Common Errors in Conducting Psychodynamic Psychotherapy: Illustrative Vignettes and Alternative Strategies

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In this paper 12 common errors that occur in the course of psychodynamic psychotherapy are reviewed. Rationales for why we consider these to be errors are described, and vignettes are used to illustrate the errors, lastly, recommendations for alternate approaches consistent with effective psychodynamic psychotherapy are presented. The errors reviewed include concerns regarding the maintenance of appropriate limits and boundaries; decisions regarding the focus and form of treatment; no-suicide contracts; fee arrangements; missed sessions; psychological testing of psychotherapy patients; selecting appropriate patients for psychotherapy; and the importance of personal psychotherapy for the therapist. The suggestions provided are consistent with what we believe are the goals of psychodynamic psychotherapy: autonomy, insight, and self-determination.

KEYWORDS: psychotherapy; misalliance; treatment errors; risk assessment; supervision

INTRODUCTION

There are many guides to conducting psychodynamic and intensive psychotherapy (Basch, 1980; Bugenthal, 1987; Chessick, 1991; Fromm-Reichman, 1950; Gabbard, 2004; Greenson, 1967; McWilliams, 2004; Paul, 1978; Rogers, 1961; Snyder, 1961; Wallin, 2007); however, the majority are grounded in various theories of personality or psychopathology and focus on general principles of psychotherapy. As such, they often provide only an overview of the therapy process without addressing

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specific problematic situations that frequently arise in the course of treatment. These basic guidelines for treatment are often referred to as the "nickels and dimes" of psychotherapy. If not handled effectively, they may prove to be stumbling blocks that confound the therapeutic process. Despite their disruptive potential, less attention is given to the rationale and strategy for dealing appropriately with such issues. Notable exceptions include Blau's (1988) review of the structure of psychotherapy and selected problematic situations; a description by Weeks, Odell, and Methven (2005) of frequent mistakes in couple's therapy; Kepecs' (1979) analysis of errors that disrupt the therapeutic process; Casement's (2002) insights regarding the dangers of clinging too tightly to the dogma of psychoanalytic theory, and Bach's (2011) manual for beginning students of psychoanalysis and psychotherapy. In a similar fashion, Altshuler (1989) describes a number of common errors seen in the therapeutic efforts of beginning student therapists. These include:

placing undue emphasis on genetic interpretations;
focusing prematurely on the transference;
providing inappropriate support, and
over interpreting material to avoid affective involvement.

He also reviews the reasons why these interventions do not further the therapeutic process and suggests alternate and more helpful approaches. The contributions of I. H. Paul (1973, 1978, 1989, 1997) strongly recommend focusing on specific techniques rather than theory to address therapist/patient interactions and dilemmas. Although he has a psychodynamic orientation, Paul maintains that effective therapy is characterized by good technique, which transcends theory in guiding and selecting interventions. To this end he explores a range of responses to typical problems in therapy and argues convincingly for the least intrusive and most helpful interventions.

While the guidelines outlined by these authors primarily address more pervasive issues in psychoanalytic psychotherapy, we have found that therapists often have more specific procedural questions, which are a recurrent source of error for them. What follows is a brief discussion of 12 frequently encountered errors in psychodynamic psychotherapy. We have also included the rationale for why we consider these to be errors that have the potential to disrupt the process of psychotherapy, and we suggest more helpful approaches to these issues. The errors discussed are derived primarily from our clinical experiences both in treating patients and supervising students and interns in clinical training programs. While a

number of these potential errors have been extensively researched, such as treating only presenting symptoms, maintaining appropriate boundaries, and no-suicide contracts, others have received relatively little attention, for example managing "no shows," treating patients with whom you cannot identify, and psychological testing for your therapy patients. The purpose of this article is to address some of the issues that are often neglected in the formal training of student clinicians and by practicing psychotherapists. We believe once these errors become habitual in clinical practice, they are difficult to recognize or change. What follows is a discussion of these twelve errors and clinical vignettes drawn from our experience illustrating their potential disruptive effects.

Failure to maintain appropriate limits and boundaries

In the course of psychotherapy, a 35-year-old female patient revealed a traumatic loss and became emotionally distraught and tearful. In an attempt to comfort her, the therapist (who was male) hugged the patient. In subsequent sessions, whenever the patient became emotionally distressed, the therapist responded by hugging her. Over time, this behavior developed into more intimate and inappropriate physical contact.

It is the responsibility of the therapist to establish and maintain the structure of psychotherapy. While this includes agreements regarding the time and place of scheduled sessions; fees and the manner of payment and cancellation policies; it more importantly defines expectations of the patient and the therapist in therapy, and the limits of confidentiality (Gabbard, 2004; McWilliams, 2004; Paul, 1978). It is the therapist's responsibility to monitor significant deviations that occur in the therapy and to address and interpret what they may represent (Gutheil & Gabbard, 1993; Levine, 2010; Pope and Keith-Spiegel, 2008). This is particularly important in the nature of the relationship between the patient and the therapist, which is unlike any other significant relationship (Barnett, Lazarus, Vasquez, Morehead-Slaughter, & Johnson, 2007; Schwartz & Olds, 2002; Slattery, 2005) because it is specifically designed to assist the patient in addressing conflicts and underlying difficulties. Allowing the exchange to evolve into something other than psychotherapy, such as a friendship or a series of casual exchanges, can easily derail the treatment and undermine the process (Lamb & Cantanzaro, 1998). For the patient, engineering an alteration in the nature of the therapy sessions can serve numerous defensive and/or manipulative ends, resulting in the avoidance of dealing with the reasons for seeking treatment. The temptations and motivations for the therapist's complicit behavior, both conscious and

unconscious, may range from a wish to be admired to hidden needs for attachment to a dependent other. As Langs (1981) noted, these are a few examples of the multitude of transference and countertransference problems that may arise during the course of treatment. Most unethical patient/therapist involvements begin on the slippery slope of enabling or encouraging boundary intrusions (Gutheil & Gabbard, 1993, 1998; Simon, 1995; Twemlow, 1997). Such breeches by the therapist may include informalities in relating, touching or hugging, inappropriate or excessive self-disclosure, laxity regarding collection of fees or length of sessions, or other instances of casual or trivializing behaviors by the therapist. All lead to a misalliance that at best renders the therapy a sham, and at worst exploits the patient. Consistent vigilance by the therapist is required to avoid boundary breaches.

Disclosing unnecessary personal information

The patient, a 45-year-old male, talked about a surprising armed attack by a political group that had recently been in the news. The therapist offhandedly commented, "These ultraconservatives are dangerous groups." By doing so, the therapist had inadvertently inhibited the patient from expressing some of his more radical and extreme perceptions and beliefs, and thereby raised a level of distrust and caution toward the therapist.

The patient has the right to ask questions and expect straightforward answers about the therapists' credentials, the process of therapy, and business matters related to the therapy (Paul, 1997, pp. 9-14). However questions of a more personal nature about the therapist's marital status, children, vacation plans, home, car etc. are usually not to be answered. The more the patient knows about the therapist's personal life and preferences, the less freedom he or she has to fantasize about the therapist. Such fantasies are typically a projection of the patient's internal life, and their expression provides essential insight into the patient's unconscious conflicts and dynamics. There are some exceptions to a therapist's disclosing personal information. For example, psychotically organized patients typically require the therapist to be less opaque (Tarachow, 1963), and decompensated severe borderline patients may require access to their therapist even when the latter is vacationing (Blanck & Blanck, 1974, p. 182). Also, if the therapist develops a significant health problem that would impact ongoing therapy, it may be appropriate to address this with the patient (Fromm-Reichman, 1950, pp. 211-213).

We concur with the traditional belief that the therapist's maintenance of a certain "blank screen" or reasonable anonymity facilitates therapy.

Unfortunately, there is considerable information available on the Internet about almost everyone. Therefore, we believe it is important for therapists to be mindful of information they post on websites or social media to avoid inadvertent disclosure of personal information that might be disruptive to the therapeutic relationship.

Treating only the presenting symptoms

A 33-year-old male patient complained about the disruptive effect of gambling addiction on his life. The therapist worked diligently to convince the patient that his irrational thinking and beliefs were maintaining his compulsive gambling. In time, the patient was able to recognize the futility of his addiction and relinquish his preoccupation with gambling. However in subsequent sessions, the patient began to discuss other forms of potentially self-destructive, obsessive behaviors, which suggested an ongoing undiagnosed underlying mood disorder.

Treating the presenting symptoms only reflects a limited understanding of the nature of psychopathology and how individuals attempt to cope with their difficulties. Numerous researchers have noted that dealing effectively with psychopathology requires an understanding of the etiology of the patient's difficulties (Duncan, 2002; Luborsky, 1995; Rosenzweig, 1936; Trimboli and Keenan, 2010; Trimboli, Marshall, and Keenan, 2013). With psychotherapy approaches that are directive and one-dimensional in the conceptualization of psychopathology, the symptom is regarded as the problem and dictates the focus of treatment. Resolving this symptom may bring temporary relief, but it is unlikely to address the underlying conflict reflected by the presenting problem. Hence it would not be surprising to find a new symptom arising in the future, which would express the underlying conflict (Cahoon, 1968; Hand & Lamontagne, 1976; Kazdin, 1982). However, with more psychodynamic approaches, the presenting symptom is regarded as the starting point for the exploration of a more complex and over-determined phenomenon. Thus the symptom is regarded as a compromise reflecting both the core difficulty and the patient's ineffective attempt to deal with the underlying conflict (Fenichel, 1945). The symptom is seen as a defense against this underlying conflict, which cannot be directly addressed until the meaning and function of the defensive behavior is understood. Exploring and neutralizing the defensive nature of the symptom is the pathway to understanding the core conflict and its derivatives (Abbass & Town, 2013; Gabbard, 2004). For example, the patient who complains he is being mistreated by the women in his life may come to appreciate that they have not singled him out for such

treatment. Armed with this understanding, he can begin to understand why it is important for him to view his relationships with women in this manner. With successful exploration of these interpersonal relationships, he may discover that he is reenacting the experience of being rejected by an important female figure, thereby reliving his core trauma. The repetition of this trauma accounts for the distress and presenting symptoms that brought him to therapy.

No-suicide contracts

A 19-year-old adolescent male was hospitalized for suicidal ideation after tracking down his birth mother and discovering he would not able to connect with her in a meaningful way. After a brief stay, he was released from the inpatient facility on the condition that he pledge to a no-suicide contract. In later therapy he ridiculed this contract, which he perceived as having trivialized his desperation and pain. Subsequently, he terminated therapy. Some weeks later, he hanged himself in a public location, ensuring he would be discovered by others, who were the recipients of his displaced rage toward his birth mother.

There may be instances when no-suicide contracts serve some clinical utility. However, their indiscriminate use is unsupported empirically and clinically, especially in the absence of adequate formal training in suicide risk assessment and an understanding of the complexity of clinical management of the suicidal patient.

The practice of using no-suicide contracts as part of the intervention with suicidal patients has been ubiquitous for at least 40 years. Initially promoted by Drye, Goulding, & Goulding (1973), and increasingly popularized by the influence of managed care, the no-suicide contract gained widespread acceptance in the absence of empirical support and rational guidelines for its use. However, in his review of no-suicide contracts and their practical and legal efficacy, Simon (1999) stated, "The notion that a legal document could prevent a patient from committing suicide is naïve and self-delusive." Other authors have asserted that the no-suicide contract, when not integrated with competent clinical assessment of suicide risk, creates only the illusion of safety. Kroll (2000) conducted a survey of psychiatrists in Minnesota and found that 77% of respondents believed no-suicide contracts to be helpful. However, 42% of respondents reported that they had treated patients, who had attempted or completed suicide despite having agreed to a no-suicide contract. Practicing clinicians should consider that patients in the midst of an acute suicidal crisis may feel coerced if asked to sign a no-suicide contract. Blau (1988) clearly indicated

that evaluating suicide risk is the assessment of the degree of overwhelming, inescapable emotional pain the patient is experiencing, and the availability of reliable supportive relationships and attachments. The primary ethical and professional responsibility for competently assessing suicide risk falls solely on the clinician, not the patient. With this in mind, we recommend that the therapist consult authors such as Blau (1988, pp. 250-255), Fowler (2013), and Rudd, Mandrusiak, and Joiner (2006), for comprehensive and sensitive discussions of how to assess and manage the threat of suicide.

Reducing fees

After attending several therapy sessions, a 50-year-old man implored the therapist to reduce fees by half because the current rate was unaffordable. The therapist agreed. The next session, the patient appeared with a gift he had purchased for his lover, and proudly informed the therapist that the gift "only cost" an amount equal to the reduced fee. After this, the patient never returned for additional sessions.

Perhaps there is no other area in the process of psychotherapy that has received as much attention as the fee. The debate ranges from those who believe that meaningful psychotherapy is not possible without an adequate fee (Freud, 1913/1958, pp. 131-133) to those who believe that reducing the fee can be used as a tool to reward the patient for reaching goals (Gumina, 1977). Curiously, the evidence is contradictory as to the effectiveness of fee payment on psychotherapy (Bishop & Eppolito, 1992; Herron and Sitkowski, 1986; Pope, Geller, and Wilkinson, 1975; Yoken & Berman, 1984). Most traditional therapists regard the negotiation of the fee as a contract that constitutes part of the structure of psychotherapy. We agree with Knapp and Vande Creek (2008) that guidelines should be established in the initial session regarding fee arrangements, and they must be specific regarding any possible contingencies. It is important for the therapist and patient to be in agreement about a realistic fee. Once the therapist and patient have agreed upon the fee arrangement, altering it may have negative consequences. In these troubled economic times, it is not unusual for patients to have difficulty meeting financial obligations, and they may legitimately be unable to honor the fee commitment they originally made (Rhoden, 2010; Treloar, 2010). While the therapist may believe the patient's request is legitimate, the therapist must be aware that agreeing to a reduction in fee is fraught with potential complications. For example, following a fee reduction the patient may begin to devalue the therapy and/or the therapist, who may be perceived as willing to conduct the therapy for his or her own needs. A reduced fee may also contribute to the

patient's belief that they are not worthy of "real" therapy. Moreover, the therapist needs to closely monitor any feeling of being exploited by the fee reduction. Such a belief, if unchecked, has countertransference implications that could compromise the therapy. As an alternative to fee reduction, the therapist might consider decreasing the frequency of sessions, suspending therapy until such time as the patient is able to financially support treatment, or referring the patient to reduced fee clinics in the community.

Managing "no-shows"

A 30-year-old female patient missed a scheduled session. Later that day the therapist called the patent to express concern, inadvertently creating a misalliance by communicating a willingness to coddle the patient. While the reason or motivation for the missed appointment may have had numerous implications, these would likely be secondary, and would not be immediately available to either the patient or the therapist for processing and understanding.

A "no-show" occurs when a patient misses a scheduled therapy appointment without notifying the therapist (DeFife, Conklin, Smith & Poole, 2010). While seemingly insignificant, calling a patient about a no-show may have the potential to undermine the therapeutic process (Gans & Counselman, 1996), with the possible exception of calling an established patient for whom abandonment is a primary dynamic. Although there may be a number of important and unavoidable reasons for missing a session, we contend that the "no-show" itself may be a significant communication. A naïve therapist might incorrectly assume that a missed session indicates a misunderstanding of the structure of therapy, thereby missing the possible unconscious resistance implicit in the behavior. In this case the therapist may be inclined to call the patient. As an alternative we recommend the therapist reserve the patient's appointment time for the next scheduled session. This would be consistent with Bach's (2011) emphasis upon maintaining the continuity of treatment for the patient who misses an appointment without contacting the therapist beforehand. If the patient returns for the subsequent session, discussing the missed appointment could serve as a fruitful source of understanding the meaning of this event. For example the "no-show" could be an expression of resistance to either the process of psychotherapy (Tidwell, 2004) or to the anxiety associated with the content of what is being discussed (Trimboli & Keenan, 2010). Contacting the patient regarding a no show may seem to be an act of concern and consideration. However, there is a danger that the patient could perceive this as an expression of solicitation by the therapist

and an indication that the therapy is more important to the therapist than it is to the patient.

Equity in charging for missed sessions

A 45-year-old male in ongoing treatment found himself sitting in the waiting room long after his appointment time had passed. When it finally became clear the therapist was not going to appear, he left. Later that day, his therapist called him and jokingly asked, "Did you feel abandoned?" However, no mention was made then or later of the therapist's having missed an appointment, nor was there any attempt by the therapist to apologize or to take responsibility for the emotional impact of the missed session. Her failure to respond empathically and responsibly reinforced the patient's feeling of being devalued, and inhibited him from discussing the feelings associated with this issue.

At the beginning of psychotherapy, the therapist typically discusses his or her policy regarding missed sessions. This includes the handling of charges for missed sessions and the practice of not charging for sessions that are cancelled by the patient with appropriate advanced notice (Gans & Counselman, 1996). However, therapists rarely discuss the policy for sessions that the therapist must miss or cancel without appropriate notice. Most often the therapist simply reschedules the appointment with no other accommodation. We believe this is inconsistent and inequitable and conveys the message that the therapist's time is more valuable than the patient's time. This also violates the equality that needs to exist between therapist and patient in order for them to effectively collaborate in exploring the patient's difficulties. Without an equitable manner of dealing with this issue, the therapist is not required to honor the implicit agreement regarding meeting times.

We believe some psychotherapists would not endorse this position. Most likely they would maintain that this practice deprives the patient of the opportunity to experience and explore feelings of anger and abandonment. We contend that these feelings will occur regardless, and can still be addressed in the therapy. Equity is a distinct issue that speaks to consistency and maintaining the therapeutic alliance. Thus, we suggest the agreement be reciprocal from the onset. The patient is expected to pay for any missed, uncancelled sessions (barring unforeseen emergencies), and the patient will not be charged for appointments cancelled within the agreed upon time period. Likewise, the therapist should agree to abide by the same policy. If the therapist misses a session without adequate notice, we believe it would be appropriate for the therapist to provide the next

session at no cost. This approach to dealing with cancelled and missed sessions is consistent with maintaining the therapeutic alliance and a working relationship that is equitable, ethical, and mutually respectful.

Conducting psychological testing with psychotherapy patients

A 24-year-old female sought treatment with a therapist, who conducted an extensive psychological testing evaluation during the initial meeting. In a subsequent session, the therapist used the psychological test findings to "explain" the patient's difficulties to her. Soon after, the patient left therapy armed with the test findings, but without having explored her feelings and perceptions of her difficulties. Instead, she had the mistaken belief that hearing an explanation of her problems constituted adequate treatment.

For psychotherapists who are psychologists, or who practice in conjunction with psychologists, there may be a temptation to perform or acquire a pretreatment psychological assessment. After all, often such an assessment can accurately determine the nature, severity, and etiology of a patient's difficulties. Given the power of this intervention, it may seem odd not to advocate using this avenue of investigation with one's own patients, or employing psychological testing results in the manner described by proponents of therapeutic assessment (Finn, Fischer, & Handler, 2012). However, we believe either practice violates the major goal of psychotherapy from a psychodynamic perspective, i.e. patients' understanding of the meaning of their conflicts and fears and the resolving of these through the therapeutic process (Abbass & Town, 2013; Gabbard, 2004; Paul, 1978). Without experiential awareness, a "test finding" has only intellectual meaning at best. Moreover, the presentation of the "test findings" subverts the therapeutic process and dictates the course of therapy regardless of the patient's readiness and ability to pursue the issues arising from the formal assessment. When psychological testing is warranted in the therapeutic process, for example, questions of possible dementia, evaluation of suicidal or homicidal potential, suspicion of a latent thought disorder, etc., another psychologist should be consulted. This evaluator should present the findings to both the patient and therapist, ideally in a joint session.

Concurrently treating members of the patient's family or close friends

A therapist was treating a 38-year-old male in individual psychotherapy. He later agreed to see the patient's younger sister concurrently in treatment. As weeks passed, the therapist found the siblings frequently complained about each other to him. Inevitably his understanding of both patients was compromised, because of the confounding information provided by each of them and their competition with each other.

Occasionally a patient in psychotherapy may ask the therapist to treat a family member or close personal friend. This request may be associated with issues relevant to the patient's treatment or may be unrelated to the patient's therapy. In either case, the issue needs to be carefully considered at the outset, as this practice may become complicated and undermine treatment. In the first instance, it is not unusual, and often is helpful, to include a family member for a limited number of problem-focused sessions, primarily as a complement to the ongoing treatment of the existing patient. It is understood that these sessions would be time limited and would focus on the primary patient's issues. However, concurrent individual psychotherapy with another family member or a close personal friend may lead to difficulties in the future for all parties. For example, issues of confidentiality may arise as it becomes unclear who said what to whom. Moreover, patients will likely struggle with the therapist's divided loyalty and/or may find themselves competing with each other to gain the favor of the therapist. Additionally, the therapist is not immune from conscious or unconscious inclinations to favor one patient over the other, thereby affecting the treatment of both individuals. These complications have the potential to disrupt the therapeutic alliance.

The therapist's wish to accommodate the patient's request should not interfere with making a judgment of what is in the long-term best interest of the patient. Therefore, it would be advisable for the therapist to refer the family member or friend to a trusted colleague following a discussion of the recommendation.

Treating patients who have few characteristics with which the therapist can identify

A therapist accepted a 60-year-old male, who was an high-level corporate executive, for treatment of depression. In the course of therapy it emerged that the patient was an abusive, sadistic husband and father, grossly unethical in his business dealings, and particularly exploitive of his colleagues and business associates. The therapist found she began to dread seeing him, and started to openly minimize his psychological concerns. Her emotional response to his pathology undermined the treatment and resulted in her pursuing a premature conclusion of therapy.

Providing counseling and/or supportive interventions for patients with whom we cannot identify (and therefore cannot readily admire) is certainly possible. The therapist may not feel an affinity for the patient, but may nevertheless regard him or her as capable of benefiting from some support or guidance. However, engaging such a person in psychodynamic psycho-

therapy with the goal of fundamental change in the patient's personality structure is problematic. Such therapy requires that the patient demonstrate the potential to incorporate the therapist's acceptance, unconditional positive regard, and admiration. Rogers (1959; 1961) referred to this as "prizing" the patient. The ability to incorporate the therapist's positive regard over time provides the emotional sustenance that allows the patient to fortify a fragile sense of self. This in turn allows the patient to face his or her fears, conflicts, and self-defeating behaviors. Kohut provided the example of the little girl, who, walking away from her mother for the first time, turns to experience "the confirming reverberation of her mother's proud smile" (Kohut, 1984, p. 186). Occasionally, we encounter patients who have not been in nurturing, self-affirming relationships. These individuals may have significant personality deficits consistent with an undeveloped and fragmented self. As a result they may have few characteristics with which the therapist can identify and empathize. We believe that the experience of genuine empathy in the therapeutic setting can be restorative and healing in and of itself, as Rogers and Kohut attested in the works cited above. In addition, empathy provides the basis for the patient's benign self-evaluation, which is essential to an emerging positive self-image. Unfortunately there may be individuals with whom therapists are unable to identify or admire, and therefore cannot provide the consistent therapeutic empathy essential for successful long-term treatment. Some therapists may be inclined to continue the treatment and to persist in the face of increasing frustration, disappointment, and perhaps unacknowledged anger with the patient and themselves. We strongly caution against this. To ignore these strong negative feelings, hoping that in time everything will sort itself out is, in our experience, naïve and unfounded. As Bach pointed out, treating patients that cause you some initial concern is done "at your own risk" (2011, pp. 6-7). Rather, the therapist is well advised to limit the therapy to supportive, problem-focused interventions instead of pursuing intensive, restructuring psychotherapy. As an alternative, we would encourage the therapist to consider referring such patients to a trusted colleague, who might be better suited by disposition and/or training to provide effective treatment.

Accommodating the patient's request for alternate forms of ongoing treatment

A 45-year-old female consulted with her therapist concerning chronic, severe headaches. After a few sessions, the patient brought up a new neuro-feedback technique she had read about and asked if it might be helpful

in alleviating her pain. Although the therapist felt the patient was depressed and somaticizing, he agreed that the patient could pursue the treatment concurrent with the psychotherapy. He did not engage in a struggle with the patient regarding her decision, because he felt she would eventually find the new technique unsuccessful and would continue psychotherapy.

It is not uncommon for patients, particularly those engaged in nondirective, insight-oriented psychotherapy, to experience frustration when they do not find rapid relief for their distress. Consequently, they may complain that the treatment they are receiving is somehow insufficient, not what they expected, or not helpful. Paul (1973, pp. 199-207) has addressed this issue in detail and essentially urges the therapist to consider temporarily modifying a strict adherence to orthodox methodology in favor of a judicious degree of flexibility. He states, ". . . it's a strange victory to have maintained therapeutic purity and to have lost the patient . . ." (Paul, 1973, p. 201). Patients' requests for more empathy, participation, or help likely constitute resistance. However, to the extent these requests are not judged to be manipulative, the therapist may be able to be more responsive. Also, the patient may ask about the appropriateness or usefulness of alternate approaches or adjuncts to treatment, such as hypnosis, medication, conjoint therapy, or any of a variety of single dimension modalities. If, in the judgment of the therapist, any of these alternative approaches seem appropriate, the therapist may consider including them as part of the ongoing treatment. Adding another parameter would be helpful only if it is not simply an attempt to accommodate the patient by acquiescing to a manipulation.

Personal psychotherapy as a prerequisite for conducting psychotherapy

A 36-year-old female patient was seeing a 40-year-old therapist. The patient was referred for marital difficulties by one of the therapist's colleagues. While listening to the patient complain about her spouse, the therapist noticed he was having feelings of annoyance bordering on revulsion. Unbeknownst to him, her behavior mirrored the criticism and devaluation he experienced in his own marriage. Lacking adequate insight about his own unresolved issues, he unconsciously acted out these issues with the patient, thereby seriously compromising his ability to treat her in an effective manner.

We believe undergoing personal psychotherapy is an essential prerequisite for the practice of psychotherapy regardless of theoretical orientation (Orlinsky, Schofield, Schroder, and Kazantis 2011). This is especially true for therapists conducting psychodynamic psychotherapy (Chessick,

1991; Geller, 2011, 2013; McWilliams, 2004). As these authors note, the patient's amalgam of feelings, uncertainty, vulnerability, fears of failure, and confusion can only be appreciated by one who has been in the patient role. Similarly, the impact of insights, particularly involving transference phenomenon and its intensity, can best be understood through the perspective of having been a patient. Moreover, the ability to recognize the emergence of previously unconscious material as it occurs in the course of treatment is more readily apparent to someone who has experienced it in psychotherapy. Recognizing the phenomenon allows the therapist to resonate with the patient's experience and facilitates the timing and the nature of interventions. More important, the experience of one's personal therapy bears directly upon the issue of minimizing countertransference distortions. At a minimum, if the therapist has not had the benefit of personal intensive psychotherapy, we would advocate practicing only under close supervision. Without therapists' being aware of their own conflicts and biases, it is much too easy to perceive these as existing in the patient. When this occurs therapy may be derailed because the therapist is following a personal agenda rather than meeting the needs of the patient. Minimizing these distortions allows patients to have the benefit of the therapist's objective observation and empathy as an aide in reaching a new conceptualization of their life situation.

CONCLUDING REMARKS

The 12 sources of error in conducting psychodynamic psychotherapy are listed in Table 1. The table also contains suggested alternative strategies to these errors.

The errors listed are not intended to be exhaustive, nor are they written in stone. Rather, they are derived primarily from our clinical experience and observations from supervision of other clinicians. While we do not consider adherence to these prohibitions compulsory, we do strongly believe it is essential that the therapist understand how treatment might be impeded as a consequence of these errors. Because of the complicated nature of psychodynamic psychotherapy, it would not be uncommon to confront the possibility for committing one or more of these errors. On these occasions, the decision about how to proceed should be made with thoughtful consideration of the impact the error may have on the patient's therapy. Implicit in our stance regarding these issues, are the values of respect for the autonomy of the patient, our belief in the therapeutic process, and most importantly, our commitment to patients' understanding of the meaning of their difficulties. The intent is to avoid coercion,

Table 1 COMMON ERRORS AND ALTERNATIVE STRATEGIES

Errors related to:	Alternative strategies:
1. Limits and boundaries	Constant vigilance for violations of boundaries or lapses in the structure of therapy
2. Therapist self-disclosure	Maintain reasonable anonymity
3. Treating only presenting symptoms	Determine underlying etiology
4. No-suicide contracts	Therapist should assess suicide risk
5. Reducing fee	Decrease frequency of sessions; suspend therapy until patient can afford treatment; referral to reduced fee clinic
6. "No-shows"	Refrain from contacting, but reserve patient's next scheduled session
7. Charging for missed sessions	Recommend reciprocity for both therapist and patient
8. Psychological testing of the therapist's patient	Involve a consulting psychologist to evaluate urgent issues and simultaneously share results with therapist and patient
9. Concurrently treating family members	Refer other family members to a colleague
10. Treating patients you cannot admire	Limit therapy to supportive or problem-solving efforts; refer patient to colleague skilled in dealing with these problematic patients
11. Patient's requests for alternate forms of therapy	Accomodate non-manipulative requests
12. Personal psychotherapy for the treating therapist	Essential; but if not possible, practice only under the close supervision of an experienced therapist

misalliance, or unconscious exploitation of the patient in order to confirm the therapist's personal dogma regarding psychopathology and psychotherapy. By doing so, we hope to foster the therapeutic goals of autonomy, insight, and self-determination.

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