Therapeutic Use of the Unpredictable: When Mistakes Lead to Therapeutic Change

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This narrative is a reflection on mistakes that occur in therapy and how they can enhance therapeutic change. Mistakes are viewed in a broader context of human relationships in which persons participate free of scripts. The need for the therapist to be a person *as the first priority in the therapist-client relationship is contrasted with playing the role of* therapist. *The author recounts an incident that occurred early in his career when he was in training to be a therapist. He discusses how he dealt with a mistake during a therapy session openly, honestly, and outside the confines of expected therapeutic intervention.*

Over the past 25 years as a therapist, I have treated most types of psychological problems with varying degrees of success. As I reflect on my experiences, it intrigues me that some of the most successful and interesting outcomes could not have been predicted at the outset. In fact, the change mechanism that occurs in individuals and families in therapy is too complex to clearly define. As a supervisor I would like to package it and give it to my students. Unfortunately, this is not so easily done.

This article is a reflection about an ignored portion of this change dynamic that I have noticed in therapy, namely mistakes made by the therapist. I believe that Carl Whitaker (Whitaker & Keith, 1981) was right when he said that therapists should guard their impotence like it was their most valued possession. By this I think he meant to guard one's discomfort and feeling of inadequacy. To paraphrase him, I would say, "Guard your mistakes like they are your most valued possessions." Mistakes make therapists human, and I have come to realize that being a person first and a therapist second is the proper hierarchy of these two roles. When being a therapist is considered the first priority, one has only to get it right. The mechanisms of being a therapist take over as one learns techniques and appropriate responses to client statements. Change is dependent on the therapist making correct responses and "therapeutic" interventions. The therapist must succeed where others in the natural social environment have failed.

On the other hand, when the person of the therapist is emphasized as Whitaker (Whitaker & Keith, 1981) suggested, one is concerned more with being an individual in a particular relationship. A person makes mistakes honestly and, hopefully, learns from them. This trial and error manner of relating occurs in our most intimate relationships. Yet, as therapists, we are overcome with fright when mistakes occur in therapy sessions.

I am not suggesting that there is no need to learn techniques, or that the therapist need not learn how to phrase comments to respond to a person in a psychotic rage. Rather, I am stating that much of what happens to change people occurs in the realm of real human interactions and emotions in which one, including the therapist, may be ill prepared to handle according to set techniques or deliberate manipulation.

The belief that mistakes may provide opportunities for change in therapy began early in my career when I was in supervised training as part of my Ph.D. program. My internship site was a large community mental health center in an inner city area of a large metropolitan area. The center's client population was mixed, with about 60 percent African American, 30 percent white, and the remainder of various Asian groups, mainly Cambodian.

The center provided many services for a wide range of clients. Many of the clients needed follow-up services after being hospitalized at the state mental hospital. A small percentage of clients were considered "growth" because they were not diagnosed with a psychotic process. These clients were having problems with relationships or adjustments to life situations. Therapists generally competed for these cases because they could used a wider range of therapeutic techniques. In general, more experienced therapists were assigned the growth clients. My observation from the standpoint of being an intern was that a therapist's reputation as an effective therapist depended to some extent on how many growth clients he or she had.

The community mental health services in the state initially were set up as aftercare programs for hospitalized clients. As these aftercare centers grew, a new philosophy was developed in the state's Department of Human Resources. This philosophy was that persons improve when they are treated in the least restrictive manner. The concept of treating clients in their "natural environments" emerged. Hospitalization was to be used as short-term treatment and the community mental health center was designated to be the long-term treatment facility. Consequently, this dual role of following up on the chronic population and providing front-line services for persons with family or adjustment type disorders generally meant that therapists were overworked and had huge caseloads.

This change in philosophy at the state level occurred a few years before I began my internship and the system had not fully adjusted to it. The number of clients in the mental hospital was dwindling while the number of clients in the community system kept increasing. At the time, I questioned the commitment of some of the old-timers (i.e., therapists who had been in the system prior to the change) who had worked with chronic clients for many years. They seemed burned out and lacking energy. Now I realize what overwork and few rewards can do to morale.

I believe that many of the chronic clients recognized that they were not the "prized" clients at the center, though this was never discussed openly. I wonder now if some of the clients' acting out episodes may have been partly a response to feeling neglected. Many of the clients were seen in monthly medication groups for the purpose of maintaining them on medication, but little or no other therapy was done with them.

When I was a student, my approach to therapy was to consider every client unique and capable of improving his/her life. My undergraduate major in philosophy and the influence of existential thinkers greatly influenced this approach to therapy. I believed then, and still do, that life circumstances, especially failures, can be the greatest opportunity for new and different behavior. I saw this first hand in some of my most chronic clients. They would tell of the most horrendous experiences that led to new and different life situations. For example, stories of dread and doom always contain the sparks of newness.

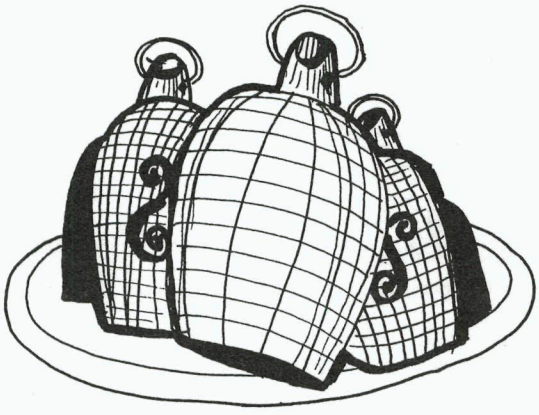
A concomitant theme as a student was that I tried to work with clients with as few presuppositions as possible. Over the years I've had to work to keep from having presuppositions and expectations linked to diagnoses. I believe that this is as much a danger for the seasoned therapists as it was

for many of the full-time therapists in the mental health center. Seeing the possibilities rather than the limitations is an ongoing challenge in therapy.

The incident that I referred to above occurred while completing my dissertation in child and family development with an emphasis in marriage and family therapy and completing my intern hours required for graduation. It was a particularly difficult time for me because I was working full-time during the day and writing my dissertation in the evening. My wife, who also worked full-time, had recently given birth to our first child. To complicate things even more, the baby had difficulty sleeping through the night. Frequently, I was exhausted and sleepy during sessions, particularly in the afternoon.

My main objective in my internship was to have enough clients to meet the requirement for graduation. I frequently would ask for more cases with little concern about the client's diagnosis. As a result, I was assigned a number of medication maintenance cases that the regular therapists considered non-therapy cases, cases that were not considered "growth." One of these cases was "Larry Hutton." (His name and other identifying information have been changed to preserve confidentiality.)

The entire mental health staff had worked with Larry at some point during his long and successful *career* as a mental client. I use the word successful in the sense that he managed to never improve despite the various services provided. He knew the game of therapy very well. Haley's (1973) belief that symptoms are very powerful is well illustrated in this case. Larry knew how therapists would react to everything he did, and like his relationship with his parents, he seemed to enjoy his manic episodes as a way to manipulate the system again.



I have to admit that for the first appointment I had not reviewed his chart because of working in a few extra clients. Ten minutes before my appointment with Larry, his last therapist gave me a quick summary. Larry was 43 years old, the youngest of three children. He still lived at home with his elderly parents, both retired and in their mid-seventies. He was considered extremely intelligent and had held high-ranking executive jobs for short periods of time. At present, he was working for the IRS as a filing clerk and during the heavy tax season, he worked for H & R Block preparing tax returns.

Larry was diagnosed manic depressive and was taking the medication Lithium. While always more or less in a manic state, he was able to avoid hospitalizations as long as he took his medication. Periodically, he would stop taking his medication and have a manic episode. His manic episodes were likely to involve the police and require several months in the hospital.

Some of the most noted manic episodes were briefly described. Once he came for his appointment with Head and Shoulders shampoo rubbed in such quantity on his head and shoulders that he looked like a Halloween goblin. Another time he went to the Kentucky Derby and while there convinced the hotel bellboy that he was Howard Cosell's assistant. Gaining entrance to Cosell's room, Larry proceeded to have a party, running up a room service tab of $300. Another time while his parents were out of town, he washed the kitchen dishes on the kitchen floor using a garden hose and household ammonia.

The most recent episode began when he stopped taking his medicine. About two weeks later at 3:00 PM in the afternoon he decided to mow the grass in the yard with

no clothes on. His house was on the corner of a busy boulevard and many passersby, both in cars and walking on the sidewalk, reported to the police that a man was mowing his grass in the nude. The police knew him because of many past contacts and took him directly to the mental hospital. It was after this episode and the discharge from the hospital that he was coming in for treatment.

While Larry had been a client at the center for years and lived with his parents, his parents had never been involved in therapy. According to Larry's former therapist, his parents would call him on the phone but refused to come in with him. They believed that Larry was sick and there was nothing anyone could do except keep him on medication. Larry was compared unfavorably with an older, successful brother who was a tax attorney.

Larry's episodes tended to parallel a family problem or circumstance. When his father had bypass heart surgery, Larry stopped taking his medication and was hospitalized at the state mental hospital in a manic state before his father was released. His relationship with his parents was up and down. They would give him double messages about his living at home. At times they would demand that he get his own apartment, but then they expected him to do needed jobs, such as painting the house or mowing the grass. Since he had his own suite with a kitchenette in his parents' home, he would sometimes isolate himself for weeks without any contact with them. Although he had this ambivalent relationship with them and sometimes threatened to move out, he never did. He described both parents as "feeble" and needing him to be there.

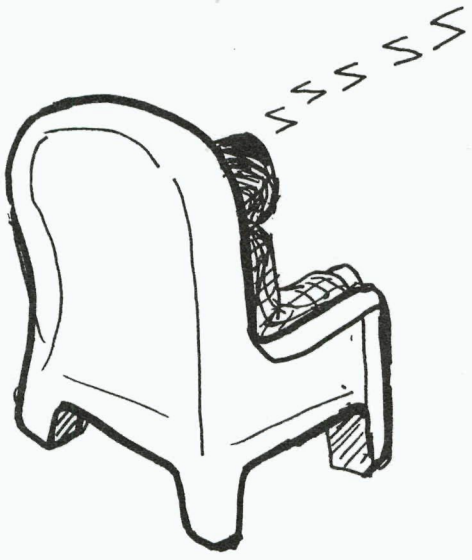
When he appeared in the doorway of my office for this first appointment, he looked like an overgrown boy. He had on khaki pants and a short-sleeved shirt. His rounded face, ruddy complexion, and white curly hair made him look like a giant stuffed doll. As I greeted him for his appointment he smiled very freely and said as he handed me a business card, "So you're the lucky one who gets me this time." I'm sure he knew that I was new and inexperienced and he would actually enjoy making my life exciting.

The business card stated only:

LARRY HUTTON
Professional Mental Health Patient

He talked very rapidly, laughing frequently, and changed subjects every other sentence. Attempts to structure the monologues led to his retelling them rather than offering explanations. After 30 minutes of working very hard to structure him with little success, my mind began to wander as I realized how tired I was. I had worked until 2:00 AM on my dissertation and the baby woke me at 4:15 AM, and I never got back to sleep. As my eyes got heavier and heavier, I noticed that the time was 3:35 PM.

Suddenly, I was startled by my own loud snore. Larry, who had been talking nonstop said, "Were you asleep?" I looked at the clock and noticed that it was 3:55 PM. My whole life as a therapist more or less flashed in front of me. I thought, "I will lose this job and not finish my Ph.D. How can I ever justify sleeping during a therapy session?" I felt the hot rush of blood to my face, and I was uncertain what to do next. I thought that if I admitted to sleeping it would be like admitting that I was a complete and total failure. Then, another line of thought entered my mind. I can't lie; I'll tell the truth. Surely he must understand that I'm overworked and have a small baby that doesn't sleep through the night. So suddenly without any more thoughts, I heard



myself replying, "Yes, I believe I did fall off to sleep."

Jumping to his feet, he went into a rage and yelled, "I pay good money for you to sleep? I won't put up with this! I can't believe that you have the nerve to sit there and sleep while I'm spilling my guts. I'm not going to pay for this session. In fact, I want another therapist." And then as an afterthought he said, "By the way, how long were you asleep?"

Looking at the clock again, I said, "I'd say about 20 minutes."

"You mean to tell me that you slept one half of our therapy time?"

"I'm afraid so."

"I want another therapist!"

"OK. You must be very disappointed in me."

"Disappointed?! Pissappointed! This has never happened to me in 20 years of mental health treatment."

"Well, sometimes novelty can be very meaningful."

Something seemed to just take over. I no longer was worried about what I was saying or felt the least bit defensive about what had occurred. The words just seemed to flow out of my mouth. Maybe this reaction is akin to what happens in an emergency when you just react and have little time to think about what you are doing. Later, you may have little or no recollection of how you reacted, but it was the right thing to do. Or, maybe I had stumbled onto something that I read later in a book by Minuchin (1974) that you need to learn about how to do therapy and then forget it when you are in a session. The therapist must learn to listen to his or her intuitions about how to intervene rather than follow a prescribed course.

"Well, the only meaning I see here is that you slept through our session."

"I'd like to share some thoughts I have about it if you're willing to do so."

"Why should I? What could I possibly learn?"

"You have every right to feel this way, but can I ask you just one question?"

"Well, I don't know. You had the opportunity before, but you were asleep!"

"OK, it's your call, but I think this question is very interesting."

"I'm really upset about this and I'm not going to let this drop!"

"So can I ask the question or not?"

"OK, just one question and that's all!"

"If you can answer this question, you can walk out of the room and demand another therapist. You can stand in the hallway and yell in a loud voice: 'Tom Roberts fell asleep during my therapy session' or anything you want to do, but if you can't answer this question, you will sit down and we'll continue talking about it. Agreed?"

"Yeah, I'd like to see this. Agreed."

"The question is: how could you continue to talk with me for 20 minutes while I'm sleeping and not know it?"

A puzzled look came on his face. He rubbed his chin, scratched his curly hair, smiled, and said in a boyish, teasing manner, "Well, I don't know, but it still doesn't justify your sleeping."

"So you really can't answer that question."

"No, I can't," he said as he slowly took a seat.

What happened next was just short of a miracle given the circumstances. Larry took a seat and the anger disappeared. I admitted that I had trouble staying awake because of getting no sleep the night before. I also suggested that he didn't seem to need me to pay attention because he talked nonstop. I explained that I lost interest in

the conversation because he could talk without needing me to respond. The idea that he could talk to a sleeping person for 20 minutes without knowing it intrigued him and became a metaphor for later treatment with him. I believe in the 30 minutes that followed he saw himself differently. He saw why coworkers avoided him and why he had difficulty sustaining relationships. We made a contract where I was to act as if I were sleeping and he had to talk slowly and pause enough to catch me napping. During subsequent sessions, I would close my eyes and he would ask me to repeat back what he was saying.

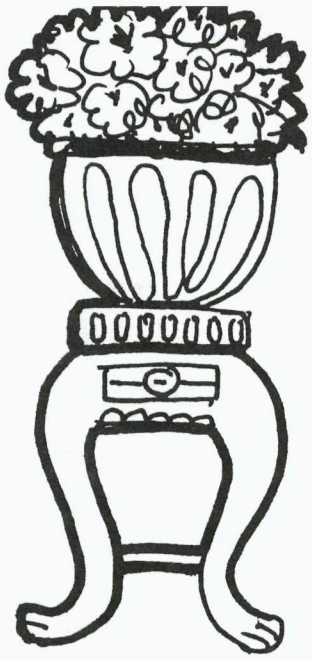
Larry was actually on my caseload for about seven years because I continued at the center for a few years after I completed my degree. During this time, he had no remissions and established his own residence. He got rid of his mental health professional patient cards and tried to find power in being sane instead. His father had a stroke and he moved back home to help his mother until his father died. We both had many cautions about this, but he did not regress. He developed a few friendships, but was still working on establishing and maintaining long-term intimate relationships when our therapeutic relationship ended when I moved out of state.

While I have seen many clients over the years since this incident, and had other situations that did not exactly go by the books, I can say that I learned more from this situation than any other I recall. First, I learned that you can use almost anything that happens between you and a client therapeutically. Therapy is primarily a relationship between people and when something occurs between the participants, the possibility of change is increased. I believe that a therapeutic change occurred with Larry because I reacted to him as a person first and didn't hide behind the therapist role. I reacted the same way I would have to my wife if the same situation had occurred. The question I asked Larry about not knowing that I was sleeping wasn't thought out, nor did I expect a certain outcome. I was simply curious how this could happen. I knew that had the situation been reversed and he fell asleep on me I would be aware that he was sleeping the moment he dozed off. The question for me was, "How could he not know this?"

His experience as a client contrasted somewhat with my inexperience as a therapist. Perhaps this inexperience helped in that I did not know the game well enough to play my part well. Not knowing the game of therapy freed me to relate to Larry in an open manner. I believe it also gave him the freedom to relate to me honestly as well. Even his anger seemed appropriate and I think I would have felt the same way had I been him. As the game of therapy changed to a discussion of two individuals attempting to understand something that happened between them, a more spontaneous interaction emerged.

Second, I learned that the therapist should not be afraid to push on the client. Therapy does not take place in a closed cloister in which there is only protection of the client. To grow, clients need to be challenged. The therapy room should be a microcosm of the real world in which there are real happenings. A therapist should not be afraid to interact with a client in the same manner that he or she interacts with significant others in his or her life.

Over the years I have noticed the work of colleagues and acquaintances who do therapy. I have much more concern about "nice" therapists who want all interactions to be kind and non-intrusive than I do about therapists who use confrontation. I am, of course, not suggesting that therapists abandon developing empathy. But I do believe that we have to let our clients know that we are real people with the same



emotions that they have and that we sometimes make mistakes and sometimes don't have answers. I believe that a good therapist is never too nice to be human.

Third, the therapeutic moment in which change occurs can happen at the time one least expects it. I certainly did not expect to have a therapeutic triumph after falling asleep in a session, but it happened. I certainly would never supervise students by suggesting that they sleep during the therapy session, but I would certainly tell students to never be afraid of what is happening in the present between them and the client.

I am reminded of a similar situation that occurred during supervision with a student. I was behind a one-way mirror observing a student conducting a therapy session with a single mother and her three children. The family had been referred by the department of family and child services because the 16-year-old son had been physically abusive to his twin 12-year-old sisters. The mother was functioning as one of the children rather than as the parent. Consequently, no household chores were being completed and there was total chaos. The 16-year-old son was attempting to take charge of the family, but didn't know how to do it. He attempted to spank the sisters for not following through on doing chores. In the session, everyone was talking at once. There was no order and the student/therapist was floundering. About halfway through the session, I buzzed the room and asked him to step out for a conference. I suggested that he lend support to the mother to reestablish her at the top of the family hierarchy and to free the son from assuming this responsibility. While I didn't tell the student how to establish order, I suggested that he set up some rules in order for the family to communicate with each more effectively. I thought it was much better for the student to think about this and decide how to address it from his own perspective than to tell him what to do.

When the student re-entered the room, the same dysfunctional communication patterns emerged. Again, there was no order and everyone was talking at the same time. After about 10 minutes, I was ready to buzz the room again for a second conference, when the student/therapist jumped to his feet and yelled in a very loud and intimidating voice, "Shut up!" You could have heard a pin drop. They all became very attentive and he pointed out how irritated he had become listening to them and not being able to structure them. He looked at the mother and said that there needed to be some rules to guide their interaction. In this way he engaged the mother to take some authority in the family. Putting the mother at the top of the hierarchy was built on in subsequent sessions, and over a short time the mother was helped to set consequences for the children and assume a parental role. While I would not endorse a therapist yelling at a family, I believe this intervention was successful because the student/therapist communicated in kind with the family. They were so used to yelling at each other that they didn't know how to respond to his genteel attempts to establish order.

Fourth, when you make mistakes in therapy always be truthful. The fact that I was truthful may have been the main catalyst in working through this situation. The temptation for therapists, sometimes, is to take the high road in the sense that we know more than the client. I believe that this posture creates a hierarchy that robs the client of his or her dignity.

If I had taken the high road by focusing on Larry's anger and his losing control, he would have been very comfortable with this arrangement because he had been put in this place so many times before. He would have demanded another therapist, who would have to deal with his anger, and the

escalation would have lasted until he found himself back in a mental hospital. Fully acknowledging the mistake and addressing his lack of knowledge of how he could talk to a sleeping person allowed both of us to grow.

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