards the end and this was a big deal' (Elaine, 3.132)

'I was thinking, "Oh god, I have got (client) again."' (Simon, 5.215)

In most cases, participants were bringing *frustrations* about the client and their therapy with the client into the therapy session:

'...tired and frustrated at the types of conversations we were having' (Alex, 3.132)

Moreover, these frustrations reflected participants' sense of heaviness and lack of desire to be in the therapy at all.

'I would just wish to god it would end' (Michael, 3.134)

‘I had a sense of unwelcomness if I am being honest’ (Simon, 5.220)

There was a sense that some participants were resigned to having a session in which they *were going to suffer*.

‘There was a bit of me feeling that I was preparing to suffer in some way for the next 50 minutes or so’ (Alex, 7.339)

Participants’ expectations ahead of the session were often based upon an accumulation of difficult experiences throughout the therapy and reflected participants’ experiences of *feeling stuck*.

‘I think I had become a bit bogged down in how difficult it had become’ (Ruth, 4.176)

## 2. *In the session*

Table 6. Participant themes relating to their in-session experience.

Super-ordinate theme	Sub-themes
<b>A: ‘There’s still nothing remarkable’</b>	Everything’s going well Not noticing anything concerning
<b>B: Not present</b>	Feeling bored Disconnected Distracted Not attuned to the session
<b>C: ‘Something’s brewing’</b>	Noticing changes in self Noticing changes in the client Unease (‘Something’s amiss’)

Participants’ experiences early on in the session continued to reflect a similar split in positive and negative feelings.

*A: 'There's still nothing remarkable'*

Those who experienced nothing remarkable prior to the session, continued at the start of the session with *no expectations of difficulties* and indeed a sense that *therapy was going well*. Rather than participants commenting on this in their accounts, a sense of *not noticing* was interpreted as implicit in their experiences.

*B: 'Not present'*

The majority of participants who described experiences of anxiety, dread, frustration and a sense of being stuck prior to the session continued to be consumed by these feelings from the beginning of the session. It is important to note, however, that not all participants who expected a difficult session beforehand experienced such feelings when in the session. Nonetheless, many participants reported feeling *distracted*.

‘I think I missed that because I felt so caught up in what was going on’ (Margaret, 13.617)

‘There was a lot going on in my head at the time’ (Simon, 3.111)

Some participants spoke about an intense feeling of being *disconnected, bored* and *cut off* from the session, almost as if they weren't present in the session.

‘...the feeling of being deadened’ (Alex, 8.361)

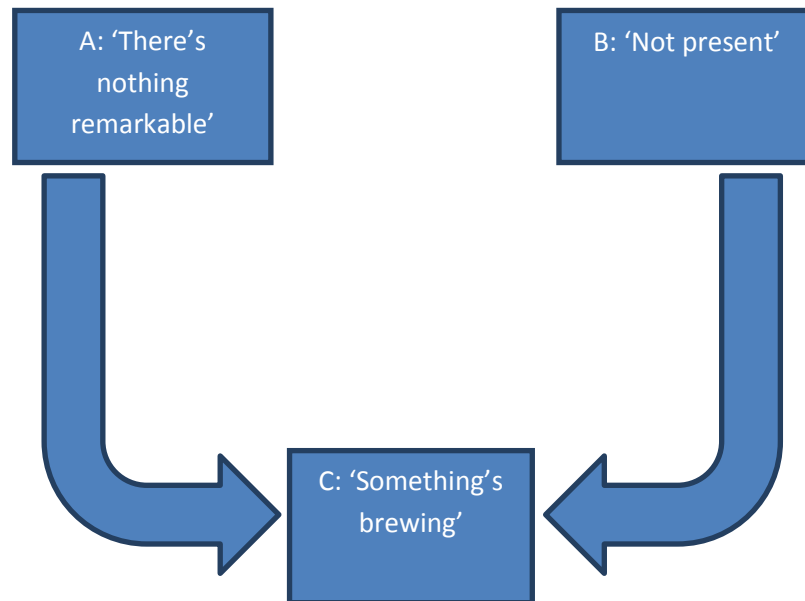
These early experiences resulted in participants ultimately *not being attuned to what was going on in the session*.

‘I hadn't realised all the things that she was doing’ (Ruth, 4.173)

Whilst there continued to be a predominant split in participants' experiences up until this point, there was an increasing convergence in participants' experiences as the session progressed, irrespective of their prior feelings. Connecting their experiences here was an increasing sense of *something not being right* (See Figure 4 below).



Figure 4. Participants' in-session experience.



*C: 'Something's brewing'*

The sense of something brewing or not being quite right was characterised by participants noticing changes, some which they described experiencing consciously at the time and others which they felt they didn't have the words for. Participants were as likely to notice *changes in themselves* as they were *changes in the client*. This early experience preceded a conscious awareness of a defined problem, yet brought about a sense of unease for participants.

One participant described their anxiety about a conversation with a client about a therapeutic boundary after the end of their therapy:

'I started to panic that he might really think that could happen'  
(Elaine, 2.79)

Another participant described also noticing the need to consciously hold himself from acting upon his frustration relating to his client:

'I did feel a sense of pissedoffness...A sense of having to reign myself in' (Simon, 7.310)

Participants also became aware that things were not right through *noticing changes in their client's presentation*. Whilst a problem had not yet been defined, most participants sensed something explicitly changing.

‘...she seemed really, really angry. You could just see it in her and you could feel it in the way she talked’ (Ruth, 4.155)

A number of participants did not notice what was changing, in that they did not detect a change within themselves or in their client. Instead, they sensed *something was amiss*. One participant spoke about a peripheral awareness of a difficulty without being fully conscious of what this was at the time:

‘an awareness of something, but not being able to acknowledge that we needed to think about the ending’ (Michael, 5.208)

### 3. *The emergence of a problem*

The emergence of a problem for participants was experienced in a number of ways (See Table 7). These were categorised as belonging to two broader categories of experience; *being told there's a problem* or *therapist becoming aware of a potential problem*.

Table 7. Participant themes relating to the emergence of a problem.

Super-ordinate theme	Sub-themes
<b>A: Being told there's a problem</b>	Experiencing criticism Noticing the client's action
<b>B: Therapist becoming aware of a potential problem</b>	Encountering a dilemma Noticing avoiding dealing with something difficult
<b>C: Client reaction confirming problem</b>	Verbal Indirect communication

*A: Being told there's a problem*

The majority of participants felt the problem emerged through it being presented to them with only their prior awareness of something changing. Some problems were presented to participants through them *experiencing criticism* directly from the client:

‘She gave me completely candidly honest feedback at what I was useless at’ (Linda, 9.448)

Others were presented through *noticing clients' reaction* or indirect communication:

‘I could tell that was really hard for her to hear’ (Ruth, 3.148)

*B: Therapist becoming aware of a potential problem*

In two participant accounts, the problem first emerged as a therapeutic *dilemma* requiring the therapist to make a decision. These dilemmas were internally directed, in that they were formulated by the therapist in response to what was happening and being spoken about in the session. Unique to these experiences was an awareness of the potential for something to go wrong and preparedness for its consequence. This is in contrast to the externally presented problems which were felt as emerging *out of the blue*.

‘I think I probably had some awareness that this was a bit of a gamble right at the beginning really when I was giving it out to her’ (Linda, 4.152)

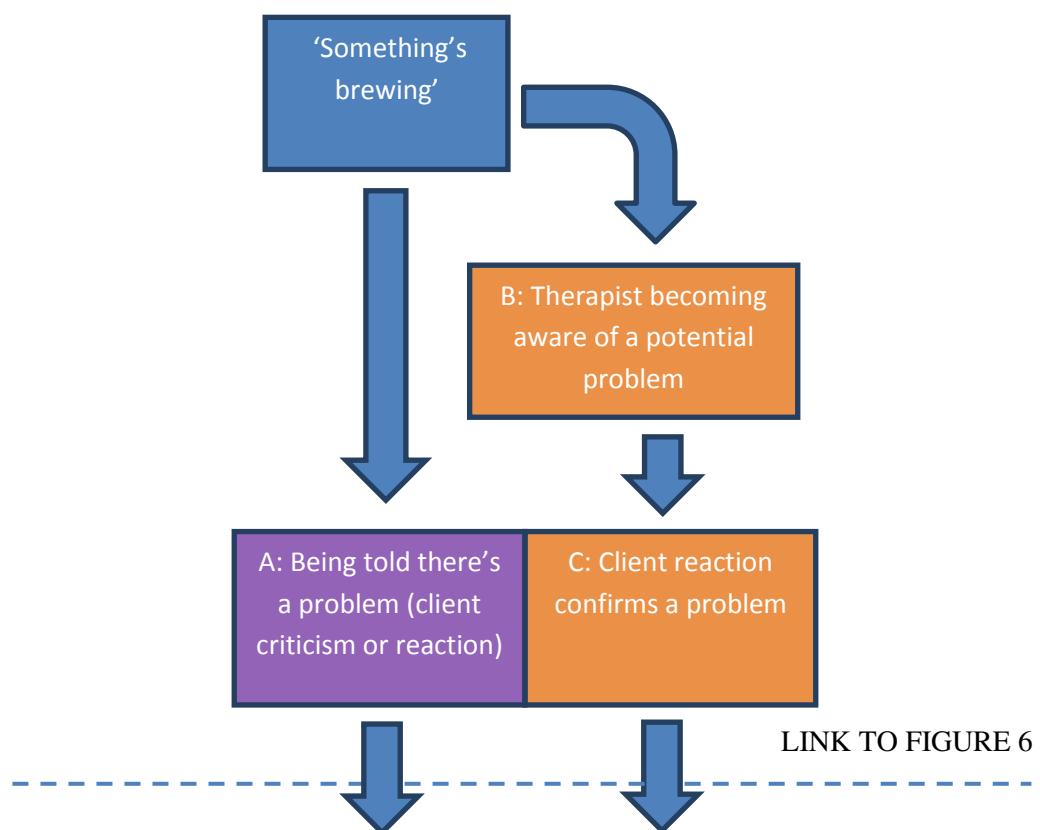
Participants' experience of dilemmas were also characterised by *doubt* and *indecision*:

‘questioning myself as to whether I should be a bit more assertive or stronger ... as opposed to being a bit of a pushover...erm...being too nice’ (Elaine, 12.549)

Problems also emerged through participants *noticing they were avoiding dealing with something difficult* in the therapy session. One participant spoke about not wanting to consider the difficult feelings he had towards his client, not even in supervision:

‘Having to hide that part of myself’ (Michael, 5.218)

Figure 5. Participants’ experience of the emergence of a problem.



*C: Client reaction confirming problem*

Two participant accounts involved a two-stage emergence of a problem. Rather than participants either told or noticing a potential problem themselves, they emerged in the first instance through participants noticing a problem and then this being confirmed by the client’s response. One participant recalled her client’s reaction to a difficult situation the therapist had recognised they had avoided dealing with:

‘...but then I saw it in his face, the kind of slightly hurt and shamed and then I was like, “shit that’s not right either”’ (Elaine, 5.239)

In such accounts, there was a progression from a problem being defined and held by the therapist, to the emergence of a problem which was recognised and shared by the therapeutic dyad.

#### 4. *The experience of being in the midst of a problem*

Participants’ experiences at this stage are again in need of some distinction. Experiences were dependent on how the problem emerged (i.e. whether participants were criticised by their clients or whether participants initially recognised the potential for a problem (which was either confirmed by their client’s reaction). It is worth noting that the emergence of the problem for a small number of participants occurred over a longer period of time and in some cases was not yet clear.

Participants’ experience of being presented with a problem by their clients were described in much more detail than those which were internally directed and comprised of various types of anxiety, feelings, thoughts and confusion reactions (outlined in Table 8).

Participants described being in an extreme state of *anxiety* when being presented with a problem either directly or indirectly by a client. Initially participants felt *under pressure* by the strength of their client’s criticism or pressured to explain themselves:

‘Putting me on the back foot’ (Simon, 8.381)

‘...certainly made me feel under the cosh’ (Alex, 11.514)

‘I felt really caught up in trying to almost have to explain myself...kind of like, “Ooh ooh I’m sorry, we’ll correct it’ (Margaret, 3.110)

Table 8. Participant themes relating to the experience of being in the midst of the problem.

Super-ordinate theme	Sub-themes
<b>Anxiety</b>	Under pressure Flustered Panic 'Survival mode'
<b>Feelings</b>	Under attack Vulnerability Frustration Feeling punished Shame Guilt
<b>Confusion</b>	Confusion Shock Disbelief
<b>Thoughts</b>	Doubts Protest Self-criticism*

\* this occurred as a participant reaction only in accounts in which they were initially aware of the potential for a problem.

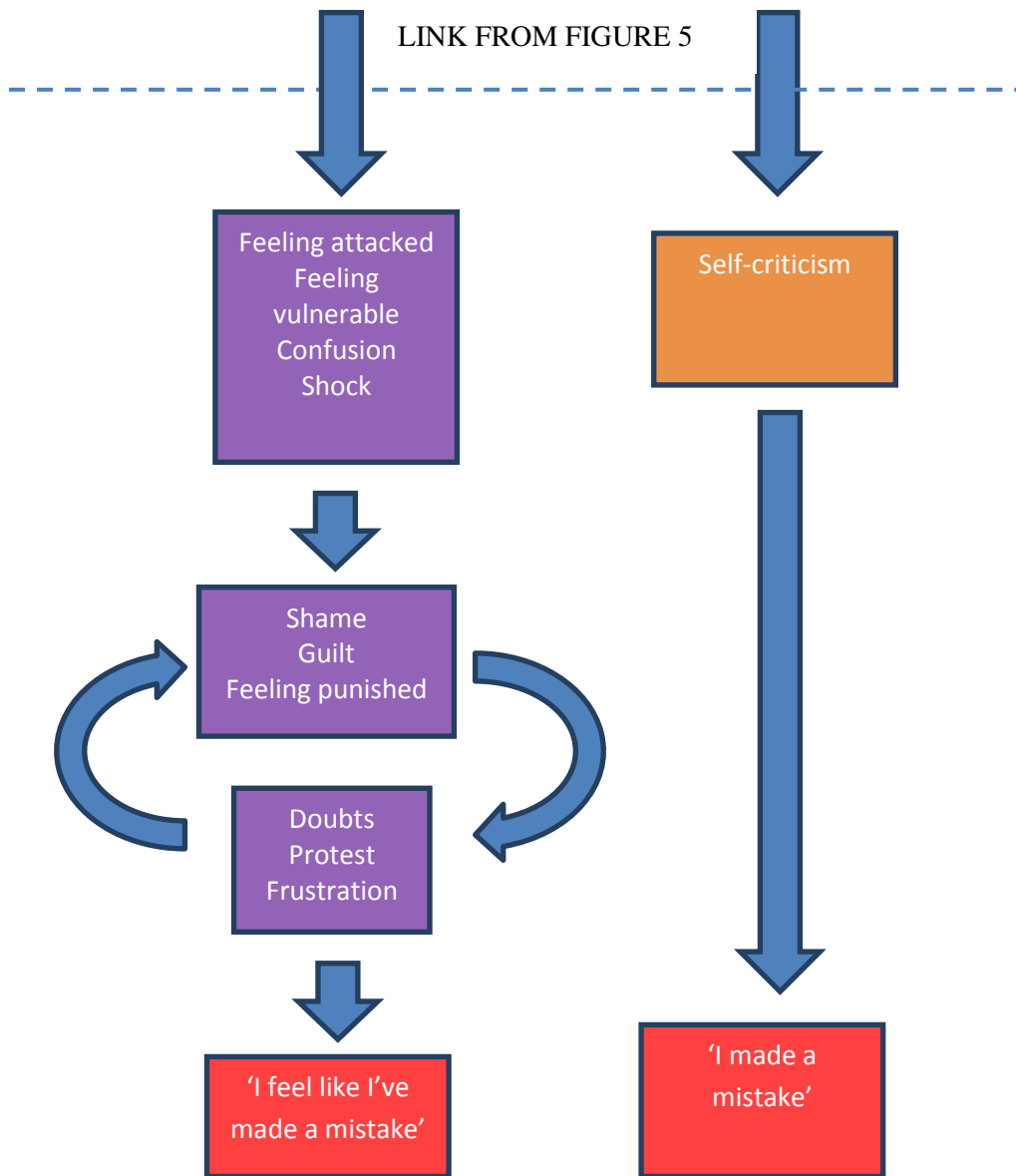
One participant described feeling *flustered*, having not had an experience of being criticised by a client in therapy to this extent:

‘It’s hard to know how to deal with it, it’s a bit unreal’ (Ruth, 5.212)

Participants also spoke about how clients’ criticism of them led them to instantly *panic* about therapy, trusting the words they were hearing:

‘shit, yeah we’re not getting anywhere’ (Linda, 12.564)

Figure 6. Participants' experience of being in the midst of the problem.



One participant spoke about his experience of being criticised in such vivid terms, such that he felt the need to *survive* the session:

'I imagine that she knew she had me 'on the ropes' ...I was knocked out, knocked into another place where it was more about surviving it, somehow...it was about getting through what on earth was going on...I didn't know where I was for a while' (Alex, 11.523)

Alongside a state of anxiety, participants experienced a number of difficult feelings, connected by a sense of feeling *under attack*:

‘...feeling quite personally attacked about not being a good enough therapist’ (Margaret, 11.543)

Associated with feeling attacked was a feeling of *vulnerability*:

‘I was feeling out of my depth really’ (Linda, 8.398)

‘...losing my objective faculties was how I experienced it for a while’ (Alex, 11.534)

Being in the midst of an attack led participants to feel a sense of *confusion, shock and disbelief*:

‘...just felt a bit like, “Oh my goodness, I can’t believe you just said that to me”’ (Ruth, 5.209)

Once participants had experienced the anxiety, panic, shock and confusion of being attacked, they then began to feel that they had made a mistake. Participants first experienced feelings of *shame* and *guilt* at this point:

‘I think I felt shame in that moment where I got it wrong’ (Elaine, 9.421)

‘I thought, “Oh I just really shouldn’t have said that. It really was not a helpful thing to say”, and to feel that it was compounding how rubbish she felt about herself’ (Ruth, 4.195)

For some participants, feeling like they had made a mistake was accompanied by a sense of protest that they had been ‘forced’ to feel this, relating to *feeling punished* by the criticism and thoughts that the criticism was excessive:



‘She really made me feel like I had made a horrible mistake’ (Alex, 3.144)

Some participants’ reactions were to feel *frustrated* at what they were being criticised for and felt like they wanted to retaliate:

‘I remember feeling that quite strongly..., “no wait, I’ve done a good job, I have’ (Margaret, 12.558)

The experience for those participants for whom the problem emerged initially through their own awareness (and confirmed through clients’ reactions) was much clearer. The reason for this is that encountering a dilemma or having an awareness that they were avoiding something difficult meant that therapists had already considered that a mistake was possible and were more prepared for such an outcome. When noticing their client’s reaction to a decision they took in therapy, they quickly resorted to a state of *self-criticism*, in which they berated themselves for having made the wrong decision or said the wrong thing; a strong telling-off:

‘I thought to myself, “You know perfectly well that this person is easily shamed”’ (Elaine, 6.253)

““Aw I’ve done it again...gone running off too fast”” (Linda, 5.209)

## 5. ‘The aftermath’

### *Relief and recovery*

Immediately following the session participants engaged in a phase of recovery, that is they began to fully experience the aftermath of the session. Participants expressed a sense of *relief* that the session in which they experienced so many difficult feelings, was over:

‘I was certainly quite relieved when she left the room’ (Alex, 11.547)

Table 9. Participant themes relating to their experience of ‘The aftermath’.

Super-ordinate theme	Sub-themes
<b>Relief &amp; Recovery</b>	Relief
	Beaten
	Shaken
	Confusion & bemusement
<b>‘Not in a good place’</b>	Anxiety
	Shame
	Guilt
	Self-doubt & Insecurity
<b>Exploration &amp; Problem solving</b>	Taking stock
	Help-seeking
	Curiosity

In addition to a feeling of relief, participants spoke about feeling negatively affected by what they had just experienced, including feeling *shaken* and *beaten*:

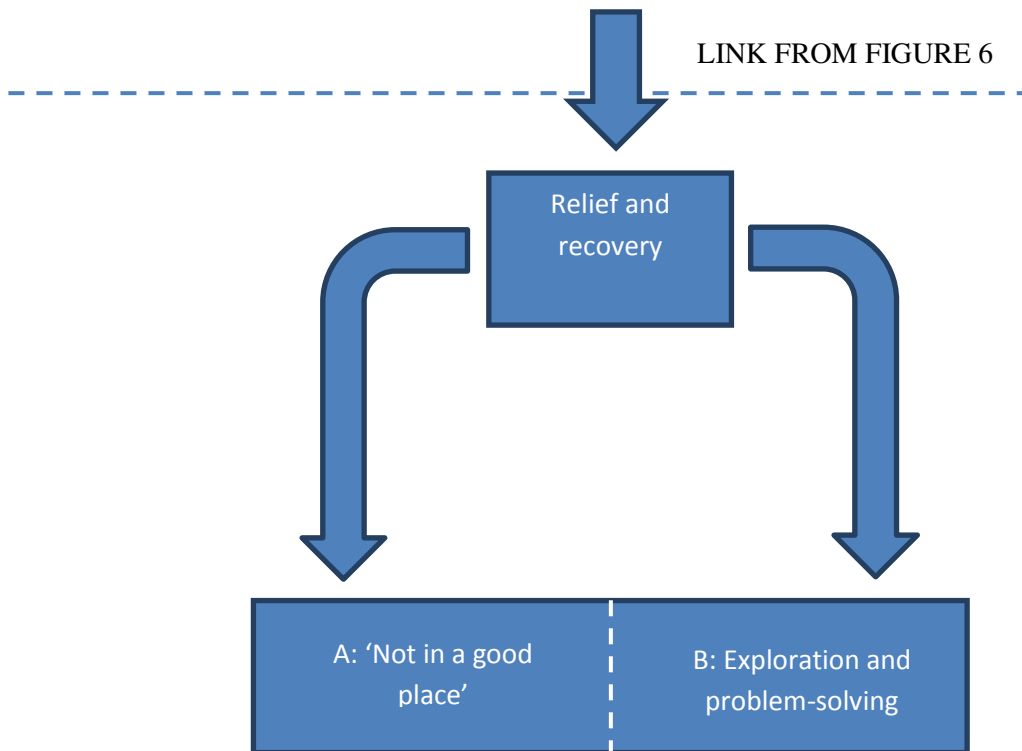
‘I literally just sat for a minute because I’d felt all this intense emotion’ (Ruth, 6.271)

‘I felt like I had taken a bit of a beating’ (Alex, 12.552)

*Confusion and bemusement* were also key elements of participants’ experience in the aftermath of their difficult session. This reflected their attempts to make sense of what had just happened:

‘How did this all get a bit messy?’ (Elaine, 6.250)

Figure 7. Participants' experience of 'The aftermath'.



Two processes followed the immediate aftermath of the session. Every participant engaged in elements of these processes. Some experienced both whilst others experienced parts of one process. For some participants being in *not a good place* led them to explore and problem-solve. Others struggled with being in a bad place and did not explore the difficulties they encountered in their session. Finally, it is worth noting that some participants engaged purely in exploration and problem-solving strategies, without feeling stuck in a bad place.

*A: 'Not in a good place'*

Participants carried high levels of *anxiety* into the period after the session, with particular features of catastrophic thinking:

‘Is she gonna complain about me?’ (Linda, 14.661)

There were powerful levels of *guilt* and *shame* following the immediate aftermath:

‘It didn’t feel good that I contributed to her feeling worse’ (Linda, 3.125)

Regarding his feelings of shame, one participant spoke about his reflections with a colleague who had previously engaged in therapy with his current client and had a similar experience:

‘We felt a bit like shamed little boys’ (Alex, 6.282)

For one participant, despite his feelings of protest at being criticised in the session, self-doubt remained in the aftermath, once he had some distance from the session:

‘It’s the doubt that creeps in isn’t it?’ (Simon, 9.405)

Feelings of self-doubt, in some cases, led to deeper *insecurities* about themselves not only as a therapist, but a person:

‘It challenged my view of myself as being a caring person and being a good therapist’ (Ruth, 9.422)

*B: Exploration and problem-solving*

Being outside of the therapy session allowed participants to *take stock* and re-evaluate what was going on in therapy that might have led to a mistake and how to address difficulties in the session. Speaking about a gap in therapy, one participant described how useful it was to stand back and consider things from a different perspective:

‘I think it was when the break did happen that it became clearer to me’ (Michael, 7.308)

Some participants channelled their initial feelings of anxiety into a sense of *curiosity*:

‘I thought, “I wonder how she’s taken what we talked about?”’  
(Margaret, 7.334)

Others took an opportunity to *seek help* from colleagues and supervisors:

‘I went and sought some re-assurance’ (Elaine, 6.295)

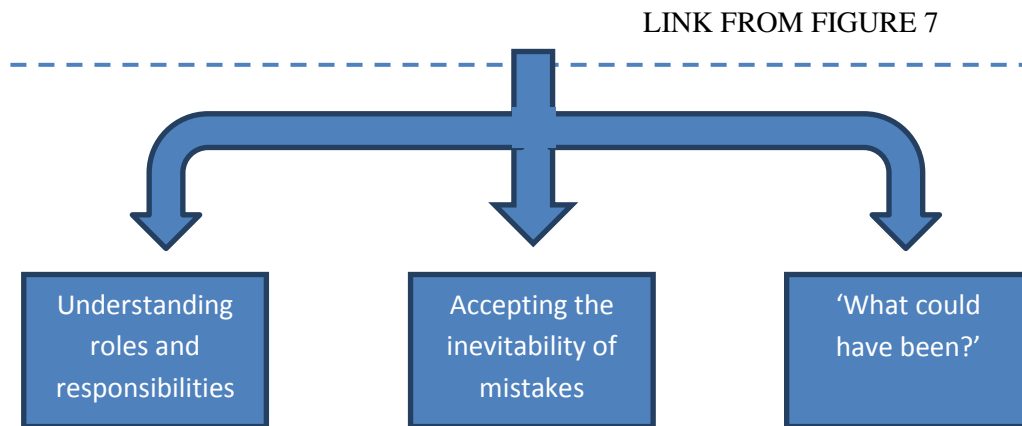
### 6. *Making sense*

Common across every participant was a set of reflections upon their experience of making a therapeutic mistake in therapy. These reflections occurred further along in the process and after both the immediate and continued aftermath. The experiences of reflection did not follow any particular pathway for participants. Instead, there were three types of reflections (See Figure 8). In contrast to the range of difficult and unprocessed thoughts, feelings and reactions both in the midst of the session and in the immediate and continuing aftermath, participants’ reflections captured a more processed and constructive perspective on their mistakes.

Table 10. Participant themes relating reflecting upon their mistake.

Super-ordinate theme	Sub-themes
<b>Understanding roles &amp; responsibility</b>	‘It takes two’ Taking responsibility (‘Owning up’)
<b>Accepting the inevitability of mistakes</b>	‘It had to happen’ ‘It was always going to happen’ Putting the mistake in proportion ‘It was worth it’/‘a silver lining’
<b>‘What might have been’</b>	Disappointment with self & process Regrets

Figure 8. Participants' experience of reflecting upon their mistakes.



#### *Understanding roles and responsibilities*

Participants undertook a process of *understanding* both their role in and responsibility for the mistake as well as those of their client. This included their understanding of the contributing factors to both the cause of the mistake as well as its repair. Some participants '*owned up*' to having made a mistake:

‘My anxiety caused the mistake’ (Elaine, 6.294)

Others acknowledged the *joint responsibility* for the mistake happening and the *joint venture in* working through the mistake in subsequent sessions:

‘It wasn’t only my fault...we worked it through and that then seemed to facilitate a significant shift’ (Simon, 2.67)

Participants *accepted the inevitability of mistakes* in different ways. Some participants alluded to a conscious justification of their actions that led to the mistake - that '*it had to happen*' – explaining the potential consequences had they not done what they did:

‘Had I been really, really boundaried in the beginning, she probably would have dropped out’ (Linda, 11.520)

Others reflected that their mistake was an *intrinsic part of the therapy*, that *'it was always going to happen'*:

'Ultimately it maybe something that was going to be, and it might just have been something that was going to happen (Alex, 13.611)

Participants often ascribed a *'silver lining'* to their mistakes that, in contrast to a conscious justification of their actions, they discovered some benefit to the therapy subsequent to the mistake happening:

'Whether we should be calling it a mistake or whether we should be calling it something that was actually material to be used in therapy' (Michael, 9.406)

Over half of all participants described a process by which they *put the mistake into proportion*, suggesting it was not as bad as it seemed or any worse than most mistakes:

'Is it a mistake beyond the ordinary? And I don't think it was a mistake particularly beyond the ordinary.' (Alex, 9.438)

Finally, participants reflected on their *regrets* about their mistakes as well as their *disappointment with themselves* on this particular occasion and with the way the *process* eventuated. Of note, is that participant regrets and disappointments were not self-defeating and did not reflect their overall sense of themselves as therapists.

'you feel like, "Uh, if only"...maybe if I picked up on this, things could have been a bit different' (Margaret, 6.272)

'If I was being a little more skilful than I am, then maybe this wouldn't have been a problem (Simon, 9.424)

'It just didn't go how I imagined I suppose' (Ruth, 7.311)

### 7. 'How I'm left'

Mistakes were considered by participants to be either *resolved* or *unresolved* (both interpersonally and internally), or left *uncertain*. The resolved mistakes were inferred through interpreting participants' transcripts, yet the experiences of unresolved mistakes were described in depth.

Mistakes were considered as unresolved both *interpersonally* and *internally*. It is worth noting that whilst some mistakes were unresolved in therapy, they were not necessarily internally unresolved.

Table 11. Participants' themes relating to 'how I'm left'.

Super-ordinate theme	Sub-themes
<b>Resolved</b>	Interpersonally Internally
<b>Unresolved</b>	Interpersonally Internally
<b>Uncertainty</b>	'Time will tell' Where are they now?
<b>Preoccupation</b>	Traumatised It's stayed with me'

Experiences of feeling *internally unresolved* included *not wanting to be judged unfairly* for an unresolved mistake:

'what bugs me more than anything is that there might be a person here that didn't see that I cared or felt that actually I wasn't doing the best that I could for them' (Margaret, 12.589)

There was a degree of *uncertainty* for some participants surrounding an on-going case, or need for supervision to come to a processed conclusion:

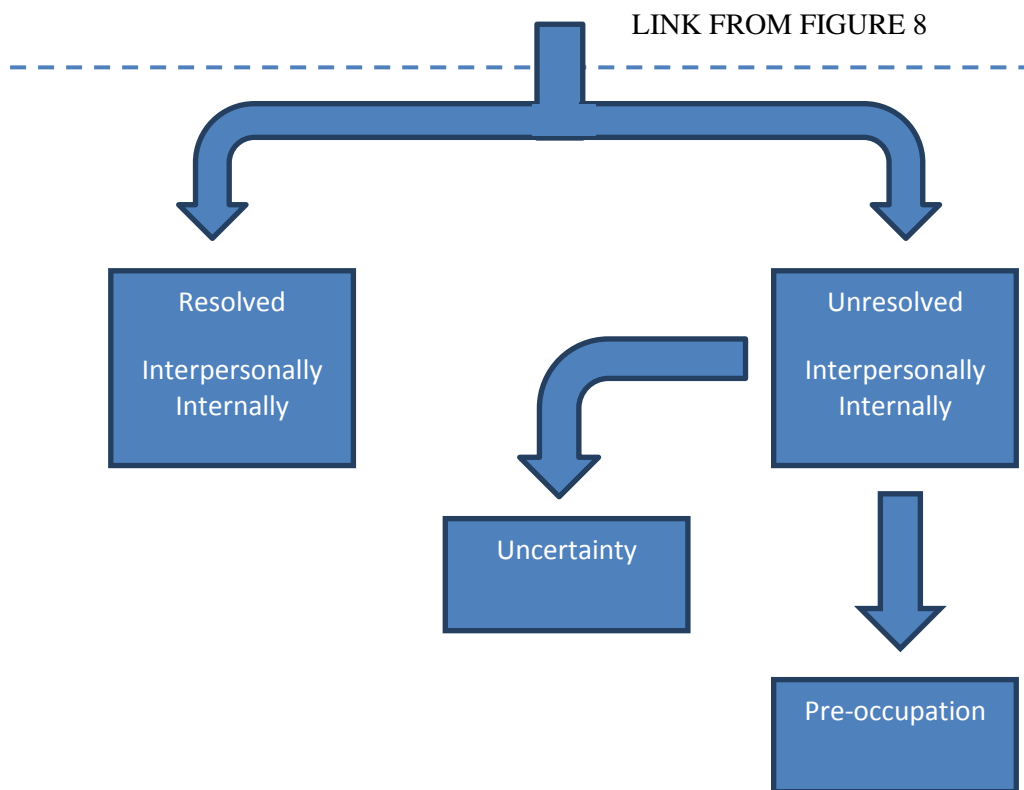
'I don't know how it will play out, that is something I am going to have think about in supervision' (Simon, 10.444)



Uncertainty also reflected participants' curiosity about what happened to their client following an unresolved mistake:

'I wonder if she is out there in the world with an axe to grind and a story for the next therapist about how the previous two pissed her off and weren't any good' (Alex, 10.462)

Figure 9. Participants' experience of 'How I'm left'.



For some participants, their mistakes impacted upon to the extent that they were *pre-occupied* by them months after they occurred and therapy had ended:

'...very forcefully a difficult memory that has sort of really lodged...there's a sense of it hitting deep' (Alex, 12.568)

One participant described how she feels traumatised by the unresolved mistake and is often full of *dread*:

‘I probably still think about her maybe once every other day...I’m still fearful of bumping into her...oh god, I don’t want to bump into her’ (Linda, 13.604)

### ***Summary of results***

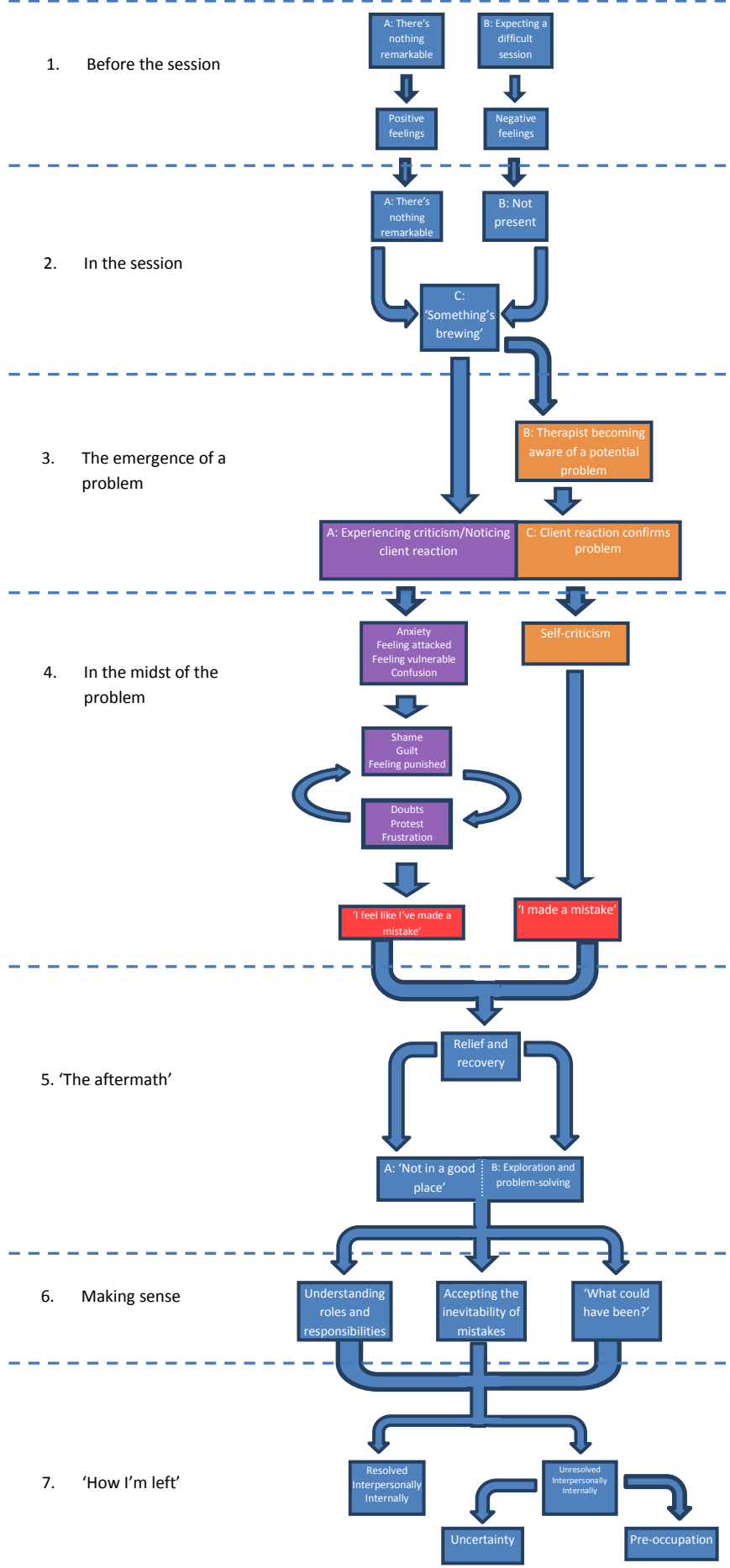
Participants’ experiences of therapeutic mistakes were viewed as a process, comprising a number of common stages and themes. Thus, rather than being experienced as a brief and discrete incident, participants’ mistakes emerged and endured across a period of time. As such, there was an interesting contrast between the characteristics of participants’ mistakes (e.g. boundary transgression, not listening to their client) and the process across which they experienced them. For example, whilst one participant described making an administrative error (a seemingly mild and innocuous mistake), they experienced it as ‘*all hell breaking loose*’. Conversely, while participants independently selected to talk about sessions in which they felt they made a mistake, their cognitive appraisal of the mistake differed from their emotional recollection of the event, reflecting a sense of ambivalence. Common across participants’ experiences was a *sense of something* changing. What was not always clear was a sense of specifically *what* was changing or *why*. As such, participants often felt their mistakes emerged *out of the blue*, in the form of client criticism. For those who were aware of the potential for them to make a mistake (in the form of a clinical dilemma), there was a sense of being *prepared* for it. As such, it was managed well. Many participants vividly described experiencing the emergence of a problem (i.e. being criticised) as indicative of a *whirlwind*: a bombardment of thoughts and emotions. All participants experienced a spectrum of reactions and coping styles in the aftermath of the session, from reeling and feeling scared, to actively problem solving and seeking help. Subsequently, participants arrived at a range of resolutions (both internally and interpersonally), with many coming to satisfactory resolutions, whereas others still struggled months later.

### ***Reflections on analysing the transcripts***

Analysing participants’ transcripts made me aware of the potential to be drawn into some unhelpful processes and provided some insight into how I should

approach the data. My initial understanding of mistakes, including a tendency to view mistakes in *black and white* terms and a propensity for self-criticism, initially impacted upon my interpretation of participants' accounts. Moreover, it was clear that criticism was a key feature in participants' accounts; participants criticised themselves or felt criticised. I found that I could be drawn into a critical role when engaging with transcripts. As such, this had the potential to distance me from participants' experience of making mistakes and to be unempathic towards their experiences. Reflecting upon this process in my research supervision was vital. In particular, there was an emphasis on bracketing my own views and opinions about participants' content in order to be a more curious and empathic researcher and better engage with the transcripts. It was also important to acknowledge how my theoretical interests could influence how I engaged with the data. For example, I often found myself tempted towards interpretations of unconscious processes, due to my interest in psychoanalytic theory.

Figure 10. Flowchart illustrating the complete process of participants' experience.



## CHAPTER FOUR

### Discussion

The aim of the present study was to explore therapists' experiences of therapeutic mistakes. Data was collected through semi-structured interviews and analysed through IPA in order to address the following research questions:

1. How do therapists constitute therapeutic mistakes?
2. How do therapists experience therapeutic mistakes?
3. How do therapists respond to and deal with therapeutic mistakes?
4. How do therapists understand the consequences of therapeutic mistakes?

The key findings from the analysis will be examined in relation to the wider literature. The findings will then be linked back to the research questions. This section will then progress to a critical evaluation of the research methodology, with a particular focus on its strengths and limitations; suggestions for future research will be made. Finally, the clinical implications of the findings will be considered alongside recommendations for clinical practice.

### *Key finding 1: Participants' constitution of mistakes was complex*

There appeared to be a difference between the types of mistakes that participants recognised in principle and those that they shared in their experiential accounts. The types of mistakes that therapists identified in principle were closely aligned with those outlined in their codes of ethics (e.g. BPS, 2009) and the existing literature, relating both to categorisations of common therapeutic mistakes (e.g. Buckley et al., 1979; Greaves, 1988) and boundary transgressions (Glass, 2003). I had anticipated that participants' experiential accounts would also reflect these types of mistakes. However, what emerged from the findings was a much more complex picture of mistakes, based on participants' experience. For example, participants' concerns regarding their mistakes seemed more important than the events themselves. Whilst participants identified common boundary transgressions, such as inappropriate self-disclosure and running over time in sessions, in principle their own accounts comprised mistakes such as

administrative errors, failures in receptiveness and expressing an interpretation that was not received well by their client, none of which are well represented in the literature.

In relation to Glass' (2003) model, the types of mistakes that participants shared appeared to be examples of ethical practice, the majority of which were non-boundary related. In other words, the findings of the current study might suggest the need for an expansion of Glass' model. Far from illuminating grey areas of ethical practice and boundary transgressions, what seems to have emerged from the findings of the current study relates to a sub-set of mistakes, namely *everyday mistakes*; these predominantly exist separate to boundary transgressions, and unethical practice. This sub-set would perhaps best be placed within Glass' ethical practice circle. It is nonetheless important to consider that whilst some mistakes certainly still exist within unethical practice (e.g. sexual misconduct, acting in an aggressive way towards clients), these were not uncovered in the findings of the current study.

Those few accounts that did relate to therapeutic boundaries commonly outlined in the literature were characterised not by a boundary transgression per se, but rather by the fear of making them. When these participants felt anxious about a breach of a boundary, they focused on protecting it. It was the action of protecting it, rather than its transgression, which resulted in their mistakes. Martin et al. (2011) discussed the way that some therapists protected their boundaries and themselves; in the process of doing so, the therapeutic relationship was compromised. This finding is also similar to Zur's (2004) suggestion that an over-emphasis on boundaries can compromise therapists' clinical judgement and thus affect the therapeutic relationship. This finding suggests that other processes may contribute to therapists' mistakes.

Another associated boundary issue related to therapists' flexibility over the therapy setting. For example, one participant felt they had changed the time and place of sessions at the client's request, with varying degrees of success. This raises an interesting issue when considering Zur's (2004) claim about boundary transgressions, that they are appropriate if they are carefully considered, with the client's welfare in mind. The participant in the current study felt that being flexible with these boundaries early in therapy, facilitated the development of a

strong therapeutic alliance. In this case, the *boundary transgression*, in Zur's (2004) terms, might be seen as carefully considered. The point at which this changed for the therapist was when the use of flexible boundaries became less conscious, less considered and impacted on the client by representing unpredictable boundaries, despite their earlier wishes (e.g. extended sessions). It was at this point that the participant constituted this flexibility as a mistake. The findings in this study illustrate the debate in the literature between boundary transgressions representing therapeutic tools, in this case flexibility in the interests of the client, or therapeutic mistakes (Hanson, 2005; Guistolise, 1996). It also alludes to the idea that mistakes are labelled as such when a negative consequence emerges.

Although participants may have had concerns about the potential for a mistake, they were only identified through feedback from their client or through reflection on their intervention. In some accounts relating to a clinical dilemma, participants in this study were aware of the potential for their decision to go '*either way*', suggesting that their considered decision may result in a positive or negative outcome. For example, had Linda's client reacted well to being given another book chapter to read (i.e. a well-intentioned action), one assumes she would not have appraised this as a mistake.

Seedhouse's (1988) distinction between evaluating behaviour either by its intention or its outcome is a useful model when examining the findings in this study. Whilst the types of mistakes participants referred to perhaps reflected more 'ordinary' or less severe mistakes, they may instead have reflected everyday therapeutic *procedures or occurrences* that were not well received by clients; these are taken to include a theoretically driven action (e.g. interpretation) or a technically correct action (e.g. finishing on time). Dalenberg's (2000) study on trauma clients' retrospective criticisms of their therapists supports this notion; client criticisms in Dalenberg's study included dissatisfaction with therapist interpretations and feelings that their therapist did not believe what they were telling them. An important implication is that these criticisms do not necessarily reflect an inaccurate interpretation or an unempathic therapist and thus examples of therapeutic mistakes. Conversely it is feasible that therapists may execute a

boundary transgression, yet this not be immediately acknowledged as resulting in a therapeutic mistake by association of its outcome.

In the context of the current study, this then raises the question as to whether all the accounts described by participants were mistakes or rather were *constituted* as such based on how they were *felt* to be as a result of their outcome in the session. In many of participants' shared accounts, mistakes were viewed initially as an otherwise technically sound judgement, rather than an objective mistake. This view is supported by Altshuler's (1989, p.79) assertion that 'few behaviours categorically and always imply a mistake'.

Another important question arises as to whether therapists constitute mistakes differently when asked to recall them, than when discussing them more generally and what might account for this. One such factor could be the difficulty therapists experience in discussing mistakes (Yourman, 2003; Dalenberg, 2004), particularly those involving emotive experiences. This would suggest that participants may have steered away from discussing severe mistakes, instead bringing examples in which they would feel less shamed and judged. Another consideration lies in the methodology. Participants' decisions to speak about more *everyday mistakes* may have reflected their interpretation of the expectations of the study, based on details in the participant information sheet or interview. In particular, it was made explicitly clear that the researcher was not interested in gross unethical behaviour. This may have led participants to consider examples of mistakes towards the other extreme and thus minor mistakes.

However, the accounts provided by participants, however minor in appearance (e.g. an administrative error), were described in highly emotive terms (e.g. '*all hell broke loose*') and as such were not experienced as minor events. Therefore, it seems unlikely that these accounts were selected solely on the basis of their severity. Perhaps then, participants recalled accounts of mistakes that were particularly salient and made an impression on them.

Indeed, many of the mistakes discussed included feelings of client criticism. Previous research has found that clients often have difficulties expressing negative feelings towards their therapist (Safran & Muran, 1996) due to their fears that doing so would impact upon their subsequent experience of therapy. Whilst this could indicate that participants' clients in the current study



were more forthcoming with criticism towards their therapists, it may be that instances of direct criticism are so rare that they stood out in participants' minds and were thus more readily constituted as a mistake. This might offer an explanation as to why so many participants recalled mistakes of this nature in the current study. This finding goes some way to understanding how therapists constitute therapeutic mistakes (Research Question 1). They appear to differentiate between their general constitution of objectively defined mistakes in principle and their subjective experiential understanding. The constitution of mistakes in participants' accounts seemed altogether more complex, based on the presence of wider contextual factors such as emotion and outcome. What appeared most evident from all participants' experiential accounts was the emotional resonance that mistakes held. In the following sections I will discuss the role of emotion and in particular the prevalence of client criticism in more detail.

***Key Finding 2: Emotion was a key characteristic in participants' experiences***

Emotion was a key feature throughout participants' accounts of mistakes, prior to, during, and after the session (See Figure 10, results section). Focusing firstly on the feelings prior to the session (See Figure 3), these were based upon an historical context of the therapy with their client, in some cases from the preceding session; these represent important intersession experiences (e.g. Schröder, Wiseman & Orlinsky, 2009). Schröder et al. (2009) conducted a study of therapists' broad intersession experiences, which yielded a number of findings relevant in the context of the current study. Schröder et al. illustrated the prevalence of the thoughts and feelings that therapists experience relating to *holding in mind* their clients between sessions; they distinguished between intersession experiences based on work related thoughts (i.e. problem-solving) and affect related thoughts (i.e. recalling feelings belonging to their client or themselves). Participants in the current study described experiencing *affect related* thoughts and feelings prior to the session in which their mistake emerged. Here, many of the participants described feeling frustrated and apprehensive about the session or the therapy as a whole. This relates to Schröder et al.'s assertion that

intersession experiences are more frequently reported by therapists who are experiencing difficulties in practice.

Emotions also played a significant role in participants' in-session experiences (See Figure 4). Participants' feelings prior to the session persisted early into the session. Furthermore, participants often noticed an emotional change within themselves as the problem emerged. Significantly, in the midst of the problem (i.e. when being criticised or noticing a client's reaction), participants experienced a range of intense emotions, including shame, guilt, feeling attacked and feeling punished. This relates to a body of literature on therapists' experiences of difficult and upsetting sessions (Smith, Kleijn & Hutschemaekers, 2007; de Oliveira & Vandenberghe, 2009; Bottrill et al., 2010), which provides some understanding related to therapists' experiences of therapeutic mistakes. The striking feature of this body of research is the emotional impact of difficult sessions on therapists. The emotional impact of these difficult sessions related strongly to those experienced in the current study, including feelings of shock, feeling overwhelmed, insecure and incompetent as well as feelings of frustration. Therapists' experiences of therapeutic mistakes can be framed in similar terms; it may be fair to assume that sessions in which therapeutic mistakes are felt to be made are also difficult sessions and similarly unsettling. An interesting contrast exists when comparing the findings of the current study with those of de Oliveira & Vandenberghe (2009). Whereas they concluded that difficult emotional reactions in therapists were a source of therapeutic error, the current study highlights a wider emotional process for a subset of difficult and upsetting sessions in which mistakes are also a feature. In particular, the current findings offer a closer examination of these sessions, whereby mistakes lie at the heart of difficult emotional experiences. In other words, whilst therapists' feelings often contributed to their perceived mistakes, they were also prominent in the midst of the problem and played a significant role in the aftermath.

Participants' emotional experience in the midst of the session (as a result of experiencing criticism from their client or engaging in self-criticism) can be understood by examining self-conscious emotions (Tangney, 1995), particularly shame & guilt. Gilbert (1998) distinguished between *external* and *internal* shame. External shame encompasses feelings that one is seen and judged in a bad light by

others, found out to be lacking in ability and being an object of contempt or disgrace; this concept could be applicable to participants' experiences of being criticised. Internal shame, on the other hand, relates to a negative evaluation of oneself, including (at its extreme) feelings of being bad, flawed and worthless; this concept could apply to participants' experiences of self-criticism after realising they had made a mistake. Gilbert asserted that shame is *involuntary* and *unwanted* and a state or place from which one wishes to escape. This notion supports participants' experience of wanting to *get through*, *escape* and *survive* the session, as well as their expressions of *relief and recovery* afterwards.

The presence of shame and guilt in the findings of the current study might also be accounted for by Tangney's (1995) suggestion that shame and guilt occur in response to individual failure. Guilt, characteristically an internal process was also a feature of participants' experiences of being criticised, yet interestingly this was not a feature of participants' experiences of self-criticism. Perhaps this might have been expected, in line with the literature on self-conscious emotions. What the current findings may allude to is the notion that both internal and external processes, whilst sometimes distinct, can also occur simultaneously.

The intensity of the emotions therapists felt in the midst of the session influenced the way in which they constituted their actions (or inactions). In some cases, stronger feelings - of guilt, shame or embarrassment - led participants to feel like they had made a therapeutic mistake of proportionate severity: the more intensely the emotion was felt, the more severe the mistake was perceived to be (e.g. '*I think it was an association to feeling ashamed really that it felt to be a such a huge mistake*' [Alex, 4.167]). Moreover, the intensity of participants' feelings appeared incongruent with their intellectual appraisal of the mistake, both in the way they reflected upon the mistake in its aftermath and within the interview. A psychological theory that addresses this finding is that described by Beck, Emery & Greenberg (1985): *emotional reasoning*; a cognitive process in which one assesses situations based upon the way one feels. This raises a question as to whether the constitution of mistakes is biased by therapists' emotional experiences within sessions. In other words, therapists may misconstrue an otherwise technically sound or theoretically informed action as a mistake, based on their emotional experience after perceiving a negative client response.

Conversely, this could imply that therapists may fail to recognise a mistake without this emotional experience.

Whilst participants' experiences in the session were characterised by intense emotions, these emotions were overtaken by feelings of relief and recovery when the session had come to an end (See Figure 7). This represented participants' opportunity to '*take stock*' and make sense of what had happened.

In summary, this finding suggests that therapists constitute whether or not they have made a mistake based on their emotional experience i.e. what feels like a mistake at the time, based upon immediate emotional feedback. This finding also provides insight into the emotional landscape surrounding therapists' experiences of therapeutic mistakes. Participants' emotions also mediated how they responded to and dealt with their mistakes. As participants recovered from the emotionally laden session, in which they reacted *unthinkingly*, they progressed towards some *thoughtful responses*. Finally, participants understood the consequences of therapeutic mistakes in terms of their emotional impact.

***Key Finding 3: Participants engaged in an on-going and iterative process of meaning making***

As outlined in the results section (See Figure, 10), a process for experiencing mistakes emerged across participants' accounts. Within this process was on-going meaning making. In the lead up to the mistake, participants were making sense of a hitherto undefined phenomenon (See Figure 5). This was characterised by a sense of '*something brewing*', with therapists also noticing changes in their client, and themselves. At this stage of the meaning making process, before a mistake had been constituted, there was a sense of something changing that was in the participants' peripheral awareness. For example, participants often described feeling bored or disconnected. There may be several existing concepts which could help to understand this process, including *empathic failures*, and *countertransference*. Mordecai's (1991) model of *empathic failures* proposed that empathic failures fuel therapeutic mistakes. The sense of something brewing may well have reflected the essence of an empathic failure. Furthermore, Mordecai believed that the responsibility for recognising signals of hidden empathic failures lays with therapists; examples of such signals include: signs of physical distress,

avoidance of eye contact, hesitancy or rapidity of speech in clients or therapists, therapist boredom, therapist feelings of inadequacy, threatened premature termination of therapy by the client or threatened or acted out boundary or contrast violations. It is interesting to note that some of these signs of empathic failures were described by participants in the current study as signs that *'something was brewing'*, particularly physical distress and boredom. Whilst these signals were often recognised, they were not always acknowledged or understood at the time and participants described being *'taken aback'* by what followed, often client criticism. In contrast to Buckley et al.'s (1979) study, which suggested there existed a number of observable therapeutic mistakes, noticeable by supervisors, Mordecai places an emphasis on the role of supervisors in recognising *signs* of empathic failures in their supervisees and thus facilitating therapists to acknowledge and understand their own processes, should therapists not recognise these themselves. At this stage in the meaning making process, participants only had a partial understanding of the situation. Whilst Mordecai's classification model has much to contribute to the current study's findings, the limitations in Mordecai's study outlined in the initial literature review must again be acknowledged (i.e. its lack of empirical basis). Also Mordecai's model suggests that many hidden empathic failures are obscured by an altogether more complex phenomenon: *countertransference*. Alternatively, it could be argued that not all client criticism derives from a therapists' empathic failure, but instead reflects clients' anxiety about a therapist action (e.g. interpretation) that highlights a sensitive issue for them (i.e. it *touches a nerve*). As such, therapists' feelings of being criticised may be viewed as a *countertransference feeling*. Either way, countertransference is an important concept for understanding participants' experiences.

Participants' partial recognition of changes within themselves can be understood in terms of countertransference. Countertransference is the term often used to refer to all of a therapist's reactions to a client (e.g. Heimann, 1950), irrespective of whether they are conscious, an unconscious reaction to a client's transference or otherwise related. For example, Casement (1990) distinguished between *personal countertransference* (that which belongs to the therapist's psychology) and *diagnostic transference* (that pertaining to the client's

pathology). Furthermore, Hayes, McCracken, McClanahan, Hill, Harp & Carozzoni (1998, p.468) claimed that countertransference is influential in therapists' use of themselves as a 'therapeutic instrument'. However, Gelso & Carter (1994) suggest that therapists' use of countertransference for gleaning important information and insight into the relationship dynamics in-session is dependent on the awareness of such feelings. Whilst there are alternative definitions of countertransference in the existing literature (Hinshelwood, 1991; Sandler, Dare & Holder, 1992), the chosen definitions were selected on the basis of their relevance to the current findings. As participants' peripheral awareness of changes within themselves were not fully understood and worked through, this insight was not available. Waska (1999) discussed therapist *enactment*; the frequent and often unavoidable nature of acting out by the therapist in response to countertransference feelings, yet claims this error is often required to fully understand the client's unconscious fantasies. Furthermore, whereas Buckley et al. (1979) found a lack of awareness of countertransference feelings itself to be a common mistake in therapy, Langs (1982) claimed that unrecognized countertransference is the most frequent *cause* of therapeutic mistakes. The implication that follows an examination of the countertransference literature is that therapists' capacity to acknowledge their countertransference reactions, understand them and act therapeutically appears to be a crucial in therapists' ability to make sense of and work through therapeutic mistakes (i.e. therapists' capacity to respond rather than react to their feelings towards clients).

Interestingly, participants' accounts suggested that they could only experience a *mistake*, once they had been appraised as such, a large part of which occurred outside the session. Participants' in-session experiences instead related to an emerging '*problem*', not yet defined as a mistake. Participants' attempts to make sense of this problem were affected by their emotional state. As discussed previously, although these difficult emotions were influential in therapists *feeling* as though they had made a mistake, therapists were yet to fully consolidate their understanding of the situation. It was clear in participants' accounts that mistakes were constituted retrospectively by participants. In other words, therapists seldom concluded that they had made a mistake within the session in which the mistake was made. For one therapist it was only weeks later, when another client issue

was discussed in supervision, that the therapist formulated that a mistake had been made. The importance of supervision in participants' experiences will be discussed later.

In the aftermath (See Figure 7), participants were attempting to make sense of what happened in the session based on a more cognitive appraisal of the situation, as well as attempting to respond through problem solving and seeking help (e.g. Schröder et al., 2009). Yet participants were also still experiencing some residual emotional effects of the session, characterised by the theme: '*not in a good place*'. Furthermore, participants were attempting to make sense of their emotional states (i.e. 'why do I feel like this?'). This element of participants' experience particularly alludes to Sullivan's (1940) notion of the entwined duality of therapists' roles. Sullivan (Sullivan, 1940, p.207) described the therapist as a 'participant-observer'; whilst a therapist's role is to observe and make sense of what is going on in the therapeutic encounter (reflecting a sense of detachment), it is their engagement and participation in the therapy that provides a source of vital information for their observation (i.e. their emotional investment and reactions). In the context of the current study, this can provide a way of understanding the oscillatory nature of participants' sense making, not only in the aftermath, but throughout the process of making mistakes.

At this stage of meaning making, participants often re-appraised their mistake in terms of its severity or in fact its existence, based on information and resources that were not available to them in the '*midst of the problem*'. This finding is supported by Hill et al.'s (2003) study on therapists' experiences of being a target of client hostility. Whereas participants in their study experienced strong feelings of self-doubt and incompetency within the session, only a small minority of client anger events were subsequently appraised by therapists to be mistakes. Furthermore, those who defined their actions as mistakes considered the client's anger to be disproportionate. This relates particularly to participants' experiences of re-appraisal in the current study, in which they questioned if the mistake was '*that bad*' or a mistake '*beyond the ordinary*'.

Based on their accounts, participants reflected upon both positive and negative consequences of making therapeutic mistakes. A common consequence understood by participants was the *unlocking* nature of their therapeutic mistakes.

In other words, mistakes represented a working through of necessary material that was needed in order for the therapy to progress. Several participants spoke about their mistakes in terms of representing a turning point in therapy with their client. This illuminates the body of literature relating to the recovery from therapeutic ruptures in psychotherapy (e.g. Safran & Muran, 1996), which claims that when a deterioration in the therapeutic relationship is dealt with properly, opportunities for therapeutic change is possible. Furthermore, McWilliams (2004) views mistakes as an opportunity to address underlying therapeutic ruptures. Given the similarity in the process identified in this study with that of a recovery from a rupture, there may be some overlap in the concepts or processes at work.

This nonetheless illustrates how some participants were left with a positive meaning of the experience of making a mistake. However, some participants' reflection upon their experience was characterised by a lack of a resolution, uncertainty and pre-occupation. In other words, the sense participants made of their mistakes continued to be grappled with, often in the context of continuing emotional experiences relating to the mistake. However, in cases where a therapy ended without resolution or in an undesirable fashion, one cannot be certain to what extent this was attributed to therapists' mistakes. In such accounts of mistakes, participants had described a therapy with on-going difficulties and complexities. Perhaps it is not clear whether it was the particular mistake that was unresolved or the broader issues in therapy. This may well relate to other elements of their experience, in terms of their experience of being criticised, or being involved in a rupture and subsequent negative feelings.

A significant proportion of participants' meaning making occurred after the session in which the mistake occurred, often in consultation and supervision with others. Thus, tied up with the meaning making process is the way in which therapists respond to and deal with therapeutic mistakes (Research Question 3). This relates to Schröder et al.'s (2009) *work related* intersession thoughts. Some apologised, some attempted to understand the mistake in terms of a formulation, whilst others sought colleague advice or re-assurance.



*The role of supervision*

The role of supervision mediated participants' meaning making of mistakes, evident both by its presence and absence. When participants took their cases to supervision, they were facilitated to make useful sense of the session, whereas a lack of this opportunity (based either on the unavailability of supervision, or a reluctance discuss the session) hindered their ability to make further meaning from their experience. This highlights the functions of supervision, including the facilitation of self-reflection (Holloway, 1995) and supporting and reducing stress (Proctor, 1994). It also highlights the need for contracting in supervision (Teitelbaum, 1990). The literature on supervision has traditionally focused on the role of supervisors in 'facilitating the development of therapeutic competence in the supervisee' (Bernard & Goodyear, 1992), 'imparting expert knowledge, making judgements of (supervisee) performance', and acting as a 'gatekeeper' to the profession (Holloway, 1997). There are many different types and models of supervision, including developmental and orientation-specific models; each has its own perspective on how much attention is paid to the interpersonal aspects of therapy and in particular how therapists' emotional reactions to clients are considered. For example, less attention is typically paid to therapists' emotional reactions to clients for therapists being supervised within a CBT approach (with a greater emphasis on client well-being and therapist competency) than in a psychoanalytically based supervision. That being said, Prasko & Vyskocilova (2010) demonstrated how the exploration of therapists' countertransference reactions (or *schematic reactions* [Beck, 1995]) can be explored in CBT supervision, through an examination of therapists' thoughts, feelings, behaviours and physical feelings. Prasko & Vyskocilova also claimed that this exploration had potential benefits for the therapeutic relationship, such as in understanding client resistance in therapy.

Teitelbaum (1990) claimed that contracting is an often overlooked aspect in supervision and can lead to misconceptions between supervisor and supervisee of the role of supervision and what each expects of the other. This may provide one explanation as to why some participants felt reluctant to take their mistakes to supervision or found that their supervision was lacking. Teitelbaum suggested that supervisors should ensure that contracts are negotiated in supervision, rather than

relying on adhering to an evaluative model of supervision, in which client problems are viewed as a function of therapists' limitations. Teitelbaum (1990, p.95) alluded to the appropriate management of supervisee anxiety in supervision, suggesting that either disruptive levels of supervisee anxiety or the absence of its discussion can impact all levels of the 'tri-personal field' encompassing supervisor, supervisee and client. Whilst therapist anxiety may relate to therapeutic mistakes, there exists no literature to directly support contracting for the discussion of mistakes in therapy, nor to indicate the discussion of mistakes as a function of supervision.

That being said, Haggerty & Hilsenroth (2011) promoted the use of videoed sessions for discussion of mistakes in supervision, including those within psychodynamic and psychoanalytic training, not only with trainee psychotherapists but for use in regular supervision for qualified psychological therapist. They claimed that the use of video provides an opportunity for the supervisory dyad to explore the content and processes within sessions, free from the limitations of second-hand therapist reporting, which are subject to memory and affect influences. An important facet of this approach is that supervisors not only observe their supervisees' videos but also share their own, contributing to a sense of openness, honesty, support and acceptance. The agreed use of video is one way to promote the discussion of mistakes and importantly the associated difficulties relating to confidence, anxiety, emotion and pre-occupation. They may also provide opportunities to discuss the significance of the stages in the lead up to potential mistakes. Whilst Zachrisson (2011) suggested the use of video may negatively impact the safety and confidentiality of the therapeutic space between therapist and client, Haggerty & Hilsenroth's (2011) suggestion illustrates some core processes that such an intervention can facilitate for making sense of mistakes in supervision.

In summary, participants' meaning making was an on-going process. Significantly, participants were making sense of different phenomena throughout the situation, both as it progressed and in its aftermath. This finding suggests that participants constitute mistakes differently at different points, e.g. as *something brewing*, as an *emerging problem* and as a *turning point*. A significant element of participants' experience of mistakes was an active and on-going engagement in

making sense of what was happening. Participants' ability to deal with and respond to their mistakes was mediated by their understanding and awareness of what they were dealing with. Furthermore, when participants dealt with the mistake, they were able to gain further meaning, often facilitated through sharing the mistake with supervisors and colleagues. A common consequence was an improved understanding of the mistake and a resolution.

What is also important to consider is that participants' mistakes were not only subject to intrapersonal meaning making, but also characterised by an interpersonal negotiation.

***Key Finding 4: Participants' therapeutic mistakes were experienced as an interpersonal negotiation***

As much as participants described their experiences of making mistakes in terms of intrapersonal processes, it became clear that there was an interpersonal negotiation between therapist and client, in their constitution and experience of mistakes and the ways in which mistakes were responded to and dealt with. Therapy is seen as an interpersonal exchange between two people (Winnicott, 1988). Participants in this study described how their clients influenced their appraisal of having made a mistake. Thus participants did not constitute their therapeutic mistakes alone. In the majority of participants' accounts, problems were often presented to therapists by their clients through either directly or indirectly expressing negative feelings towards their therapist. This was then perceived by therapists as criticism. Those participants who recognised the potential for a mistake independently often then received confirmation from their clients, which led them to believe they had made a mistake. This serves to provide an interpersonal and subjective context to the emergence of therapeutic mistakes.

Of particular relevance here is Hill et al.'s (2003) study on therapists' experiences of being the target of hostile anger versus suspected and unasserted anger from clients. These concepts strongly relate to participants' experiences in the current study of feeling directly or indirectly criticised, respectively. Those who experienced hostile anger (in Hill et al.'s study) and feelings of being criticised (in the current study) similarly reported feeling taken aback, frustrated, anxious, incompetent and flustered when on the receiving end of a perceived

*attack* by clients. Furthermore, participants in Hill et al.'s study who experienced hostile anger expressed feelings of frustration, retaliation and avoidance, again similar to the current study's findings, in which participants described feelings of protest, frustration and retaliation. Hill et al.'s findings support the findings in the current study of an interpersonal negotiation of a mistake, between therapist and client, characterised by feelings of criticism. The experiences of participants in this study were not of making a clear-cut and well-defined mistake, which impacted upon the therapeutic relationship; instead, mistakes were constructed through a process between therapist and client. In addition, Safran et al. (2001) suggested that therapists are likely to respond to clients' expressions of negative feelings with expressions of their own negative feelings; this in turn can detrimentally affect therapy outcome.

A central theme of participants' experiences within this interpersonal exchange was a sense of attack (e.g. '*I had a feeling that I was under cross examination*' [Linda, 13.600]). This was not only observable through participants' experiences of feeling criticised, but also present in participants' responses to being criticised, characterised by a sense of retaliation and frustration (e.g. '*...annoyed because he was just kind of pissing on the therapy effectively and putting me down*' [Simon, 10.483]). Attack also featured in participant accounts where they criticised themselves. Also, as discussed earlier, participants often experienced frustration towards their clients prior to the session, based upon previous session material or feelings. This sense of *attack* was characterised for some in the description of an *in-session* experience, which felt like a *battle* (e.g. '*it felt like I was being knocked into another place*' [Alex, 11.531]); participants described the importance of *getting through* or *surviving* the session; In summary, attack featured between therapist and client and within therapists. A theory that could account for this interchange is that of *Cognitive Analytic Therapy* (Ryle, 1989), in particular *reciprocal roles*. This theory describes how individuals can find themselves drawn into one of two roles related to a particular behaviour (e.g. being critical-feeling criticised) or internalising both roles (being self-critical-feeling criticised). In the current study, it was evident that in cases where therapists were not directly criticised by their clients in relation to a mistake, they tended to be more self-critical.

Whilst participants described difficult interpersonal experiences, characterised by feeling criticised and attacked, it was nonetheless necessary feedback in order to first respond to the emergence of a problem and to subsequently make sense of it. One then wonders what happens if clients' negative feelings are not expressed either directly or indirectly. A useful way of thinking about a problem before it has been brought into full awareness is that of a *therapeutic rupture* (Safran & Muran, 1996). Safran & Muran (1996, p.447) define therapeutic ruptures as, 'patient behaviours or communications that are interpersonal markers indicating critical points in therapy for exploration'. Furthermore, Safran & Muran (1996) distinguished between two types of rupture markers: *confrontation* and *withdrawal*. Applied to the current findings, this suggests that participants' *in-session* experiences were reminiscent of therapeutic ruptures, the markers of which related to clients' direct or indirect negative feedback, respectively.

Safran & Muran (1996) also posited that therapists were responsible for facilitating clients to address their reluctance to express negative feelings, based on an awareness of the potential for, or the presence of a hitherto unacknowledged rupture. In the present study, it appeared that clients independently shared their negative feelings towards their therapist, who was *caught off-guard* or made aware of a problem *out of the blue*. Whereas Safran & Muran (1996) asserted that clients often display a reluctance to share negative feelings about their therapist (towards them), the findings of the current study suggested that clients were often forthcoming with criticism. This disparity merits further investigation, perhaps through interviewing clients and ascertaining the factors involved in acknowledging and dealing with negative interpersonal feelings in therapy.

That clients directly criticised their therapist in some cases and indirectly communicated a problem in other, suggests that therapists were unaware of the presence of a rupture or a mistake, until such feedback, as Nathanson's (1992) research would suggest; Nathanson's assertion was that ruptures are often hidden and go unrecognised. This would then serve to highlight Safran et al.'s (2001) recommendation of the importance for therapists in recognising ruptures in therapy and thus Mays & Franks' (1985) claim that it is the responsibility of therapists to prevent further deterioration, once ruptures are recognised. This

notion is further developed in light of the findings in this study, which identified a continuum of awareness of a problem, starting from a lack of awareness, to noticing changes (i.e. '*something's brewing*'), to fully acknowledging a problem. This would suggest two things; firstly, therapists have a range of information with which to acknowledge the presence of a problem in therapy, however the information which most effectively crystallises a problem arrives from clients. Secondly, if clients do not communicate any criticism towards therapists, the exploration of genuine and necessary ruptures is unlikely to happen.

This implies the need for therapist strategies for promoting the awareness of problems further along this continuum, with or without their client's help. Epstein & Simon's (1990) Exploitation Index is an example of a strategy that aims to facilitate therapists' awareness of such issues. Whilst the current study enabled participants to reflect upon their experiences in the interviews, their reflections suggested that this was not always achievable when problems were emerging in therapy, in the lead up to therapeutic mistakes. This, along with other recommendations will be discussed in relation to the section on clinical implications.

In summary, therapists' constitution of therapeutic mistakes can be understood through exploring the concept of therapy as an interpersonal exchange between two people. Furthermore, participants' experiences can be understood in terms of initially unspoken ruptures in therapy that emerged through an interpersonal negotiation, which ultimately led therapists to construe the situation as a mistake. Participants in this study did not talk about their mistakes as the product of an independent action that had a direct impact on the client. Instead, mistakes were co-constructed and reflected a communication between therapist and client (at different levels of consciousness). The interpersonal negotiation was largely characterised by feelings of being criticised or having one's action confirmed as unsatisfactory. What followed appears to resemble the interpersonal processes common to therapeutic ruptures, experienced by participants as a sense of *attack* or a *battle*. The resolution of mistakes, when possible, was aided by opportunities for reflection and reformulation as part of another significant interpersonal exchange, that of supervision (discussed earlier).

### ***Evaluation of methodology: Strengths and limitations***

This study focussed on a relatively uncharted area in psychotherapy research. Previous research has focused on either an objective classification of mistakes relating to distinct client groups and specific groups of training therapists or the experience of training therapists in their work with a particular sub-type of typically *difficult to treat* clients. Other literature has focused on researchers' personal experience, observations, case studies or commentaries.

### ***General research design and methodology***

This study utilised IPA (Smith et al, 2009) in order to explore therapists' experiences of therapeutic mistakes. The data that emerged from the use of this methodology predominantly comprised participants' experience and meaning making and served to highlight how the study adhered to the standards, assumptions and procedure outlined by Smith et al. (2009). One consideration, however, was the way in which the participants' experiential data was presented as part of a process. The use of a flowchart/model reflected ways of structuring findings, reminiscent of those used more commonly in a grounded theory approach to qualitative data (Miles & Huberman, 1994).

### ***Sampling and recruitment***

A strength of the participant recruitment strategy was that it yielded a relatively homogenous group of psychological therapists working in the NHS (in Yorkshire), working with adults using talking therapies on a one-to-one basis in a consultation room. Whilst not all participants were clinical psychologists or worked solely with working age adults, I was not aware of any reasons for treating participants differently. In fact, a strength of the research was that the findings reflected some commonalities in the experiences across the whole sample, the findings of which can be of interest and applicable to all psychological therapists of varying theoretical orientations. By the same regard, this could also reflect a limitation of the study and raise the need for caution in interpreting the findings. One could argue that the findings are applicable to all but specific to none. In other words, the findings may lack strength when particular psychological therapists are interpreting the findings. For example, only

two psychoanalytic psychotherapists were interviewed. It is unrealistic to suggest that the findings represent the experience of therapeutic mistakes for all psychoanalytic psychotherapists. That said, even if seven psychoanalytic psychotherapists had been interviewed, the representativeness of the findings to psychoanalytic psychotherapists might still be questioned.

More generally, the recruitment strategy, consisting of e-mail invitations to 97 psychological therapists only yielded nine responses, two of which, following discussion about the research, decided not to participate (see method section). As such, the psychological therapists who decided to take part in the study also represented the minority of psychological therapists that were invited. Thus it is also worth considering what made these participants *want* to participate. As a result, the findings in the study may be based upon a particular *type* of therapist, for example one which is reflective, courageous, interested in the topic or in need of an extra space for talking about mistakes.

Furthermore, this sample may indicate a self-selection bias, in that participants chose to talk about their mistakes because of a sense of self-assurance or confidence in talking about their potential limitations or anxieties. This might also have the potential to limit the general applicability of the findings to those who are already comfortable acknowledging and discussing therapeutic mistakes. An implication, and perhaps an obvious paradox, is that it is not clear how participants who chose not to share their experiences (i.e. the majority), experience therapeutic mistakes; they may, for example, consciously avoid the topic due to discomfort or anxiety. Answers to these questions might yield some interesting findings.

### *Interviews*

A limitation of all qualitative interviews is that data collection relies upon participants' recollection of events. Furthermore, in this study, many participants were recalling mistakes that happened months or years ago (amongst hundreds of other cases). Some participants expressed their difficulties in recalling specific details regarding events (and thus preventing activation of experiential memories). Whilst participants could describe the events in broad details, some found it difficult to provide clear experiential accounts. This was characterised in



participant's use of language, such as '*I can imagine I was feeling*' and '*I was probably thinking*', whilst two participants requested to look in case notes. As such, it was not clear, at times, whether participants were recalling their experience at the time or attributing current thoughts and feeling to their experience. It was also possible that participants' levels of anxiety and embarrassment relating to their mistakes may have also influenced the detail in their accounts. Interventions to facilitate participants' fuller recollection of their mistakes were considered, such as allowing participants to examine their case notes or prepare a case in detail, either during or prior to the interview. However these interventions may have promoted an over-reliance on written summaries of their sessions and as such participants may have been providing a rehearsed and overly processed account of their experiences. In summary, whilst the limitations of the interviews were identified, they nonetheless represented the most sensible way of eliciting participants' accounts.

To facilitate participants' memory recall, interviews were, when possible, held in the participants' clinic room. This is based on evidence from Godden & Baddeley's (1975) research on context dependent memory; the notion that people remember information better in the same place in which the memory was encoded. Moreover, it was likely that a familiar environment would allow participants to feel more comfortable when discussing potentially emotive and unsettling material. Therapy rooms also provided a quiet environment conducive to reflecting on their experiences and reflected a strength of the interviews.

A significant observation was how participants used the interviews. Some participants appeared to use the space, to also reflect upon their mistakes, in some cases for the first time. This allowed participants to often consider their mistakes from different perspectives. This is an example of what Boothe, von Wyl & Wepfer (2010, p.261) referred to as 'updating'; a function of narrative, which allows individuals to emotionally re-engage with their experience. For some participants, the interview provided a sense of containment for difficult feelings associated with making mistakes. As such, some participants commented that they had found the interview useful for reflection, challenging and engaging.

*Quality checks*

As outlined in the method section, the research was subject to a number of guidelines for reviewing qualitative research (Elliott, Fischer & Rennie, 1999). The purpose of this was to evaluate the quality and reliability of the findings, through a number of self-monitoring and other quality checks. A summary of chosen quality checks are provided, along with the evidence to support them.

*Owning one's perspective:* This refers to the researcher's pre-conceptions, assumptions and values relating to the area of research and providing an understanding of how these may influence the interpretation of data and communication of findings. Throughout the research study, I have described my personal reflections on both the topic area as well as my engagement with the data (e.g. data collection, data analysis) in an attempt to explore how my pre-conceptions and values, both as a psychologist in clinical training and researcher may have impacted on the way in which I undertook the research. These reflections were kept separate in order to minimise the influence of these on the data analysis and to ensure that the data was grounded in the participants' words.

*Situating the sample:* This refers to the description of the key features of the sample, including relevant demographic characteristics. This has been demonstrated in the current study through the provision of detailed pen portraits. These included not only key characteristics of the participants (e.g. professional title, length of experience, theoretical orientation), but also their general understanding and opinions of mistakes as well as a brief summary of participants' accounts of their mistakes. This information provided some important context for understanding the participants in this study.

*Grounding in examples:* This refers to the provision of examples to illustrate the way the researcher has analysed the data and understood the resultant findings. In this study, an audit trail of the analysis of each transcript as well as the group analysis was conducted. Examples of data analysis can be found in Appendix VI. In addition, the findings displayed in the results section were supplemented with supporting participant extracts from the interviews. These demonstrate a transparency in the researcher's thinking as well as the opportunity for one to consider alternative perspectives.

*Providing credibility checks:* These refer to a number of processes by which categories, themes and accounts are checked for credibility - in other words, how seriously they can be taken. Throughout the data analysis, participant themes were discussed with the research supervisor. Such checks included cross-referencing between themes and participant data to assess the credibility of the researcher's interpretations (i.e. to assess whether the interpretation could reasonably be deduced from a particular section of the transcript). In addition, the researcher and research supervisor analysed a sample of text and compared emerging themes; the rationale for this was to assess the credibility of the researcher's process of coding the data. The analysis was consistent with an iterative process, based on feedback and questions within supervision.

### ***Future research***

While the study yielded a common process relating to psychological therapists' experiences of therapeutic mistakes, it also served to highlight some areas that may warrant further research. As discussed previously, despite the purposive recruitment strategy of psychological therapists, the majority of participants were clinical psychologists. Further research might aim to replicate the study with a more focused recruitment strategy targeting other specific types of psychological therapists (e.g. psychoanalytic psychotherapists, counsellors, CBT therapists), to examine any similarities and differences in the processes and experiences identified in the current study.

Due to the *everyday* nature of mistakes shared by participants in the current study and the fact that these reflected only the examples that they chose to share, further research could examine direct observations of *everyday* sessions, through audio or video analysis. A qualitative research technique such as Interpersonal Process Recall (Elliott, 1986) could elicit detailed experiential accounts of mistakes to develop the findings from the current research. This method of data collection, involving the use of retrieval cues, could address the limitations of the current study relating to participants' memory of sessions.

This study linked to a number of existing areas of psychotherapy, in particularly how mistakes were often characterised in terms of therapeutic ruptures. Whilst there is empirical evidence to link both therapeutic alliance and

ruptures to therapy outcomes (e.g. Safran & Muran, 1996), there has been no research linking therapeutic mistakes to outcome. Whilst it was beyond the scope of the current study to examine this, this could represent an area for future research; a longitudinal study across whole therapy cases could examine this relationship. Furthermore, the use of video (mentioned above) could give rise to a quantitative study examining the impact of therapeutic mistakes on therapy outcome, in which frequencies of mistakes might be monitored across a whole therapy and therapist and client reactions recorded. These could then be cross-examined with therapy outcomes, based on psychometric outcome measures.

Supervision was mentioned by participants to be an important part of their meaning making process and was influential both through its presence and absence. This finding could benefit from more detailed examination, in light of the minimal emphasis on the function of supervision in discussing therapeutic mistakes and in turn the lack of empirical research. Further research examining supervisors' and supervisees' experiences of discussing mistakes in supervision might provide some useful insight into the key processes involved as well as some of the difficulties and obstacles.

### ***Clinical Implications and recommendations***

The results of the current study, when discussed with reference to the research literature generate a number of clinical implications. Firstly, it was clear how participants seemed to benefit from reflecting upon their experiences in the research interviews. The essence of participants' interview experience was the opportunity to have a unique space to talking purely about their mistakes. A similar opportunity to speak about such difficulties either incorporated into existing clinical supervision or through the implementation of additional reflective practice would enable therapists to further learn from their mistakes. What seems important for the exploration of mistakes is not necessarily the type or model of supervision (of which there are many), but the inclusion of particular *dimensions* of supervision, such as the opportunity to explore therapists' emotional reactions towards clients within an open and honest relationship. Supervisors might consider creating time for mistake-oriented discussion or cases, in which they would intentionally invite therapists to think of things that hadn't gone well.

Another clinical implication relates to the research findings as well as the observations of the research interviews. It was clear that participants felt mistakes were difficult to talk about, yet actually speaking about them was seemingly beneficial, both for therapists and their understanding of their therapeutic relationships. Important factors accounting for this difficulty included an association with shame and guilt as well as the lack of priority given by therapists to talking about *perpetually difficult cases*. Ever increasing levels of work demands and time pressures and thus reduced resources also hinder the discussion of *difficult to talk about* mistakes. Any promotion of the discussion about mistakes in supervision would need to be given a great level of attention and to be fully negotiated and understood within an existing or unique supervision contract (e.g. Teitelbaum, 1990). Moreover, it would be recommended that supervisors take a significant proportion of the responsibility for this. Also of importance would be the negotiation surrounding the required boundaries and conditions for these discussions to take place (such as the type of feedback, openness and honesty, clarity on personal reactions vs. professional response). Whilst this, in principle appears no different to the types of contracts already available in supervision and indeed therapy, the findings in the current study, supported by the wider literature, indicate that the discussion of mistakes warrants separate consideration. Haggerty & Hilsenroth's (2011) research on the use of session videos in supervision to share experiences of mistakes between both supervisor and supervisee, provides a useful way of promoting supervision as an environment in which therapists feel supported to openly and honestly discuss mistakes, without the fear of judgement or reprimand. An alternative, and perhaps less intrusive way of promoting in depth discussion of mistakes, with a particular emphasis on therapists' emotional experiences of therapy situations would be through the use of therapist process notes.

The current findings suggest that therapists were often over-sensitive to thinking that they had made a mistake, based upon their initial feelings. An implication is that experiencing client criticism or feeling that one has made a mistake, might not always indicate that a mistake has occurred. Hypervigilance to therapeutic mistakes might lead to subsequent and frequent misinterpretations of neutral events as mistakes. Ultimately, this could undermine therapists' sense of

confidence and competence and create a *safe* and less effective therapist. A hypersensitivity to mistakes could produce potential *blind-spots* for therapists, which could prove unhelpful for therapists; in turn therapists may well encounter more mistakes. It is therefore important for therapists to consider the interpersonal dynamics within the therapeutic relationship, in addition to their technique: in particular finding a way within their therapeutic approach to understand these (be that through transference and countertransference, enactment, schematic reactions, therapeutic alliance, or therapeutic ruptures). Teaching specifically addressing these areas in relation to therapeutic mistakes and incorporating an interactive element for discussion of theory-practice links would increase therapists' awareness of these relationships for use in their clinical work. Furthermore, therapists could benefit from re-framing mistakes as unavoidable and opportunities for reformulating in therapy, which many of the participants did in this study.

Another recommendation for understanding difficult and negative feelings associated with making mistakes (particularly brought about through client criticism) would be the use of personal therapy, particularly therapies that were psychoanalytic or psychodynamic in orientation. This links to the literature on countertransference, which is claimed to be both a therapeutic tool, yet also the greatest source of therapeutic mistakes (Langs, 1982). A lack of understanding or misinterpretation of countertransference feelings may prevent therapists from acknowledging mistakes and thus important therapeutic material. Personal therapy would help therapists to understand their own processes to better distinguish between Casement's (2002) *personal countertransference* and *diagnostic transference*. Thus, therapists would be able to work better with their own feelings and be more open to exploring their meaning, rather than acting them out, to the detriment of the therapy or indeed creating another mistake (e.g. Waska, 1999). Whilst the evidence for personal therapy is weak, it is suggested that therapists who have experienced personal therapy, feel that they work better with their clients (Macran & Shapiro, 1998). Thus, it is important to consider the role of personal therapy for therapists.

As many participant mistakes were identified retrospectively, often by their client, this implies a need to address therapists' broad awareness of their

potential for making mistakes. What emerged from the data was that when mistakes were acknowledged and addressed (either internally or interpersonally), therapeutic relationships and outcomes were often positively affected. If therapeutic mistakes are not brought to light by clients and not acknowledged by therapists (i.e. if '*something's brewing*' does not progress to the '*emergence of a problem*'), important therapeutic material may be lost. Seen in terms of the therapeutic rupture literature, the lost opportunity to recover from a rupture may impede therapeutic change.

One way in which this could be addressed would be the development of a self-assessment index for therapeutic mistakes, similar to that of Epstein & Simon's (1990) *exploitation index*. Therapists could use such a tool as part of their supervision in order to rate instances that could represent warning signs relating to the potential for therapeutic mistakes within therapy cases. These might include: the frequency at which therapists are going into sessions feeling frustrated or finding themselves feeling '*not present*' or '*disconnected*' from their client. Thus, therapists would not need to rely purely on feedback from their clients in order to acknowledge potential difficulties in therapy, whether these are signals of empathic failures, therapeutic ruptures or the emergence of a therapeutic mistake.

Another key finding relates to the wide range of consequences of experiencing therapeutic mistakes, in particular the impact of mistakes upon therapists' intersession experiences. As well as supervision, the findings highlight the importance of self-care. Norcross (2000, p.710) suggested a number of self-care strategies in recognition of the 'hazards of psychological practice' for therapists. Self-care with respect to therapeutic mistakes might also indicate the need to find a balance between the number of cases on a therapist's caseload and the time therapists afford for reflection upon their cases. This relates to participants' reflections on how moments of insight and key learning often emerged at points in the therapy where they had more space to think. This implication and recommendation could be seen to hold relevance to multiple stakeholders, including therapists, supervisors and service managers. In particular, it suggests a need to consider the balance between service demands alongside those of therapists, given the complexity of their work; this study has highlighted this through exploring one element of this. There is also a need for considering

self-care outside of work (Norcross, 2000) so that therapists do not become prone to therapist burn out (Maslach & Jackson, 1981), and instead are able to start sessions, even with difficult therapies, with the majority of their '*objective faculties*' (Alex, 11.542) intact. This recommendation is based on the findings that a large proportion of participants began sessions with unprocessed and unaddressed negative feelings.

In summary, the recommendations based on the findings and their clinical implications relate to the consideration of many inter-session activities; supervision, teaching, personal therapy, self-awareness and self-care. Finally, relating the findings in the current study to the ethical guidelines and codes of conduct for therapists provides a broader clinical implication. If therapists can be careful to reflect upon mistakes in therapy, take them to supervision and in particular consider the interpersonal aspects of therapeutic encounters, then it is perhaps more likely that the quality of clients' therapeutic experience will be enhanced. Furthermore, this is likely to help towards the aims of providing clients with an *ethical* therapy.

### ***Conclusion***

This study examined therapists' experiences of therapeutic mistakes. From participants' accounts of their therapeutic mistakes, a group process emerged that spanned across more than just a discrete error, session, or in some cases therapy. Mistakes were often ill-defined and were subject to emotional and meaning making processes, both intrapersonally and interpersonally negotiated. Participants described dealing with a progressive and somewhat changing phenomenon; from experiencing general positive or negative feelings, to noticing something changing, to encountering a *problem* in-session, followed by meaning making outside the session. As participants emerged from an emotional experience and achieved some distance from the mistake, opportunities emerged to view their mistakes from different perspectives. Participants' complex experience of therapeutic mistakes provides an altogether different picture of mistakes than that described in the existing literature, based on objective and discrete categorisations and observations of therapeutic mistakes in others. The focus on participants' experiences of mistakes has provided some insight into



therapists' everyday practice and continuing struggles with common issues in therapy. The study illuminated some existing areas of literature which provide the basis for future research.

### *Closing reflections*

A significant motive for my exploration of therapists' experiences of therapeutic mistakes was my interest in how other therapists deal with mistakes. My opening reflection posited the idea that I had undergone a transformation from seeing mistakes as necessarily avoidable to often helpful. Having conducted this research, I am not so sure whether this process is a linear one. What I have gleaned from my examination of therapists' experiences is a sense that the experience of therapeutic mistakes is a common and on-going process for therapists. In other words, therapists commonly encounter a mixture of feelings and perspectives not just throughout their career or therapy cases, but across individual therapy sessions. Whilst I might wish to see the perspective of therapeutic mistakes as inevitable and necessary for therapeutic growth and positive outcome, as a mature and constructive one, it is perhaps unrealistic to expect this to always hold. What I have observed from undertaking this research is that it doesn't always feel good at the time or prevent therapists from wanting to 'escape' sessions. These less processed feelings and perspectives, instead of representing a less mature response, perhaps reflect a *normal, necessary* and indeed *valuable* part of the process of acknowledging and responding to therapeutic mistakes. I will take a great deal from my experiences of conducting this research and a sense of reassurance from what seems to be a commonly experienced and complex area in psychotherapy.

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## **Appendices**

### ***Appendix I. Participant e-mail invitation.***

*Research Study: Therapists' experiences of therapeutic mistakes*

*Researcher: David Aaron*

#### **Psychological therapists working one-to-one with adults in consultation rooms using talking therapies.**

My name is David Aaron and I am a Psychologist in Clinical Training on the Doctorate in Clinical Psychology programme at the University of Leeds. I am interested in therapists' experiences of therapeutic boundaries, decisions and dilemmas in therapy. This study focuses particularly on therapists' experiences of therapeutic mistakes using a qualitative design. It is hoped that this study will help further the understanding of therapeutic mistakes and help future practice.

The study would involve meeting with me for an interview. The interview would be at a location that is convenient for you and would normally last about an hour. This project has received ethical approval from Leeds Research Ethics Committee along with NHS Research & Development.

Should you require more details about the study or wish to participate, please contact me at this e-mail address. I will send a detailed information sheet to interested therapists and discuss a potential interview date and time.

Many thanks for your time,

**David Aaron**

**Psychologist in Clinical Training**

**University of Leeds**

***Appendix II. Participant information sheet.****Research Study: 'Therapists' experiences of therapeutic mistakes'*

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who is conducting the study?

The study is being conducted by David Aaron, currently a second year psychologist in clinical training at the University of Leeds. The research is a doctoral thesis as part of the course.

What is the background information and purpose of the study?

All psychological therapists encounter dilemmas in clinical practice requiring the use of decision making and clinical judgements. This presents the potential for boundary crossings and therapeutic mistakes. Existing research suggests they may result in varying outcomes. This is often dependent on how we reflect upon and deal with mistakes. Limited research has explored therapeutic mistakes and only through the examination of the perspectives of supervisors of trainee psychological therapists. This study aims to explore psychological therapists' experiences of therapeutic mistakes in order to further our understanding of the processes, appraisal and practice involved in experiencing and dealing with them.

Why have I been chosen?

You have been chosen as you fit the criteria of being a psychological therapist who works on a one-to-one basis with adults in a consulting room. These criteria were selected as most of the literature on therapeutic boundaries, relationships and mistakes have been conducted within these settings.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form) and you can still withdraw at any time without it affecting any benefits that you are entitled to in any way. You do not have to give a reason.

What would taking part involve?

You are invited to meet with me for approximately 45-90 minutes to discuss your experiences of therapeutic mistakes. A semi-structured interview will be used in order to allow for a broad range of experiences to be discussed. Interviews could be conducted at a place of your convenience. Any travel expenses will be reimbursed. Interviews will be audio recorded and transcribed. Any personal details or personal information provided during the interview will be removed from subsequent transcripts and reports. Both the recording and transcript will be securely stored.

At the end of the interview I will ask whether you are happy for your data to be used or whether you would like part or all of your data removing ahead of its analysis. You would have a limited time following the interview in which to withdraw partial/full consent. Once the study is written up, the audio recordings and transcripts will be kept securely by the University for seven years. There is a possibility that your data may be required for subsequent analysis in similar future research. You can still take part in the study if you do not agree to your information being stored for future research.

What are the ethical issues involved?

Your participation in the study and all the information you provide will be kept strictly confidential. Whilst I am interested in therapists' experiences of therapeutic mistakes, I am not interested in hearing therapists' accounts of therapeutic violations or gross misconduct, including sexual encounters. Any such disclosures would result in confidentiality being broken and appropriate agencies contacted (e.g. police, safeguarding bodies, BPS, service managers, research supervisors). Otherwise, your responses will be kept and stored in the strictest of confidence. All personal details you provide (names/places) will be anonymised

and you/those you describe will not be identifiable in any transcripts or subsequent reports/publications.

#### Possible risks and benefits

Whilst talking about therapeutic encounters and your role in therapy may be uncomfortable or distressing, it is possible that taking part in this study will be a positive or helpful experience. It is hopeful that your contribution to this study will have benefits for psychological services and the wider theory base such as therapeutic mistakes and decision making.

#### What will happen to the results of the research study?

The study will be written up into a doctoral thesis. There is also the potential for academic papers and conference presentations as a result.

#### Contact details

If you wish to take part or find out any further information about the study, you can contact David by e-mail: [ps07dwa@leeds.ac.uk](mailto:ps07dwa@leeds.ac.uk) or at the following address:

David Aaron

Leeds Institute of Health Sciences

Charles Thackrah Building

101 Clarendon Road

University of Leeds

Leeds

LS2 9LJ

(01133 432732)

Supervised by:

Dr Carol Martin

[c.martin@leeds.ac.uk](mailto:c.martin@leeds.ac.uk)

(Address and phone number as above)

If you decide to take part, and then have any concerns or complaints about your experience of taking part, you can speak to me in the first instance. I will do my

best to address the issue. If you wish to complain more formally, you can do this by contacting Clare Skinner by e-mail: [governance-ethics@leeds.ac.uk](mailto:governance-ethics@leeds.ac.uk) or at the following address:

Faculty of Medicine & Health Research Office  
Room 10.110, Level 10  
Worsley Building  
Clarendon Way  
University of Leeds  
Clarendon Road  
Leeds  
LS2 9NL  
(01133434897)

Thank you for taking the time to read this information sheet. I look forward to hearing from you.

David Aaron  
Psychologist in Clinical Training  
Supervised by Dr Carol Martin and Dr Sheila Lewis

**Appendix III. Participant consent form.***Research Project: 'Therapists' experiences of therapeutic mistakes'**Researcher: David Aaron*

The purpose of this form is to establish whether you have been given sufficient information about the above research project and understand what is involved if you decide to take part in this project. (please initial all that apply)

I confirm that I have read the information sheet (Version 1 – dated 06/06/2011) and had a chance to ask any questions.

I understand that I do not have to provide information that I don't wish and am free to withdraw from the study at any time (without having to give a reason).

I give my initial consent for the interview to be audio recorded.

I understand that my responses will be kept confidential (research supervisors will see only anonymised responses as part of research quality).

I give consent for anonymised extracts of the interview to be used in subsequent reports.

I understand that the University will store my data following this study. Any Future research will only be done if the project has been given ethical approval (You would be contacted again should this be the case).

I agree to take part in the above research project and will inform the principal investigator should my contact details change.



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 Name of participant

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 Date

---

 Signature

---

 Lead researcher

---

 Date

---

 Signature



***Appendix IV. Interview schedule.***

*Research Study: Therapists' experiences of therapeutic mistakes*

*Researcher: David Aaron*

*Interviews with therapists will be informed by the following interview schedule, however such semi-structured interviews allow for flexibility. As such, not all questions will necessarily be asked nor in this order.*

**INTRODUCTION**

**Thank you for taking the time to meet with me today and agreeing to participate in this study. I'll go over the information sheet that I provided you, which outlines the study to check that you'd still like to take part.**

[Consent form] **Any questions?**

**BASIC INFORMATION**

**Before we start I'd like to ask you a few questions about your job that will help me to understand more about the participants in this study.**

What is your theoretical orientation/what theories and/or models do you use in your therapeutic work?

What type of clients do you normally see?

How do you work typically?

How long have you worked psychotherapeutically with clients?

Could you tell me what previous experience you've had working psychotherapeutically with clients?

**MAIN INTERVIEW**

**1. As you know, I'm interested in talking to therapists about mistakes to find out about their thoughts and experiences. Can you think of a session that comes to mind where you considered you'd made a mistake?**

What had the session been like?

What expectations did you have for the session beforehand?

What happened?

What were you first aware of?

What were your thoughts/feelings at this stage?

(Concerns/fears/anxieties)

How did you come to realise a mistake had occurred?

How did you react?

What did you think/feel/do?

What sense did you make of your feelings/reactions?

How was it that you came to see this as a mistake?

**2. How did the situation develop?**

What was it like in therapy after this?

What contribution did it make to therapy?

How did this affect the client's feelings/behaviours?

**3. How did you manage this situation?**

Did you do anything differently to your regular practice?

What did you do (or think about doing) that you don't normally do in practice?

What did you not do that you normally do in practice?

How did you use supervision/colleagues?

What use did you make of professional and ethical codes?

**4. What impact did this have?**

In/out of work

Therapeutic relationship

Supervision

**5. How did it play out/resolve?**

What do you think contributed to its resolution?

[If the mistake did not resolve] What prevented its resolution?

[If the mistake is part of an on-going case] What has happened since?

How has the situation impacted on therapy since?

**6. What do you think about it now?**

What did you learn?

About yourself?

About therapy?

What might you do differently if you encountered this situation again?

What sense do you make of this mistake thinking about it now?

What impact has this had on your current practice?

*[General prompts: What did you do? What were you feeling at this point? Could you tell me more about that? Could you say more about your feelings/thoughts/behaviour/X/Y? What sense did you make of that?]*

**7. What made you choose to describe this particular case? (might ask for a contrasting example e.g. typical vs. exceptional OR past vs. recent)**

Do you have any other examples of cases where you felt you made a mistake?

**8. How have you come to think about mistakes in therapy?**

What do you conclude from your experiences?

Have your views or attitudes towards therapeutic mistakes changed following your experiences?

What potential benefits are there to therapeutic mistakes?

What advice would you provide to other psychological therapists about therapeutic mistakes?

**9. Is there anything else you'd like to add to what we've talked about?**

Thank you for talking to me.

*Appendix V. 'Who said what' table.*

Stage of mistake	Super-ordinate theme	Theme	Participant (Mistake number)															
			Alex		Linda		Elaine		Simon		Michael	Ruth		Margaret				
			1	2	1	2	1	2	1	2	1	1	2	1	2			
<b>1. Before the session</b>	<b>A: 'there's nothing remarkable'</b>	<i>Positive feelings</i>			✓	✓									✓			
		Enthusiasm				✓												
		Everything's going well			✓	✓										✓		
	<b>B: 'I'm expecting a difficult session which is no different to usual'</b>	<i>Negative feelings</i>	✓	✓			✓	✓	✓	✓	✓	✓	✓	✓			✓	
		Frustration	✓					✓		✓	✓							
		Anxiety/Dread		✓			✓			✓							✓	
		Preparing to suffer		✓				✓		✓							✓	
	Feeling stuck										✓	✓						
<b>2. In the session</b>	<b>A: Not noticing anything remarkable or different</b>	Everything's going well			✓													
		Not noticing anything concerning				✓	✓				✓							
	<b>B: Not present/caught up</b>	Feeling bored		✓														
		Disconnected	✓	✓									✓					
		Distracted							✓	✓								✓
		Not attuned	✓	✓										✓				
	<b>C: 'Something's brewing'</b>	Noticing changes in client	✓					✓	✓	✓			✓	✓				
		Noticing changes in self				✓	✓			✓	✓	✓	✓					
		Unease ('Noticing something amiss')							✓		✓							

<b>3. The emergence of a problem</b>	<b>A: Being told</b>	Experiencing criticism		✓	✓		✓			✓	✓			✓	✓	✓		
		Noticing client's action				✓		✓						✓				
	<b>B: Therapist becoming aware of a potential problem</b>	Encountering a dilemma	Doubt			✓												
			Indecision			✓			✓									
		Avoiding dealing with something difficult						✓					✓					
<b>C: Client confirming problem</b>				✓						✓				✓				
<b>4. 'In the midst of the problem'</b>	<b>Anxiety</b>	Under pressure			✓						✓				✓			
		Flustered											✓					
		Panic					✓					✓				✓		
		Survival mode	'time slowed down'			✓												
			Disorientated			✓												
			Caught up			✓											✓	
			Getting through it			✓												
	<b>Feelings</b>	Under attack			✓		✓				✓	✓					✓	
		Vulnerable			✓		✓									✓		
		Frustration			✓													✓
		Feeling punished		✓	✓													
		Shame						✓										
		Guilt													✓			
	<b>Confusion</b>	Confusion			✓						✓			✓			✓	
		Shock													✓			
Disbelief													✓					
<b>Thoughts</b>	Doubts			✓					✓									

		Protest	✓	✓					✓				✓		
		Self-criticism			✓		✓								
<b>5. 'The Aftermath'</b>	<b>Relief &amp; Recovery</b>	Relief		✓					✓			✓			
		Beaten		✓		✓						✓			
		Shaken										✓			
		Confusion & bemusement					✓					✓			
		Anxiety		✓		✓	✓							✓	
	<b>'Not in a good place'</b>	Self-defeating	Shame	✓	✓										
			Guilt			✓									
			Self-doubt							✓				✓	
			Insecurity											✓	
	<b>Exploration &amp; problem solving</b>	Taking stock								✓	✓	✓			
Help-seeking			✓			✓									
Curiosity													✓		
<b>6. Making sense</b>	<b>Understanding roles and responsibility</b>	'It takes two'				✓			✓						
		Taking responsibility/'owning up'		✓				✓		✓				✓	
	<b>Accepting the inevitability of mistakes</b>	Conscious justification ('It had to happen')					✓		✓	✓					
		Intrinsic part of the process ('It was always going to happen')			✓			✓			✓			✓	✓
		Putting the mistake into proportion			✓	✓	✓	✓				✓			

		'It was worth it'/'a silver lining')			✓				✓		✓				
	<b>'What might have been'</b>	Disappointment	With self	✓			✓			✓		✓		✓	
With process				✓								✓			
Regrets			✓		✓		✓				✓			✓	
<b>7. 'How I'm left'</b>	<b>Resolved</b>	Interpersonally			✓		✓		✓		✓		✓		
		Internally	✓		✓		✓		✓		✓		✓		
	<b>Unresolved</b>	Interpersonally	✓	✓		✓						✓	✓		✓
		Internally		✓		✓				✓					✓
	<b>Uncertainty</b>	'Time will tell'						✓		✓					
		'Where are they now?'		✓		✓									✓
	<b>Preoccupation</b>	Traumatised				✓									
'It's stayed with me'			✓								✓	✓		✓	

**Appendix VI. Section of transcript analysis.**

Elaine transcript

<p>101</p> <p>102</p> <p>103</p> <p>104</p> <p>105</p> <p>106</p> <p>107</p> <p>108</p> <p>109</p> <p>110</p> <p>111</p> <p>112</p> <p>113</p> <p>114</p> <p>115</p> <p>116</p> <p>117</p> <p>118</p> <p>119 R.:</p> <p>120</p> <p>121</p> <p>122</p> <p>123</p> <p>124</p> <p>125</p> <p>126 P:</p> <p>127 R:</p> <p>128</p> <p>129</p> <p>130</p> <p>131 P:</p> <p>132</p> <p>133</p> <p>134</p> <p>135</p> <p>136</p> <p>137</p> <p>138</p> <p>139 R:</p> <p>140</p> <p>141 P:</p> <p>142</p> <p>143</p> <p>144</p> <p>145</p> <p>146</p> <p>147</p> <p>148</p> <p>149</p> <p>150</p>	<p>thing,...and I would say I think this is what is going on, however I recognise this is really difficult and if you do decide not to come back, I understand, and if you do come back this is, we will talk about what we agreed as to what will come next, and think about the discharge. Anyway, he did come back and he had written a very long response to the letter I had written and he suddenly talked about the fact he, if he ended it himself, he was getting control back over the, if you like, so I was like when he said that - 'shit, have I done it wrong? Should I have just left it?' because it was very like 'do you don't you do you don't you??' because there is that, the person is taking control back and can ...however there is ...at the ending, but he said you know, because I had written, I respect your decision if you don't come, I haven't then taken the control away again so it kind of all worked out OK in the end. But there were lots of moments where 'have I messed this up'...therapeutic relationship and you could make a mistake either way. You often, you often do because you have to get drawn into the dynamic and have to know what's going on.</p> <p>I am wondering where you talked about different moments where there was 'have I done it right, have I done it wrong' or you said there was a few different moments (hmmm) I am wondering whether we could go back to the start of that session and if you could kind of talk me through how that session went and how we could look a little bit more closely at some of those situations and some of those moments. Would that be OK?</p> <p>Yeah</p> <p>So you mentioned that you had been talking a few weeks prior about the end of therapy, and you mentioned that this particular session that came to mind, can you tell me a little bit about your thoughts coming into that session on that day?</p> <p>Erm (long pause) I don't know (laughs) I don't know if I can (laughs) I guess I can imagine I was probably quite apprehensive about the fact we were coming towards the end and this was a big deal. Erm....about, I worry about thinking about how much attention do I pay to the fact that we are ending, how much attention do I pay about the context in particular to this last trauma? And yes, so, weighing up what was the best sort of thing to do.</p> <p>Were you attempting to answer some of those questions you were weighing up or?</p> <p>Erm....yes I suppose I was having a little conversation with myself that if my client decided, if he felt that he did need to go through, relive the trauma one more time that that's what we do. But, his is kind of, his demeanour when he got there, his demeanour seemed very different in terms of this angry, high emotionalism, he seemed a lot calmer, a lot quieter voice, a lot softer tones not as fast, he speaks very fast when he is stressed so it kind of indicated to me that he got to the point with that particular trauma perhaps he didn't need to go back and relive it again. And that he was, it was more important to think about</p>	<p style="border: 1px solid green; padding: 2px;">Panic</p> <p style="border: 1px solid green; padding: 2px;">ANXIETY</p> <p style="border: 1px solid green; padding: 2px;">what should do?</p>
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reaction  
apprehensive  
- check says  
this, I feel  
that.

language  
- hesitation  
- memory diff  
- avoiding  
talking about  
emotion?  
description

decision  
making

internal  
dialogue

speaking about client/  
not her exp.

3



*Appendix VII. Ethics Approval Letter.*

## National Research Ethics Service

### NRES Committee Yorkshire & The Humber - Humber Bridge

Yorkshire and the Humber Research Ethics Office  
 First Floor  
 Millside  
 Mill Pond Lane  
 Leeds  
 LS6 4RA

Telephone: 0113 3050127

04 July 2011

Mr David Aaron  
 Psychologist in Clinical Training  
 The Leeds Teaching Hospitals NHS Trust  
 Leeds Institute of Health Sciences  
 Charles Thackrah Building  
 101 Clarendon Road, Leeds  
 LS2 9LJ

Dear Mr Aaron

**Study title:** Therapists' experiences of therapeutic mistakes  
**REC reference:** 11/YH/0218

The Research Ethics Committee reviewed the above application at the meeting held on 22 June 2011. Thank you for attending to discuss the study.

#### Ethical opinion

The Committee asked you how you intended to store and transfer data during the study. You stated that all data will be stored on the 'M' drive at the university, which is a secure drive. You explained that data will be transferred using an encrypted memory stick or by email using encrypted software. You confirmed that your home laptop is secure.

Members asked you if there is an alternative way of obtaining the therapist's email addresses other than through the head of department. You confirmed that staff email addresses are available on the Trust internal directory.

The Committee highlighted to you that a copy of the advert had not been included in the application pack. You stated that you will be approaching 60 therapists; therefore you were confident that you will obtain your small sample from this number. You explained that you should not need to use the advertisement. Members asked you to remove this detail from the proposal or create the advert and submit it for review as an amendment.

The Committee asked you about your experience in interviewing and research. You explained that you regularly interviewed clients as part of your role as a psychologist in training. You stated that you have been involved in a research project that required you to interview carers.

Members asked you if participants will have already had the opportunity to discuss therapeutic mistakes with a supervisor. You stated that the therapists will have access to supervision, but that it was the therapist's decision whether to raise mistakes in supervision.

The Committee asked you if you will give participants the option to view the transcript of their interview and allow them to make changes to the content. You informed the Committee that at the end of the interview you will ask participants if there is anything that was discussed in the interview that they would like removing. You explained that giving participants time to think about the interview and then request changes may delay the analysis of the data.

Members asked you where the interviews will be taking place and whether you had consulted the university's lone worker policy. You stated that interviews will be held at the therapist's place of work or the university.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

#### **Ethical review of research sites**

##### **NHS Sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

#### **Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

1. The consent form should include the following standard clause 'I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from [company name], from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.' You may remove 'medical notes' if this is not relevant to your study.
2. The consent form should include initial boxes



It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation

#### Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of insurance or indemnity		10 September 2011
Interview Schedules/Topic Guides	1	06 June 2011
Investigator CV		06 June 2011
Letter of invitation to participant	1	06 June 2011
Other: CV - C Martin (Supervisor)		03 June 2011
Other: CV - S Lewis		06 June 2011
Participant Consent Form	1	06 June 2011
Participant Information Sheet	1	06 June 2011
Protocol	1	06 June 2011
REC application		
Referees or other scientific critique report		21 March 2011

#### Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

#### After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of

changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).

**11/YH/0218**

**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely



**Dr David Horton**  
Chair

Email: [nicola.mallender-ward@nhs.net](mailto:nicola.mallender-ward@nhs.net)

*Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments*

*"After ethical review – guidance for researchers"*

*Copy to: Mrs Rachel E de Souza, University of Leeds  
Dr Marios Adamou, South West Yorkshire Partnership NHS Foundation Trust*