KLIP-IN-DIE-BOS ***TRAILING COAT-TAILS***

How to Fail as a Therapist

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Too much emphasis has been placed upon how to be successful as a therapist, and far too little has been written about how to fail. In this article I will describe twelve steps for failing. It is my contention that any therapist can achieve failure with the proper training.

What has been lacking in therapy is a theory of failure. Many clinicians have assumed that any therapist could fail if he wished. Recent studies of the results of therapy, however, indicate that the spontaneous improvement of patients is far more extensive than was previously realised. There is a consistent finding that between 50 and 70% of the patients on waiting lists not only do not wish treatment after the waiting list period, but have fully recovered from their emotional problems. According to these findings, a therapist who does no more than sit in silence and scratch himself will have at least a 50% success rate with his patients. How then can a therapist be a failure?

The problem is not a hopeless one. Trends in the field suggest that it can be approached by devising procedures for keeping those patients from improving who would ordinarily spontaneously do so. Obviously, merely doing nothing will not achieve this end.

The central pathway to failure is based upon a nucleus of ideas which, if used in combination, makes success as a failure almost inevitable.

Step A: Insist that the problem which brings the patient into therapy is not important. Dismiss it as merely a symptom and shift the conversation elsewhere. In this way a therapist never learns to examine what is really distressing the patient.

Step B: Refuse to treat the presenting problem and offer some rationale, such as the idea that symptoms have roots.

Step C: Insist that if the presenting problem is relieved, something worse will develop. This myth will encourage patients to co-operate by developing a fear of recovery.

One might think this nucleus of ideas alone would make any therapist a failure, but the wiser heads in the field have recognised that other steps are also necessary.

It is particularly important to confuse diagnosis and therapy. A therapist can sound like an expert and be very scientific without ever risking a success with treatment if he uses diagnostic language. For example, one can say a patient is passive-aggressive, or he has deep-seated dependency needs, or he has a weak ego, or he is impulse-ridden. No therapeutic interventions can be formulated with this kind of language.

Put the emphasis upon a single method of treatment, no matter how diverse the problems which enter the office. Patients who will not behave properly according to the method should be defined as untreatable and abandoned. Once a single method has proved consistently ineffective, it should never be given up.

Have no theory, or an ambiguous and untestable one, of what a therapist should do to bring about change. However, make it clear that it is untherapeutic and unprofessional to give a patient directives for changing. He might actually follow them and change. Just imply that change happens spontaneously when the therapist and patient behave according to the proper forms. With that emphasis, ideas about what to do to bring about change will not develop. One should also insist that change be defined as a shift of something in the interior of a patient so that it remains outside the range of observation and cannot be investigated. With the focus upon the underlying disorder, questions about the unsavoury aspects of the relationship between therapist and patient need not arise.

Should student therapists insist upon some instruction about how to cause change, and if a frown about their unresolved problems does not quiet them, it might be necessary to offer some sort of idea which is untestable. One can say, for example, that the therapeutic job is to bring the unconscious into consciousness. In this way the therapy task is

defined as transforming a hypothetical entity into another hypothetical entity, and so there is no possibility that precision in therapeutic technique might develop. If some of the advanced students insist on more technical knowledge about therapy, a discussion of working through the transference is useful. This provides young therapists with a chance to make transference interpretations and so have something to do.

Insist that only years of therapy will really change a patient. This step brings us to more specific things to do about those patients who might spontaneously recover without treatment. If they can be persuaded that they have not really recovered but have merely fled into health, it is possible to help them back to ill health by holding them in long-term treatment. Fortunately the field of therapy has no theory of overdosage, and so a skilled therapist can keep a patient from improving for as long as 10 years.

As a further step to restrain patients who might spontaneously improve, it is important to offer warnings that they might suffer psychotic breaks or turn to drink if they improve. The concept of underlying pathology helps everyone to avoid taking action to help patients recover. If patients seem to improve even during long-term therapy, they can be distracted by being put into group therapy or sensitivity training.

The therapist should focus upon the patient's past. The therapist should interpret what is most unsavoury about the patient to arouse his guilt so he will remain in treatment to resolve the guilt.

Ignore the real world the patient lives in and publicise the vital importance of his infancy, inner dynamics, and fantasy life. This will effectively prevent either therapists or patients from attempting to make changes in their families, friends, schools, neighbourhoods, or treatment *milieus*. Naturally they cannot recover if their situation does not change. Talking about dreams is a good way to pass the time and so is experimenting with responses to different kinds of pills.

Avoid the poor because they will insist upon results and cannot be distracted with conversations full of insight. Also avoid the schizophrenic unless he is well-drugged and securely locked up in a psychiatric penitentiary. If a therapist deals with a schizophrenic at the interface of family and society, both the therapist and patient risk recovery.

A continuing refusal to define the goals of therapy is essential. If a therapist sets goals, someone is likely to raise a question whether they have been achieved. At that point the idea of evaluating results arises in its most virulent form.

It is absolutely necessary to avoid evaluating the results of therapy. Only by keeping results a mystery and avoiding any systematic follow-up of patients can one ensure that therapeutic techniques will not improve and the writings of the past will not be questioned.

This programme of failure is obviously not beyond the skill of the average well-trained therapist. Nor would putting this programme more fully into action require any changes in the clinical ideology or practice taught in our major universities.