

The Art of Being a Failure as a Therapist

Jay Haley

Director, Family Research, Philadelphia Child Guidance Clinic
Philadelphia, Pennsylvania

Too much emphasis has been placed upon how to be successful as a therapist and too little has been written about how to fail. Twelve steps for failing in psychotherapy are described within the proper ideological framework, and it is argued that any therapist can achieve this end with proper training.

What has been lacking in the field of therapy is a theory of failure. Many clinicians have merely assumed that any psychotherapist could fail if he wished. Recent studies of the outcome of therapy, however, indicated that spontaneous improvement of patients is far more extensive than was previously realized. There is a consistent finding that between fifty and seventy percent of patients on waiting list control groups not only do not wish treatment after the waiting list period but have really recovered from their emotional problems – despite the previous theories which did not consider this possible. Assuming that these findings hold up in further studies, a therapist who is incompetent and does no more than sit in silence and scratch himself will have at least a fifty percent success rate with his patients. How then can a therapist be a failure?

The problem is not a hopeless one. We might merely accept the fact that a therapist will succeed with half his patients and do what we can to provide a theory which will help him fail consistently with the other half. However, we could also risk being more adventurous. Trends in the field suggest the problem can be approached in a deeper way by devising procedures for keeping those patients from improving who would ordinarily spontaneously do so. Obviously, merely doing nothing will not achieve this end. We must create a program with the proper ideological framework and provide systematic training over a period of years if we expect a therapist to fail consistently.

An outline will be offered here of a series of steps

to increase the chance of failure of any therapist. This presentation is not meant to be comprehensive, but it includes the major factors which experience in the field has shown to be essential and which can be put into practice even by therapists who are not specially talented.

1. The central pathway to failure is based upon a nucleus of ideas which if used in combination make 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 a patient.

Step B: Refuse to directly treat the presenting problem. Offer some rationale, such as the idea that symptoms have "roots," to avoid treating the problem the patient is paying his money to recover from. In this way the odds increase that the patient will not recover, and future generations of therapists can remain ignorant of the specific skills needed to get people over their problems.

Step C: Insist that if a presenting problem is relieved, something worse will develop. This myth makes it proper not to know what to do about symptoms and will even encourage patients to cooperate by developing a fear of recovery.

Given these three steps, it seems obvious that any psychotherapist will be incapacitated, whatever his natural talent. He will not take seriously the problem the patient brings, he will not try to change that, and he will fear that successful relief of the problem is disastrous.

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

2. It is particularly important to confuse diagnosis and therapy. A therapist can sound ex-

pert and be scientific without ever risking a success with treatment if he uses a diagnostic language which makes it impossible for him to think of therapeutic operations. For example, one can say that a patient is passive-aggressive, or that he has deep-seated dependency needs, or that he has a weak ego, or that he is impulse-ridden. No therapeutic interventions can be formulated with this kind of language. For more example of how to phrase a diagnosis so that a therapist is incapacitated, the reader is referred to *The American Psychiatric Association Diagnostic Manual*.

3. Put the emphasis upon a single method of treatment no matter how diverse the problems which enter the office. Patients who won't behave properly according to the method should be defined as untreatable and abandoned. Once a single method has proven consistently ineffective, it should never be given up. Those people who attempt variations must be sharply condemned as improperly trained and ignorant of the true nature of the human personality and its disorders. If necessary, a person who attempts variations can be called a latent layman.

4. Have no theory, or an ambiguous and untestable one, of what a therapist should do to bring about therapeutic change. However, make it clear that it is untherapeutic to give a patient directives for changing – might follow them and change. Just imply that change happens spontaneously when therapists and patients behave according to the proper forms. As part of the general confusion that is necessary, it is helpful to define therapy as a procedure for finding out what is wrong with a person and how he got that way. With that emphasis, ideas about what to do to bring about change will not develop in an unpredictable manner. 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 is uninvestigable. With the focus upon the "underlying disorder" (which should be sharply distinguished from the "overlying disorder"), questions about the unsavory aspects of the relationship between therapist and patient need not arise, nor is it necessary to include unimportant people, such as the patient's intimates, in the question of change.

Should student therapist who are not yet prop-

erly trained 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 ambiguous and general idea which is untestable. One can say, for example, that the therapeutic job is to bring the unconscious into the 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. Part of this approach requires helping the patient "see" things about himself, particularly in relation to past traumas, and this involves no risk of change. The fundamental rule is to emphasize "insight" and "affect expression" to student therapists as causes of change so they can feel something is happening in the session without hazarding success. If some of the advanced students insist on more high-class technical knowledge about therapy, a cloudy discussion of "working through the transference" is useful. This not only provides young therapists with an intellectual catharsis but it gives them a chance to make transference interpretations and so have something to do.

5. 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. (One can always claim that only long-term treatment can really cure a patient so that he will never ever have a problem the remainder of his life). Fortunately the field of therapy has no theory of over-dosage, and so a skillful therapist can keep a patient from improving for as long as ten years without protest from his colleagues, no matter how jealous. Those therapists who try for twenty years should be congratulated on their courage but thought of as foolhardy unless they live in New York.

6. As a further step to restrain patients who might spontaneously improve, it is important to offer warnings about the fragile nature of people and insist they might suffer psychotic breaks or turn to drink if they improve. When "underlying

pathology” becomes the most common term in every clinic and consulting room, everyone will avoid taking action to help patients recover and patients will even restrain themselves if they begin to make it on their own. Long-term treatment can then crystallize them into therapeutic failures. If patients seem to improve even in long-term therapy, they can be distracted by being put into group therapy.

7. As a further step to restrain patients who might spontaneously improve, the therapist should focus upon the patient’s past.

8. As yet another step with that aim, the therapist should interpret what is most unsavory about the patient to arouse his guilt so that he will remain in treatment to resolve the guilt.

9. Perhaps the most important rule is to ignore the real world that patients live in and publicize the vital importance of their 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, and so one guarantees failure while being paid to listen to interesting fantasies. Talking about dreams is a good way to pass the time, and so is experimenting with responses to different kinds of pills.

10. Avoid the poor because they will insist upon results and cannot be distracted with insightful conversations. 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 therapist and patient risk recovery.

11. 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. If it becomes necessary to define a goal, the phrasing should be unclear, ambiguous, and so esoteric that anyone who thinks about determining if the goal has been achieved will lose heart and turn to a less confused field of endeavor, like existentialism.

12. Finally, it cannot be emphasized enough that is absolutely necessary to avoid evaluating the results of therapy. If outcome is examined, there

is a natural tendency for people not fully trained to discard approaches which are not effective and to elaborate those which are. Only by keeping results a mystery and avoiding any systematic followup of patients can one ensure that therapeutic technique will not improve and the writings of the past will not be questioned. To be human is to err, and inevitably a few deviant individuals in the profession will attempt evaluation studies. They should be promptly condemned and their character questioned. Such people should be called superficial in their understanding of what therapy really is, oversimple in their emphasis upon symptoms rather than depth personality problems, and artificial in their approach to human life. Routinely they should be eliminated from respectable institutions and cut off from research funds. As a last resort they can be put into psychoanalytic treatment or shot.

This program of twelve steps to failure – sometimes called the daily dozen of the clinical field – is obviously not beyond the skill of the average well-trained psychotherapist. Nor would putting this program more fully into action require any major changes in the clinical ideology or practice taught in our better universities. The program would be helped if there was positive term to describe it, and the word ”dynamic” is recommended because it has a swinging sound which should appeal to the younger generation. The program could be called the therapy which expresses the basic principles of dynamic psychiatry, dynamic psychology, and dynamic social work. On the wall of every institute training therapists, there can be a motto known as *The Five B’s Which Guarantee Dynamic Failure*:

- Be Passive
- Be Inactive
- Be Reflective
- Be Silent
- Beware