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The dimensions of therapists' thoughts in response to therapy failures.

Susan E. Hawes
University of Massachusetts Amherst

THE DIMENSIONS OF THERAPISTS' THOUGHTS IN RESPONSE TO THERAPY FAILURES

A Dissertation Presented

by

SUSAN E. HAWES

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Approved as to style and content by:

John Carey, Chairperson of Committee

Ronnie Janoff-Bulman, Member

Howard Gadlin, Member

Marilyn Haring-Hidore
Dean of the School of Education

DEDICATION

I would like to dedicate this dissertation to my partner, Jonathan Sivitz, who has been unflagging in the support and loving encouragement he has given me throughout the years it has taken to complete this work. Without him I would surely have not come so far. And so, in many ways, this achievement is as much his as it is my own.

I would also like to dedicate this thesis to my daughter, Becky and my son, Micah, who have been so patient with their mother's frequent and erratic immersions into the morass of demands that accompany the completion of a doctoral degree.

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Finally, I cannot express my gratitude enough to those psychotherapists who gave hours of their valuable time to me and this research. Each one of them went to great lengths to schedule times to meet with me and persisted in tasks that were difficult and without immediate return. Indeed, this study is the product of their generous exertions and intimate self-disclosures.

ABSTRACT

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IN RESPONSE TO THERAPY FAILURES

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SUSAN E. HAWES, B.A., UNIVERSITY OF MASSACHUSETTS

M.A., UNIVERSITY OF CALIFORNIA AT BERKELEY

M.Ed., HARVARD GRADUATE SCHOOL OF EDUCATION

Ph.D., UNIVERSITY OF MASSACHUSETTS

Directed by: Professor John Carey

This research study has explored the kinds of thoughts that therapists report having had in response to their experiences with therapy failures. The central goal was to develop a model for organizing therapists' thoughts to form a basis for further investigations into therapists' conceptual processes for coping with and learning from therapy failures.

The methodological approaches used in this study were designed to conform to a set of hermeneutic and social constructionist assumptions about the development and function of "meaning making," as it applies to both psychological research and the therapeutic relationship. Thus, the research methods replicated a social construction process, using a "community" of participants for all stages of data gathering and analyses.

The application of Thought Listing and Multiple Sorting Procedures in combination with Cluster and

Multidimensional Scaling Analyses yielded a three dimensional solution with which to organize these therapists' thoughts. Additional findings suggest that the ways in which therapists examine therapy failures is socially constructed and may function to preserve therapists' core beliefs. The three dimensional solution challenges the usefulness of an exclusively causal model for understanding therapists' reflections on failures.

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CHAPTER ONE

INTRODUCTION

Psychotherapists and counselors, like all professionals, are not always successful in attaining the goals they set for themselves. Research on therapeutic outcome indicates that successful terminations of psychotherapy occur in about 65% of the cases (Luborsky et al., 1975; Lambert, Shapiro & Bergin, 1986). The remaining 35% of cases are presumably non-successes, or "failures." In spite of the adage that it is possible to learn much about one's successes from one's failures, little or no attention has been paid to the effects of failure on the therapist (Hawes, 1987; Coleman, 1985; Foa & Emmelkamp, 1983). Indeed, we know very little about the effects of failures on therapists or what and how therapists learn from their failures (Hawes, 1987).

Research in social cognition over the last thirty years suggests that people naturally engage in efforts to understand the meaning and/or future implications of their own and others' actions (Heider, 1958; Jones & Davis, 1965; Kelley, 1973). Support has been found for the hypothesis that negative outcomes catalyze heightened levels of inquiry when compared to those levels catalyzed by positive outcomes (Wong & Weiner, 1980). Research into

so-called "biases" in human inference processes has led to the discovery that human rationality does not necessarily keep to the guidelines of reason proposed by logic and the scientific method (Nisbett & Ross, 1980; Kahneman, Slovic & Tvesky, 1982). Some have suggested that our current models of reason and rationality may simply be a sophisticated set of biases or schemata themselves, and that our methods for understanding ourselves and the world may not be able to achieve the highly esteemed position of "objectivity" (Hawes, 1984; Gergen, 1985). These and other studies concerned with the functioning of mental structures or schemata in the human inference process have attempted to explore the various ways in which people actively construct their interactions with their world.

Parallel developments in the areas of philosophy, social science, literature, and psychology have considered the making of meaning to be a fundamental state of human "being" and have chosen respectively to focus on the hermeneutics of philosophical engagement, interpersonal action, creative expression, and psychological inquiry (see Gadamer, 1965; Rabinow & Sullivan, 1979; Szondi, 1975; Gergen, 1985; Gergen, 1987). It was the combined influence of these theoretical resources that led to the posing of this project's research questions, that is: What are therapists thinking when they experience failures, and how can their thoughts be organized or interpreted?

In this study I have attempted to address these questions from a hermeneutic, or interpretive, position. I hope that this research will contribute to the transformation of the topic of failures from its apparent status as non-topic for community discourse to a fertile ground upon which psychotherapists can explore the interpersonal construction of the therapeutic process. I hope that this research will facilitate therapists' critical understanding of their own learning from failure. A long-term goal of this and similar research projects would be to further the open discussion of therapy failures, such that therapists would be encouraged to examine not only the ways in which they make meaning of their therapy experiences but also the impact these ways of understanding have on the therapeutic process.

The medium for the study was therapists' linguistic renditions of their experiences with failures. I chose research methods which appeared to approximate the rekindling or replication of a process of meaning making. As I assumed that the research participants were engaged in activities similar to those of my own, that is intentional interpretations of the research process, the investigator-participant differences were understood as primarily a function of role and responsibility rather than of process.

In summary, the specific purposes of this project were to a) gather information about the possible range of therapists' thoughts once they have determined that a therapy process has failed, and b) explore some of the ways in which these thoughts can be organized and interpreted by therapists themselves. The general purposes of this study were threefold: 1) to begin an inquiry into the ways in which therapists understand negative treatment outcomes; 2) to break the ground for future inquiries into the social construction of the therapeutic undertaking; and 3) to provide a platform for willing therapists to openly examine the ways in which they are construing their experiences in therapy.

Statement of the Problem

There has been a developing interest in the topic of failure in therapy (Coleman, 1985; Foa & Emmelkamp, 1983) as well as a history of research into the effects of negative therapy outcome on clients. However, we know very little of either how failure to succeed in helping a client is experienced by therapists (Hawes, 1987) or how therapists are influenced by experiencing failure.

The effects of failures upon individuals in achievement situations have been studied extensively by social psychologists inquiring into the relationship

between failed outcomes and motivation, expectations, emotions and attributions (see Weiner, Frieze, Kukla, Reed, Rest, and Rosenbaum, 1971; Weiner, 1979; Weiner, 1984; Dweck, 1975; Abramson, et al., 1978; Weiner, 1986b; Wong & Weiner, 1984; Diener & Dweck, 1978; Janoff-Bulman & Brickman, 1982). No similar studies have been attempted that specifically address this issue with psychotherapists (Hawes, 1987). Extrapolating from these general studies of failure to the psychotherapeutic population has led me to hypothesize that therapists may interpret their failures in ways that are consistent with certain aspects of their personalities and prior experiences, and that these ways are shared across certain groups of therapists. That is, therapists probably have "biased" responses to failures which are related to pre-existing cognitive structures. These biases may influence the ways in which therapists understand and cope with failures.

There has been some indication that therapists' overly high expectations for therapy outcome result in professional burnout and a distorted view of clients (Kestenbaum, 1984; Pines, 1982; Faber & Heifetz, 1982). It's very likely that most therapists experience some form of failure at a moderate rate, since the research into premature terminations from psychotherapy suggests that therapists in clinical settings experience the sudden and

unexplained withdrawal of their clients from treatment at a rate of approximately 35% (Hawes, 1987; Baekeland & Lundwall, 1976). However, we do not yet know what cognitive processes mediate experience of failure for therapists, nor how therapists' cognitive responses may or may not affect their subsequent performance.

It is difficult to know whether therapists actually learn something productive from their failures or if they continue to re-experience similar disappointed outcomes with little change in their attitudes or actions. Without some knowledge of the kinds of thoughts and thought processes therapists have, that is, the meaning they make of their failures with their clients, it is difficult to evaluate the quality of their learning. Similarly, given the paucity of instructional literature on the topic of failures in therapy, where do therapists learn to cope with the failures they experience? What is the social medium for that learning? Finally, do the processes of understanding therapy failures change as the experience of the therapist increases? If so, it would be interesting to learn if there is value in teaching beginning therapists some of the interpretive styles used by experienced therapists to make sense of and benefit from their failures.

Certainly, some exploration and understanding of what how therapists think must precede the implicational

investigation into the costs and benefits of such thought processes, both for the clients and for the therapists.

Objectives

Therefore, in light of these problems, this study is positioned near the very beginning of a process of multiple investigations into therapists' understandings of their experiences performing psychotherapy. As a foundational study, it was designed to address the problem of determining what therapists think when they fail and the underlying principles that may be reflected in the organization of those thoughts.

The first objective was to collect a sample of thoughts or self-statements from a group of therapists, which ideally would contain as great a range of these as possible. The object was to emphasize the range of the sample of thoughts over the representativeness of the thoughts. Therefore, thoughts were gathered from a diverse group of therapists of different treatment modalities, levels of experience and gender.

Such a collection would be in and of itself meaningless unless some form of organization were imposed upon it. It is assumed that we naturally engage in organizing and conceptualizing whenever we attempt to understand a set of objects and that this process of

organization represents one of the constructive aspects of the person's experience in the world (Kelly, 1965). Therefore the second major objective of this study was to formulate a taxonomy or set of general constructs from these thoughts. Such a set of constructs or dimensions of thoughts after failure would then make it possible in subsequent studies to learn something about the ways in which these thoughts can occur within the population of therapists and how the possible effects of these thoughts are judged by therapists. From a hermeneutic standpoint (see Rationale) such a taxonomy functions as an interpretive structure with which to increase our critical awareness of therapists' construals of failures that should catalyze increased reflection on the part of therapists on their own interpretive processes.

Because there appears to have been no actual theory development in this area, there is little in the way of "expertise" I have to bring to the conceptualization of these thoughts into taxonomic form beyond that of which any therapist (including the participants of this study) is capable. In the interest of maintaining as much as possible an authentic connection between the data's origins and its subsequent analysis (organization, interpretation), I have considered the research participants as co-experts in the establishment and

interpretation of a meaningful taxonomy of the sample of thoughts after therapy failure.

In summary, the objectives of this project are to both learn something about the range of possible thoughts that therapists may have in response to a therapy failure and come to some understanding about the meanings assigned to these thoughts through exploring possible ways in which they are organized into major themes or dimensions.

Rationale and Assumptions

This study originates from my interest in hermeneutic interpretive processes (Gadamer, 1965; Ricoeur, 1981) and social constructionism (Gergen, 1985). This research reflects my efforts to apply these philosophical stances to the issue of the ways the in which therapists make sense of their own experiences performing psychotherapy. My commitment to adopting a hermeneutic position has led to my postulating a critical examination of the ways in which therapists interpret their experiences, how their implicit and explicit theories of reality affect the meanings they make, and how these theories and meanings are interpersonal, that is, are socially constructed and negotiated as opposed to existing in any way outside the shared cultural traditions of the therapist.

The essentially hermeneutic orientation that underlies this study has been absorbed over the years from

the hermeneutic philosophical writings of Hans-Georg Gadamer (Gadamer, 1976; Warnke, 1987; Bernstein, 1983), emerging Social Constructionism in psychology (Gergen, 1985), and interpretive and dialectical approaches to social and psychological research (Taylor, 1979; Rabinow & Sullivan, 1979; Polkinghorne, 1984; Howard, 1984; Brandt, 1982; Harre & Secord, 1979). Thus, my questions about the therapists' understanding of their experiences are not intended to separate the personal from the social context in which meanings are constructed, and consider that interpersonal context to be additionally constrained and socially constructed in a specific culture. This orientation has been aptly described by Kenneth Gergen (1985) in the following way:

> Social constructionist inquiry is principally concerned with explicating the processes by which people come to describe, explain, or otherwise account for the world (including themselves) in which they live. It attempts to articulate common forms of understanding as they now exist, as they have existed in prior historical periods, and as they might exist should creative attention be so directed (p. 266).

Hermeneutic Philosophy

My study does not attempt to provide an in-depth analysis of the history of therapists' understanding of their professional experiences. However, it will be assumed that what is uncovered in the analysis of these data does not exist for its own sake above history, that

is, prior to their conceptualization by the participants. As Gergen (1985) asks: "How can theoretical categories be induced or derived from observation . . . if the process of identifying observational attributes itself relies on one's possessing categories" (p. 266)? It follows then that the topic to be considered in this study is not failure itself. Failures are considered here not to be entities in and of themselves but to be interpretations of experience, "circumscribed by culture, history, or social context" (Gergen, 1985, p. 266). Therefore the objects of this study are interpretations of failure, which cannot be considered as separate from the acts of understanding that constitute them.

From the hermeneutic standpoint, our interpretative acts exist in a historical context. Gadamer proposes that our "directedness" or approach to the world is mediated by our preunderstandings (Vorverstandnisse) or prejudices, and these preunderstandings have in turn been historically constituted. In some ways, Gadamer's (1976) description of the role of preunderstandings sounds very much like something taken from recent cognitive schemata theories:

> It is not so much our judgements as it is our prejudices that constitute our being...Prejudices are not necessarily un-justified and erroneous, so that they inevitably distort the truth. In fact, the historicity of our existence entails that prejudices, in the literal sense of the word, constitute the initial directedness of our openness to the world. They are simply conditions whereby we experience something--whereby what we encounter says something to us. (p. 9)

According to Gadamer, all observations constitute themselves through a prior organization of our experience, whether they are scientific observations of natural phenomena or are inquiries into human processes and expressions. The limitations of one's ability to interpret oneself and one's situation are derived from one's circumstances and experiences, which are in turn "informed by the history and culture to which we belong (Warnke, 1987, p. 169). Therefore, the existence of one's preunderstandings is not something that can be transcended by means of method.

Warnke (1987) points out that the importance of Gadamer's major work, Truth and Method, goes beyond the attention it pays to prejudice and the influence of history. She considers him to be firmly committed to a notion of the potential for understanding to be progressive rather than bound to aimless relativity:

> Understanding (Verstehen) for Gadamer is primarily coming to an understanding (Verstandigung) with others. In confronting texts, different views and perspectives, alternative life forms and world views, we can put our own prejudices in play and learn to enrich our own point of view (p. 4).

Gadamer proposes that true dialogue, with a person or text, confronts the individual with an "otherness" that calls that person's preunderstandings in question. Whether one's position is changed or not as a result of a dialogue, one is not left in one's original state of

knowledge, but has been informed by this social exchange. Therefore, we are not isolated by our prejudices or completely limited by them, because hermeneutic understanding involves a process of continual revision of one's premises through dialogue. For Gadamer, understanding "involves achieving consensus on meaning or, in other words, placing two sets of prejudices into a relationship with one another" (Warnke, 1987, p. 110) and creating a fusion of the horizons of one's preunderstandings. Gadamer's hermeneutics is therefore an effort to surmount the implicit relativism contained in the function of preunderstandings and to propose dialogical understanding as something "reasonable" and progressive (Warnke, 1987).

The influences of Gadamer's hermeneutics upon my study are many. First, the very focus on failures in therapy as a medium for therapist interpretive action has been founded on Gadamer's (and Schleiermacher's before him) assertion that the "effort of understanding is found wherever there is no immediate understanding, i.e., whenever the possibility of misunderstanding has to be reckoned with" (Gadamer, 1965 p. 157) and that unexpected or negative experiences are what constitute the "hermeneutic situation." The hermeneutic situation is created when something has become problematic, confronts

one with its "otherness," or goes against one's expectations, and requires the following of us:

> The authentic intention of understanding . . . is this: in reading a text, in wishing to understand it, what we always expect is that it will inform us of something. A consciousness formed by the authentic hermeneutic attitude will be receptive to the origins and entirely foreign features of that which comes to it from outside its own horizons. Yet this receptivity is not acquired with an objectivist "neutrality"; it is neither possible nor necessary, nor desirable that we put ourselves within brackets. The hermeneutical attitude supposes only that we self-consciously designate our opinions and prejudices and qualify them as such, and in so doing strip them of their extreme character. In keeping to this attitude we grant the text the opportunity to appear as an authentically different being and to manifest its own truth, over and against our own preconceived notions (Gadamer, 1979, pp 141-142).

Thus, I assume that failures can confront therapists with a situation that warrants their calling into the forefront of their attention the preunderstandings that usually guide them in their work and allowing those assumptions to be questioned by the negative outcome. Whether or not therapists actually respond hermeneutically to their failures is an implicit question of this research. However, I believe that failures may be a very potent moment from which to examine some of the ways in which therapists are understanding their work.

Gadamer's hermeneutics is also the basis for an assumption I have about the responsibility of therapists. I believe that therapists ought to be ethically bound to

take "authentic hermeneutic attitudes" toward their work. They should be prepared to criticize the historical, cultural and personal "situatedness" of their understandings of their work and its effects. This means that they should consciously examine their prejudices as they surface in dialogue with clients, peers and supervisors. Gadamer states that reflection "on a given preunder-standing brings before me something that otherwise happens behind my back" (1976, p. 38). An experience with an unexpected outcome calls for not a simple search for causal explanations, but an awareness of how one's preunderstandings guide the nature of one's efforts to explain failure. What follows is a dialectical process that occurs when confronting the otherness of a text and, as expanded by Ricoeur (1979) and Hekman (1984), a human action. Understanding becomes a dialectical movement between our preunderstandings and that which we are trying to understand. This process has been called the "hermeneutic circle" and it occurs, as indicated above, whenever understanding becomes problematic. Unproblematic situations do not require an interpretation of their meaning, in that they fit into an already preexisting set of expectations. Therefore, successful terminations in therapy would not require the same kind of self-reflection as negative outcomes.

Another influence of Gadamer on this study is the recognition that an interpretation of an event has effects

upon subsequent events. The awareness of and the analysis of those effects is what Gadamer calls the consciousness of effective history (Wirkungsgeschichtliches Bewusstsein). This awareness of the potential for one's interpretations to have effects is considered to enhance interpretation. This concept forms the basis of my assumption that failures and how they are understood affect the subsequent experiences of therapists (and, of course, their clients). An awareness on the part of therapists that their interpretations of failure affect future outcomes could encourage them to examine their assumptions more critically. This process should in turn increase their understanding of the event of failure's effects upon them and upon their clients.

This proposed study assumes that how failures are interpreted affects therapists and their subsequent actions. If one stays in the logic of the hermeneutic position, however, the effects themselves are not entities but are socially constructed experiences which require interpretation. More importantly, the presupposition that such effects exist in relation to therapists' understandings of their failures forms the reason for proposing this study, for without this assumption of "effective history," this research project would pose a mildly interesting, though hardly influential, set of questions. Once one assumes that how we understand

something somehow affects it, then we have a responsibility to learn more about that understanding. I will be reserving an analysis of how therapists' interpretations may affect their future actions for another time.

Finally, this study is guided by Gadamer's proposition that the medium of all human understanding is language. While how we know is not directly available to us, what we know is often represented in linguistic form that has in turn been socially constituted. Therefore, the object of this inquiry is not the internal processes of the therapists, but rather their rendering of their thoughts in language. At this time it is not possible to know whether there is any link between our represented thoughts in language and actual mental processes. The assumption of such a link has found some forceful criticism (Nisbett & Wilson, 1977). Social constructionism proposes an alternative to focusing all attention upon internal processes by switching one's concern over to "the language forms that pervade society, the means by which they are negotiated, and their implications for other ranges of social activity" (Gergen, 1985, p. 270). The term "thoughts" in this study could perhaps have been replaced with "self-statements," as the intention here has been to explore what therapists "say" (consciously think) to themselves during a failure experience. "Thoughts"

was, however, decided on, because it is commonly used to connote conscious self-talk and is more part of our social vernacular than "self-statements," which tends to be limited to the psychological idiom.

Social Constructionism

The social constructionist approach described by Kenneth Gergen (1985) is related, though not explicitly so, to the hermeneutic perspectives developed in Gadamer's work. It differs in two specific ways: it fails to address the dangers of relativity suggested by Gadamer's commitment to "Bildung" (education) through dialogue, and it introduces the social milieux in which understandings are constructed.

Only brief time will be allotted here to acknowledge the former, as it cannot be discussed briefly. The reader can be referred to the writings of Richard Bernstein (1983) and Georgia Warnke (1987) for thorough and interesting discussions of the issues related to overcoming the relativism of hermeneutic and interpretive theories. Let it only be said that constructionism has to tackle the problem of a potentially rampant permissiveness and lack of standards implicit in its theory, because, as Foster (1987) suggests, there is ultimately nothing to prevent one from imposing one world view over others, if all beliefs are held to be relative and equally true. Gadamer, as mentioned above, proposes that a dialogue in

which both participants are changed by allowing themselves to be open to the truth of each other's horizons of preunderstanding (or assumptive worlds) can transcend the relativity of the hermeneutic situation. Gadamer's concept of change through dialogue has been applied to the therapeutic situation before (Ricoeur, 1970; Habermas, 1968). Therapists assume that therapy is a progressive vehicle for change, and thereby imply that all "truths" are not equally valid, but they may typically be uncritical of the historical context of their own theoretical treatment assumptions, and thus not open to learning from a dialogue with their clients in the way that Gadamer intends. Clearly, as a means of attaining critical awareness of the historical situatedness of their approaches, it is important for therapists to examine their assumptions in light of the history of the healing "professions" (Frank, 1973). In addition, therapists may not allow their biases to be challenged by those of their clients.

I have approached this problem by perceiving this research as the beginning of a public dialogue on the topic of therapists' interpretations of failure. Through continued discourse on this topic the therapeutic community may arrive at some productive consensus on the value of their ways of understanding therapy outcomes.

Gergen (1985) distinguishes social constructivism from both the empirical models of knowing and the

"cognitive revolution," the two favored influences on psychological research and theory. He suggests that the former is challenged by constructionism's invitation to "suspend belief that the commonly accepted categories or understandings receive their warrant through observation" (1985, p. 267), and that the latter's emphasis on internal mental processing leads ultimately to either "the quagmire of innate categories or solipsism (or both)" (1987). He states:

> To retain the wisdom of the [cognitive] approach and simultaneously avoid the conceptual pitfalls, many social theorists have shifted their emphasis from the mental construct to the domain of linguistic construction. Thus, the categories of understanding are traced to the social milieu. The forestructure of understanding is generated within the social process of developing intelligibility systems. In this sense, what we take to be the facts owe their existence to the social process whereby meanings are generated and events indexed by these meanings. These are not independently identifiable, real world, referents to which the language of social description is cemented. (p. 6).

It is my hope to explore the therapist's understanding of therapy failures within the context of his or her social community. That is, I assume that the ways therapists have of processing and organizing their experiences with failure (and other outcomes) have emerged from a community of shared linguistic events. "Therapy failure" is understood here to be a concept whose meaning can only be found within the therapeutic community itself and that it may have no universal meaning outside that

context. In addition, therapists bring their personal histories along with their cultural experience within a profession to the event. Therefore, this project plans to elicit and analyze those linguistic representations of the therapists' responses to failure in such a way that these responses and ways of organizing them remain uniquely their own and yet can also be compared with those of other therapists. Participants will also be asked to organize thoughts other than their own, in recognition that therapists are engaged on a regular basis in interpreting thoughts and feelings that belong to themselves and to their peers.

The urgency of this study is that this topic has been broached so seldom in the literature as to warrant the belief that therapists' social constructions of therapy failures have been predominantly <u>implicit</u> constructions, and therefore happen "behind the backs" of many therapists. I assume that therapists do reflect upon their failures, but believe that there has not been a consensus in the therapeutic community that recommends bringing failure into the arena of public discourse (Coleman, 1986). However, I assume that how a therapists understands their failures is socially constructed, however implicitly, since training situations are generally places where therapists discusse "mistakes" and find a model for how to interpret disappointed outcomes in

the supervisor. Whenever a case is publicly presented, therapists engage in interpreting the actions of both the therapist and the client, using the models for doing so that are available to him or her in the community. The intention of this study has been to shine a light on an implicit taboo for the purpose of turning failures into vehicles for enhanced self- and client understanding. As Brandt (1982) states:

> A hermeneutic psychology . . . makes it possible to pursue a psychology of psychologists and a psychology of psychology, namely a critical, self-reflecting psychology, and thereby a discussion of what is relevant to whom and for what (p. 55).

The research methods utilized in this project have been guided by the theories outlined above. Rabinow and Sullivan (1979) assert that interpretive social science, in opposition to logical empiricism, larger systems approaches and structuralism, is

> constructive in the profound sense of establishing a connection between what is studied, the means of investigation, and the ends informing the investigators. But at the same time it initiates a process of recovery and reappropriation of the richness of meaning found in the symbolic contexts of all areas of culture (p. 13).

The methods I chose to use were intended to elicit the idiosyncratic language used by the participants themselves and not that devised from any theoretical or abstract preunderstanding on my part. It was my intent throughout

the study to keep the data as meaningfully consistent with the world of the participants as possible and to impose the minimum of limits on that relationship between the participants and the data as I can at this time.

Many research projects underestimate the humanity of their subjects by considering their intentions and decisions within the laboratory situation as undesirable, contaminating factors, such as "subject error" or "subject's artifacts" (Viney, 1987; Howard, 1984; Polkinghorne, 1984; Brandt, 1982). Brandt suggests that hermeneutic psychologists conduct research in such a way as to maximize freedom, dialogue and cooperation between the investigator and the research participants and minimize the assumed distance between inferential sophistication. Both researchers and their participants bring their preunderstandings and freedom of choice to the research situation. Therefore it is a form of "hubris" for a researcher to assume a superiority of inferential orientation ("objectivity"). Instead, the emphasis should be on cooperation and compromise between "horizons of preunderstanding", as Gadamer might suggest. Both investigator and participant are involved in interpreting their situations, as well as their own and others' actions and experiences, and investigators should be as interested in the interpretations of their participants as they are in their own. Interpretive approaches to human research

propose that people, even in experiments, should be treated as whole, active, intentional beings rather than as passive objects whose only truth lies in their observable behaviors (Polkinghorne, 1984).

Below is a compilation of the factors inspired by the theorists mentioned above that a hermeneutic psychological research project would consider important in the consideration of a research design. I attempted during the planning of this study to apply these kinds of considerations to this specific design.

1) Take as its object the linguistic forms that are consistent with the group it hopes to understand;

2) Consider the social aspects of those constructs;

3) Make explicit the goals or future effects of the research;

4) Minimize the distance between the methods of inquiry and participants' world, that is, the relevance of experimentation to social and person concerns is heightened (Polkinghorne, 1984);

5) Use volunteer participants who are informed of the research goals and procedures, and given opportunities to comment on and criticize the research process itself;

6) Investigator will explicitly acknowledge her preunderstandings prior to and during the research process.

7) Be aware of the effective potential of the research process itself, and inquire into its possible effects.

I consider this section on Rationale and Assumptions to be only a partial explication of those preunderstandings of which I am aware. Some salient issues described above have been: the goal of making failures and their interpretation explicit in order to facilitate increased dialogue on the topic; the assumption that people constantly are engaged in interpreting their experiences and that the medium for these interpretations is language; that preunderstandings mediate our interpretations, whatever method we use to facilitate our inquiries; that the way we understand has effects upon our future actions; and that our preunderstandings are constructed in a social-historical milieu.

In the above section on Hermeneutic Philosophy I indicated the importance Gadamer places on the historical situatedness of all understanding and acknowledged that it is not the intent of this study to examine in depth its historical underpinnings. Nevertheless, it is important to explicitly recognize, however briefly, that the questions asked and the approach used here are informed and constrained by the recent wave of cross-disciplinary dialogue on alternative methodologies for the sciences. Indeed, I might have found little support for such a project had it not emerged in the context of a number of similar ventures. In the end, only history will reveal the value of such an approach to human research.

It is important, in addition, to acknowledge that I bring other, more personal or idiosyncratic forms of bias to this study. For example: my mind and intellectual sensibilities are aroused not by simplicity and clarity but by diversity and complexity. Thus, I find it easier to assume that there are different ways of perceiving the same event than I do to assume generalizability of forms. Reductionist methods tell me little about what I want to know. I am more typically drawn to the interpretation of symbolic forms than I am to the application of logical or mathematical constructs. As a former student of literature and currently a student of counseling, I am intrigued by people's stories about themselves and their experiences (their personal narratives) and curious about my responses to their stories. I perceive myself to be less "useful" when I am engaged in the application of specific methods to specific problems.

Finally, I have found therapy failures to be personally painful experiences that have repeatedly forced me to examine the assumptions I bring to the therapy process. It is not rare for me to ask myself if therapy can provide the best solutions for a client, or to ponder the role that I am playing as a therapist in a culture that has invented psychology. I blame myself too much, question the appropriateness of my methods, and feel more alone with my failures than I think is necessary. I have

wanted to learn, for personal as well as theoretical reasons, how therapists make sense of and cope with their failures, and in the process, make it possible for us all to feel a little less alone when we experience them.

Delimitations

In light of the previous section, it should be clear that the goals and methods of this study were not intended to conform to criteria for traditional quasi-experimental, nomothetic research. The results pertain to the realm of social discourse rather than to the realm of "facts" and are not intended to lead to the formation of general laws about therapists' mental processes. Instead, the goal is to begin a dialogue concerning the ways in which some therapists appear to make sense of their experiences with failure. As Gergen states:

> Accounts of social construction cannot themselves be warranted empirically. If properly executed, such accounts can enable one to escape the confines of the taken for granted. They may emancipate one from the demands of convention. However, the success of such accounts depends primarily on the analyst's capacity to invite, compel, stimulate, or delight the audience, and not on criteria of veracity.

This does not mean that "anything goes" so much as it addresses the historicity and biased nature of all forms of research, be they nomothetic or idiographic, empirical or interpretive. This study has attempted to use methods that fit into those deemed acceptable for exploratory

research by the research community. It distinguishes itself primarily in its assumption that the results of this study need not be proven universal in order to be understood as meaningful by the community for whom it is intended. In fact, its "qualitative" overtones may even increase its accessibility for most practicing psychotherapists (Keely, et al., 1988), and its interpretive stance places it in the center of a dialogue on methods amongst Counseling Psychology researchers (Polkinghorne, 1984; Howard, 1984; Polkinghorne, 1983; Martin et al., 1986).

As indicated above, the objects of this study were the linguistic renditions of what therapists recalled having thought at the time of a treatment failure, and therefore was limited to conscious cognitive contents. No presumption has been made that these explicit thoughts refer to actual mental processes as such. The focus is on socially constructed understanding of an event, not on overt behaviors or internal processes.

For purposes of keeping the scope of this project from extending beyond what can reasonably be accomplished in a dissertation project, the thoughts and the dimensions constructed from the thoughts were not analyzed with regard to other variables, such as therapists' personalities, therapeutic modality, perseverance and/or

success in the field, etc. This project was focused exclusively on describing a range of thoughts and their possible organization.

The major limitation to be found in this study is that it was not able to elicit therapists' expressions of their thoughts as they occurred in the immediate context of a therapy failure. Because this kind of research on therapist process is rarely performed, it was thought to be less threatening for therapists to be questioned after-the-fact and through the use of a scenario format. An ideal study, which may be more easily performed after a study such as this has been published, would be to engage in dialogue with the therapists immediately after they have acknowledged a failure as having occurred.

Significance

This project finds perhaps its greatest significance in the fact that this may be one of the first such research studies into therapists' understanding of their therapy outcomes that has been performed.[1] It has been only until recently that investigations have been made into therapists' cognitive processes during therapy

[1] In March, 1989, Kottler and Blau published a book (The Imperfect Therapist) that explores therapists' experiences with failures in therapy. Due to the lateness of it's appearance, it will not be reviewed or considered in this disseration. Its analysis appears to be based primarily on case study material.

sessions (see Chapter Two). I believe that this area is only beginning to find an interest in the Clinical and Counseling communities, and is growing in part because of the "cognitive revolution" and the interest in applying some of the attitudes formed in the interpretive social sciences to psychology (Gergen, 1985).

This project is part of an attempt to open up discussion on a topic which has received little or no attention in the literature: failure and its effects upon therapists. A hermeneutic psychology asserts the need for psychologists to be aware of their biases and socially constructed assumptions as a way of making understanding take place. For that reason, the significance of this study may be that it begins an important dialogue amongst therapists about their failures and how they believe they can best be learned from, and at the same time will open up for critical awareness some of those implicit pre-understandings about failure.

Finally, I hope that the dimensions found in this study of therapists' thoughts after failure will form the foundation from which to ask more questions about therapists' interpretive processes (particularly as therapists grapple with the outcomes of their work), and to in turn explore the social communities that support these processes.

CHAPTER TWO

REVIEW OF THE LITERATURE

This review explores some of the research literature that is indirectly related to the topic of therapists' understandings of their therapy failures. The purpose of this review is to place this research project in a community of current research with similar concerns.

One of the areas to be considered below is the therapist inference process in the performance of psychotherapy, a topic that has received more attention from the research community of late. While the specific approaches to that topic are not for the most part directly relevant to this study, they are presented as representations of a growing recognition in clinical and counseling research of the importance of therapists' interpretations of events in psychotherapy. Another focus of this chapter is on the relationship between how the relative silence among the therapeutic research community on the topic of therapy failures has been interpreted by that community and how that silence might be interpreted by principles developed in recent literature on social cognition. The implications of these areas for this project and their relationship to the rationale that guides this research will be discussed.

Therapists' Inferences

In recent years several studies have been published which inquire into the ways in which therapists make meaning from their experiences in performing the tasks of psychotherapy (Turk & Salovey, 1985; Hill & O'Grady, 1985; Borders, 1988; Sternitzke, et al., 1988; Ward, et al., 1985; Plous & Zimbardo, 1986; Martin et al., 1986; Langer & Abelson, 1974; Snyder, et al., 1976). While there appear to be relatively few efforts to understand therapist inferential processes, especially in light of the amount of attention paid to such issues as human inferences, cognitive mediation and assumptive worlds by social cognition research, there does seem to be a growing desire among researchers to explore the psychotherapeutic relationship through the use of a cognitive mediational paradigm. Jack Martin, a major proponent of a cognitive mediational approach for psychotherapy research proposes that:

> identifying cognitive as well as overt behavioral events in process and product research on counseling permits more convincing generalizations about lawful behavioral regularities in counseling (Martin, et al., 1986, p.115).

The types of concerns most typically explored in the research on therapist cognitions have been: therapist intentions and their relationship to therapist behaviors, client responses and client behaviors (Hill & O'Grady,

1985; Martin et al., 1986), therapist attributions (Ward et al., 1985; Plous & Zimbardo, 1986; Sternitzke, et al., 1988; Langer & Abelson, 1974; Snyder, et al., 1976; Snyder, 1977), the effects of therapists' attributional self-presentation on supervisors (Ward & Friedlander, 1985) and therapist burnout (Farber & Heifetz, 1982).

One of the earliest forays into the topic of therapist inferences was Langer and Abelson's (1974) research on therapists' labeling biases. Their study inquired into the effects of prior labeling on therapists' assessments of the mental health or disturbance. Langer and Abelson (1974) found that "traditional" or psychodynamically trained psychotherapists, who had been told that an actor they were viewing on video tape was a client, were more likely to perceive him to be mentally disturbed than when they were told that the actor was a job applicant. By contrast, behavioral therapists under the same circumstances described the actor or interviewee as fairly well adjusted, no matter how he was labeled by the experimenters. These results suggest that psychodynamic therapists were more inclined to this type of bias than behavioral therapists.

Snyder (1977), in replicating and expanding on the original Langer and Abelson study, not only obtained support for the above results but also found a correlation between the severity of the presumed interviewee maladjustment and the dispositional locus of the problem.

Specifically, his study showed that psychodynamic therapists were more likely to make the fundamental attribution error when attempting to identify the origin of a problem than were behavioral therapists. The Fundamental Attribution error refers to the overestimation of the role of dispositional factors or intrinsic personality characteristics, in the causation of an individual's behavior. This bias toward internal causes in the former group of therapists might explain their susceptibility to labeling biases, since they are much more likely to accept personality as a determining factor than the behaviorists. The latter would be less likely to be swayed by labels because of the weight of importance they place on situational determinants.

Snyder et al. (1976) continued to examine clinicians' attributions, having been influenced by Jones and Nisbett's (1971) theory that empathy can direct an observer's attributions in a more situational (more like the actor) direction and Batson's (1975) discovery that observers tend to make dispositional assessments of a client's problems in spite of the client's attributions to situational causes. Their research found support for the biasing effect of role upon an observer's attributions for a client's problems, that is, for the power of empathy to transform an observer bias into an actor bias.

Finally, Plous and Zimbardo (1986) learned that therapists who identify themselves as psychoanalytic in

their orientation were more inclined to use dispositional explanations for the problems of others, and that behavioral therapists and nontherapists tended to use situational explanations more often than dispositional ones. Psychoanalytic therapists in this survey also favored physical explanations for certain problems they might incur, while the same problems when found in others were considered by them more often than not to have psychological origins.

The above research studies imply not only that certain therapists are more susceptible to certain attributional biases, but that therapists' biases may be altered when the therapist is made aware of the presence of a distorting prejudice. Another implication for this study is that therapists who differ in their fundamental philosophies of the therapy process may differ somewhat predictably from each other in the ways that they interpret their clients' and, perhaps, their own actions.

James Guy has recently written a book that explores the Personal Life of the Psychotherapist (1987). His purpose was to examine some of the factors that are involved in how therapy impacts upon the therapist, and his book is one of the first to take such a comprehensive interest in this topic. One of the major factors Guy describes that pertains to this study is the therapist's theoretical orientation, which he states:

> [constitutes] a world view which colors one's perceptions and perspective, providing a framework for organizing data and life experience both in and out of the consulting office . . . It becomes a way of thinking, interpreting, and understanding events, emotions, and behaviors in both oneself and others. It impacts the therapist's very personality by influencing his or her inner experience (p. 65).

According to Guy and the studies he cites, therapists' theoretical orientation has probably the greatest influence on their work.

Jerome Frank (Mahoney & Freeman, 1985) has assigned similar import to the therapeutic "rationale" held by therapists, proposing that many theoretical orientations not only rationalize their techniques to be irrefutable but that these orientations also are supported by the milieu of "like-minded" peers. The combination of a kind of theoretical impermeability with a social network works to maintain, Frank suggests, "the therapist's sense of competency, especially in the face of inevitable therapeutic failure" (p. 73).

Guy goes on to state that the choice of a theoretical orientation results from a combination of the therapist's "personal perspectives, philosophical presuppositions, world views, and values" (p. 62). Because, as Guy proposes, the therapist has chosen an approach to fit his or her personality and beliefs, the personal investment in that therapeutic rationale is likely to be very great, and

may lead the therapist to be inordinately protective of his or her theory of the psychotherapeutic process and overly critical of other approaches.

Ironically, there is little evidence to support the advantages of applying one treatment methodology over another, which challenges the belief that most therapists entertain: that their understanding of what constitutes effective therapy is somehow better than different methods used by other therapists. These conflicts between methods have clouded over the real question of what is it about therapy that does help clients, an area that is plausibly analyzed by Frank (1963) in his book Persuasion and Healing. In spite of the apparently distorted view of what works and what doesn't work that has grown out of the territorial battles between therapeutic methods, Guy indicates that therapists who feel that their training in a particular method prepared them well, and who feel strongly attached to their theoretical orientation, seem to derive the greatest satisfaction from their work.

Guy's (1987) work also looks into the stressful aspects of the therapy process for therapists and reports that there are several areas that therapists identify as difficult. Some of these are: "1) recurring doubts about the efficacy of treatment; 2) difficulty evaluating progress; 3) emotional constraint; 4) the need to set aside personal problems; 5) patient devaluations and

attack; and 6) inevitable patient terminations and abandonment" (p. 246). He cites some of the research on therapist burnout as indications of therapists' vulnerability to the demoralizing effects of clients' premature terminations and other negative treatment outcomes. Burnout has been defined as "a state of fatigue or frustration brought about by devotion to a way of life, or relationship, that has failed to produce the expected reward" (Freudenberger & Richelson, 1980, cited in Guy, 1987, p. 249). Indeed, many therapists apparently consider therapy dropouts to be one of the more stressful experiences in their work, and yet very little is known about how therapists experience these as such.

As there is not a great deal known about the impact of therapy on the therapist, in spite of the fact, that "the inner experience of the therapist has come to be acknowledged as an important variable in the psychotherapeutic process" (Farber and Heifetz, 1982, p. 529), Guy's book is a useful introduction to the topic and paves the way for future investigations, such as this project.

Inquiries into Interpretations of Failure

Psychotherapy failure is a variable in the psychotherapeutic process that has only recently begun to attract the interest of both practitioners and researchers

(Foa & Emmelkamp, 1983; Coleman, 1985; Hawes, 1987). The apparent reluctance on the part of the therapeutic community to openly discuss failures, much less consider them as important sources of information about the therapy process, may be seen as representing some possible ways in which therapists understand their failures. Investigators into therapy failures all refer to the research community's silence on this topic, and each suggests some possible reasons for that reticence.

For example, Foa and Emmelkamp (1983) in their collection of essays on failures in behavioral psychotherapies reason that:

> of course, failures always exist; they are just not reported that often. Contact with clients has taught us that clinical practice is not as simple as that portrayed in text-books. After thorough assessment and application of the appropriate techniques we still fail occasionally. What has made this realization even more painful is the fact that failures have not been openly discussed. This reticence fostered the belief that if one encounters a treatment failure, then one is a failure as a therapist. For if the therapist had made a correct behavioral analysis and subsequently applied adequately the appropriate procedures, success would have been inevitable. This might be a reason for the scarce literature on failures and for the little attention given to the few that exist. (p. 3).

Graziano and Bythell (1983) in the same volume on failures in behavioral psychotherapy add another dimension--political survival. They point out that psychotherapy needs to amplify its successes and down-play its failures in order to effectively garner political support, and

suggest that the refusal to admit to the occurrence of negative outcomes is a "functionally effective professional behavior and has become characteristic of the traditional applied mental health field in general." (p. 407).

Sandra Coleman (1985) has compiled a selection of therapists' confessions of failures in the family therapies. Her anthology's very credibility, she admits, rests paradoxically on the outstanding <u>successes</u> of its participants because, she states, in "order to earn the right to publicly fail you must first succeed--and do so famously." (p. 4). Thus, it seems that for therapists there may be a moderate amount of shame or embarrassment associated with failure and also that the community may only be able to tolerate admissions of failure from those who have a history of immoderate success.

I found another paradox in Coleman's book: given both the negative stigma attached to admissions of failure and the relative absence of public confessions of the experience, I found an overwhelming, and perhaps unrealistic willingness on the parts of Coleman's volunteers to accept <u>personal</u> responsibility for their failures. For example, Segal and Wazlawick consider that:

> "It would be easy to explain away this failure by using the time-honored argument that the severity of the pathology and the resistance of the family made them unfit

> for treatment. However, as Don Jackson used to say, "There are no unsolvable cases, there are only inept therapists." (p. 4).

How is it that therapists seem so willing, on the one hand, to publicly take the entire onus of blame for a failure on themselves and, on the other hand, seem so formally reticent on the topic? Indeed, the topic is filled with paradoxes. For example, Ward & Friedlander (1985) found that counseling supervisors viewed counseling trainees and their supervisors as more responsible for client deterioration than for client improvement! This essentially leaves a therapist in a no win situation, with no credit for success and all the credit for failure. Is there, then, some community need to inflate the public knowledge of successes and conversely keep the lid on the examination of failures as a way of counteracting the imbalance of weight placed on the therapists' shoulders for failures? Perhaps the reluctance to admit to failure must be examined as occurring in a context where failure typically calls forth only one out of several possible attributional loci (Weiner, 1979), and is therefore a healthy alternative to immobilizing self-blame. If the over-riding cultural norm dictated that the cause of negative outcome had to be dispositionally assigned, then, with the relatively high rate of client turnover, therapists would have understandable motives for keeping quiet on the topic.

Such an attempt to deflect attention from the self after negative outcomes has been called a defensive, self-esteem preserving tactic by attribution theorists (Ross, Bierbrauer & Polly, 1974).

However, Coleman's "confessors," as indicated above, felt no need to down-play their roles in bringing about the disappointed outcomes that they share with their readers. These experts are not only admitting to having failed, but finding themselves primarily, though rarely exclusively at fault. Is this because they are so above the average psychotherapist that they feel impervious to comments about their "ineptitude," as Coleman suggests, or is their loquacity more understandable when viewed in relation to its context? Coleman's book Failures in Family Therapy imbibes the discussion of one's failures with a positive connotation (bravery) and with potential educational implications (learning from failure). Therefore, the self-esteem of these authors may be better served by making what Ross, Bierbrauer and Polly (1974) describe as a counterdefensive attributional statement than it would be by defensively locating the causal origins of the failure in factors outside themselves. Bradley (1978) proposed that, in certain situations, such as those in which the person believes that his or her performance is the focus of primary concern, it is enhancing of one's self-esteem to find fault with one's own actions after a failure.

Ward & Friedlander (1985) examined the effects of such self-presentational tactics when they were used by trainees in a supervisory context and found there to be a correlation between trainees' attributions for their clients' improvement or deterioration and the ways in which they were judged by their supervisors. Specifically, defensive trainees were found to be more self-confident while counterdefensive trainees were considered to be more socially skilled. Attributional style did not seem to correlate with how responsibility for failure was attributed to the trainees by their supervisors; that is, all trainees, regardless of how they made attributions, were considered to be more responsible for negative therapeutic outcomes than were their clients.

These kinds of questions suggest two generalizations: that how one attributes causes can be attached to one's personality or personal style, and the ways therapists make sense of their failures is determined by certain motivational factors. Above all, these premises propose that biases mediate our understanding of achievement outcomes. This study, however, is guided more by the evidence for the general proposition that therapists' understanding of their work is mediated by biases than it is by more specific references to the dominance of motivated attributional processes.

Hawes (1987) has done a review of the literature on attributional biases and their implications for

understanding the ways in which therapists think about therapy failures. Her conclusions were that, while research into attributional biases may help inform therapists of how they should critically examine their tendencies to be biased in their assessment of clients and the therapy process, attributional methods themselves cannot adequately describe the complexity of social inference processes. She concluded:

> The meaning a therapist makes from a therapeutic outcome touches upon more than the dimensions of possible cause. Her culture and its history, her personal history, her role as therapist, the history and values of her psychotherapy methodology, the therapy context and its cultural meaning, and much more contribute to the outcome and function of her inquiry into failure and success. In addition, the meaning a therapist makes has some implications for her client (and vice versa), who also is present with a web of his own meanings that surround his understanding of the experience of therapy. (p. 179).

While an attributional model might be applied to the topic of therapists' understandings of their therapy failures, there are other criticisms of the theory that are compelling. For example, some critics (Tetlock & Levi, 1982; Fiske & Taylor, 1984) suggest that the act of interpretation commonly called a search for causes (attribution) may have more to do with the search for meanings, and that more at issue than the veracity of an assigned cause is <u>personal understanding and coping</u> that are the result of that inquiry (Hawes, 1987).

In one section of Hawes's review of attribution theory's relevance for interpreting therapists' thinking about their failures, the motivational approaches to formulating the functions of attributions were compared to cognitive and social knowledge theories about biases. It is the latter's formulation that has come to have the greater implications for this study. Cognitive research into human inference processes has been classified into two major orientations (Tetlock & Levi, 1982): a model based on normative mental processes, such as Correspondent Inferences (Jones & Davis, 1965), Discounting, Augmentation, and Covariation (Kelley, 1967), and top-of-the-head-phenomena (Nisbett & Ross, 1980); and an approach based on "models of social knowledge" which generally proposes that:

> individuals bring their prior experiences, organized into principles and broad categories to each new situation. These broad categories are able to rapidly assimilate new experiences to their existing models without having to alter these models in any significant way. These categories influence and guide our perceptions and decrease the amount of conscious thought required by each new experience. (Hawes, 1987, p. 92).

Proponents of this approach posit that these categories, classification systems, or schemata are the ways through which we construct our perceptions, and ultimately create an "assumptive world" (Frank, 1963) for ourselves. Mental structures are understood at the most

basic level as actively determining what we perceive by organizing our sensory experiences. The schema concept has also been extended to embrace knowledge at all levels, including theories, ideologies, and metaconcepts of knowledge itself. In the area of perception, schema are understood to decide what is important for us to know. They may also influence what we remember after the fact (Snyder & Uranowitz, 1978) or, by determining what is salient information in any given situation, influence what we pay attention to (Taylor & Fiske, 1978). As Goleman (1985) asserts: "every act of perception . . . is an act of selection (p. 243).

Moreover, schema have been held responsible for the tendency for people to persevere in their beliefs in spite of discrediting information (Nisbett & Ross, 1980; Fiske & Taylor, 1984). This conservatism with regard to theory change has been found to be present in scientists and laypersons alike (Ross & Lepper, 1980), and there is some evidence that the intractability of one's theories and, by extension, schemas may have a positive, self-preservation purpose (Janoff-Bulman & Timko, 1987). Goleman (1985) describes this tendency in this way:

> we are piloted in part by an ingenious capacity to deceive ourselves, whereby we sink into obliviousness rather than face obvious face threatening facts. This tendency toward self-deceptions and mutual pretense pervades the structure of our psychological and social life. Its very pervasiveness suggests that self-deception may have proven its utility in evolution. (p. 241)

Janoff-Bulman and Timko (1987) are in agreement that denial or self-deception are ultimately beneficial to the person, even though the "truth" is avoided. They propose, in keeping with Popper's (1963) views on scientific knowledge, that the "stable knowledge structures [preserved by theoretical conservatism] provide us with the necessary equilibrium to function in a complex, changing world". (p. 140). Mahoney and Lyddon, in their essay on constructivist psychotherapy, have translated this idea of conservatism to the therapeutic situation and the phenomenon of client "resistance," proposing that resistance, rather than suggesting a motivational deficit or avoidance:

> reflects natural and healthy self-protective processes that serve to protect the individual from changing too much, too quickly. In this view, resistance is a basic adaptive process that prevents core psychological structures from changing too rapidly . . . (Mahoney & Lyddon, 1988, p. 221)".

The therapist's resistance to explore his or her therapy failures may function not so much to preserve self-esteem as to maintain core beliefs. Therapists may respond to failures by examining only those areas that are not globally threatening to their comprehensive theories of personality and change, which may in turn affect mild or subtle changes in perspective. Thus, therapists could question their specific actions within a treatment paradigm, or explain a failure within the logic of that

paradigm without ever having to challenge core beliefs about themselves or about their treatment philosophies. Kuhn (1962), in his theory of the history of scientific thought, described this process as one of gradual, "additive adjustment" through which the overall structure of the dominant paradigm could be preserved. Incremental change within a core schema or world view protects the "higher order postulates" from violation and a traumatic upheaval that would require the building up of new postulates (Janoff-Bulman & Timko, 1987).

Sometimes failures in therapy are sufficient, in the right context, to provoke just such an upheaval. Coleman (1986) describes this theoretical revolution in therapists as a "developmental transition" which can be brought into awareness by a failed therapeutic process. In the example she describes below, the individual therapist experienced a shattering challenge to his fundamental therapeutic assumptions. He had been primed for this vulnerability by increasing dissatisfaction with his approach.

> [this therapist] discusses the impact of his experience with the L family on his professional development. He suggests that his failure 'shook me to my roots, my "epistemological roots"' making 'what seemed perfectly "correct" then, now appear "wrong"'. One would suspect that [the therapist] was somehow ready for personal change and that the L family became the viable catalyst. As [the therapist] reviews his epistemological errors, it becomes increasingly apparent that his previous integration of concepts and techniques must have been open to modification. How often a therapist is on the edge of making a developmental transition is not known, but given the advances that are constantly

> being made in family therapy, professional growth must be an integral component of being in this rapidly advancing field of behavioral science. (p. 358).

Based on the recent inquiries into the usefulness of denial, excuses and illusions in maintaining personal mental health (Snyder & Higgins, 1988; Taylor & Brown, 1987; Janoff-Bulman & Timko, 1987) and the above discussion, this study seeks to come at the question of therapists' inquiries into their failures from the vantage point that therapists may understand their failures in ways that correspond to their core beliefs about themselves and the work that they do. These beliefs have been developed over time in a social community that has encouraged the fostering of certain kinds of beliefs. Moreover, one's core beliefs exist as structures of the mind, and these structures are protected and maintained by the effects they have on our ways of knowing the world.

In summary, this review indicates that explorations into the area of therapists' inferences are worthy and timely pursuits, given the little we know either about the impact of therapy on therapists, or how therapists' interpretations of their disappointed experiences in therapy affect both their work with clients and their

professional satisfaction.[2] The literature reviewed here also suggests that while little has been said publicly about therapy failures, there are some indications that increased discourse amongst therapists on this difficult topic would be welcomed. Research on social cognition indicates that people's perceptions of their experiences are guided by preexisting sets of assumptions or expectations, and that these "biases" develop out of the relationship between an individual and his or her social world. Therefore, if one is to learn more about how the therapist makes meaning from therapy failures, one needs to consider that meaning as both highly personal and as constructed within a social context. Finally, this review leads one to anticipate that a therapist's social schemata relating to therapy process and therapy outcome may be fairly intractable, and that meanings made outside the logic and language of a therapist's assumptive world will be rare events.

[2] The Imperfect Therapist (1989) by Kottler and Blau was published in March of this year and was not available in time to be included in this review. While its contents had no direct bearing on the goals and direction of this research, the composition of such a work supports the proposed significance of the issues examined here. The authors reportedly have drawn on their own experiences with failure, as well as on case studies from the literature and on interviews with prominent therapists to examine not only the experience of failure and the counterproductivity of defending against it, but the causes of failures and how to learn from them as well.

CHAPTER THREE

METHODOLOGY

Research Questions

This research posed two exploratory questions, each to be investigated in two distinct but interrelated phases of the study. The first question asked for a possible "universe" or range of self-statements that therapists recall having made to themselves when they experienced a failure in their work with a client. The second question concerned the ways in which these same therapists organize a sample of these statements into meaningful categories.

Question #1: What responses are provided by a sample of psychotherapists when they are asked to list the thoughts they recall having had after they realized that a recent therapy with a client had, in their estimation, failed?

Question #2: How does the same sample of therapists conceptually organize the thoughts collected in question #1, and how do they describe the underlying principles and categories they used in that organizing process?

Question #2a: What conceptual groupings of the sample of thoughts after therapy failure result from a cluster analysis of the whole group of participants' organization of these thoughts?

Question #2b: What are the major underlying dimensions of these thoughts after failure that can be derived from a multidimensional scaling analysis of both the whole group's and each individual's organization of these thoughts, and are there any significant differences between the weights assigned to these dimensions by the individual participants?

In addition to these specific research questions, I asked the participants in the Interview (see Appendix B) such questions as: how they know when they have failed, what their definitions of therapy failure are and how those have evolved. They were also asked about their typical responses to therapy failures and how their training as therapists did or did not prepare them to fail. These questions were intended not only to provide a context in which to interpret the results of the research questions, but also to connect this study more firmly to its original rationale, that is, that therapsists' ways of making sense from failures are socially constructed and affect their relationship to their profession.

Participants

The participant sample in this study was made up of 20 Massachusetts psychotherapists practicing in private or community mental health care settings that are located

either in the Pioneer Valley Region of Western Massachusetts or in the Boston area. All participants were asked to perform a minimum of two major tasks: the recollection and listing of their "thoughts after therapy failure" for analysis, and the sorting of those items as a means of eliciting their conceptual organization patterns of those thoughts. At the completion of both tasks, every participant was invited to have a part in the interpretation of the data analyses results.

When considering how many subjects to use in a Q-sorting technique, what is "required are enough subjects to establish the existence of a factor for purposes of comparing one factor with another" (Brown, 1980). The smallest number of people required for a "stable" multidimensional scaling solution can be determined by using the following formula, cited in Ellis and Dell (1986): $N = 40\ R/(I-1)$, where N is sample size, R is the expected number of dimensions, and I is the number of stimuli. Because the projected number of items (sample size) was to exceed 40, the number of sorters was effectively a negligible concern.

However, because the first question was concerned with uncovering a range of possible self-statements that a therapist might make after failure, this study attempted to conform to that goal by using 20 participants and selecting from the large sample of statements produced by the participants those which appeared to be as

different from one another as possible. This effort at creating heterogeneity in a sorting sample is considered to be a way of improving the "comprehensiveness that is desirable . . . and tends to produce a sample of stimuli more nearly approximating the complexity of the phenomenon under investigation" (Brown, 1980, p. 189).

The participant sample consisted of 12 female and 8 male therapists, the majority of whom have had more than nine years of experience in the performance of psychotherapy. Three participants had completed a masters in psychotherapy, seven had their masters in social work, and the remaining ten had completed doctoral level training. Eight participants represented themselves as using predominantly a psychoanalytic and/or a psychodynamic approach with their clients, while four were predominantly grounded in a systemic conceptualization of treatment. Three therapists considered themselves to be using a systemic approach between 40-50% of the time, and using other forms (cognitive, psychodynamic, psychosynthesis) the remainder of the time. The remaining five split their practices among several treatment methods, including behavioral, client-centered, expressive, systemic, and psychodynamic. Eleven of the participants treat people of middle to high socioeconomic status, seven report that they treat predominantly lower income clients, and two therapists see their caseloads as split fairly evenly between the disadvantaged and advantaged.

Overall, the sample of participants in this research demonstrated some diversity both in the methods they apply in the work and the socioeconomic backgrounds of the people they treat. There did not appear to be very much repetition in the kinds of presenting problems treated by therapists across the sample. By and large, the therapists were an experienced group. Some therapeutic modalities are underrepresented or not represented at all in this sample. Given the popularity of behavioral approaches among many American psychotherapists in some regions of the country, there are strikingly few behavioral therapists sampled here. However, behavioral therapy appears to be less prevalent in the northeastern section of the United States, from whence this sample was drawn. Client-centered and expressive therapists were also not well represented.

Measurement Techniques

The data collection process was broken down into two phases, each of which involved a different measurement technique: 1) the collection of the participant psychotherapists' recollected self-statements after a therapy failure by means of an adapted Thought Listing Procedure; and 2) the elicitation of the participant psychotherapists' ways of conceptually organizing those

statements according to similarity by means of a Multiple Sorting Procedure. The Thought Listing Procedure was concerned with responding to the first research question and the Multiple Sorting Procedure formed the basis for the remaining questions posed here.

The Thought Listing procedure is considered to be one among several ways of educing cognitive processes and structures (Cacioppo & Petty, 1981; Blackwell, Gallassi, Balassi & Watson, 1985; Clark, 1988). Kendall and Hollon (1981) have grouped the existing variety of cognitive assessments into four methodological categories: 1) Recording methods, such as Think Aloud techniques, which require that subjects express their thoughts concurrent with their performance of a specific task; 2) Production methods, such as Thought Listing, which ask subjects to recall their thoughts after a time interval and frequently have them record them with paper and pencil; 3) Sampling methods, in which thoughts are reported after a random signaling cue; 4) Endorsement methods, in which subjects indicate the occurrence or non-occurrence of a thought in response to a predetermined series of items.

The Thought Listing Procedure was developed as a self-report device in the late 1960s at Ohio State by Brock and Greenwald and is currently one of the more common means used to elicit cognitive processes. Its use has expanded in recent years due to social psychology's interest in what people say to themselves in contexts

where they are exposed to persuasive messages intended to change their attitudes (Cacioppo & Petty, 1981), and to cognitive psychotherapists as well, who are targeting thoughts as potential arbiters of behavior change (Meichenbaum & Cameron, 1981; Mahoney & Freeman, 1985; Reda & Mahonney, 1984). Cacioppo and Petty (1981) report that:

> the greatest potential of the technique was in its power to generate testable hypotheses by helping us to identify important dimensions of a person's reportable subjective reactions.

Due to the relatively nascent state of research into cognitive assessment methodology, no single approach out of the four identified above appears to be consistently more reliable or valid than any other, and it remains to be clarified "what each strategy does measure and under what conditions accurate assessment can be assured" (Clark, 1988, p. 13). Research so far has found the validity of Thought Listing to be somewhat more evident than that of current recording and sampling methods. It has also been shown to be a "superior method for assessing evaluative . . . cognitions" (Blackwell, et al., 1985). Endorsement strategies have the greatest research support on measures of validity (Clark, 1988), but this approach was not deemed suitable for gathering exploratory data, due to its reliance on a predetermined set of items. In a study performed by Clark (1988), Thought Listing was compared with other attitude measures for its reliability,

and the results of both split-half (+.78) and test retest (+.64) were found to be acceptably high.

The nature of the instructions delivered to the participants is thought to be consequential (Cacioppo & Petty, 1981). Although subjects are in some instances asked to list thoughts that have been elicited by a stimulus, this assumes that subjects are capable of identifying the actual cognitive effects of a stimulus, which is an assumption not without its strong critics (Nisbett & Wilson, 1977). Therefore, asking for all the thoughts that occur to a person is considered to be the least restrictive form of instruction. Cacioppo and Petty (1981) found that, when they asked individuals to gather thoughts within a specific time frame, "the demand to produce a particular type of response was minimal" (p. 315). In contrast, those persons who were asked to list all thoughts they have upon a particular topic produced more topic-relevant thoughts (fewer "irrelevant" items) and appeared to have felt compelled to demonstrate "open-mindedness and intelligence" in their responses.

Therefore, this study asked for all the thoughts that a participant could recall having had at a particular time (at the point of having identified a treatment failure). As mentioned in Chapter One, it was not assumed that therapists tapped into actual mental processes during this procedure. Rather, the thought-items produced at this

time are viewed as communications about thoughts which may have occurred to the therapists at the time of their experience of failure, that is, self-statements. Subjects were instructed to search their memories for an experience with a client which they believed to have ended in failure. Once they had completed their recollection out loud, they were asked to list out loud the thoughts they remember having had at that time. The investigator recorded the therapists' statements on a form designed to unitize the statements (see Appendix A). It was decided to have the participants designate what constitutes a thought unit by going over with them what the investigator had recorded, rather than having the investigator interpret which of the recorded items constitute a whole thought. This strategy was deemed to result in fewer investigator-contaminated items (Cacioppo & Petty, 1981) and attempts to insure that the majority of interpretive acts are performed by the participants.

It was also decided to have the participants state their thoughts out loud rather than asking them to write them down. This decision was based primarily on feedback from the participants: all of whom, when given the choice between writing and stating their thoughts, indicated that they preferred not to write them down. This procedure had the additional advantage of maintaining behavioral consistency in the transition from case description to

thought production than when participants are asked to write down their thoughts.

The effects of the thought listing instructions used in this study probably most resemble the topical form of instruction described above, since the process of recalling something from long-term memory would naturally not be the same as reporting items from short-term memory. Therefore, it is quite likely that the responses derived have been influenced by "self-presentational motives." However, as suggested in the Rationale and Review of the Literature, such biasing of what therapists may divulge is viewed here as a reflection of social construction and individual development. Such "contaminants" need not at this juncture be distinguished from the data, since the goal of this study is not to reveal the nature of any internal processes per se, but to discover the communicative aspects of therapists' experiences.

However, it is hoped that the participants' screening out of certain thoughts during the retrieval process was balanced out by the "screening in" of a set of salient and meaningful thoughts. Salience has been targeted by having made the interval between the stimulus (in this case, the recollection of an experience in therapy) and the listing as brief as possible. This essentially dual-recollection approach is considered to be the most pragmatic and

expedient at this exploratory stage of the research. Although thought listing gathered at the moment after an experience with failure would have most likely led to the improved validity and immediacy of the results, such a strategy was considered infeasible at this time.

The thoughts sampled in this manner were combined and edited to form a total list of statements. This total list made up the items that were investigated in the second phase of the study. The original statements were collected into a group and then, due to their tendencies to be overly context-specific, were put through two stages of refinement in order to make them readily understandable by a variety of therapists (see Data Analyses). In making this total list, every effort was maintained to preserve as much as possible the language of the participants. This procedure complies with the suggested means for developing the contents for Q-sorting methods. Because the goal of the sorting methods is to allow subjects to speak for themselves

> the preferred items in most instances are those freely given by subjects with as little tampering and modification by the investigator as possible. The goal . . . is to retain a certain naturalness and to minimize where possible . . . a situation in which the act of measurement overly affects the phenomenon being measured (Brown, 1980, p. 190).

It must be said that the loss of individual "color" and context that is the necessary result of these

refinements was regrettable, but was deemed necessary. The primary reason, other than intelligibility, for collapsing, refining and discarding items was to be left with a manageable number of statements for the participants to sort, while retaining as much of the diversity as possible. The first sample of total refined statements derived from the original collection of over 200 items was 110 in number. Those 110 statements were printed on four identical sets of 2"x 4-1/4" cards in preparation for Phase Two: the Multiple Sorting procedure.

The Multiple Sorting Procedure has emerged in relationship to two similar methodological traditions; George Kelly's repertory grid (1955) and William Stephenson's Q-Methodology (1953). Each of these identifies as its focus the individual world view of the respondents and assumes that this world view is "built around the categorization schemes people employ in their daily lives" (Canter, Brown & Groat, 1985).

Q-methodology focuses on the subjective experience of its subjects and seeks to learn how the subject, rather than the observer, construes a set of items:

> The thrust of Q methodology is therefore not one of predicting what a person will say, but in getting him to say it in the first place (i.e., by representing it as a Q sort) in the hopes that we may be able to discover something about what he means when he says what he does (Brown, 1980, p. 46).

In other words, the act of sorting items into categories is considered a way of eliciting the sorter's subjective

understanding of those items in a format that minimizes the investigator's influence.

The Multiple Sorting Procedure used in this study asks participants to sort a set of items into groups according to each item's similarity to items within one pile and difference from items in other piles. This procedure leaves the choice of the organizing principle used to assign items to a pile up to the individual participant and encourages the respondent to use more than one criterion to guide their discrimination between items. Once a sorting of one set of items has been completed, the participant is requested to give an explanation for the way in which she grouped the items and to name the specific categories (piles) that she made. The rationale for this "least restrictive" approach is "the belief that the meanings and explanations associated with an individual's use of categories are as important as the actual distribution of the elements into categories" (Canter, et al., 1985, p. 88).

The Multiple Sorting Procedure has been developed in reaction to the "restrictiveness" of most standard data analytical methods. Its proponents, Canter, Brown and Groat (1985), charge that commonly used statistical methods: 1) limit data to those with a linear order, categorical data being "difficult to accommodate; 2) limit the structuring of the variables so that it is identical

for all participants; and, 3) tend to "be restricted to those that are based on assumptions of underlying linear dimensions." They advocate for procedures that both allow the participants to express their views in their own way and provide information with sufficient structure to be systematically analyzed and reported. Both the repertory grid, which constrains the process of concept formation by its bipolar elicitation procedure and is limited in its use to a small set of items, and the Q-sort, which not only specifies the categories themselves but typically uses a forced distribution format for category assignment, impose a priori specific frameworks upon the concept elicitation process. The Multiple Sorting Procedure seeks not to impose upon the data a specific view of the structure of concept formation.

Canter, Brown and Groat (1985) also distinguish multiple sorting from the ways in which many multi-dimensional scaling procedures gather proximity data. These methods typically require subjects to form a proximity matrix by rating the similarity of paired items, because the theory perceives judgments of similarity as "the primary means for recovering the underlying structure of relationships among a group of stimuli" (Shiffman, et al., 1981, p. 19). The proponents of the Multiple Sorting Procedure, which involves more than one set of similarity ratings for the items contend that

> perceived similarity is a more complex phenomena than can be accurately described by a single rating. Perceived similarity may, in fact, be defined by a set of multiple categorizations based on a wide variety of criteria. In many cases it is the overall pattern that emerge as a result of the concepts people themselves naturally apply to the objects or elements that is of psychological concern. (Canter, Brown & Groat, 1985, p. 86).

Another problem with the simple rating of paired similarities, other than the overwhelming amount of time required for rating larger sets of items, is the inevitable loss of information which would result, since it is impossible to determine from a rating scale what criteria the individual uses to decide that one of the pair was more or less similar to the other. Some of the advantages of a multiple sorting approach lie not only in allowing for multiple categorizations but also in requesting information directly from the participant about his or her sorting criteria. This additional qualitative information can also be applied to the interpretation of more formal data analysis techniques.

How the multiple sorting procedure is set up and subsequently analyzed depends upon the focus of one's research questions. It is possible to inquire into either the different ways in which one person conceptualizes a set of items, or the differences between groups in their concept formation, or the differences among the items themselves. The latter, which is a focus of this study,

is concerned with learning something about the conceptual systems or dimensions shared by a group or groups of individuals.

This goal can be approached by creating a symmetrical association matrix comprised of the frequency with which each item co-occurred across sorts with all the other items in the set. This process assumes that the greater the frequency of co-occurrences between a pair of items, the greater their similarity. Such a similarity matrix can be analyzed by either a non-metric multidimensional scaling program (Canter et al., 1985) or by a cluster analysis, both forms of analysis having the objective of illustrating possible patterns of association or relationships between the items. In addition, Individual Multidimensional Scaling programs can perform analyses on individual matrices derived from this sorting procedure. Such individual analyses can be used as one approach to the portrayal of differences between individuals in their conceptual organization of the same set of elements (Carroll, 1972). Its primary uses in this study were to check for any major disecrepancies in the ways in which participants were sorting the items and to examine the weight that the particpants put on the dimensional solutions.

The Multiple Sorting Procedure is very conducive to qualitative and idiographic analysis as well. Specifically, the designated reason for a particular

sorting and the ascribed commonalities or names of the individual groupings of items may respectively be understood to represent for the participant a conceptual dimension and its underlying categories. The reasons and categories of each sort are explicated in the language of the participant and need not be shared by the investigator or any other person. If more than one sort occurs, it is possible not only to compare both the structure and content of sorts performed by any single respondent but also to compare specific types of sorts between individuals.

Procedures

Participants in this research were approached directly by phone, at which time they were informed of the full nature and goals of the study. All agreed to take part in both phases of the research, and they were told that at the second meeting they would be invited to participate in the data analysis phase of the research. Appointments were made to meet individually with each participant.

In the first meeting, the therapists were informed that this exploratory study was interested not only in the responses they provide to the research questions, but in their ongoing impressions of this project as a whole.

Time was allotted at each phase for participants to express both their critical comments and their ideas concerning the study's future implications for the therapeutic community.

Thought Listing and Interview

The meetings all took place in the participants' offices, with the exception of two therapists, who preferred to meet in their homes. These initial meetings began with the reading and signing of Informed Consent Forms (see Appendix H), which provided a summary of the research goals and a review of the research procedures from beginning to end. At that point, participants were invited to ask questions concerning the procedures.

Following the introduction, participants were asked to engage in silently recalling to themselves, and subsequently out loud for the investigator, the most recent instance in their practices of psychotherapy which they would identify as having ended in therapeutic failure (see Appendix A). Participants were asked to include a description of presenting problems and any details of the process that led up to their understanding the therapy as a failure. The case description was requested as both a precipitant for the recall of the therapist's thoughts and as a way of learning something about the context in which the thoughts occurred. Participants were informed that the case presentation would play no part in the research

questions and would not in any way be reported in this study. The whole interview was tape-recorded.

The specific definition of the concept of therapeutic failure was left up to the participants to determine. While the potential variability of participants' conceptualizations of failure may appear to threaten the results with confusion, both the absence of an overarching theoretical definition of treatment failures and this study's chosen interest in therapists' individual responses to a subjective experiences, call for the participants to generate a memory which conforms best to how they understand failure in their own experience. At the end of this session, each participant was asked in a brief interview to describe the definition of failure that she/he applied during this procedure (see Appendix B).

At the point at which the participants completed their recollections of their most recent therapy failures, the thought listing procedure commenced. The therapists were asked to report the specific thoughts which they remember having when they realized that this particular therapy process had failed. Their thoughts were written by the investigator on a specific form provided (see Appendix A) that has been designed to record thoughts as individual units. At the end of the thought listing, the investigator went over with the participant each recorded thought, in order to insure that they had been accurately rendered on the form.

The next portion of this phase of the study was a brief exit interview (see Appendix B) which was intended in part as a means for the participant to voice his or her comments and questions concerning the data collection process. It had the additional purpose of gathering information about the therapists' 1) personal definition of therapy failure and its evolution, 2) criteria for identifying that a failure occurred, 3) typical responses to failures, 4) training for failures, and 5) conjectures about how their "mentors" might define their therapy failures. The results of this interview are informally analyzed in Chapter Four.

The first phase ended with the participants filling out a demographic questionnaire (see Appendix D). The questionnaire recorded information about the therapist (age, gender, years of experience, preferred therapeutic modality), typical client population (individual, group, couples, families), and the type of agency in which he or she practiced. The demographic information was intended to provide descriptive information on the particular community of therapists responsible for producing the results of this study.

Multiple Sorting

In this portion of the study, the investigator met individually with the same set of participants for the

purpose of eliciting their patterns of conceptually organizing a sample of the thoughts gathered in the preceding phase.

In preparation for the second phase of data collection, the individually gathered results of the thought listing process were compiled into a single, representative sample of all the participants' thoughts (see Data Analyses section for a description of the editing process).

This phase of the data collection took place once again in the offices of each participant. The investigator began the session by first reviewing the purpose of this portion of the study and then introducing the Multiple Sorting Procedure (see Appendix C). Participants were asked to sort the first of the three sets of 110 cards, each card containing an individual thought, into "groups in such a way that all the thoughts in one group are similar to each other in some important way and are different from those placed in other groups." The sort itself was unstructured, insofar as no pre-designated number of piles or number of thoughts within a pile were imposed upon the sort. Upon completion of their first sorting of the individual thoughts, the participants were asked to state their reasons for having sorted the cards the way in which they did. After their responses, they were asked to indicate what it is that

"the thoughts in each group have in common." The reason for the sort and the contents of the designated categories were recorded by the examiner for later analysis.

The participants were then asked to "sort once again" the identical statements in a new deck of randomly ordered cards, but this time using a different organizing principle or reason than the one they used to sort the first set. The procedures were otherwise the same as those used during the first sort. At the end of this second sort, participants were asked to repeat the process one more time, using yet a different reason for their similarity assessments. No more than three sorts were performed per participant.

In this application of the Multiple Sorting Procedure, a limit has been placed upon the number of necessary and possible sortings (three). The rationale for this decision was based upon both the length of time required for participants in the pilot study (Appendix M) to perform four to five sorts of only forty (40) items and on the judgement that, in certain instances, five sorts seemed to stretch people's conceptualizations of the items beyond that which they would normally attempt. A minimum number of sorts were specified because, in order to analyze the differences between items, the sorters must be considered to be somewhat homogeneous. In this case their homogeneity was represented by the identical number of times that they sorted the items.

This phase ended with an exit interview, during which time participants had the opportunity to express their reactions to the sorting process and offer any insights they may have had into the research process so far. At this point they were asked whether they would like to volunteer to participate in the final analysis stage of the project. Nineteen of the twenty participants indicated that they might be interested and arrangements were made to contact them at the appropriate time. One person, who said that she was no longer interested in the project, chose to end her commitment at this time.

Phase Two. This phase was concerned with eliciting from interested participants their interpretations of the results of the data analyses. Due to my time constraints and my desire to minimize the level of demand on the participants' full clinical schedules, the involvement in this task was limited to written correspondence (see Appendix I).

The task put before these volunteers was to respond both to the data as it had been portrayed by the cluster and multidimensional scaling analyses (see Data Analyses) and to my interpretations of those analyses. I was essentially asking them to corroborate or critique the ways in which I have attempted to make sense of the possible groupings of their thoughts as they were performed by them in the Multiple Sorting Procedures.

The participants who expressed potential interest in the interpretive phase were all sent the following information (see Appendix I):

1) A selection of the ways that participants sorted the thoughts in Phase Two.
2) An abbreviated representation of the Cluster Analysis results.
3) An abbreviated representation of the Multidimensional Scaling Analysis.
4) Representations of my interpretations of the results.
5) A form upon which to respond.

Because the approach to this study recognizes that research can be an "affecting process", an additional question was included in the packet mailed to all participants: did the participants find that their thinking about failures in therapy had in any way been affected by their participation in this study? It was requested that responses be mailed back to me within a week of their receipt by the participants in order for their insights to be recorded in the final dissertation.

Data Analysis

Question One

The data gathered to respond to the question: "What thoughts do therapist participants recall having had after a recent therapy failure?" are listed in Appendix E. The data list, organized by participant, contains the literal statements made by this sample of therapists, after they had been asked to list the thoughts that they recalled

having had after an experience of a therapy failure. Participants produced an average of approximately 10statements apiece.

The analysis of the data list consisted of a collapsing of the number of statements to a size that was considered manageable for the Multiple Sorting Procedure. On two separate occasions I collaborated with two different collegues to refine the results of the thought listing in the following ways: statement redundancies were collapsed, clarification and abbreviation of some statements were performed, and several statements were discarded, due to their appearing to resemble general reflections on the topic of failures in general rather than thoughts in response to a participant's specific experience of failure.

An example of two collapsed items are: "I got caught up in wanting to save her, even though I knew I couldn't" and "I felt I wanted to save her, which I usually don't feel anymore." The second statement was used and the first was not. The following is an example of a clarification and a collapsing of statements from the same therapist: "I reflected on the first contact. Specifically, in the initial phone call, how I reacted defensively to the patient's narcissism. And how this became the 'secret' paradigm for subsequent contacts," and "I kept playing it over in my mind, back to the first phone call. There was something going on at the beginning

that I didn't pay enough attention to," became "There was something going on at the first contact that I didn't pay enough attention to. It may have secretly become an influence in the therapy."

An example of a refinement is the following: "'You stupid shit' (to myself) and I was at the same time furious with him" was changed to less idiosyncratic language: "I am angry with the client and with myself." A statement like this one, which was considered to be narrative rather than a statement of thought, was removed: "Initially I began to go home after the session feeling like a failure. At first I looked at factors outside the treatment for the cause of these feelings. Then they were identified as being connected to my client by my supervisor." The following statement was not included because it appeared to be a general reflection, not a thought specifically related to the failure described by the participant: "Failures force me to look at things differently, and see what I may be taking for granted, reminding me that I need to be as fresh and thoughtful for each new alliance as I can." Complete lists of both the actual thoughts listed by participants and the abridged list are recorded in Appendices E and F, respectively. The resulting list of one hundred and ten (110) thoughts can be found in Appendix F.

Question Two

The reduced sample formed the data for responding to the question: "How do the participants describe the underlying principles and categories that they used to organize the thoughts?"

The organization of those statements was accomplished initially by means of the Multiple Sorting Procedure. That procedure elicited from each participant, in addition to the actual groupings of thoughts, their reasons for sorting the thoughts they way they did. The reasons given for each of the various sorts are understood as representing the underlying principles or criteria upon which the participants based their construal of the items. In addition to the reasons for a sort, participants were asked to name the individual categories (piles) constructed in each sort. These categories can be seen to form the structure of a particular construct. The resulting principles and categories used by each participant in the multiple sorting procedure have been reproduced in Appendix G.

Essentially, the analysis performed on the Sorting results was an informal and descriptive one, intended to discover any qualitative similarities and differences in the ways in which the participants approached the sorting of the thoughts. This latter piece of information will be used during the interpretation of the Multidimensional

Scaling and Cluster analyses to facilitate the naming of the respective dimensions and groupings.

The sample of thoughts sorted by the participants had to be reduced once again, due to the limitations on the number of variables that Alscal Multidimensional Scaling Analysis could accommodate. The sample was reduced to 100 thoughts (see Appendix F). The ten thoughts discarded from the analysis were determined to be very similar to ten other items by a preliminary cluster analysis of the 110 matrix and are listed at the bottom of Appendix F. Matrices were produced which recorded the number of times each item co-occurred with each other item throughout all the sorts, that is, the number of times each thought was sorted with each other thought. A single matrix recorded all the participants and their sorts together, and then a series of individual matrices, comprised of each participant's three sorts, was formed to be used in the the cluster and MDS analyses. These matrices are understood to ordinally represent the similarity of each thought to every other thought, the highest degree of similarity being represented by the total number of times an item was sorted (60) and the highest degree of difference being represented by zero, or no co-occurrence. This ordinal information will in turn be interpreted in the cluster and MDS analyses as distance (proximity) measurements.

In response to Question #2b, the search for ways of grouping the therapists' thoughts after failure was performed by a cluster analysis of the total matrix of item co-occurrence across participants. Specifically, an item-by-item matrix was compiled from the total number of sorts performed by all participants. Cluster analysis is a set of mathematical techniques used to divide a set of items (objects) into relatively homogeneous groups based on estimates of similarity, in order to represent the structure of that stimulus (Davison, Richards & Rounds, 1986; Kachigan, 1986). Once a measure of similarity has been obtained, as in the multiple sorting procedure, and a matrix has been formed, an algorithm is used to cluster the items into groups based on inter-item proximity in a one-dimensional space. In this instance, an SPSS-X CLUSTER program was used to analyze the data from the multiple sorting procedure, which uses Euclidean distance measurements to determine the proximity of items to each other. The use of the Euclidean formula makes an analogy between similarity and proximity in space. The results of this analysis have been represented in a hierarchical fashion, whereby smaller, more similar clusters are "nested" in larger, more general ones (Kachigan, 1986). The cluster "tree" was subjected to a content analysis by me and subsequently by volunteers from the group of participants in which both the nature of the groupings

were studied by examining their component parts and relationships between the groupings were explored.

Multidimensional scaling analysis (MDS) was applied to addressing Question #2c, in an effort both to discover a possible underlying structure (as opposed to groupings or clusters) of the therapists' thoughts after failure and to reveal some of the possible differences among individuals in the way this structure is used. MDS is often used in conjunction with cluster analysis, and yet the former is generally considered mathematically more complex. It first assumes a multidimensionality of space in its effort to analyze the proximity of items and then attempts to discover the planes that best represent these relations in the fewest possible dimensions. J. P. Forgas describes MDS as

> clearly a most useful method in the social sciences. It allows the quantified description of complex and elusive stimulus domains. It can greatly help in the construction of taxonomies,...In cognitive social psychology in particular, MDS is one of the most promising techniques for the detailed analysis and study of implicit cognitive representations of the social world (in Harre & Lamb, 1986, p. 227).

This model has recently demanded increased attention from researchers who are interested in the investigation of "private phenomenological worlds of individual counselor and client" (Fitzgerald & Hubert, 1987; Hill, & O'Grady, 1985; Friedlander & Highlan, 1984; Ellis & Dell, 1986) and/or the "implicit categorization function of

schemata" (Robins, 1987; Forgas, 1982; Smithson, Amato & Pearce, 1983) in social perception. It has been chosen for this study because it may reveal subtle themes in the ways therapists think about their failures. Another positive feature, given the exploratory nature of this study, is that MDS is frequently used to help "systematize data in areas where organizing concepts and underlying dimensions are not well developed," is low in experimenter contamination, and can generate large amounts of information and yield "stable spaces" without needing large numbers of subjects (Shiffman, et al., 1983, p. 3). Finally, Individualized MDS allows for the exploration of group hetero-or homogeneity through the analysis of individuals' different weightings of the dimensions.

MDS seeks to identify abstract dimensions which are interpreted as underlying the similarity attributed to the items by the raters. While there are many forms of MDS, all are united by the shared intentions of distilling some pattern that may lie hidden in the data and representing that pattern or structure in a geometrical model (Shepard, et al., 1972). The output of an MDS procedure is typically a set of coordinates along specific dimensions and a "perceptual map" or plotting of those coordinates in space (Kachigan, 1986).

> In MDS, stimulus coordinates are interpreted in terms of meaningful stimulus groupings or ordering along a dimension. A substantively meaningful grouping of a stimuli is a set of stimuli that cluster together in a region of

> the multidimensional solution space and hence are similar according to the data. In addition, they share some common feature that can account for their similar representation (Davison, et al., 1986, p. 180).

Like cluster analysis, the data necessary for MDS are one or more similarity matrices from which proximity data are inferred. Different similarity measures can be used, such as correlations, similarity judgments and co-occurrence frequencies (Fitzgerald & Hubert, 1987), and it is the latter which was used here. These measures can be obtained through paired similarity ratings or sorting procedures, such as the multiple sorting procedure used here.

There are two major forms of MDS analyses: metric analysis, which assumes interval level properties for the data, and nonmetric, which assumes ordinal data. The data from this study are ordinal. Weighted nonmetric MDS, or individual differences MDS (Carroll, 1972; Carroll & Chang, 1970), can provide information about the ways in which individual participants use or "weight" the dimensions differently. These individual scaling models do not assume total homogeneity in the ways that participants use perceptual space or emphasize dimensions, and are able to indicate by Subject Weights the "degree to which the fixed dimensions underlying the scaling of the objects (the group space) have to be stretched or shrunk to represent the data for that particular subject"

(Fitzgerald & Hubert, 1987, p. 478). The weights have been understood to characterize the differences in the ways individuals conceptualize the same items. Thus, individual MDS analysis, which has been used here along with nonmetric MDS, permits one not only to represent the interrelationship amongst the items and to discover the underlying dimensions of those relationships, but to examine individual or group differences in the ways in which the dimensions were emphasized. This analysis, which has been performed by the SPSS-X ALSCAL program, had as its data each individual participant's co-occurrence measures represented by separate proximity matrices for the weighted MDS (Indscal) and by a total matrix of all the participants' sorts for the euclidean nonmetric MDS. The results contain both fixed dimension coordinates and the weightings of each individual for each separate dimension (see Appendices K and L).

The interpretation of the pattern of spacial distance relations from an MDS analysis can be done using formal statistical analyses or informal intuitive methods. An example of the former is the use of multiple regression analyses in which the independent variables are the stimulus coordinates and the dependent variables are the mean ratings of attribute, adjective, or personality scales (Fitzgerald & Hubert, 1987; Robins, 1987; Ellis & Dell, 1986; Falbo, 1977). An informal interpretation can

range from a "simple inspection of the objects and what they denote" (Fitzgerald & Hubert, 1987) to a content analysis of the clusterings along a dimension. Another possible method is to use the information gathered from the cluster analysis to help interpret the dimensional clusterings.

This study relied on informal analyses of the MDS coordinates, in combination with the information derived from the cluster analysis and from the principles and categories used by the participants to sort the items. Most regression techniques require that the research come up with the dependent measures prior to and outside of the study itself, by means of such methods as a pilot study, development of an adjective list, or application of a preexisting theory to the development of these measures. Because I have sought to impose as little outside criteria onto the results as possible and also have chosen to keep the analysis within the realm of the participants' understandings of the material, I performed the interpretation of the MDS dimensions and cluster analysis grouping informally, and have included the similarly informal interpretations of those participants who volunteered for Phase Two (see Procedures).

Both the Euclidian and Indscal MDS analyses accomplished by the Alscal program include Kruskal's (1964) measure of fit, or Stress Value. Stress values

indicate how well the coordinates for a specific number of dimensions describe the actual proximity relationships of the data. In many instances, the fit measure is a major consideration when deciding how many dimensions are needed to adequately represent the data. The lower the Stress Value, the better the representation. To improve the fit the number of dimensions can be increased, but as the quantity of dimensions increase, so does the difficulty in interpreting the results. Therefore, the decision on the number of dimensions to be used in the final analysis typically relies both on the goodness-of-fit measures and on the interpretability of the dimensions. The ideal result is one which achieves the "highest dimensional solution in which all dimensions can be interpreted. Considerations of interpretability tend to override those of fit" (Davison, et al., 1986). Here, the final decision was based primarily on interpretability and secondarily on Stress Values.

Individual differences in the weighting of the dimensions derived from the multidimensional analysis were examined and any major signs of different approaches to organizing the thoughts were noted. The Indscal results also provided information on how strongly the individual participants weighted each dimension.

CHAPTER FOUR

RESULTS

This chapter presents both the results of the inquiries into the two research questions and a description of the participants' responses to the seven interview questions. Although the latter are not the central foci of this study, the information provided there will be included in my considerations in the next chapter of the implications of this study.

Question #1

The literal responses to the first research question,

> "What responses are provided by a sample of psychotherapists when they are asked to list the thoughts they recall having had after they realized that a therapy with a client had failed?,"

are far too numerous to be presented in this section, and have instead been recorded in Appendix E. In some of the cases I chose to include on this list statements drawn from the case discussions which seemed reflect spontaneously thoughts that were later not present in the thought listing. These were not, however, included as part of the edited list used in the analyses.

The Cluster and MDS analyses of the sortings of statements gathered by the thought listing technique seem to confirm that a diverse range of therapists' thoughts were indeed elicited in response to the first research

question. In spite of drawing from a relatively small sample of therapists, the thought statements were diverse enough to make it difficult, not only for me and my collegues to collapse them into a more concise sample, but also for participants with an abbreviated set of thoughts to agree on their conceptualization. As indicated in the introductory sections above, for the purposes of Q-sorts and MDS analyses, a range of items is prioritized over representativeness and this range should be stable enough to support confidence in the results. Although I consider this study to have successfully sampled a range of possible therapists' thoughts after therapy failures, it is my impression that this particular range of thoughts might have been extended somewhat with the inclusion of participants with different characteristics

Question #2

The second question posed in this project,

> "How do the same sample of therapists conceptually organize the thoughts collected in question #1, and how do they describe the underlying principles and categories they used in that organizing process?,"

was approached by asking participants to organize a set of edited thoughts by means of the Multiple Sorting procedure, which yielded for each participant three different ways of organizing the thoughts into groups.

A review of the contents of all the various sorts revealed some agreement on the part of the participants in the use of three explicit principles to organize the thoughts. In the first of these principles listed below the use was unanimous.

1. Locus of Responsibility or Locus of analysis or concern. Statements were grouped according to such categories as:
   a) self
   b) self as a therapist
   c) client
   d) outside others
   e) the interaction between the therapist and client
   f) reflective statements that harbor no blame (philosophical in tone)
   g) expressions of the therapist's affect.

2. Feelings and Gut-level responses versus objective, "professional" causal inquiries. Typically a bipolar sort, statements were designated as representing feelings or thoughts.

3. A variety of Evaluative Sorts, that is, those in which the participants judged the value of a therapist's making particular self-statements. For example:
   a) useful (constructive) or not useful (blameful) thoughts to have;
   b) thoughts do or don't reflect receptivity to learning from the experience;
   c) mature or immature statements;
   d) voices of experience and inexperience reflected in the thoughts;
   e) thoughts as responses to Feeling like a Failure (from beating oneself up to learning from the experience;
   f) neutral (objective) or over-involved (too subjective) thoughts;
   g) from blameful to non-blameful kinds of thoughts, with one group acknowledging mutual responsibility of therapist and client.

Locus of Analysis sorts, as I have chosen to call them, were performed by nineteen of the twenty therapists

and were, in all but two instances, accomplished on the very first attempt at sorting the thoughts.

A distinction between affective or feeling statements and those that were perceived as more objective or emotionally distant was made by seven therapists in one out of their three organizing sorts. In addition, almost all of the Locus (see 1g) sorts contained a distinct pile in which those statements considered to reflect therapists' feelings were placed.

Ten of the participants sorted the statements into what I have understood to be "evaluative" sorts. Many of these participants indicated that they were considering the thoughts from the position of a supervisor concerned about the effects certain thoughts might have on the morale or potential learning of the therapist. It is quite possible that this way of organizing was suggested by my instructions after the first sort to approach the statements "wearing a different hat". However, in spite of those instructions, this style of organizing the data occurred to only half of the participants. These ten "evaluative" sorts were certainly not the only sorts in which the participants expressed value judgements about the one hundred and ten statements. Within sorts of varying organizational principles, the participants expressed their concern about thoughts that were "too pessimistic" or, in contrast, those they said seemed to

"white-wash" the negativity of the outcome and its implications. Some statements were overly blameful of either the therapist or the client, while others were contrasted on a scale from "openness to definitiveness." Similar estimations of the quality of particular statements also occurred in categories under other sorting principles, such as overly blaming, denying, and superficial categories, but the sorter as "judge" was most evident in the above "evaluative" sorts.

In addition to the three principles discussed above, the participants chose to organize the thoughts in some of the following ways:

4. The statements do or do not fit my (sorter's) specific experience/ "Things I would or wouldn't say".
5. Hopeful and Pessimistic Thoughts.
6. From statements that are informative about the therapy process to those that could be made in any other context.
7. Questions and Statements of fact.
8. The language reflects differences in systemic and linear thinking.
9. Statements acknowledge failures in thinking and feeling processes in the therapy relationship.
10. Statements you would find written for publication and statements that might be spoken with a supervisor.
11. Statements that either reflect a belief that the world is controllable or suggest that therapists cannot control people.
12. The voices of shame and of guilt.

As one might surmise, this multiple sorting task of 110 items was not a simple undertaking for most of the participants. While some approached it playfully and were able to complete all three sorts in about 60-75 minutes,

others labored for more than two hours to complete the task. One participant almost withdrew from the study altogether at this point. Another required information about the goals of the research before she could complete a third sort. Others sorted three times, but essentially repeated at least one sorting principle in the process, while some participants discovered three distinct ways of discriminating between the thoughts, and in rare cases considered their third sort to be the one that really "said it" for them. Others were convinced, until they tried, that they could sort no more than once.

The enormous quantity of items appears to have been a greater determining factor in the difficulty of the sorts than the number of times the participants were expected to sort. Such a large sample of items was clearly difficult to hold in memory, particularly on the initial sort, and may have hindered an efficient classification for some individuals. Three sorts of fifty items would surely have been a less taxing endeavor, as four to five sorts of forty thoughts in the pilot study proved.

Question # 2a

After the multiple sortings had been configured into a single symmetrical matrix of all sixty individual sorts, two cluster analyses were performed. The first cluster

analysis (see Appendix J) was used to determine which ten thoughts of the 110 were similar enough to any others to be eliminated from the sample. By examining the dendogram results, the following edited thoughts numbers, 82, 75, 78, 103, 66, 34, 24, 17, 11, 5 were considered to be similar enough to thought #s: 72, 3, 6, 16, 35, 33, 48, 21, 1, 81 to be deleted. The number of thoughts had to be decreased by ten because the Alscal Multidimensional Scaling Program could not accommodate a matrix larger than one hundred (100).

A second cluster analysis (see Figure 1) was performed on the combined group matrix. The hierarchical dendrogram plot of the results was analyzed for semantic relationships between thoughts grouped together and eighteen meaningful clusters were readily discerned. The principles used by participants to organize the items in the Multiple Sorting Task were examined to guide the naming of these clusters (see Figure 2 for a hierarchical portrayal of the clusters' interpretations).

Two general groups were found at the top of the hierarchy and appear to dominate the relationships of the items: 1) Expressions of Affect by the therapist; and 2) Analyses of the Problem or Failure.

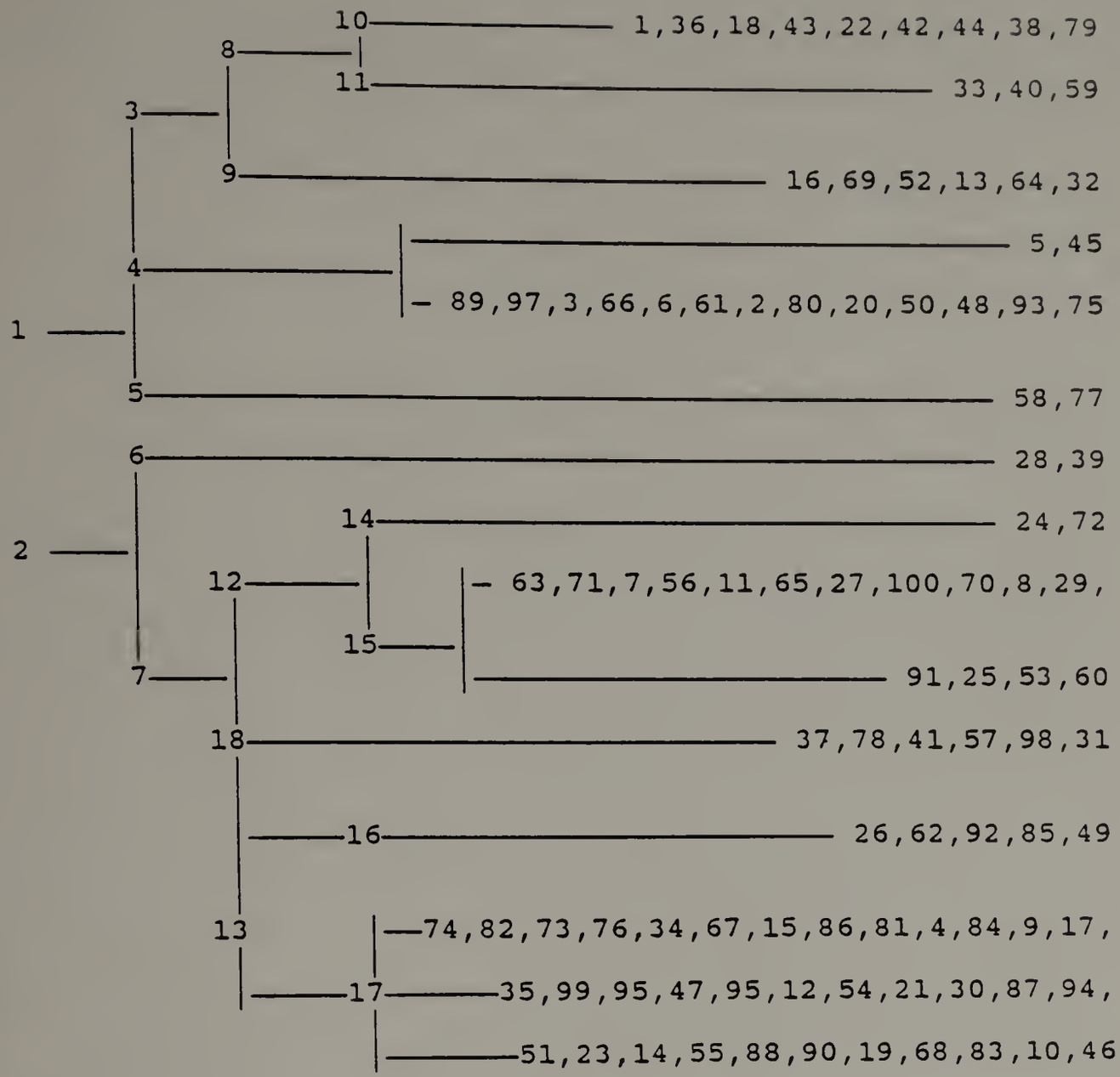

FIGURE 1

100 Item Cluster Dendrogram

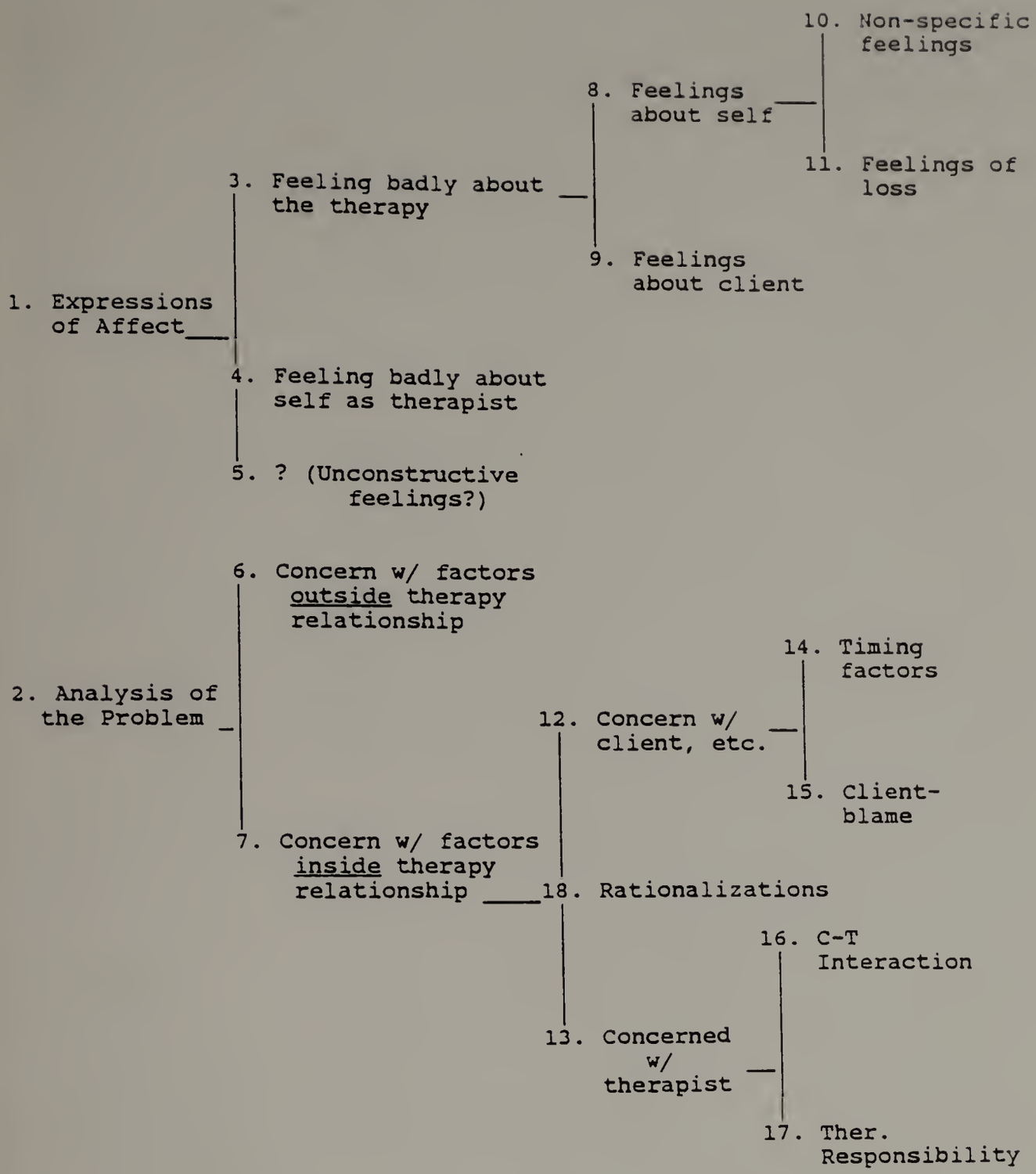

FIGURE 2

Cluster Interpretation Plot

The former concept, Expressions of Affect, has been broken down into three groups: 3) Feeling Badly about the Therapy, 4) Feeling Badly about one's Self as a Therapist; and 5) Feeling statements that may have been judged as Extreme by the participants. The concept of Feeling Badly about the therapy has been divided into two groups: 8) Feelings about the Self; and 9) Feelings about the Client. Finally, those feelings that are concerned about the self appear to be grouped under 10) Non-specific Feelings and 11) Feelings of Loss.

The Analyses of the Failure category contains two subgroupings: 6) Concern with Factors Outside the Therapy Relationship and 7) Concern with Factors Within the Therapy Relationship. The latter has three distinct groupings: 12) Concern with the Client, 13) Concern with the Therapist and Therapeutic Interventions, and 18) Philosophical Musings on the outcome or "can this be called a 'failure?'". Some participants referred to this latter group as "silver lining", "Pollyanna", or "non-linear". Thoughts grouped under Concern with the Client were further broken down into 14) Not a Failure: Timing factors related to client's experience and 15) Blaming of the Client. The category of Concern with the Therapist can also be seen as divided into two smaller units: 16) thoughts acknowledging Client-Therapist Interaction

and, the largest of all the subgroups across categories, 17) thoughts examining the Therapist's Responsibility for the failure.

Question # 2b

A simple euclidian Multidimensional Scaling Analysis of the total matrix of all participants' three sorts yielded a plotting of the edited thoughts along three dimensions. The stress value for the single matrix was .15, indicating a fair representation of the items' true proximities. The decision to halt the analysis at a three dimensional solution was based primarily on the interpretability of the a three-dimensional solution. It was my assessment that increasing the solution to four or more dimensions would confuse more than increase one's understanding of the meaning of the items' similarity. A two-dimensional result produced a significantly weaker goodness-of-fit measure (.226) and more general solution, that is, a two-dimensional solution produced groupings that were fairly difficult to interpret.

The three-dimensional solution was interpreted by initially examining the placement and respective contents of each of the 100 thoughts along all three dimensional plots (see Figures 3-5). This, in conjunction with referring back to the Multiple Sorting and Cluster Analyses categories, produced three tentative

interpretations of the dimensions. Because there was still some lack of clarity in how to understand the positioning of all the thoughts along the axes, I decided to base my conceptual definitions of the dimensions by interpreting the group of thoughts with the most extreme coordinates on the axes (see Appendix M for all coordinates). Typically, I included only those thoughts with coordinates above 1.0/-1.0 or 1.5/-1.5. The interpretation of these extremely placed thoughts led to my making the following interpretation of the three dimensions:

Dimension 1: A continuum between Objective Analyses and Expressions of the therapists' Feelings.

Dimension 2: The Locus of the therapist's Analysis or Concern, spanning from the Self, to self/client Interaction, to Client and others outside the therapy relationship.

Dimension 3: Styles of Coping with or Rationalizing the outcome: from philosophical, non-blaming statements, including expressions of loss, to statements that reflect an absence of objectivity and an overly blaming attitude.

Some examples of statements clustered at the more extreme points along these dimensions will help to explain their interpretation. At the positive end of Dimension One's axis such thoughts are clustered as: "I feel bad about myself as a therapist," "I feel sad," and "I feel like a failure when someone leaves prematurely." All the statements of feeling can be found in this area of

Dimension One. At the opposite end of this dimension are statements that appear to be efforts to objectively explain what may have occurred, such as: "I think new meaning may have occurred, but it seems like a little in light of her many issues", "We didn't have an alliance", and "She was so terrified to let in the opinions of others because that meant some loss to her."

Dimension Two was also fairly clearly differentiated according to the locus of the therapists objective analyses or affective concern. For example, at one end of the axis we find statements like: "I should have been more clear in my assessment of the client's strengths and needs," "I didn't hear the client," and "I knew I wasn't good enough to be a therapist." These statements focus exclusively on the therapist and his or her actions/ feelings. On the opposite end of the axis are statements concerned with the client or other persons outside the therapist, for example: "Maybe it was time for her to stop," "He was so unwilling to look at his internal stuff and could only talk about surface issues," and "She's very devaluing . . . a classic borderline." Clustered neatly between these two poles of Dimension Two on the Objective Analyses section of Dimension One, were statements that reflect the interaction between the client and the therapist: "We didn't have an alliance," "Boundary Issues were confused from the beginning," and "We just didn't connect."

Dimension Three was somewhat more difficult to interpret, however it seems to be concerned with the ways in which therapists cope, well or badly, with treatment failures. On one end of the axis there were thoughts clustered that appear extreme in their pessimism and blamefulness: "She's very devaluing . . . classic borderline," "The client may have given up on therapy forever," and "I feel cooler and distant towards them. They're not my clients anymore." On the other end of this axis were such statements as: "I don't believe in coincidences. So she came here for something I have to offer her, whether I am able to see what exactly that is or not," "I feel something quite unfinished," and "Maybe it wasn't a complete failure . . . how could they go back to being the same after that?" Some of the thoughts clustered here that were also on the Expressions of Feelings dimension appeared to be concerned with recognizing and coping with the loss of a relationship, while those that were on the side of Objective Analyses ranged from philosophical rationalizations with a positive sense of the outcome and blaming, pessimistic statements. It is my informal impression from participants' comments during the sorting procedure that the former pole may be more positively valued than the latter.

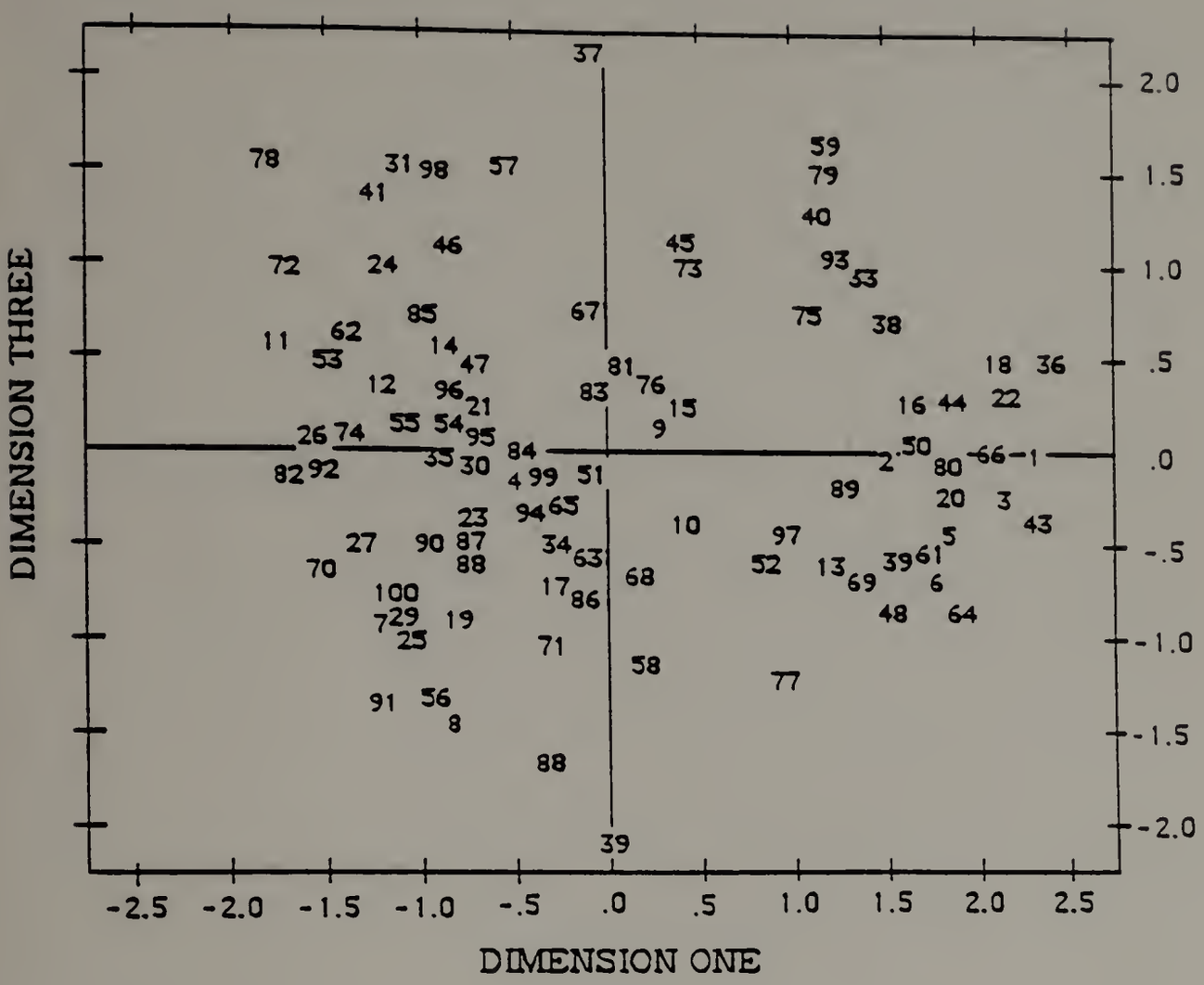

FIGURE 3

Dimensions One and Two

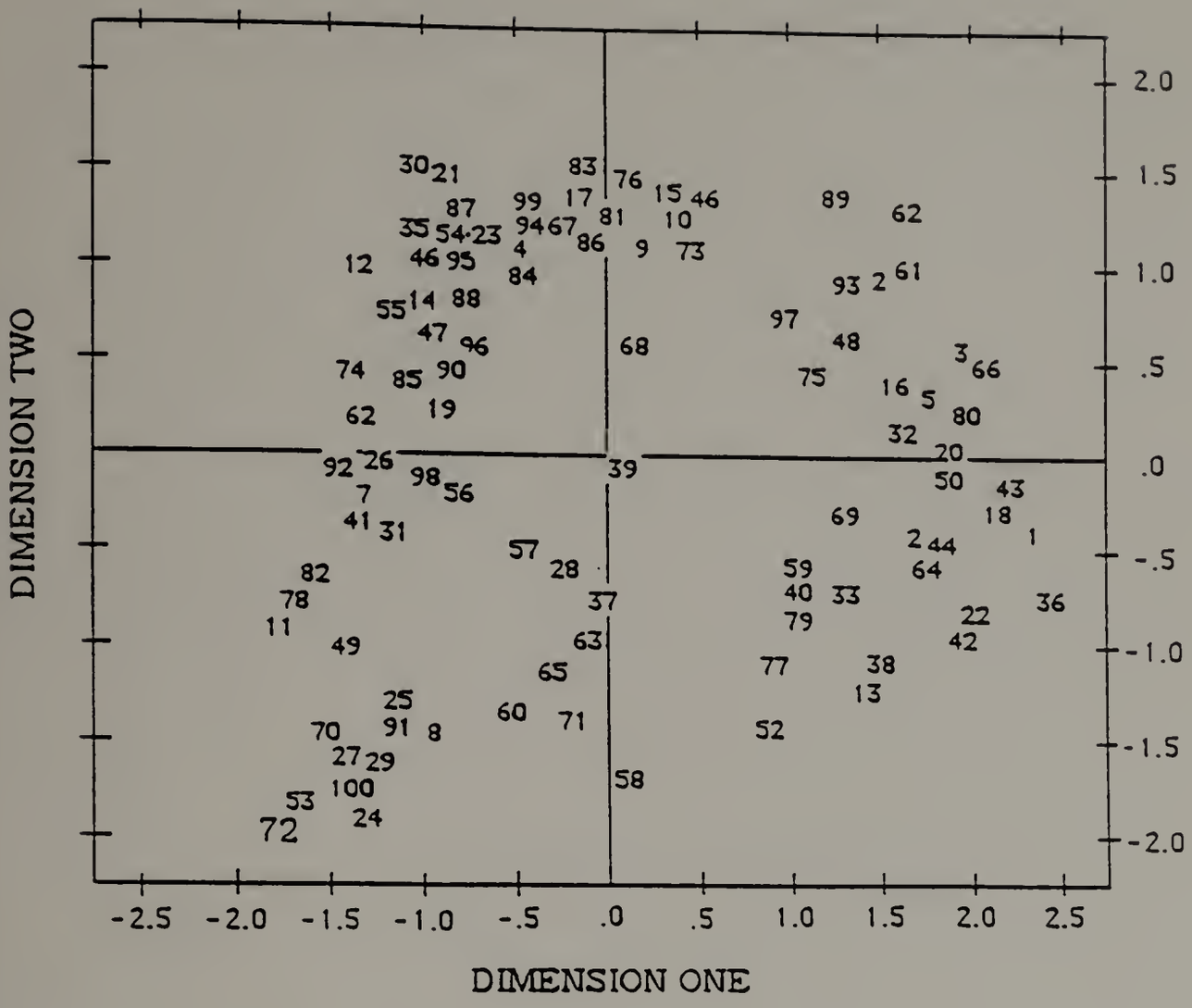

FIGURE 4

Dimensions One and Three

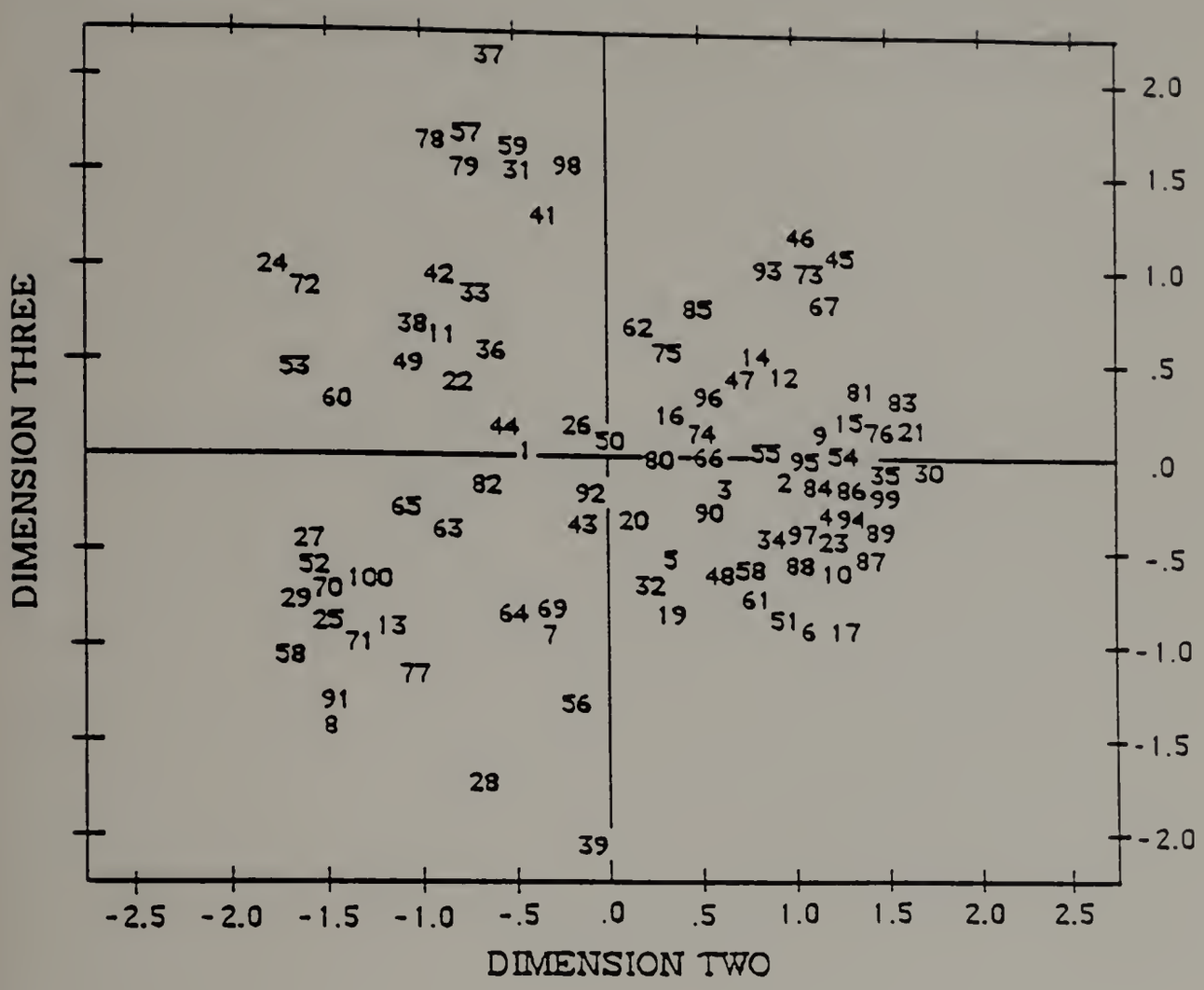

FIGURE 5

Dimensions Two and Three

A second MDS analysis was performed using individual matrices of each participant's sortings of the edited thoughts. Individual Weighed MDS produced three-dimensional plottings similar to the above single matrix euclidian analysis, and provided additional information about each participant's individual weighting of the dimensions (see Table 1). The subject weightings indicate that only one of the participants (#3) approached the sorting in a significantly different way from the other nineteen, having sorted the thoughts more repeatedly along dimension one than anyone else. Another participant (#11) was consistent in her low weighting of all three dimensions (See Appendix L for a plotting of subject weights). Otherwise, the participants clustered together in their weighting of the three dimensions. However, the average importance placed by all participants on the dimensions is relatively low. This variance across the twenty individual approaches to the organization of the thoughts is reflected in the poor average stress value of .330.

The return rate of participants to the second, interpretive phase of this project was low. I believe this occurred for two reasons: 1) The packet mailed to the participants contained too much detail and was not sufficiently well organized to insure a rapid understanding on their part of the tasks they were expected to perform; and 2) Without personal contact with the

TABLE 1

Subject Weights

Subject	Weirdness	Dimens: 1	2	3
1	.0452	.3182	.3133	.2881
2	.0607	.1504	.1535	.1399
3	.4453	.6488	.2388	.2242
4	.0564	.2577	.2605	.2378
5	.0725	.1170	.1212	.1133
6	.0243	.2711	.2512	.2219
7	.0365	.2639	.2532	.2369
8	.0844	.2279	.2354	.2303
9	.0665	.2050	.2024	.1991
10	.0287	.1725	.1586	.1535
11	.0684	.0940	.0946	.0914
12	.0935	.1743	.1875	.1779
13	.0267	.1721	.1613	.1517
14	.0688	.2614	.1983	.1999
15	.0907	.2080	.2258	.2077
16	.0393	.2266	.2205	.1928
17	.0558	.2091	.2102	.1941
18	.0616	.1663	.1705	.1540
19	.0789	.1711	.1829	.1631
20	.0301	.1946	.1799	.1737

investigator, their motivation to do yet another moderately involving task for this study was significantly diminished. Given more time and better organization, I am certain that this phase could have produced a greater response and thereby made more of an impact on the interpretation of the results (see Appendix N for participants' contributions).

Four of the participants (#s 19, 4, 20, 5) offered their ideas for interpreting the clusters and dimensions. I took some of their thinking into consideration, specifically the removal of attributional overtones from

Dimensions One and Two, and the more evaluative quality in Dimension Three's interpretation. I chose not to adopt some of their language because I wanted to avoid terms that are readily identified with a specific theoretical approach to treatment such as "systemic" and "participatory."

A larger number of participants returned their responses to the question of whether or not their participation in this research affected their thinking about failures (#s 15, 20, 19, 4, 12, 3, 5, 10). All but two of these therapists indicated that the process had informed their understanding of therapy failures. Some preferred the first part of the study, because the chance to think out loud about their experiences was a rewarding and clarifying experience. Others liked the sorting task because it gave them an opportunity to learn something about how other therapists were understanding their failures. One participant said that he appreciated both procedures equally.

In summary, the results of these analyses suggest that these therapists' reported self-statements after experiences with therapy failure are diverse but can conceivably be organized along three distinct principles or dimensions. Thus, they can be represented as: Expressions of Affect/Objective Analyses, Locus of Analysis or Concern, and Quality of Rationalization or

Coping. While these dimensions, constructed from the multidimensional scaling of participants' multiple sorting of edited thoughts, were only minimally weighted by each participant, the group was consistent in its weighting of them. The stability of the three MDS dimensions interpreted here is strengthened by the appearance of these three themes in both the Multiple Sorting Procedure and the cluster analysis. The MDS analysis has been prioritized because it provides a number of usable categories than either the sorting principles or the cluster analysis and because the third dimension suggests an evaluative principle similar to those explicitly used on occasion by some participants to organize the thoughts.

Participants' Interview Responses

> "It may be that asking the question is more important than finding the answer."
>
> J. Pratt

> "This is high-risk work. It's emotionally high-risk work, and I think that understanding failures is part of what keeps one able to go back in there the next time, and to be as open, attuned to someone as one can. I think that if I harbor guilt, it can have a cumulative effect in terms of [my] confidence as a therapist...My thinking about failure influences how I go on."
>
> Participant

The following section contains a consolidation of the participants' responses to the seven questions posed them in our first meeting's concluding interview (see Appendix B). The interview was intended to provide qualitative information concerning the ways in which these particular

therapists conceptualized failure and their personal understanding of how these concepts developed. In the last question therapists were invited to comment on the research and make suggestions for future investigations into the topic.

Question A: How did you know that this [particular therapy] was a failure?

When asked this question, seven of the participants pointed to their clients' premature terminations as the major factor in their conclusion that the therapy had failed. Each of these particular clients left the therapy relationship "early" and without the endorsement of their therapists. Two of these clients dropped out of therapy, and were not seen by the therapist to discuss their decision to terminate. Three additional client-precipitated terminations were signaled by dramatic gestures by the clients: two suicide attempts and one psychiatric hospitalization.

The second most frequent indicator for these therapists of a treatment failure were the therapists' "feelings," that is, their intuitive sense about the outcome or process of the therapy. Some of the five participants in this category indicated that they had been feeling badly about themselves in sessions with the clients, were over-involved, or simply didn't feel right about the therapy. While there may have also been

external factors suggesting that the treatment was failing, such as lack of improvement or a client's expressions of dissatisfaction with the therapy, the most salient factors for these participants were their own feelings about the relationship.

Two therapists said that they realized they no longer knew what to do to be helpful to their respective clients. Another three participants focused on more tangible indicators, such as the therapy not having fulfilled the original treatment goals at termination or the therapist having made a terminal error in a session.

Some participants suggested that their understanding of the outcome as a failure was distinctly colored by their expectations of themselves and the therapy process. Feelings that one should be able to help everyone or that one should always know what one is doing exacerbated both their confusion as to what to do and their frustration with themselves and their clients.

Question C: Do you have a working general definition of therapy failure? If so, what. If not, why?

While all but one of the participants felt that they had a working definition of therapy failure, four openly stated that they preferred not to use the term "failure." One therapist wondered "how can anybody know what a failure is? How egocentric to imagine that you have an agenda for what is supposed to happen for a client!"

Others, in a similar vein, suggested that therapy is not a linear process and therefore, one cannot clearly show a distinct causal relationship between what the therapist "does" and changes in the client's "problem." For example: "Help doesn't come by doing something to someone. It comes from providing space and a safe environment where people do for themselves." For some, any definition of therapy failure would be relative to one's treatment expectations: "Failure depends on your concept of what you're doing".

In keeping with the above observation, a variety of definitions for therapy failure were offered, ranging in focus from pragmatic, observable criteria (not fulfilling a specific contract) to more abstract or existential indicators (therapy did not result in client having "new meaning"). This range did not seem consistently to reflect differences in the therapists' methodological orientations, a finding which I did not anticipate. This blurring of the lines between modalities may have been an artifact of region from which the participants were drawn. This sample of participants were collected from an area where systemic therapists have become increasingly "constructivist" in their thinking about the purposes of therapy and, similarly, many psychodynamic therapists are considering more systemic influences on the therapy relationship. Formerly, such global changes as an altering of a person's personality tended to be the goal

of some psychodynamic therapies. Now, however, many of the systemic therapists in this sample admitted that they no longer target specific behavioral changes as the goal for a treatment, and instead seek changes in a client's "understanding". Indeed, an identified behavioral therapist in this group indicated that, for him, successful treatments need not contain actual symptom relief!

Some of the analytic therapists defined therapy failures as those times when countertransferential issues impeded the therapy work, or as "empathic failures" that may lead to a therapy failure. This theme was clarified by one participant who, in defining failures as premature terminations, asserted that "empathic failures are the stuff upon which therapy is made: [but] if the client doesn't return, these are never resolved." On the other hand some of the psychodynamic therapists optimistically considered premature terminations as "failed opportunities," rather than as complete failures, since they believe that the client will most likely continue to work on his or her issues with some other therapist at some other time.

Several of the therapists talked about causes of a failure when they attempted to define it. The timing of a therapy was sited by more than one of the participants as a critical factor in the outcome of a therapy. Some

indicated that a client may not be ready to change or that stresses outside the therapy may be impacting on the therapist's ability to meet the demands of a particular therapy relationship. Failures were also described as failures in the relationship, the interaction, or as resulting from a poor match between therapist and client.

There were participants who considered therapy outcome to be an existential question, in which the client's process of understanding takes on ontological importance. For example, failure can be understood as a breakdown in the cooperative pursuit of meaning by client and therapist. One therapist felt torn between his own goal for clients (changes in their relationship to the world), which grows out of his treatment model, and the more tangible goals of improved coping or minor symptom relief, the attainment of which may lead the clients to end treatment. While these two examples came from psychodynamic therapists, the use of "meaning" as a criteria for evaluating the goal of therapy was shared by therapists of several modalities, particularly therapists trained in more recent systems approaches.

A few of the participants had more pragmatic aspirations, and so defined failures as those times when the original goals of treatment were not met or when the therapist failed to define treatment goals with the client early in the therapy. Cases of no improvement or a

worsening of the client's condition were also sited as possible definitions of therapy failure. Had there been greater representation in this sample from the behavioral or cognitive/behavioral therapies, in which specific treatment outcomes are targeted, it is likely that more pragmatic definitions would have been offered.

Question D: Would you say that this definition has evolved for you? If so, can you say a little about how it evolved?

All but two of the participants considered their definitions of failure to have evolved from years of experience actually performing psychotherapy (as opposed to being educated in therapeutic techniques). In general, the evolution was away from a view that endorsed exclusive power to either themselves or the client for the outcome, that is, away from the concept of blame or unilateral responsibility. Many reported finding the position of holding themselves directly responsible for the complete course of treatment to be untenable. The discomfort brought on by that expectation has over time become mitigated by their reinterpreting the meaning of their roles a therapist or by their accepting more "realistic" definitions of their abilities. One therapist described her process in this way:

> I think over the years I've gotten away from the feeling that somehow we as therapists are responsible for bringing about change in a person. Even though I don't deny that I'm being paid and that I'm here to do something. But the more I take on the responsibility of making someone change, the less effective I become. If I become emotionally tied up in

> their achieving certain things then I become part of their problem...if I don't get caught up in their somehow achieving things for my own ego, to prove that I did a good job, then I think that therapy's a lot freer.

A like-minded systemic colleague said that her understanding of failure is vaguer now than it once was, that she feels less responsible for failures when they occur, and that her understanding of her responsibilities have changed. She no longer considers it to be her job to make change happen to someone. She is responsible for creating an environment or setting in which change is possible.

Several participants spoke of learning over the years to see "the bigger picture" when understanding therapy failure. They have learned to put the specific issues between therapist and client in a context that reaches beyond the therapy dyad to include society and the culture at large. This approach is essentially non-attributive in it's intent and therefore distinguishes itself from therapies that attribute causes of success and failure in the therapy to the "interaction" or to the "system". This is a logically and politically difficult position to maintain in a profession that demands "results". For example, the act of describing what it is one does when that has no direct relationship to what happens results in some paradoxical arguments:

> the reason I felt like a failure is because a lot of the time I said to myself "I don't know what to do; that's a failure." The motivating

> emotion behind "I don't know what to do" is "I should know." And I don't take that part of myself very seriously. But at that point I did take it more seriously; there were some things I should be able to figure out. [And what has changed for you?] Since then? I realized there isn't a right way to do anything. Because nobody has the answer to a particular problem. I mean, everybody has various answers, but there is no prescription, there just isn't. [How do you know if you're helping?] You ask. And I asked [the client] and she said "yes!" (laughs). Then I need to look at that. I think it's a very creative process. I have a hypothesis that is continually changing with new information. I might define some therapy as a failure at one moment and discover that it was a resounding success at another moment! I have too much respect for human beings' complicated processes to think that I can stop action at any moment and label. Seems totally absurd to me. Presumptuous, that's the word I'm looking for.

As a group, the more experienced therapists in this sample felt they had become over time less blameful, less rigid, and less self-conscious in their responses to failures. Some psychodynamic therapists felt that they had grown more adept in recognizing the interaction of their personal issues with those of the client as a primary cause of poorer treatment outcomes, whereas, as less experienced therapists, they had been prone either to blame themselves "globally" or to view the client as untreatable. One therapist noted in her sorting of the cards that a blaming of the client is part of the process of coming to understand the failure, stating that "blame needs to be externalized before a higher level of understanding can occur", higher level indicating, once again,

a "bigger picture" or more objective and complex understanding of the variety of forces that can lead to failure. One of the therapists remarked that he defined failure differently depending on the socioeconomic and history of his clients. While he accepted much of the responsibility for his role in contributing to failure with an advantaged client, he considered the most influential factors behind failures with disadvantaged, multiple problem clients to lie with society.

Some of these therapists said that they have learned that it is unreasonable for them to assume that they can help everyone and, as a result they have grown more discriminating in their choices of whom to treat. They now consider themselves to be more realistic about the range of their skills and more knowledgeable in their assessment of clients' needs. Most participants indicated that they now felt less resistant to facing their own treatment failures. For them mistakes have become precipitants to learning rather than self-incriminating and shameful experiences.

Question F: What would be your typical responses to failure in your therapy?

> "It's a continuum between 1) a reminder of my incompetence, feelings I bring from childhood, and 2) the tremendous ability to rationalize, structure words to give meaning that diminishes the pain."

The statements by the nineteen therapists who answered this question were informally analyzed for "type"

of responses using the results of the scaling and cluster analyses. Fifteen of the therapists acknowledged that they had feeling responses to failures, such as anger, frustration, and/or sadness. The feelings statements could be broken down further into primacy of feelings in the response; that is, where feelings appeared to be the most salient experience for the therapist; feelings concerned with the self; feelings concerned with the client; feelings in combination with analyses of the problem; and generalized feeling statements with no object. The remaining five statements were singularly concerned with analyses of the failures, which could, along with the combined group above, be broken down into analyses that explore the "bigger picture," analyses that examine the therapist's role, and statements that examined both the therapist's and the client's contributions to the outcome.

Two of the participants (see quotes above) indicated that the ways in which they thought about their failures had an influence on their how they felt about themselves as therapists and several expressed their need to avoid depression by increasing either their detachment or diminishing the degree of power they attribute to themselves.

Question G: How were you or weren't you prepared to fail by your training in psychotherapy?

Fifteen of the participants responded to this question by stating that failures were not openly or explicitly discussed during their training as psychotherapists. Some attributed this relative silence to programatic decisions to focus on models demonstrating successful outcomes and on the positive features of specific psychotherapeutic schools. One therapist humorously described the training tapes he had been shown, which were intended to demonstrate specific interventions by experts in the field, as "dog-and-pony shows." This kind of exclusively positive modeling might affect trainees' expectations in at least two ways: they can enter the field naively expecting to succeed with all cases if they apply the techniques properly, and they can feel inappropriately self-critical when their work fails to achieve the pace and the neatness of the edited clips they viewed in their training programs.

Many of the participants decried the silence of their training on the topic of failure, and felt that they entered the field unprepared to deal with the experience. One participant observed, however, that no one is ever really "prepared" to fail. She felt it was more important for therapists to have support going through it, and that failure ought to be "normalized" through open discussions. The responses to this question suggest that

failure does indeed "happen behind the backs" of therapists in training and that an increased dialogue on the experience is desirable.

Supervision was cited more than once as the place where the participants learned to make sense of their failures. One of the analytic psychotherapists stated that she was "helped to appreciate the impact of how in this work there would be many losses and how it would be important for me to work on my own issues of loss." Another therapist, who bridged systemic and dynamic therapy modalitites said that failures in individual therapy were "isolating experiences", while failure on a family team was softened by peer support: "I don't really know if the team ever allows you to fail. They reframe everything!"

Some of the therapists experienced failures in their early placements in clinic sites as public and humiliating experiences in which they felt blamed by other therapists at the clinic for any negative outcome. One person felt that this was due to therapists projecting their own frustration and hopelessness of working with socio-economically deprived clients onto others. Participants also suggested that this phenomenon is paralleled by incidences in which therapists in clinic settings avoid painful self-incrimination by collaborating in their projection of blame onto clients. The use and direction

of blame can also pertain to the kind of modality in which one was trained: an ex-Gestalt practitioner indicated that problems in the therapy were usually translated into issues for the client to work out "on the pillow", while an ex-dynamic therapist explained that he had been trained to see failure as "client resistance." Systemically trained therapists have been known to use a sophisticated form of client blame in which failure is attributed to the intractability of the family system or to sabotage from the larger system outside the treatment dyad. As indicated above, most of the therapists in this sample, the majority of whom practice privately, stated that although they no longer stop at attributing blame as a means of understanding failures, they were not trained explicitly in how to think about failures in any manner.

Question 7: What aspects of the issues raised by this interview are of particular interest of importance to you? Are there any not raised here that you believe would be important to address in the future?

There were two major themes that emerged from participants' responses to this question. About half of the therapists were interested in how guidelines for understanding therapy failures might be developed for training purposes, or in the supervisory relationship and its role in the development of a therapist's definition of treatment failure. Two participants, who are engaged in the training of therapists, indicated that the experience

of reflecting on the topic of failure in this study led to their discussing the topic more directly with their trainees.

The other half of this sample appeared intrigued with the prospect of learning something about how other therapists are understanding their experiences with failed therapies. In these instances, the sorting task was considered the most interesting procedure. For some participants the most interesting facet of this research was the occasion it provided for them to explore in the presence of someone else their own conceptualizations of treatment failure. Understandably, these participants seemed to have found the first meeting more interesting than the second. The question of differences in how men and women conceptualize failure was brought up by one participant. In consideration of the other necessary component of the therapeutic experience, another therapist wryly observed "What would patients be saying about for therapists to have this?".

CHAPTER FIVE

DISCUSSION

This section will examine in greater detail the findings and implications of the research questions. This will be followed by a discussion of the participants' responses to the Interview questions, into which I will integrate the results of an informal analysis and categorization of the therapists' actual thought listings (see Appendix E and O). Following upon the discussion will be a critique of the methodology. The chapter will end with some suggestions for future research projects. Before beginning this discussion, I will summarize the major findings.

In terms of the two research questions, this study has been successful in discovering the ways in which therapists' thoughts in response to therapy failures might be organized conceptually. The strength of these findings are underscored by the strong consensus from the various measurements (Multiple Sorting principles, Cluster and MDS analyses) on two to three useful dimensions with which to organize these particular therapists' thoughts. The three MDS dimensions consolidate many of the themes that emerged in the other two analyses, and it is my impression that they give a more complex portrait of the kinds of thoughts therapists report having than traditional attribution

models. The dimensions: 1) Objective Analyses/Expressions of Feelings, 2) Locus of Analysis or Concern, 3) Styles ofCoping, encompass the diversity of the sample of therapists' thoughts in response to therapy failures that an exclusive category of causal inquiry cannot. In addition, the bilateral breakdown of causal loci into internal or external categories that has been used in attributional analyses does not allow for the expression of therapist and client interaction as these methods have.

With regard to the more general purposes of this study and its guiding rationales, the less formal inquiries have produced some interesting findings. Informal analyses of the Interview responses firmly suggest that the ways in which therapists define therapy failure are socially constructed, that is, they emerge from social interactions with peers and supervisors in the context of performing psychotherapy, and decisively not from explicit academic and theoretical training per se. Indeed, the definitions used by individual participants do not seem to be consistent with any particular therapeutic modality. There also appeared to be a modest consensus among these participants that there are better and worse ways to think about failure, with the majority advocating for non-blameful, almost philosophical analyses that deny both the therapist and the client unilateral control for the outcome of the therapy process. In most of the

participants' cases, this less blameful, more "objective" attitude was something which evolved for them from experience. As was the case in the organization of the thoughts, expressions of feeling were a highly vocal group in these therapists' statements to themselves.

However, when participants' actual reported thoughts were examined using the three dimensions derived from this study, some discrepancies appeared between therapists' conceptualizations of failure and their typical ways of thinking about their own experiences with failure. The actual loci of their analyses, as was reported in the Thought Listing Procedure, would not have been predicted from either their respective definitions of failure or from their specific treatment modalities. In other words, "systemic" therapists did not have more "systemic" kinds of thoughts, and analytic therapists did not over-attribute to clients' pathologies. These participants as a group resembled Coleman's (1985) authors in their propensities to examine themselves and their actions when attempting to understand their failures.

A single locus of cause model, such as self versus other, did not appear suited to incorporating the processes of therapists' self-talk in situations of failure, for most of the experienced participants seemed to explore a range of possible loci before resolving the problems for themselves. The informal results of this

study seem to counter the application of a simple causal model to the conceptualization of therapists' thoughts after failure. There is some evidence to suggest that understanding and coping may indeed be by-products of therapists' efforts to make meaning (Fiske & Taylor, 1984).

Finally, as a rule, most of these participants did not appear to seriously question their fundamental treatment assumptions in the process of understanding therapy failures. While some of the statements appeared to strike out at a therapist's sense of worth as at therapist ("I knew I wasn't good enough to be a therapist"), not all of these participants expressed such thoughts and of those that did, only one of them who withdrew from practice, pursued that line exclusively. The purpose for this may be, as suggested in Chapter Two, the preservation of a therapist's core sense of self, which is considered to be affected by attacks of certain fundamental assumptions. An interesting aspect of this discovery is that this failure/resistance to challenging one's fundamental treatment philosophy generally occurred in the midst of what might be considered an excessive degree of self-examination and self-criticism. The processes that may be working to preserve the therapists sense of integrity and avocation appear complex and deserving of future inquiry.

Specific Results

There is a qualitatively high degree of consistency between the explicit themes elicited in the sorting procedure and the "implicit" themes revealed in the Cluster and MDS analyses. The latter yielded a relatively stable and interpretable set of dimensions of therapists' thoughts in response to therapy failures. While the three dimensions that have emerged in this study are interesting in their own right, I particularly find the ubiquity of the "locus of analysis" sort/dimension, to be worthy of further discussion.

The overwhelming preference evinced here for a locus of analysis sort appears to suggest that an attributional construct is a very salient schema with which to interpret statements made after a failure. This theme also emerged in the pilot study (see Appendix N). However, not all participants considered their locus sort to be concerned with cause or attributing "blame", breaking it down instead according to "objects of the therapists' concern". For clearly not all the thoughts grouped together on this dimension were concerned with cause: some examined the effects of the failure ("I'm worried about them . . ."); others recalled conditions without intimation of cause ("I felt I wanted to save her . . ."). It was this distinction, along with both the pejorative use of "blame" in the context of evaluative sorts and the input from

participants' interpretations of the dimensions (see Appendix O), that led me to use the terms "locus ofanalysis" rather than "locus of responsibility" to describe these dimensions.

Several participants observed that the performance of the first sort, which typically was organized according to locus of responsibility or analysis, was a more inductive process for them than the later sorts, stating that they had responded more intuitively to the actual contents of statements on their first exposure to the thoughts. In those instances participants' second and third sorts were viewed as more theoretical and less "spontaneous." It appears from this that locus of responsibility or analysis can be a powerful schema not only for therapists' conceptualizations of these thoughts but for their understanding of disappointed outcomes as well.

While these phenomena may appear to confirm an extension of Attribution Theory's proposed importance of locus of cause in people's thoughts after failures to the experiences of therapists (Heider, 1958; Wong & Weiner, 1980), there were some interesting approaches to conceptualizing the thoughts revealed through this methodology that are not typically elicited from traditional attribution research. For example, in almost every instance the locus of analysis sorts included at least one category for statements of affect. In some

locus sorts, individuals created categories that noted the absence of an attributive concern ("no blame") in some of the analytic statements. Thus, while it seems that thesetherapists perceived in their own statements a high frequency of expressed interest in examining the possible factors that impact on therapy outcomes, it is also evident that they find that the analysis of blame is not the therapist's only consideration, nor is it necessarily the most constructive of concerns. These participants may have been making a semantic distinction between "blame" and "responsibility", which would warrant further investigation. The imposition of evaluative organizational principles onto the data by many of these therapists suggests that coping with and understanding failures in ways that protect the humanity of the therapist and the client may figure as important as designating the causes of failures. This is in keeping with of the observations made by some Attribution Theory critics (Tetlock & Levi, 1982; Fiske & Taylor, 1984).

A close examination of the MDS solutions reveals that along Dimension One, the Objective Analyses grouping (Figure 3) in its interaction with Dimensions Two's Locus of Analysis or Concern, has been broken down into three foci: the therapist, the interaction between therapist and client, and the client. While the extreme poles of the Locus of Analysis dimension reflect an internal/external

form, midway between those poles lies a large group of thoughts concerned with the interaction between therapist and client. The stability of this group is supported by asimilar Interaction cluster formed in the Cluster analysis. Its importance for this study lies in the challenge it poses for the simple internal/external locus of control grid used in the study of attributions after failure (Weiner, 1979). Therapists in this sample considered themselves in the context of their relationship with the client, and vise versa. Therefore any model of therapists' thoughts should include such an interactive category.

It is clear from all the analyses that feeling statements form a thematically consistent category that is easily distinguishable from all the other statements. While the actual salience of an expression of affect category was not readily apparent from a review of the sorting principles, its presence in the cluster and MDS analyses resulted in a "hindsight effect" that uncovered the regular presence of "feeling" categories in all the "locus" sorts.

Both the cluster and MDS analyses revealed that, like the locus of analysis type of statement, expressions of affect have loci or objects of focus. That is, this grouping was broken down minimally into two categories: feelings relating primarily to the therapist's experience

and those projecting out to the client (and any additional "significant others", such as supervisors). However, as a whole, expressions of affect clustered less clearly into interpretable groups along the locus dimension than did those found on the Objective Analyses end of that continuum.

In regards to participants' concerns with the value of certain thoughts, multiply sorted groupings based on participants' evaluations of their quality were made in two contexts: as categories within a sorting and as the principle "reason" underlying the creation of a set of categories in a sort. The use of evaluative groups suggests that many of these therapists explicitly believe that the ways in which therapists think about their failure has some effect on their work as a therapists.

An awareness of the effectiveness of one's thinking surfaced in the Interview responses as well. Some participants felt that how one understands failure is in part constructed by one's interaction with peers and supervisors and others suggested that feelings of failure are the direct result of one's expectations of oneself as a therapist. When speaking of the evolution of their definitions of treatment failures, participants specifically noted that the character of their thinking had improved over the years, typically from blameful and naive to non-blameful and "realistic." This shift was

felt to have improved their morale and self-esteem. It was my impression from some of the participants' interview responses that how one handles (conceptualized) difficult therapies can be as important to a therapist's continuance in the field as one's work conditions. From the cognitive point of view, the avoidance of attributing responsibility in exclusively one direction could be understood as a schema with the major purpose of coping with a difficult and ambiguous field.

This awareness of the effects of one's thinking on one's self-esteem is in keeping with theories that recognize the effects of biases and other preunderstandings on individual experience, and thus is consistent with some of the hermeneutic and social constructionist assumptions that have formed the basis for this research. It would be useful to examine at another time the contents of these and other evaluative sorts of therapists' thoughts as a way of increasing our understanding of which kinds of thoughts are considered by some therapists to be more or less useful and the reasons for those evaluations.

Neither the Cluster nor the MDS analyses produced what I could decisively term an evaluative dimension, per se, but I do consider the third dimension to reflect judgements by the participants on certain styles of coping both rationally and emotionally with failures. When the

Objective Analyses/Expressions of Affect dimension (First) interacts with the Third Dimension (Styles of Coping) relatively few affective statements extend into the extreme points on the third dimensions axis, with the exception of statements of loss at the upper end, and some statements that put some emotional distance between the therapist and the client in some instances through acts of blaming the client. On the objective or rational end of dimension one's interaction with dimension three the statements on the upper end appear to reflect both philosophical considerations of the outcome and musings on the possible beneficial effects of the treatment. While for some of the participants these kinds of thoughts were purely escapist rationalizations, others found the question of "how does one really know the long term effects of a therapy encounter, good or bad?" to be a crucial concern and/or a reflection of their philosophy of treatment. Statements that appeared to me and to those participants who responded to the Interpretive Packet (see Appendix N) as moderately reactive and lacking objectivity were clustered at the other end of this dimension. Two of the participants who offered their suggestions for interpreting the results (see Appendix N) found the upper end of the third dimension to be more "neutral" or incorporating of the "larger picture" and the lower end as "defensive" and "subjective". However, the perceived

quality of these emotional and rational "coping styles" would have to be assessed in another context, as it is possible to see reasons for challenging the value of either end of the pole.

The interaction of Dimensions Two (Locus of Analysis or Concern) and Dimension Three (Coping Style) revealed a broader range of coping statements referring to loci other than the therapist. Statements that were concerned with what the therapist did or didn't do clustered closely together between the two poles of the third dimension, whereas statements that considered the client, the therapy interaction or other factors spanned the whole axis of dimension three. One possible way of interpreting this discrepancy is to ask whether or not the therapists find the examination of themselves to be less uncertain than coping with factors that may be outside their control, such as the loss of a client, the interaction between them, or the attitudes and behaviors of others.

The three dimensions derived from this project, informed as they are by both the explicit organizing themes of the Multiple Sorting Procedure and Cluster analysis, can be considered to form the basis of a taxonomy of therapists' thoughts after therapy failures. For the purposes of theory development, these dimensions or schema can lay the groundwork for a more extensive examination of the ways in which the kinds of thoughts a

therapist has may or may not relate to his or her beliefs, assumptions, and expectations concerning the therapy process. It would also now be possible to more systematically trace the social construction of a therapist's schema for failures in supervisory and educational contexts. This taxonomy facilitates and encourages the investigation into the value of certain types of thoughts in a therapist's openness to learning from failure and his or her feelings of competence. The dimensions suggest that it may be fruitful to look at both therapists' affective responses to failure and their objective analyses, and how in each of these areas we would want to consider the loci of the therapist's concern and his or her style of coping. We also might want to examine the frequency of certain types of statements used by a therapist to process the experience of failure.

Additional Findings

In this section I will be discussing some of the participant's responses to the interview questions (see Chapter Four) in reference to some of the issues raised in Chapters One and Two and in light of the specific results discussed above. I will incorporate into this discussion informal interpretations of the types of actual thoughts expressed by the participants in the Thought Listing Procedure (see Appendix O).

It appears from participants responses, both in the description of their experiences and in the interviews, that therapy failures are very potent experiences for therapists that catalyze intense feelings and a great deal of self-examination. Here are representative statements of these effects by two participants:

> "I had trouble sleeping at night after I met with her due to obsessive thoughts. I would replay over and over our conversations and worry about next session; "what I can say or do differently that may pull her in?" My obsessiveness is a way, I think, of working out my anger at her, since I know it is inappropriate to be openly angry with her."

> "Failures force me to look at things differently, and see what I may be taking for granted, reminding me that I need to be as fresh and thoughtful for each new alliance as I can...Failure, more than success, forces me to reflect on the whole therapeutic relationship and the responsibility that's involved in it; how what you did or didn't do had an effect on someone."

This degree of affective and reflective mental activity in the participants that was reportedly brought on by failures supports the view that experiences that contradict our expectations create a hermeneutic situation, i.e., a situation that demands understanding. These results are also consistent with a similar proposition by attribution theories that failures produce elevated levels of inquiry into the causes of those outcomes over those levels typically provoked by success (Wong & Weiner, 1984).

When one returns to the original statements made by the participants during the thought listing procedure and informally categorizes them according to the dimensions derived from the multidimensional scaling analysis, some interesting findings emerge. For example, all of the participants made attempts to examine the etiology of their failures, but seldom in ways that suggested any of them would be satisfied with single "locus" explanations. In their processes of thinking about the failures, many of them touched on a diverse range of loci and possible reasons for the failure. Each participant's series of thoughts routinely contained expressions of affect, with or without objects. Most of the analyses focused on either the therapist, client or the therapist-client interaction, with the former appearing most frequently across all individuals.

The chosen objects or loci of the participants' analyses could not in this study be related to their preferred therapeutic philosophies. That is, dynamic therapists did not appear stereotypic in underestimating the role of situational influences on an outcome, as might have been predicted from other studies (Plous & Zimbardo, 1985). Indeed, in my informal review of the types of actual statements made by participants, I found that several of the psychodynamic therapists appeared more inclined to use analyses of the interaction between

themselves and their clients than any of the other participants. In light of the the ways in which some "systemic" therapists had described their definitions of failure as having evolved away from looking for a single cause to incorporating the "bigger picture," the paucity of similarly complex statements coming from them was startling. I would have expected more statements from systemic therapists that reflected the complexity of their concepts of outcome. However, such an expectation on my part may have been too facile, given that there are other similar incongruities. For example, one of the least complicated definitions of outcome (premature termination) coming from a participant who also appeared to produce the greatest number of interactive statements in her thought listing.

As a result, I believe that the statements presented by participants in this sample argue against any simplistic predictions about how people of different therapeutic modalities may differ in their thoughts after failure. This is supported by the clustering together of the individual participants in their weightings of the three dimensional MDS solution (see Appendix L): there was no evidence of significant individual differences in use of the dimensions that could be attributed to affiliations with particular therapeutic modalities.

Similarly, analyses of the client's contributions to the failure occurred across all groups and individuals, and only very few of the actual statements reflect the presence, much less domination, of a dispositional bias. These therapists focused more on their own oversights and foibles than on their clients', and regularly considered the context of their relationships. Although different modalities might differ in their explanations of the origins of psychological distress, not one of these therapists considered an attribution to the character or symptomology of a client to be a viable or even ethical explanation for the failure. The apparent resistance of the participants to blaming the client would leave the responsibility for the matter in their own or in fate's hands (with "fate" being the embodiment of the seemingly mystical interactive, systemic forces).

Does that imply the use of counterdefensive attributions? There was no evidence to counter Bradley's (1978) contention that in situations where individuals believe they are the focus of attention, they may experience enhancement of their self-esteem by finding fault with themselves. Indeed, an acknowledged benefit of participating in this study was the occasion it gave for one to focus on oneself in the company of another who was clearly interested in what one had to say. Beyond the situational influence, however, there are other factors

that may influence this phenomenon. This style of explanation can also be thought of as being socially constructed. To describe the participants avoidance of attributions to the client as counterdefensive, I think, overestimates motives and does not explore the probable consensus amongst member in the therapeutic community that when therapy fails, they had better take stock of their role in that failure, regardless of one's epistemological position on cause. It may be that there are amongst therapists implicit and, in some cases, explicit assumptions that therapists <u>are</u> responsible for therapy's that have gone awry (Ward & Friedlander, 1985; Segal & Wazlawick in Coleman, 1985). At the same time, these participants suggested how important it is to avoid excessive self-examination. One way to take responsibility and yet not take it to heart may be to express one's feelings and focus on a range of possible factors.

Another informal finding was that the majority of analyses reported by less experienced therapists seemed to focus almost exclusively on the therapist. These participants had few, if any, statements exploring the roles of their clients and/or other factors beyond their control. Experienced therapists, in contrast, appeared to explore a greater variety of possible reasons for the failure and touched on a range of possible loci. It is

for that reason that examining the position of certain types of thoughts in the context of a process or series of thoughts will be an important next step in understanding the ways in which therapists make sense of therapy outcomes.

It may be that the relative silence on the topic of failures is a result of therapists' tendencies to reflect heavily on their own contributions to an outcome in settings where public shame often accompanies an admission of failure. In situations where admissions of failure do not draw blame from one's peers, participants report a supportive reframing of the failure in ways that mitigate the shame by spreading attributions out to "the system", timing, or the deprived socioeconomic context of clients who present multiple problems. Several participants reported that peers have shown them empathic recognition of the difficulty in treating a particular client. All of this takes place in a social context that demands results, where there is increased pressure on therapists to accomplish more in less time and to be able to account for more specific changes to specifically diagnosable disorders. This latter context, as Graziano & Bell (1983) propose, may be the most powerful reason for the community's avoidance of public discussion of failures.

If the thought listing results in any way represents how therapists may reflect on a failure, they suggest that, while the silence on therapy failures is a pubic

phenomenon, therapists do not appear to avoid talking to themselves about their failed outcomes. Indeed, several participants complained of the isolation of their own self-reflections and were appreciative of the opportunity provided by this research to openly examine their ways of making sense of these particular therapy failures.

Another probable contribution to the absence of public discourse on the topic of failures may come from the training experiences of therapists, which in the cases of these participants, demonstrated a remarkable avoidance of any overt discussion of failure as a therapeutic phenomenon. Most of the participants report having learned to make sense of frustrating or disappointing therapies from their supervisors and peers in their work experiences subsequent to their education in psychology. Since most research comes from institutions of higher learning where failures may not be openly considered, publications on failure would be rare.

As mentioned above, in the interview and in individual comments from participants there is evidence to suggest that therapists' ideas about failure are socially constructed predominantly from experience in the performance of therapy and interaction with their peers and supervisors. Several of the participants expressed their desire to see failure openly discussed during training and to have modeling for how to cope with

failures explicitly introduced into the training of therapists. In the context of their own relatively implicit learning about how to cope with failure, many participants indicated that they had come to believe there were "better and worse" ways to do make sense of failures. Specifically, overestimating one's own or the client's contributions to the failure was viewed critically. In spite of this, however, most of these therapists' actual statements in response to a failure were concerned with analyzing their behaviors or expressing their feelings. As indicated earlier, the theoretical training of these therapists did not consistently find expression in the nature of their thinking after failures, thus the results suggest an absence of theoretical definitions of failure. The absence of theoretically grounded definitions may help explain this discrepancy, and may account, in turn, for the uncertainty in this area expressed by participants.

The issue of how best to think about and cope with a failed therapy outcome came up in the sorting of the statements, and has been carried over in my effort to examine the actual thoughts that therapists reported having had in the thought listing. As indicated in the discussion of the interview responses, there was some agreement on the need for therapists not to dwell on attributing cause exclusively to themselves or to their

clients. Therapists have to feel open to learning from their mistakes, something which can hardly occur if they are "beating themselves up," as more than one person stated. It is my opinion that the systemic view, that cause for a failure was outside the control or understanding of the therapist, is difficult to sustain, both logically and in the actual process of thinking about failures, as evinced by the analysis of actual thoughts (see Appendix O).

As suggested above, one clue to a "better" schema or model for thinking about and coping with failures may lie in the kinds of thoughts therapists have, that is, in the variety of thoughts therapists report having. As mentioned above, many of the more experienced participants demonstrated a range in the types of thoughts they reported, as opposed to a tendency to dwell on their own errors in judgement. Although there is not enough of a sample here to argue this point, it does suggest that further investigation into the range and, perhaps, flexibility of more mature therapists' self-talk in comparison to that of beginning therapists would be useful. In light of this, it might be interesting to explore some of the more recent considerations of "mindfulness" in the context of psychotherapists:

> "Mindfulness" is a state of alertness and lively awareness at both cognitive and emotional levels, that is expressed in active information processing characterized

> by cognitive different iation. Mindfulness involves awareness of context and the flexibility of thinking that can lead a person to the creation of multiple perspectives and new ways of looking at things. (Strickland, 1989)

The thought processes of experienced and responsible therapists may have more qualities of mindfulness than that of beginning therapists, whose uncertainty and inexperience may lead them to be overly simplistic in their understanding of therapy outcomes. One of the more experienced therapists noted that she believed an initial blaming of the client, or externalization of the cause of a failure was a step in the process of coming to a "higher" understanding. This, and the above consideration of a range of thinking reinforce the need for research into the process of a therapist's thinking about failures. The dimensions found in this study may provide a fruitful basis for such research.

Only one participant allowed himself to examine his fundamental assumption or core beliefs about therapy as a result of his failure experience, by indicating that he may have been rigid and inflexible in his assumption that family therapy was the only way to be helpful in that particular case. Another person's core beliefs about her preparedness to be a therapist were shaken up so severely by her experience with failure that she stopped practicing several years ago and is still uncertain as to whether she ever wants to return, in spite of having recently finished

a doctorate in the field. Aside from this, not one of the therapists in this study indicated that the failure in any way challenged their personal theories. While several therapists questioned their abilities ("I knew I wasn't good enough to be a therapist"), they did not seem convinced that they were hopeless cases, and did not seem to limit their thoughts to excessive self-blame. In addition, the therapist who left her practice expressed a higher ratio of thought concerned with herself than the other participants.

Several of the participants expressed an awareness of the biases they bring in the form of therapy modalities to the understanding of therapy outcomes. This sense of the relativity of their own experiences was expressed in statements like: "failure depends on your concept of what you're doing" and "since I believe the relationship is the most important factor in successful treatment, I feel like a failure when someone leaves prematurely." A few of these therapists' statements reflect a recognition of the ways in which one's philosophy of treatment affects one's understanding of failure. For example:

> From some points of view, the treatment was successful: the symptom was relieved, the client had a positive therapeutic experience... but from my perspective the client stopped at an important point of working through an important part of the therapy: the transference. Therefore, I saw it as a premature termination and a therapeutic failure.

It may well be true that questioning one's basic assumptions or core beliefs is indeed a rare occurrence, except with less experienced therapists who perhaps overestimate their own roles in the process, or are less habituated to a specific treatment approach. The more mature practitioners may have committed to both a treatment philosophy and a sense of their own worth as therapists which they no longer allow to be exposed to serious challenge, even when they may acknowledge that theirs is not the only possible way of viewing the problem. This pattern is consistent with how these therapists saw the development of their understandings of failures: away from exclusive blame and toward a limited responsibility for therapy outcomes. In each case, this was seen as a progressive, self-protective and more "mature" development.

The defense of therapists' core beliefs was also anticipated in light of the recent work on the use of denial as a self-preservational tactic to preserve core structures and world views (Janoff-Bulman & Timko, 1987). As mentioned in Chapter Two, this resistance can have a positive function of preserving the stability of the individual, while at the same time conceivably allowing for incremental changes to occur in one's fundamental beliefs. I believe that it is something like the preservation of core structures that the more mature

therapists were alluding to when they discussed their evolution from self- or client-blame to a more "realistic" or relativistic conceptualization of their failures and expectations for success.

Why, then, does this resistance to challenge fundamental assumptions appear frequently to go hand in hand with an almost excessive degree of self-examination and criticism, if not self-blame? One is tempted to hypothesize that certain kinds of inquiry in volume can function as "noise" which distracts the individual from asking certain questions. As indicated in the introduction to this section, some therapists focused on themselves a great deal in their Thought Listing, but gave definitions of failure that suggested that they had no direct control over the outcome. For others, failure is inevitable, but for the vigilance of the therapist, and yet their reported thoughts incorporate the interaction between themselves and their clients.

Given the findings discussed in this section, surely it would be important to learn more specifically how therapists come to adopt certain ways of thinking about their failures, that is, how these ways are socially constructed in the contexts of supervision and/or peer case presentations. While it may be that experienced therapists show greater "mindfulness" than beginning practitioners, we know very little about the processes of

therapists' self-talk in response to treatment failures. It would be interesting to learn if experience and/or dialogue with one's peers lead to the exploration of a broader range of thoughts, as was suggested by this study's results.

Although more than a few therapists advocated for taking the "bigger picture" into account when they think about failures, this occurred very rarely in the actual sampling of theirs and others' thoughts. I found the discrepancy between what some of these participants theorized about failure and what they actually reported having thought to have been a fascinating occurrence, and I would like to examine the relationship of these processes in the future. The absence of a questioning of fundamental assumptions on the parts of most of these participants suggests that there is some benefit to protecting those assumptions, yet we still know very little about the ways in which they are defended. The optimum situation would be one where the therapist can preserve his or her core sense of worth and still allow some of her assumptions to be questioned by the situation of the client-therapist relationship. Or, do therapists persevere because they insure that their assumptions are only confirmed? This area deserves more study.

Critique of the Methodology

In this section I will critique the components of the methodology applied to this research project, and make recommendations for its future application.

Sample of Participants

The participants who were asked to volunteer their time and reflections to this research project indicated that they were very interested both in contributing to the process and in having an opportunity to learn something about how other therapists are coping with failure. Their very availability for this study presumably makes them a "biased" sample, for they "represent" therapists willing to talk about failures, not those who are silent on the topic. As representativeness was not a sought after feature of this sample, these biases can be seen as descriptors of this particular "community" of therapists. Therefore, the statements and organizational approaches provided by this sample can be understood as merely suggestive of the possible self-statements and concepts of therapists who are willing to discuss failure.

This sample was made up of therapists who practice a range of therapeutic modalities and treat a variety of client presenting problems in settings located in either urban or rural locations in Massachusetts. While a range of experience was represented, the sample was skewed in the direction of participants having had more experience

in the practice of therapy. The gender ratio was acceptable, however all but one of the therapists were caucasian Americans. The sample may have been strengthened in the range of statements it could produce had it included greater cultural diversity and one or two additional behavioral therapists. Nevertheless, this sample of psychotherapists appears to have succeeded in meeting its fundamental purpose, which was to produce a diverse set of items to organize.

While the use of a larger pool of thought-producing participants might be a factor to consider, this does not seem warranted, for at least two practical reasons: it would create a larger sample of thoughts that would, in turn, have to suffer even more dramatic reduction by investigators in order to form a sortable and analyzable number of items; and a larger pool would potentially alter the consistency of the research design, as the employment of an even larger number of participants in the sorting procedure would make the project too unwieldy. The expansion in number of participants is a consideration typically made when representativeness or randomness are sought after; that is not the case here.

Thought Listing Procedure

The adapted use of a thought listing task proved to be an efficient and fruitful means of producing a diverse sample of statements from the participants. In altering

the typical format to allow for more spontaneity in the therapists' expressions, I may have given more latitude to longer, more cumbersome and idiosyncratic statements, which later required more editing and reduction by me than they otherwise might have. I conclude that, in light of the pilot study sample of thoughts, which were produced under typical conditions (written statement) and were as a rule shorter that those in this study (verbalized statements) (see Appendix M). The effect of this choice was an increase in investigator involvement for the sake of greater continuity between the acts of case description and the listing of the thoughts. Another investigator might prefer the written format for its conciseness (which may be an artifact of the writing task) and for the resulting lower level of investigator contamination of the thoughts. I preferred to emphasize the ease of participant self-expression, which I believe enriches the content of the sample.

I find the major limitation of the thought listing procedure to be its inability to replicate or provide access to a process of a therapist's self-reflections in situations of failure. Reliance on units of thoughts suggests an empiricist position which is not shared by the guiding assumptions of this project, that is, that one can access the truth of a phenomenon by primarily examining its components. On the contrary, I consider the thoughts

produced by therapists not as existing in isolation, but as standing in relationship to one another. These relationships might be represented as a process or as a defining context.

The understanding and organization of the individual thoughts during the sorting procedures also appeared to be influenced by the thoughts being taken out of their original context. I observed some difficulty in the participants knowing how to assess the meaning of a statement when they did not know the statements that may have preceded or followed it. I often heard the words "well, where I place this would depend on. . .."

The above criticism of the thought listing procedure certainly does not invalidate its use here, but it does call for a qualification of the results and suggestions for ways to expand on these findings. Knowing that therapists have certain types of thoughts is an important piece in the investigation of therapists self-statements after failure. However, such a taxonomy is not a sufficient means of understanding how therapists' self statements might represent a <u>coping process</u>. It would be, therefore, important to augment the findings of this research with further explorations into the ways in which the meaning of these kinds of thoughts may or may not be influenced by their context in a series or set of interrelated thoughts. Thought listing would be unsuited

to such a task, which calls for a recording method, such as a Think Aloud Technique applied to a supervisory dialogue, for example.

Multiple Sorting Procedure

I found the Multiple Sorting Procedure to have produced necessary access to the explicit ways in which participants approached and organized the same set of items. As indicated earlier, for some this was a most unpleasant task, while for others it proved to be a satisfying learning experience. I am sure that research on the possible reasons for this variability could be fascinating for cognitive psychology, but I am not certain that it had any effect on the quality of the sorts.

Given the difficulty of sorting items more than once, it remains a question whether or not multiple sorts, as opposed to a single Q-sort, makes an important methodological contribution here. In effect, the majority of participants were in agreement on how to sort the thoughts the first time around. Do the additional sorts give us any more important information about the thoughts that therapists have and how those thoughts are understood? If one is interested in having access to qualitative information on the explicit reasons for similarity decisions, I have to respond with a resounding "yes!" The multiple sorting task has revealed not only that analyses and feelings are salient concepts along

which therapists might organize therapists' thoughts after failure, but also demonstrated some of the values therapists bring to the understanding of these thoughts.

Therefore, this method has revealed that the participants found it important, if not the most pressing of concerns, to assess the implications that therapists' thinking has on their practice. Thanks to this procedure, it is possible to suggest that many of these participants responded to the initial sorting of the thoughts inductively, by focusing primarily on the structure and content of the statements. This was followed in most cases by a second or third sort that was less inductive, guided more by their concern for the implications of the thoughts. This latter information in some ways is of greater value for the psychotherapy community than the former, because of its concern for the pragmatics of meaning in psychotherapy. As indicated elsewhere in this text, therapists seemed aware that their own ways of meanings (expectations, philosophies) impact on how they interpret therapy outcomes, and several felt that these meanings should be explicitly monitored.

Cluster and Multidimensional Scaling Analyses

I found the combination of the above procedures with the Cluster and Multidimensional Scaling analyses to have been a satisfying and theoretically consistent way of approaching the questions posed in this research. Each

approach to conceptualizing the data reflect certain biases (be they personal, structural or mathematical) that are successfully counterbalanced by comparison with the other approaches. The mathematical analyses provide expedient and reliably applied structures to the participants' sorting of the data, which make them desirable tools in any effort to explore discriminatory information or human concept formation. While MDS is a useful way of uncovering a low number of implicit dimensions or themes in a set of items, I have found the larger number of groups in a Cluster analysis to provide valuable information that can assist in the interpretation of MDS solutions. The latter may not be as necessary a component if one begins one's research with a specific theory one hopes to examine against the data.

The results of the mathematical analyses confirmed both the complexity of therapists' thoughts after failure and the interpersonal variance in individuals' conceptualizations of those thoughts. Nevertheless, these analyses have demonstrated with reasonable stability that therapists share to a modest degree certain ways of organizing this set of statements.

The Cluster and MDS methods of analysis are preferred for this kind of study because the variability discovered among individuals is understood as a sign of individual difference rather than as an error in measurement. The

confidence one can have in these results is strengthened by their appearance in all three methods used in organizing this data.

Summary

Overall, I have been very satisfied with the methods applied in this research project and with the results they helped create. I consider this approach to, in many ways, have modeled a process of a social construction. The self-statements and the processes of discriminating between them all took place amongst the same community of psychotherapists. I was clearly a part of the community, and essentially performed similar tasks, as I both sorted the actual statements to make an edited list and as I interpreted the MDS and Cluster groups much in the way that the participants had named the principles they used to sort the statements. These methods have enabled me, with moderate success, to achieve a "consensus on meaning" (Warnke, 1987), which was an overarching concern behind this research.

Perhaps a significant drawback for this kind of approach is that it is a labor intensive endeavor for both the investigator and the participants. I often caught myself wishing for a smaller, more easily sorted, less idiosyncratic set of statements, for that would have made everyone's task lighter. But now, with the work behind us, I consider the size to have been a small measure of

the complexity of a task that perhaps ought not to be oversimplified at the risk of losing that enriching complexity. I felt similarly about the MDS solutions, which may have been stronger had I used fewer sorters. What might I have sacrificed to gain greater certainty? When I consider that I began this process with the assumption that our self-talk and conceptualization processes are irrevocably complex and frequently idiosyncratic, I should be delighted with a process and results that confirm that expectation! Is that my personal preference for complexity speaking? One's biases do rather color one's approach.

Topics for Future Inquiry

There are several areas one could explore that would build on the results of this exploratory study. In some instances, the data from this research could be examined differently to yield new information. In other cases, the taxonomy of dimensions resulting from this project can be expanded or applied to address new questions. In all cases, these questions are designed to contribute to the development of a theory about the ways in which therapists cope with failures. The following is a list of some of the areas I would consider important to investigate in light of what has been described above.

1) Using the data from this study,

a) reanalyze only the set of "evaluative" sorts using cluster analysis and MDS to learn what kinds of groups emerge.

b) More formally categorize this study's actual thoughts after failure using the dimensions found here.

2) Reexamine the same two questions with different groups of therapists in order to learn if there may be yet other dimensions of thoughts after failures.

3) Using experienced therapists sample their evaluations of a selection of thoughts after failure: perhaps a structured Q-sort according to the principle of "constructive versus non-constructive thoughts to have." Inquire into the reasons for their placement of the thoughts.

4) Explore the development of concepts of failure and success in the supervisory relationship by means of production and sorting methods. And/or, facilitate the their development through an exchange of concepts, using sorting measurements early and late in the supervisory relationship.

5) Investigate the processes of self-talk used by therapists to understand treatment failures using the a think aloud procedure and dimensions to categorize the component thoughts. Use "mindfulness" theory to examine the processes.

6) Explore whether or not such factors as length of practical experience, satisfaction in the field, and therapeutic modality are related to the kinds or range of thoughts therapists report having when they fail/succeed.

7) In what instances do therapists question their fundamental assumptions about the treatment process, and when the do, what is the impact of that questioning?

8) How do the types of thoughts, the thought processes, and the rationales for treatment outcome interact to preserve/undermine therapists' core beliefs about themselves and their approaches to treatment?

I believe that questions 3-6 would prove most useful for the field of psychotherapy at this time, as it seems to be crying out for models on how to cope with failures in ways that do not shirk responsibility and at the same time do not overestimate the control of the therapist. The first two ideas for future research are concerned predominantly with expanding on this study's response to the original set of research questions.

The last two proposed topics express my ongoing concern for how we as therapists (and psychologists) come to "change our minds", if we do. These will not be simple undertakings. However, its purpose is strongly related to the concern we have for client change, that is for helping clients to change their minds about the nature of their experience and thereby improving their experience as human

beings. Another important factor to consider is that the altering of one's fundamental assumptions, as pointed out early in this document, may not always be beneficial. It behooves us to learn something about how these changes do or do not occur both in our clients and in ourselves as helpers and in what instances such changes should be our goal.

APPENDICES

APPENDIX A

THOUGHT LISTING INSTRUCTIONS AND FORMS

I AM INTERESTED IN LEARNING SOMETHING ABOUT THE RANGE OF WAYS IN WHICH THERAPISTS THINK ABOUT THEIR THERAPY FAILURES. I WOULD LIKE TO APPROACH THIS BY ELICITING FROM YOU THE THOUGHTS YOU REMEMBER HAVING HAD AFTER A RECENT INSTANCE IN WHICH YOU EXPERIENCED WHAT YOU WOULD CONSIDER TO HAVE BEEN A THERAPY FAILURE. I WOULD LIKE YOU TO RELY UPON YOUR OWN PERSONAL NOTION OF WHAT CONSTITUTES THERAPY FAILURE. LATER I WILL BE ASKING YOU DISCUSS THOSE AND OTHER RELEVANT DETAILS, BUT FOR THE MOMENT, I AM ONLY INTERESTED IN THE THOUGHTS YOU REMEMBER HAVING AT THE TIME AND NOTHING ELSE.

WOULD YOU NOW PLEASE TAKE A MOMENT TO RECALL ALOUD FOR ME THE MOST RECENT INSTANCE IN WHICH THE OUTCOME OF A PARTICULAR THERAPY PROCESS APPEARED TO YOU TO HAVE FAILED. IN OTHER WORDS, BRIEFLY DESCRIBE BOTH THE CLIENT'S PRESENTING PROBLEM AND ANY RELEVANT DETAILS ABOUT THE THERAPY PROCESS PRIOR TO THE MOMENT IN WHICH YOU IDENTIFIED IT AS A FAILURE. (record response)

WHAT I WOULD LIKE YOU TO DO NEXT IS TO LIST FOR ME THE THOUGHTS YOU REMEMBER HAVING UPON REALIZING THAT THE THERAPY HAD FAILED. I WILL BE RECORDING THEM, AS YOU SPEAK, ON THIS FORM. I'D LIKE TO ENCOURAGE YOU TO RESPOND AS CANDIDLY AS YOU CAN AND TO INCLUDE ALL THOUGHTS, NO MATTER HOW INSIGNIFICANT, UNUSUAL OR UNCOMFORTABLE THEY MAY SEEM. WHEN YOU HAVE FINISHED LISTING THEM, I WILL GO OVER WITH YOU WHAT I HAVE WRITTEN, TO MAKE SURE THAT I HAVE UNDERSTOOD YOU CORRECTLY.

Interview # _____

#1

#2

#3

#4

#5

#6

#7

APPENDIX B

PARTICIPANT INTERVIEW QUESTIONS

A) HOW DID YOU KNOW THAT THIS WAS A FAILURE?

B) WHAT DID YOU DO ONCE YOU KNEW THAT IT WAS A FAILURE?

C) DO YOU HAVE A WORKING GENERAL DEFINITION OF THERAPY FAILURE? IF SO, WHAT? IF NOT, WHY?

D) WOULD YOU SAY THAT THIS DEFINITION HAS EVOLVED FOR YOU? IF SO, CAN YOU SAY A LITTLE ABOUT HOW IT EVOLVED?

E) HOW DO YOU IMAGINE THAT THE THERAPIST WHOM YOU MOST ESTEEM WOULD DEFINE HER/HIS THERAPY FAILURES? WHAT MODALITY DOES SHE/HE PRACTICE?

F) WHAT WOULD BE YOUR TYPICAL RESPONSE TO FAILURES IN YOUR THERAPY?

G) HOW WERE YOU OR WEREN'T YOU PREPARED TO FAIL BY YOUR TRAINING IN PSYCHOTHERAPY?

H) WHAT ASPECTS OF THE ISSUES RAISED BY THIS INTERVIEW ARE OF PARTICULAR INTEREST OR IMPORTANCE TO YOU? ARE THERE ANY NOT RAISED HERE THAT YOU BELIEVE WOULD BE IMPORTANT TO ADDRESS IN THE FUTURE?

(record responses)

APPENDIX C

MULTIPLE SORTING PROCEDURE AND FORMS

MULTIPLE SORTING INSTRUCTIONS

I WOULD LIKE YOU TO LOOK AT THESE CARDS. ON THEM ARE PRINTED SINGLE STATEMENTS ELICITED FROM A INDIVIDUAL PSYCHOTHERAPISTS. THESE STATEMENTS REFLECT WHAT THESE THERAPISTS RECALL HAVING SAID TO THEMSELVES IN RESPONSE TO A THERAPY FAILURE. SOME OF THESE ITEMS YOU MAY RECOGNIZE AS SIMILAR TO YOUR OWN PREVIOUSLY SAMPLED STATEMENTS.

ONCE YOU HAVE LOOKED AT THEM I WOULD LIKE YOU TO SORT THEM INTO GROUPS IN SUCH A WAY THAT ALL THE THOUGHTS IN ANY GROUP ARE SIMILAR TO EACH OTHER <u>IN SOME IMPORTANT WAY</u> AND DIFFERENT FROM THOSE IN THE OTHER GROUPS. YOU CAN SORT THE STATEMENTS INTO AS MANY GROUPS AS YOU LIKE AND SORT AS MANY STATEMENTS INTO EACH GROUP AS YOU LIKE. IT IS YOUR VIEWS THAT COUNT. THERE MAY BE TIMES WHEN SOME OF THE STATEMENTS DO NOT FIT INTO THE OVERALL REASONING OF A SORT: IN THAT CASE YOU MAY WANT TO CREATE A "MISCEL-LANEOUS" PILE FOR THOSE STATEMENTS.

WHEN YOU HAVE CARRIED OUT A SORTING, I WOULD LIKE YOU TO TELL ME THE <u>REASONS FOR YOUR SORTING THEM THAT</u> WAY AND WHAT IT IS THAT THE THOUGHTS IN <u>EACH GROUP HAVE IN COMMON</u>.

WHEN YOU HAVE SORTED THE STATEMENTS ONCE I WILL ASK YOU TO <u>DO IT AGAIN</u>, THAT IS, TO SORT THE STATEMENTS ACCORDING TO THEIR SIMILARITY USING ANY <u>DIFFERENT PRINCIPLES</u> YOU CAN THINK OF. YOU WILL BE ASKED TO PERFORM THIS PROCESS <u>THREE</u> TIMES. PLEASE FEEL FREE TO TELL ME WHATEVER OCCURS TO YOU AS YOU ARE SORTING THE THOUGHTS. Should the participant indicate that they are having trouble coming up with a second or third way to sort the cards, give the following prompts: I OFTEN TELL PARTICIPANTS TO APPROACH THE THOUGHTS WEARING A "DIFFERENT HAT", THAT IS, PERCEIVE YOURSELF IN A DIFFERENT ROLE THAN YOU DID FOR THE PREVIOUS THOUGHT. OR, YOU MAY LIKE TO IMAGINE THAT YOU ARE LISTENING TO THE THOUGHTS RATHER THAN READING THEM.

THANK YOU VERY MUCH FOR YOUR TIME AND ASSISTANCE WITH THIS PROJECT. (Discuss sorting process; invite participant to be involved in final interpretation of the results; arrange meeting to go over results.)

SORTINGS: PARTICIPANT #

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	S1	S2	S3	S4
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	S1	S2	S3	S4
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PARTICIPANT #

SORT #.....:

REASON: .....

.....

CATEGORIES:

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2).....

3).....

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6).....

7).....

8).....

SORT #.....:

REASON:.....

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CATEGORIES:

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8).....

COMMENTS:

APPENDIX D

PARTICIPANT QUESTIONNAIRE

NAME: _____

AGENCY: _____

1) How many years have you been practicing psychotherapy?

Circle one: a) 1-3 b) 4-8 c) 9- 15 d) 15-

2) What professional degree do you have? Circle one:

a) MA/MEd b)MSW c) EdD/PhD d)MD

3) Were you primarily trained in a specific psychotherapy method? Circle: yes / no.

If so, what was that method:

a) Psychodynamic
b) Psychoanalytic
c) Client-Centered
d) Family Systems/Strategic
e) Expressive
f) Behavioral
g) Cognitive
h) Other ( )

4) What percentage of the time would you estimate that you practice any of the following therapeutic methods?

a) Psychodynamic.....%

b) Psychoanalytic.....%

c) Client-Centered.....%

d) Family Systems/Strategic.....%

e) Expressive.....%

f) Behavioral.....%

g) Cognitive.....%

h) Other ( ).....%

5) What percentage of the time would you estimate that you work with these clients:

a) Individuals.....%

b) Families.....%

c) Couples.....%

d) Groups.....%

e) Low socioeconomic clients.....%

f) Middle to high socioeconomic clients.....%

APPENDIX E

ACTUAL THOUGHT LISTINGS

SUBJECT #1

1) Failure to join with I.P. as much as with parents.

2) Fear to lose family if I would not join with parents first.

3) Inflexibility: sticking to the idea that family therapy may work and not considering the parent's request for individual attention to I.P. enough.

4) Rigidity about role of family therapist versus individual therapist for I.P.. I did not allow experiment with I.P. individually.

5) I was stuck in keeping trying to join with parents in the hopes of gaining more access to information, to no avail, however.

6) I did not address the referring context enough, consistently, i.e discuss and state the.....?....., their ambivalence about the referral, their growing disease/ discomfort with any inquiry, and continuous hostility and rejection in their affect and behavior.

7) I failed to be sensitive to sexual abuse issues between stepfather and IP and to favor more interaction between them.

8) failure to articulate and formulate in very concrete language the goals of each step/session in therapy to myself (team) and the family.

SUBJECT #2

1) I reflected on the first contact. Specifically, in the initial phone call, how I reacted defensively to the pt's narcissism. And how this felt like it became the "secret" paradigm for subsequent contacts.

2) I thought about the contract of psychotherapy. Both how I understand the pathology and how I offered a course of treatment that was insufficient.

3) I thought about treatment modalities, and my ambivalence and anxiety about never being sure what would be helpful.

4) I thought about differential diagnosis and how it might have been helpful to be more clear in my assessment of strengths and needs.

5) One thought was about my lack of experience with people like this client, and, yet, how I learned to both be a better therapist. also how I shouldn't work with certain patients.

6) I thought about my confusion as to what constitutes failure. If we remained stuck, but I made a good intervention in the end, could I feel okay about that?

7) I thought a lot about therapist anxiety centered on the inability to help someone, and how it is often acted out. Also, how it could be better contained by accepting my limitations.

8) On one hand I thought I sort of did something right around getting her terminated because it was not good what we were doing but what I was stuck with was: what did we do for one year? Did I do a real piece of work with her? I don't know if she'll see another therapist. I have no clues as to whether...all I know is that her life was a mess when she came in, its a mess now.

9) I felt really bad about myself as a therapist.

These are statements taken from the case review, not the thought listing.

a) When she ended, there was this incredible sense of relief on my part, because she'd been incredibly difficult to sit with.

b) I thought about the whole issue of neutrality. I became ambivalent (like the client) I could never make up my mind whether to be an analytical therapist with her or a support/confrontive therapist....So after a while I started feeling a little like her and that what I got stuck on in terms of failure: for a year I felt like I was floating out at sea with her and possibly making the problem worse.

c) I felt like my own character became embroiled in this in a way that didn't work.

d) I kept playing it over in my mind, back to that first phone call. (She pissed me off. I was sarcastic). I didn't even know who she was. There was something going on at the beginning that I didn't pay enough attention to.

SUBJECT #3

1) I felt a little upset. I was dismayed.

2) I felt that I had missed something there.

3) My expectation of what I could do exceeded what was possible with this couple. Therefore, I didn't do other things that might have been more helpful.

4) My overestimation of what was possible in the therapy resulted from my being emotionally moved by the tragedies in the clients' lives, which resulted in my not being more helpful.

5) I was also a little annoyed. I am always annoyed with people for being in crisis.

6) I remember turning myself off emotionally towards them, becoming cooler and distant. Rather than getting depressed and caught up in countertransference issues, I chose to turn off. I literally said to myself: they're not my clients anymore.

SUBJECT #4

1) Frustration: somehow I was not able to come up with the right words, the right metaphors, the right way of seeing things that she could hear what I was trying to say to her to help her.

2) After a time, and it was a long time, a year, I remember after the sessions just feeling exhausted, tired. I felt like I was trying too hard. And I believe that trying too hard doesn't really work.

3) Sometimes I felt tired during the sessions, when I'd hear her say the same things again I'd say: Oh no, here we go again! What can I say this time that's going to get through?

4) It was frustrating when she said that a session had been helpful and would come in the next time and present the same concerns all over.

5) I felt guilty for taking her money for this work, since I felt I didn't feel like anything was happening.

6) She was so unwilling to look at internal stuff, and could only talk about surface issues.

7) She was in an abusive situation, abusive to herself, and was not able to see how to change that.

8) She may be able to do more in therapy at another time.

9) There's more that needs to be done before she can be helped with her problems as she presents them.

SUBJECT #5

1) I think I felt upset that something that was done by me was misinterpreted by the client.

2) I felt threatened--she wasn't threatening, but I perceived it as a threatening thing.

3) Mixed feelings: on the one hand I'd felt she was working so well and was on her way to feeling better, and then it stopped and I wasn't going to be allowed to help her.

4) I didn't feel angry: I felt embarrassed. I may have stepped into a trap that was inadvertently set by her.

5) Maybe I should have been a little more aware of where she was at the time.

SUBJECT #6

1) I experienced a loss of objectivity, I wanted to absolve myself and shift the blame to the client's mother for interfering. (Which was not hard, since she had been the one to terminate the therapy between me and her child).

2) I felt suddenly cut off from a person I'd developed a relationship with.

3) I had feelings of sadness.

4) I was invested in really wanting to help this client, and now, because of some external factors I was being prevented from preceding with the process.

5) I also wonder, at what point along the line should I have done things differently. I began to think: "knowing what I now know, if I were to redo this situation, what would be the things that I would do differently. What can be learned from this.

6) Failures force me to look at things differently, and see what I may be taking for granted, reminding me that I need to be as fresh and thoughtful for each new alliance as I can.

7) How did my interaction with this person harm him; was it more harmful than therapeutic?

8) Did this failure confirm the client's belief that his condition can't be helped?

9) Failure, more than success, forces me to reflect on the whole therapeutic relationship and the responsibility that's involved in it; how what you did or didn't do had an effect on someone.

10) I wonder what really did happen to this client; what, if anything is he going into next?

11) Timing was a factor in the mother's decision to prematurely terminate.

SUBJECT #7

1) Where does one begin with all the different related issues of the client? Maybe I should have prioritized.

2) Maybe I should have contracted with her.

3) Maybe I should have separated my needs as a helper, "do-gooder" from what was therapeutic.

4) I was worried about the dependency issues I was fostering.

5) What is my role? I felt caught between my impulse to "fix" her problems and a theoretical orientation that says not to.

6) I looked at myself as part of the system and examined the ways I might have been colluding with her old sense of herself.

7) To what extent did our interaction result in her having new meaning in any aspect of her life?

8) Some new meaning did occur, but seemed like little in light of her many issues still left unchanged.

SUBJECT #8

1) I should have paid more attention to husbands discomfort, but I don't know what I would have done differently, since his discomfort had to do with talking about people's relationships.

2) Maybe I inadvertently invited them to leave by mentioning that as an option; presented them an either-or situation of his discomfort versus his daughter's improvement.

3) I felt bad that they dropped out.

4) I felt a little angry and confused about the father's decision.

5) Later on I felt maybe it wasn't a complete failure...how could they be the same?

6) I felt I had failed, didn't reach the family; it was my job to help them and I didn't.

7) I was worried about them; they seemed to be in a critical place--anything could have happened.

SUBJECT #9

1) She'd never been protected by her family; there was a lot of sexual, drug and alcohol abuse.

2) While I felt it was a failure, I would not abandon her like every else, and continued to see her.

3) We had a nice relationship; but she was very confused. She never really felt love. There was a lot of transference; she wanted me to be her mother and that couldn't happen.

4) I thought about what I could have done, but didn't think there were many other things I could have done.

5) I tried working with the family but it went nowhere.

6) I got caught up in wanting to save her, even though I knew I couldn't.

7) I knew she wasn't telling me a lot, and that I wouldn't know it.

8) In spite of all the collateral work I did with the school, they encouraged her to drop out at 15. Then I really felt like a failure.

9) It was tough.

10) Therapy was a good connection between client and myself, but the therapy was not a success.

11) She was too young to benefit from individual therapy, being in a process of being abandoned by her family; at that age, something has to come from the family.

SUBJECT #10

1) How did I get drawn into that argument?

2) I'm supposed to be a professional and I not acting that way.

3) I lost control, how did I get so out of control, so angry?

4) Maybe I'm in the wrong career field.

5) Supervisor wasn't much help; he gave me a real hard time.

6) I blew it, it was a significant failure on my part.

7) I need to think about my own anger and ego, and how I needed to manage them. I can learn from this.

8) This was embarrassing and painful for me.

9) Client may have given up on therapy and suffered long-term harm.

SUBJECT #11

1) I still don't know what is going on with client.

2) I'm not clear I could have done anything differently.

3) I feel a nagging that there was something there in the client or the system that I was not picking up.

4) I would feel hopeful, and then my hopes would be dashed.

5) I felt frustrated because client was so compliant.

6) Watching other helpers get angry saved me from getting angry with her. (Otherwise I might have felt angry).

7) I felt bewildered, and because I wasn't clear I kept changing my stance.

8) Perhaps if I had been less understanding, less caught up in empathy I might have been more helpful.

9) Client conned many people into seeing her as more functional than she really was, and I let her down by letting her do that to me.

10) I pride myself on working well with adolescents, but no matter how well I felt I was doing, it still appeared that I wasn't able to reach her.

11) At times I felt stupid; she was telling me something but I wasn't hearing her.

12) I felt sad, hurt, frustrated.

SUBJECT #12

1) This is yucky; I fucked up.

2) I hadn't paid attention to dynamics because of my stuff; I wasn't attending to my own issues.

3) I felt angry with her and with myself.

4) I felt relief.

5) I felt badly; I wanted very much to continue the work with her.

6) I felt sad, and I felt as thought I had failed her.

7) I had a wish to put it onto her at first, and then flipped it over and blamed myself personally, globally.

8) I got hooked into her projective identification.

9) I felt her issues were too close to my own, I was over-involved, too much of my own stuff, heart, for her. I sympathized with her situation.

10) As the alliance got built, I wasn't acknowledging our pathologies and their intersection.

11) I felt I wanted to save her, which I usually don't feel anymore.

12) Client projected blame for her situation onto me, and while I identified it as projective identification, I didn't use it in the sessions.

13) I was narcissistic in my sense of my knowing what she was feeling, in suggesting my wisdom from having already been through what she was experienced; all couched in an attempt to be helpful.

14) She was so terrified to let in the opinions of others, because that meant some loss to her.

15) I needed her to be healthier than she really was, because I was seeing many very disturbed clients.

16) I am aware of the vulnerability of clients when therapists are not paying attention to their own stuff.

SUBJECT #13

1) "You stupid shit" (to myself) and I was furious with him.

2) I was very surprised by his departure, and that helped me to reflect how I had not understood his capacities. He had a history of being saddled with having to appear healthier than he really was.

3) He'd responded well to a self-psychology modality and had gotten into a strong, idealized self-object transference, and therefore he saw me as someone to whom he could bring his needs, and I was a regulator for him. I failed him by not regulating his self-esteem, anxiety and his impulse to run.

4) While it was inevitable that I should fail him in some capacity, ideally it would occur in a non-traumatic way. Here the failure was that he no longer was there to work it through. His experience had been so devastating that he had to flee.

5) It may be that what I was seeing as his anxiety was mania. Did he leave because of that? I wondered what would have happened if I had talked about this with him?

6) He was such a mess, he never told me, and I never appreciated it.

7) Did he have to leave because I was never able to name the intensity of his experience?

8) He felt powerless, and he ended up leaving me feeling powerless: he left me feeling the kind of feelings he had.

SUBJECT #14

1) Initially I began to go home after the session feeling like a failure. At first I looked at factors outside the treatment for the cause of these feelings. Then it was identified as being connected to her with the help of my supervisor.

2) My feelings (of failure) may be a projection of what the client was feeling and how she wanted me to feel, a failure.

3) Part of it was real (my failure) since I'd run out of things to say, but it (failure) was also her theme.

4) At one point I got angry at her, which allowed me to set boundaries between us and to confront her about the treatment.

5) Before that, I identified with her and would get angry along with her at the people in her life.

SUBJECT #15

1) I should try harder, do more of rather than change what I'm doing. "Maybe I'm not.....; What am I leaving out?"

2) I should consult more.

3) I felt frustrated sitting with the family and with their lack of movement.

4) I begin to envision myself as part of the system.

5) I start not wanting to see them.

6) I wanted, then, to try something very different, like a purely behavioral approach.

7) I felt angry with the parents: frustration towards the father's alcoholism and mother's passivity and dependence.

8) I decided to put a hold on the family treatment, and consult with the son's individual therapist.

SUBJECT #16

1) It's not like an empathic failure, although that is not out of the question; it feels like I can't connect with, grasp her. She's elusive.

2) I have guesses about what is going on, based on my understanding of bulimics, but I'm not sure.

3) Whenever I make an intervention/interpretation, I feel like I'm not getting through; she won't let me in.

4) I find myself pulled in with adopted clients, by wanting to be their "best mother".

5) She's very devaluing, classic borderline.

6) I have trouble sleeping at night after I have met with her due to obsessive thoughts. I replay over and over our conversations and worry about next session; what I can say or do differently that may pull her in. My obsessiveness is a way, I think, of working out my anger at her, since I know it is inappropriate to be openly angry with her.

7) I've come to believe that Bulimics who become assymptomatic in the first year of treatment (no longer purge) become terrified of their surfacing feelings and experience the loss of their "drug", the purging. They seem fearful of losing their relationships.

8) I feel like the treatment has barely begun and they want to leave.

9) I fear that she will go back to having her symptoms; these are the kind of clients I rarely hear from later on, so I have no idea what happens to them after they leave.

10) I'm disappointed.

11) I feel angry.

12) I need to let go...even though I have an idea that therapy for her should happen in a certain way, everyone has their own time schedule. Maybe it is time for her to stop.

13) Since I believe the relationship is the most important factor in successful treatment, I feel like a failure when someone leaves prematurely.

SUBJECT #17

1) I felt horribly guilty, too guilty.

2) I felt totally inept in a way that paralyzed me as a therapist.

3) I reflected on all my previous cases and felt it was inappropriate for me to have been working with her.

4) I felt that I did not want to practice and that it was time to quit.

5) I felt I wanted to have more training and wanted to be analyzed before I practiced again.

6) I was terrified at the level of responsibility the therapist has for the client.

7) I didn't know what I was doing. I thought I had all the time in the world.

8) I think I gave her credit for being much healthier than she was because I was impressed with her degree.

9) Client got progressively worse during treatment and hinted at her desperation.

10) We didn't really have an alliance.

11) I didn't really hear her.

12) I wasn't able to call her on a thing.

13) It was another failure that I didn't insist on continuing to see client after client had been hospitalized.

SUBJECT #18

1) I was unable to hear what was happening with client's spouse as what was happening in the transference.

2) By holding the line (not engaging in chit-chat at a point where client's attention had shifted to topics related to me) I did the right thing therapeutically, but by not going into it, by responding crisply, I may have indicated to client that I was not someone with whom the client could safely discuss his fantasies.

3) We failed to continue to pursue meaning in the therapy; we no longer were exploring what things meant.

4) From some points of view, the treatment was successful: the symptom was relieved, client had a positive therapeutic experience, and it did not seem that client wouldn't be prepared to re-enter therapy some other time. But from my perspective the client stopped at an important point of working through an important part of the therapy: the transference. Therefore, I saw it as a premature termination and a therapeutic failure.

5) I felt a sinking feeling: "Gee, I'd better consult with someone about this therapy termination.

6) I was left with a feeling of something being quite unfinished.

7) There were some cues from the client that I might have engaged with differently, which would have enabled client to talk more directly about client's feelings towards me.

8) I found it difficult to engage in a helpful pursuit of client transference with the client. This difficulty may relate to countertransference issues, that is my fatigue, a difficult caseload, and other personal factors.

9) Client organization made it impossible to stay with me for reasons that may span from client's fear of a more regressive relationship in the therapy to client's simply being satisfied with symptom relief.

SUBJECT #19

1) I had the feeling of something unfinished, the natural process of saying goodbye that should occur face to face didn't happen. I felt a longing for something that didn't happen in the session.

2) All along I was thinking that I had never been able to get to the mother, to work on her issues with her mother in the therapy.

3) Looking back then, it seemed like a lack of connection.

4) I felt responsible for not naming the experience I was having sitting with her, the underlying quality of my experience, and thereby opening the door, interpreting it, recontexualizing it. That's the therapist's responsibility.

5) I was feeling badly. I felt regret.

6) Afterwards I did some thinking about how the boundary issues had been confused from the very beginning.

SUBJECT #20

1) I'm being used.

2) I'm bored.

3) I don't know what to do. Somebody else would know how to do this.

4) I shouldn't be doing this.

5) I knew I wasn't good enough.

6) If I were only more.....(brave, assertive, rude) (the following are thoughts that continue to be a way in which she understands therapy outcomes, while the above are no longer a serious response for her).

"At the time when I was thinking of this as a failure those (above) were the thoughts that I had. I also had a larger context in which I was thinking, if you're interested in those thoughts....[sure!]. Those are the same thoughts that I have all the time, they're not specifically relevant to this case. There's another half of me that focuses on all cases as working."

7) I can't know enough from seeing somebody one hour a week to know if anything is happening or not--my perspective is too small. There's no way I can know what things seem like to her. I didn't identify with her enough to imagine what effect I was having on her.

8) I don't believe in coincidences: so, she's here for something that I have to offer, whether I can see it or not.

9) Feeling bored and frustrated is how I react to feeling invisible...that's all my stuff, and it gets in the way of my being able to see her clearly.

APPENDIX F

EDITED THERAPISTS' THOUGHTS

1) I feel sad, hurt, frustrated.
2) I fucked up.
3) I feel really bad about myself as a therapist.
4) My sympathy for the client's situations and experiences blinded my judgement.
5) I want to be analyzed before I practice again.
6) I knew I wasn't good enough to be a therapist.
7) I had never been able to get her to really talk about mother, to work on her issues with her mother in the therapy.
8) She's very devaluing...a classic borderline.
9) I felt I wanted to save her, which I usually don't feel anymore.
10) I didn't know what I was doing. I thought I had all the time in the world.
11) I think that some new meaning may have occurred, but it seems like a little, in light of her many issues still left unchanged.
12) There was something going on at the first contact that I didn't pay enough attention to. It may have secretly become an influence in the therapy.
13) The client makes me feel like a failure.
14) If I had engaged with some of his cues differently, he would have been enabled to talk more directly about his feelings towards me.
15) I feel like I was trying too hard. Trying too hard doesn't really work.
16) I have been feeling bored with our sessions.
17) I needed her to be healthier than she really was, because I was seeing many very disturbed clients.
18) I'm disappointed.
19) I got hooked into her projective identification.
20) I feel like a failure when someone leaves prematurely.
21) I may have been inflexible: sticking to my own ideas about what would work and not listening to the client's.
22) I feel angry.
23) Somehow I was not able to come up with the right words, the right metaphors, the right way of seeing things, so that she could hear what I was trying to say to help her.
24) Maybe it was just time for her to stop.
25) There's more that needs to be done before she can be helped with her problems as she presents them.
26) We didn't really have an alliance.
27) She was so terrified to let in the opinions of others, because that meant some loss to her.

28) I really want to help this client, but am being prevented by external factors from proceeding with the process.

29) He was so unwilling to look at his internal stuff, and could only talk about surface issues.

30) Maybe I should have at some point prioritized the client's issues.

31) I don't believe in coincidences. So, she came here for something that I have to offer her, whether I am able to see what exactly that is or not.

32) I feel the need to absolve myself and shift the blame.

33) I am worried about them; anything could have happened to them.

34) No matter how well I have felt I was doing, it still appears that I haven't been able to reach him.

35) Maybe I inadvertently invited them to leave by even mentioning that as an alternative to the stress of a potentially successful therapeutic process.

36) I feel sad.

37) What can be learned from this?

38) I was very surprised by his departure.

39) My supervisor wasn't much help; he gave me a real hard time.

40) I feel suddenly cut off from a person I've developed a relationship with.

41) Is it a complete failure? I really believe that it was in the client's best interest that I admit I was not able to help him and terminate the therapy.

42) I feel relieved.

43) I feel horribly guilty.

44) I feel angry with the client and with myself.

45) I've needed to consult more.

46) What can I say or do differently that may pull her in?

47) I wonder whether I had been fostering the client's dependency on me.

48) I am terrified at the level of responsibility therapists have for their clients.

49) We had a good connection, but still the therapy didn't seem to help.

50) I feel guilty for taking her money for this work, since I feel like nothing is happening.

51) I failed him by not regulating his self-esteem, anxiety, and his impulse to run.

52) I've felt frustrated with the client's lack of movement.

53) Was he terrified of the feelings that were surfacing in the therapy?

54) I may have indicated to him that I was not someone with whom he could safely discuss his fantasies.

55) If I hadn't thought they were so capable, I would have tried different things that might have proven to be more helpful.

56) She conned me into seeing her as more functional than she really was, and I let her down by letting her do that to me.

57) I feel maybe it wasn't a complete failure...how could they go back to being the same after that?

58) The client may have given up on therapy forever.

59) I wish I could continue to work with this client.

60) He felt powerless, and he ended up leaving me feeling powerless: he left me feeling the kind of feelings he had.

61) I really feel like a failure now that all my collateral work outside the therapy has proven to be futile.

62) Looking back, we just didn't connect.

63) It feels like I can't connect with, grasp her. She's elusive.

64) I'm being used.

65) It was frustrating when she said that a session had been helpful and then would come in the next time and present the same concerns all over.

66) I shouldn't be doing therapy.

67) I feel a nagging that there was something there in the client or system that I was not picking up.

68) I wish I hadn't persisted so long in something that wasn't going to work out anyway.

69) I'm annoyed with them for being in crisis.

70) She was too young to benefit from individual therapy without the support of her family.

71) Whenever I've made an intervention/ interpretation, I've felt like I'm not getting through; she won't let me in.

72) She may be able to do more in therapy another time.

73) Maybe I shouldn't work with certain clients.

74) Did he have to leave because I was never able to acknowledge the intensity of his experience?

75) I feel upset that something I did was misinterpreted by the client.

76) I've been anxious and confused about what would be helpful, therefore, I've been inconsistent in my approach.

77) I feel cooler and distant towards them. They're not my clients anymore.

78) Did our interaction result in him having new meaning in any aspect of his life?

79) I feel something is quite unfinished.

80) I feel anxious, because, deep down, I feel I should be able to help everyone who comes to see me.

81) I didn't really hear the client.

82) Did this failure confirm the client's belief that his condition can't be helped?

83) How might my interaction with this person have harmed him?

84) I found it difficult to engage in a helpful pursuit of client transference with the client, which may have been due to: my fatigue; countertransference issues; my already difficult caseload; and other personal factors.

85) We failed to continue to pursue meaning in the therapy; we no longer were exploring what things meant.

86) I didn't pay attention to the dynamics because of my stuff; I wasn't attending to my own issues.

87) I failed to articulate and formulate in very concrete language the goals of each step in therapy to myself and the client.

88) My fear of losing the parents prevented me from joining effectively with the problem child.

89) I don't know what to do. Somebody else would know how to do this.

90) I did not openly discuss with them their ambivalence about the referral, nor their persistent hostility and rejection.

91) She wanted me to be her mother, and that couldn't happen.

92) Boundary issues had been confused from the beginning.

93) How did I get so out of control? So angry?

94) I should have been more clear in my assessment of my client's strengths and needs.

95) As the alliance got built, I wasn't acknowledging our individual pathologies and their intersection.

96) I may have been part of the system, colluding with her old sense of herself.

97) I'm supposed to be a professional and I'm not acting that way.

98) I've reflected on all that I did, and I'm not sure what, if anything, I would have done differently.

99) If I had been less understanding, less caught-up in empathy, I might have been more helpful.

100) I think the client terminated prematurely either because he was satisfied with symptom relief or because he feared deeper analytic work.

Thoughts removed after they had been sorted, prior to MDS Analysis:

82) I feel that I no longer want to practice and that it's time for me to quit.
75) I feel totally inept in a way that paralyzes me as a therapist.
78) I want to have more training.
103) I wasn't able to confront her on what I thought were important issues.
66) Maybe I should have contracted with her.
34) I suspect that she's not telling me about some kind of abuse, and that she never will tell me.
24) This is embarrassing and painful for me.
17) I am feeling badly. I feel regret.
11) I feel a sinking feeling.
5) I'm inexperienced with clients like this.

APPENDIX G

MULTIPLE SORTING RESULTS

PARTICIPANT # 19

SORT # 1

REASON: Whether a statement fit my experience of failure with this particular client (presented at phase 1 interview), so only those items that fit that experience were sorted together.

1) FIT my experience with this client.
2) Did NOT FIT my experience with this client.
3) I'm AMBIVALENT about these. They are interesting, and if I thought about them more, some might fit and others not.
4) These now fit my understanding, but only since our last meeting. I've been giving a lot of thought to my experience with this termination [of the therapy].

SORT # 2

REASON: In my role as supervisor, looking at: what one was doing with their experience, were they reflecting, blaming, expressing their feelings?

1) Therapist blaming him/herself, holding self responsible for the failure.
2) They're either blaming the therapy or the patient, an externalization, not willing to look at themselves.
3) Just a feeling tone without assigning meaning, no object and no meaning assigned.
4) Key pile: allows one to play with difference between internal and external. (I'd like to see myself saying some of these). More reflective in their intent, and attempt to assign meaning, play with ideas a little bit, hypotheses.
5) Reflective about self as a professional, but removed from the case.

SORT # 3

REASON: From the observational point of view, what is the object of these statements: the self, the therapy, the client?

1) Self as object, not just blame. This is about "I".
2) Patient without oneself in mind.
3) These put both self and client in the picture. Both and the therapy. Ideal. That's what I try to do; look at more than one side.
4) A real externalization, not to the client; takes it out of the frame of the therapy.
5) Externalization with the client, perceptually putting the client out.

PARTICIPANT # 4

SORT #1

REASON: Based on the particular part of an issue that a person looked at, a particular quality or point of view, maybe.

1) Failure in clinical practices (techniques, etc); clinical understanding.
2) Based on client-based failure, responsibility lies with the client.
3) Based on client's personal qualities, personalizing the loss.
4) Feeling angry toward the client or self; blaming, devaluing, demeaning.
5) Looking at therapy as a third entity, lies between blaming the self or the client.
6) Personal failure as a professional.
7) Looking for meaning in the failure; putting it in a bigger context, more philosophical.
8) Miscellaneous.

SORT # 2

REASON: Based on a sense of Time, either closing the experience off into the past, or allowing it to stay alive. Opening or closing to the experience.

1) Experience as encapsulated, as separate from on-going reality, locked into the past. Not something current.
2) A continuum, an ongoing issue. Relationship is still existing in the present. Acceptance of it being still alive. The end was not concrete, finite.

SORT #3

REASON: A sense of gut level feelings and a sense of professional feelings. Gut = more personal. Professional = more jargonese, distancing.

1) Gut level feelings, immediacy of feelings.
2) Distancing, professional jargonese, less immediate feelings.

PARTICIPANT #14

SORT #1

REASON: Based on what the therapist was internalizing in an emotional way, or intellectual way, and what the therapist was externalizing.

1) Therapist wasn't really in a meaningful relationship with the client. Feelings were more surface level. Failure wasn't such a big deal.
2) Therapist blaming it on other people outside therapy.
3) Therapist blames it on stuff with client, client's internal; stuff; makes assumptions about client's diagnosis and how that would lead to certain things in therapy.
4) Therapist rationalizing using professional lingo. "Lets be observational about this"; not putting it on self or anyone else.
5) Therapist rationalizing about themselves. Internalizing the failure in an intellectual way.
6) Nonrational emotional stuff. Therapist's own feelings.

SORT #2

REASON: How much hope or lack of it there is about failing in therapy.

1) Totally pessimistic. Therapist making judgements about their entire futures.
2) Pessimistic, but about immediate situation. A temporary feeling of hopelessness.
3) Emotionally neutral, statements don't tell you much about whether it's optimistic or pessimistic. Objective.
4) Hopeful statements about clients and the therapist's work.

SORT #3

REASON: Statements that reflect factors in the therapeutic process in descending order of informativeness.

1) Most informative statements on the therapeutic process.
2) Talk about being a therapist but not about the therapy process.
3) Talk about feelings and other factors that don't necessarily belong exclusively in therapy, could be made in any field about failure or disappointment.

PARTICIPANT #7

SORT #1
REASON: About failures: my fault,client's fault, locus of responsibility.

1) Client's responsibility.
2) Internal (therapist) responsibility.
3) Interactional responsibility.
4) Feeling states indicating failure.
5) Really external locus.
6) A reflection, no blame.

SORT #2
REASON: Statements and questions.

1) Clear statements, definitive.
2) Less definitive, more questioning statements.
3) Question and statement combined.
4) Questions with implicit statements contained in them.
5) Open-ended questions.

SORT #3
REASON: Thoughts and feelings.

1) Thoughts.
2) Feelings.
3) A thought that expresses a feeling.
4) A feeling that expresses a thought.

PARTICIPANT # 20

SORT #1

REASON: (Based on statement contents). About blame or responsibility and (based on statement form) feeling statements.

1) All feeling statements "I Feel".
2) How I fucked up. Specific things I did wrong.
3) General statements about my incompetence.
4) Why the responsibility lies with the client.
5) Silver lining (it wasn't so bad after all).
6) General statements without attributing responsibility.
7) Opposite of silver lining: looking back, things look worse rather than better.
8) Miscellaneous.

SORT #2

REASON: Things I would or wouldn't say.

1) Things I've said upon occasion.
2) Too specific to individual cases I've not had.
3) Things I haven't said.

SORT # 3

REASON: Useful or not useful thoughts to have (this sort occurred after the sorting had been discontinued due to the client's inability to come up with a third way of organizing these statements. It was cued by a discussion on the potential for this research to examine the positive or negative implications of certain kinds of thoughts.)

1) Might be useful thoughts; likely to be able to use these constructively.
2) Not useful.
3) Useful to notice, but not useful to be having. Provide information about what's not working.

PARTICIPANT #3

SORT #1
REASON: Feelings versus explanations.

1) Statements, expressions of feeling.
2) Explanations, attempts at understanding, explaining, rationalizing.

SORT #2
REASON: Subjective experiences.

1) Subjective. Statements of experience.
2) Subjective. Feelings in context.
3) Subjective. Statements of feeling that are open-ended, nondirective, reflections.
4) Miscellaneous (explanations).

SORT #3
REASON: Explanations.

1) Explanations of failure with the therapist implicated as responsible for the failure.
2) Explanations of failure with the client implicated as responsible for the failure.
3) Questions, reflections on the interaction between the therapist and client with no sense of blame. Open-ended.
4) Miscellaneous.

PARTICIPANT #9

SORT #1

REASON: Some I never would have said, some I might say, some are blameful, and others are constructive and nonconstructive doubts.

1) I never would have said these.
2) These I might say, when I am frustrated or not doing as well as I'd like.
3) Blameful of the client.
4) Are about the relationship.
5) Doubts: I don't think they are very constructive.
6) These may be more constructive doubts.
7) Statements about me, the therapist, that may or may not be helpful.

SORT #2

REASON: I sorted for feelings of total failure.

1) Feelings of total failure.
2) Hindsight, second-guessing.
3) Hindsight, but are more positive.
4) Feelings.
5) Silly.
6) I don't like this one, it is too blameful.

SORT #3

REASON: Responses to feeling like a failure.

1) Beating yourself up for feeling like a failure.
2) Justification for feeling like a failure.
3) Taking responsibility for feeling like a failure.
4) Learning from feeling like a failure.

PARTICIPANT #2

SORT #1

REASON: Type and level of analysis: focusing on the therapist, the client, the relationship, or other factors outside the therapy.

1) Client-blaming; locus of the problem is found in the client pathology.
2) Something about an analysis of countertransference; more responsibility given by the therapists to themselves for the failure.
3) My favorite: an analysis of the relationship. It feels more dynamic.
4) Most are about how the therapist feels; have to do with the countertransference, but are not analyses of it. They seem final, unalterable.
5) A metaphysical response.

SORT #2

REASON: Issue of a learning experience; whether or not there is a receptivity to learning.

1) Open to learning from the experience.
2) Defensive and therefore not open: expressions of guilt.
3) Defensive and therefore not open: expressions of paranoia.
4) Defensive and therefore not open: undifferentiated in terms of guilt or paranoia.
5) Miscellaneous.

SORT #3

REASON: Mature versus not mature responses.

1) Mature; protective of both the client and the therapist; looking at the whole picture.
2) Grandiose; an overconfidence in the therapist's technique; not quite looking at the whole picture.
3) Depressive: too great an emphasis on the therapist for the client, a kind of narcissism.
4) Miscellaneous.

PARTICIPANT #5

SORT #1
REASON: (unstated).
1) Therapists feelings of failure.
2) Therapist feeling like they did things that were not helpful; focus on feelings about what the therapist did.
3) Putting blame on the client for the failure. Devaluation of the client.
4) Similar to #2, but here the therapist missed something.
5) Self-doubts, therapist needs more help, no guilt or blame.
6) Feeling about the negative impact on the client of the failure.
7) Surprise, therapist caught unaware.
* 8) Learning. 42
* 9) Blaming someone outside therapy. 44
10) Need to deal with easier issues.
11) Florence nightingale effect: needing to help everyone.
* 12) No guilt. Defensive? 108
* 13) Relief. 47
14) Concern about client.
* 15) Pollyanna. 87

(* means placed in a miscellaneous pile, due to the fact that there were only one item in each.)
Pile #16=miscellaneous.

SORT #2
REASON: How people were using first person pronoun, or making it a couple, and some things that put the focus on the client.
1) "I" statements.
2) "me" statements.
3) "my" statements.
4) "we" statements.
5) Statements on an "other", without the self involved.

SORT #3
REASON: Statements referring directly to the therapy context in the use of subject/object forms, and statements that are not necessarily unique to the therapy experience.
1) Statements that have the word "client".
2) Statements that have the word "therapy".
3) Statements that have the words "therapy and client" both.
4) Statements that have the word "therapist".
5) Non-therapeutic or client statements. You could look at these and not realize that they have anything to do with therapy.

PARTICIPANT #6

SORT #1

REASON: Generally dealing with responsibility for failure.

1) Therapist accepts responsibility for the failure.
2) Therapist putting blame onto the client.
3) Reaction pile: expressions of Feelings.
4) Lack of training/supervision/preparation.
5) Complete self-doubt.
6) Factor "X" was responsible for the failure, something outside the therapy.
7) Concern for the outcome of their work on the client.
8) Shared responsibility for the failure: it was "us".
9) Confused responses; I don't quite understand how to categorize them.

SORT #2

REASON: (none given).

1) Self-examining; the therapist questions the self.
2) Inexperience.
3) Self-accepting statements, feelings with a sense of openness.
4) Feelings that therapy is not what they should be doing.
5) Statements the pertain to over or under-estimations of the self or the client.
6) Feelings of loss.
7) A sense of labeling.
8) Recognition of the responsibility of therapy.
9) An issue of the timing not having been right.
10) Miscellaneous.

SORT #3

REASON: (none given).

1) Procedural pile: questioning one's procedures.
2) Questions own suitability for doing therapy.
3) Inexperience.
4) Lack of trust in the relationship.
5) Lack of objectivity.
6) Feelings of genuineness.
7) Therapy process-oriented.
8) Shouldn't be doing therapy.
9) Loss.
10) Deep concern for client welfare.
11) Acceptance of responsibility.
12) Timing wrong, no blame.
13) Miscellaneous.

PARTICIPANT #15

SORT #1
REASON: Blame and who gets blamed.

1) Therapist blames self.
2) Therapist blames client.
3) Factors of timing, things outside therapy, supervisor.
4) Feelings after the fact; don't attribute blame.
5) More philosophical responses, philosophical mandarins.

SORT #2
REASON: Language difference in systemic and linear thinking.

1) Language describes more of a linear way of thinking, and therapist in a power position with the client.
2) Language reflects more of a systems thinking and less of a one-up/ one-down position between the therapist and the client.
3) Miscellaneous.

SORT #3
REASON: Differences in feeling and thinking: cognitive failure and failure in emotional connection.
1) Therapist blames self and client: failure due to a thinking process that wasn't right, and intellectual failure.
2) Therapy failed because of some emotional factor from either therapist or client.
3) Seemed not to really differentiate between cognitive or emotional lack in these.
4) Feelings after the fact.

PARTICIPANT #8

SORT #1
REASON: A responsibility sort.

1) Therapist taking primary responsibility for failure and trying to explore it.
2) More weighted toward blaming the client, although there are some in here where it's not clear if that is completely the case.
3) Therapist emoting, not blaming or exploring.
4) Blaming factors other than the client or the therapist.
5) Worry: what will happen to the client.
6) Taking on of responsibility that goes over the edge to "I'm worthless"; less analytical about the failure.
7) Looking at it differently, not blaming; looking at what does it mean other than "failure."
8) Feelings, but not bad ones, not agony.
9) Looking at a bigger picture of what it means to be a therapist.

SORT #2
REASON: Blame self.

1) Any statement that indicates self blame.
2) Therapist totally blames the client: client pathology is the issue.
3) Feelings by therapist that aren't blame or guilt.
4) Analytical, defensive work, no guilt.
5) Anything good that the therapist can see coming out of this.
6) Miscellaneous.

SORT #3
REASON: Statements I would or wouldn't say.

1) Statements that I can imagine myself making.
2) Statements that I can't imagine ever coming out of my mouth.

PARTICIPANT #10

SORT #1
REASON: I feel connected versus not connected with these thoughts.

1) These I really connected with: about me fucking up on this particular case, included some statements that blame the client!
2) I connected with these, but not in this particular case of my therapy failure.
3) These I don't connect with.

SORT #2
REASON: Subjective versus objective thoughts.

1) When I'm being over responsible and blaming: too subjective.
2) When I'm being more objective.

SORT #3
REASON: Statements that might be made either by me as an experienced or as an inexperienced therapist.

1) Experienced.
2) Inexperienced.

PARTICIPANT #16

SORT #1

REASON: Some self blame, some complete self blame, some interaction blame, some countertransference, etc: Guessing about the reason form failure.

1) Complete self-blame, feel they should leave the field.
2) Being left.
3) Therapist has been left and is pondering the reasons.
4) Therapist basically feel they did a fine job, and can't see how they had anything to do with the therapy failure.
5) Wondering about the underlying reasons for the therapy not working, without a lot of self blame, but also allowing for their own contributions.
6) Countertransference.
7) Wondering if the therapy had any effect at all.
8) Questioning the communication and whether or not there had been a relationship.
9) Blaming externals.
10) Self-blame: needs more education.
11) Self-blame: feeling helpless.
12) Pure affect.
13) Blaming the client.

SORT #2

REASON: (unstated).

1) Therapist left with feelings; still ruminating, the affect is still there.
2) Appears as if the therapist is left with no feelings. "It's over; time to move on".
3) Wondering, story-telling: trying to imagine and explain what happened.
4) Remorse, regret, pining away, if-onlys, wondering if something could have been done differently.

SORT #3

REASON: How do they reflect growth on the part of the therapist?

1) Statements where I feel you can't really grow from these.
2) Ambiguous; helpful if you work with them, but not if you stay stuck in them.
3) Could be a really stuck statement or could reflect serious growth: the decision to give up doing therapy.
4) Growth statements: what can be learned from this?

PARTICIPANT #17

SORT #1
REASON: (none given).

1) Therapist theoretical view of what went on.
2) Therapist affect.
3) Therapist self-doubt.
4) The wish to know more.
5) It's not the therapist: it's either the patient or somebody else.
6) The therapist's inability to be helpful with that particular patient.
7) Reflections.

SORT #2
REASON: The quality of the statement.

1) Definite statement: therapist presents it as "true". They "know" this.
2) Questions, with no effort to answer them.

SORT #3
REASON: Where the therapist focuses: where and whom they focus on.

1) Attention is on themselves.
2) Attention is on patient.
3) Attention is on relationship between therapist and patient.

PARTICIPANT #11

SORT #1
REASON: Who's the focus of the blame.

1) Giving reasons why it didn't work that have something to do with the patient.
2) Therapist not paying enough attention.
3) I was somehow responsible.
4) Client was incapable (not blaming).
5) "Well, what's the meaning of life?" questions.
6) I'm so bad, I should be shot.
7) I'm not real good, I'm not going to quit, but I need some help.
8) We didn't have a good connection.
9) I'm going to protect myself with all sorts of bullshit.
10) It's all her fault and it pisses me off.
11) The whole enterprise is scary to me.
12) I just feel sad.
13) I don't care.
14) It was a mess from the beginning.
15) I need more training.
16) It feels unfinished.
17) It really wasn't a failure, maybe.
18) I should've changed my technique.
19) I fucked up!
20) Nobody helped me.

SORT #2
REASON: Between something said in supervision to those written up more distantly in a journal.

1) Statements you would find written for publication.
2) Statements you would find spoken in supervision.

SORT #3
REASON: (none given).

1) The world is a controllable place, and if I had done something right, the therapy would have been a success. Therapy can be controlled.
2) La dee da! We don't really have control over people.

PARTICIPANT #13

SORT #1

REASON: An endeavor to make some kind of meaning from the specific to the general. There were repeated locus statements, and also "I can't make meaning" statements.

1) How am I defining failure? Making sense of the specific failure.
2) Self as locus; self affect about the experience.
3) Self as locus: making the self responsible.
4) Self as locus: something about the self in relation to the clinical process.
5) Patient as locus: a kind of blaming.
6) Patient as locus: something about the clinical process via the patient.
7) A more general meaning made out of the experience.
8) "I can't make meaning out of this"; a sense of confusion and helplessness on the part of the therapist.
9) A third party.
10) The relationship.

SORT #2

REASON: The voice of shame.

1) Clear statements of countertransference, therapist resistances.
2) Guilt and the desire to be absolved.
3) About hiding...shame and depression. The experience of the discrepancy between one's ego ideal and where one is.

SORT #3

REASON: Aspects of the unconscious struggle. Some express an early, more primary process frustration, while others are more present, developed, grown-up. "This is all such a muddle to me. I know it either in a primitive or in a grown-up way." They are all, we are all talking about ourselves.

1) Early frustration and suffering. A child's way of dealing with painful experiences.
2) A more grown-up way of dealing with painful conflicts.

PARTICIPANT #12

SORT #1
REASON: (none given).

1) How a therapist feels about herself as a therapist doing therapy. How she views herself as a therapist.
2) How a therapist feels about the dialogue with the client, the mutuality and connection between them.
3) Self-statements about herself.
4) Client-focused thoughts, devoid of interaction with the therapist.

SORT #2
REASON: Black and White!

1) Neutral, what one would say as a therapist who was not overinvolved. Clear, healthy.
2) Statements that the therapist says when she can't see clearly, has too much unresolved and takes too much on. Self-concept problems.

SORT #3
REASON: (none given).

1) Example of a very punitive superego view of working with a client.
2) Acknowledges that failures are based on the interaction with the client.
3) Without blame; self-statements without blame.

PARTICIPANT #18

SORT #1

REASON: Different types of failure:technique, judgement, self-analysis, case management. The technical aspects of failure. Failure at their craft, plus the more immediate emotional kinds of reactions.

1) The emotional experience from the impact of the termination.
2) A range of self-flagellations: reveal a kind of collapse of therapist self-esteem in the face of their loss. A therapist in crisis.
3) Turning to an outside authority; suggest that some help from outside could change the course of things. Need for consultation.
4) Attacks on the character of the patient. What brought them to therapy is blamed for the failure. (I think that blame needs to be externalized before a higher level of understanding can be attained and learning can take place).
5) Problems in the initial formation of the alliance. The seed didn't sprout or take root, something is built in that causes the therapy not to work.
6) Something outside the therapy sabotaged the treatment.
7) Failure in relationship after it has been established. Involve a misperception of the client or the client is keeping something central to the therapy outside the room.
8) Therapist failed the client because of own humanity, their countertransference.
9) Fate.
10) Therapist may have subtly ended treatment because she/he felt frustrated with the client's unchangeability.
11) Failures in approach, craft, technique across different schools. A breakdown in competence of the therapist.
12) Statements having to do with consequences of failure; unfinished business.
13) Questions into what was really going on, what can be learned from this.

SORT #2

REASON: How one feels, makes sense of the failure. What's the impact of that.

1) Feelings: understanding in terms of something not happening. Cool, detached.
2) Feelings: therapist being helpless.
3) Feelings: therapist being in the wrong profession.
4) Feelings: sadness and disappointment that something has come to an end before its time.

PARTICIPANT #18 continued,

SORT #2 continued

5) Feelings: frustration that the therapist couldn't help the client, feeling powerless, that the therapist should be helpful.
6) Questions concerning the long term harm or benefit to the patient, with focus mostly on the harm.
7) Idea that therapist should have come up with the right words.
8) Therapist couldn't hear the client for a variety of reasons pertaining to the therapist.
9) Feeling angry with the client. The client has hoodwinked the therapist.
10) Initial joining up was a problem, persistent difficulty due to a crack in the foundation early on.
11) Patient is just obstructionistic, they don't want to talk about what's inside.
12) The client was scared.
13) "I don't knows".
14) Inexperience of the therapist.
15) Miscellaneous.

SORT #3
REASON: (none given).

1) Gut reactions, immediate, without reflection.
2) Questioning own conduct, might she/he have done something differently.
3) Assessments of patients' misconceptions of therapy, their failure to be good clients.
4) Getting at the mutual contribution, trying to understand the interaction.
5) Blameless situation, difficult, but blameless.
6) Outside faction failed the therapeutic alliance.
7) Miscellaneous.

PARTICIPANT #1

SORT #1

REASON: Amount or nature of participation that was discussed by the therapist.

1) Criticism of one's most specific errors or failures and omissions.
2) Generalized description of the impasses or failures with taking some responsibility by therapist in some vague sense (i.e., not specifically).
3) Only discussing the patient's share of the participation in the failure (not necessarily negatively).
4) Very simple and generalized feelings and reactions of the therapist.
5) Feeling reactions that are attacking the professional identity of the therapist.
6) Very current emotional concerns about the left-overs of the failure.
7) Generalizing reflections about what may have been learned from the case.
8) Structural or external contributors to the failure.

SORT #2

REASON: We, They/him/her, and me.

1) Discusses the interaction, the participation. Uses the word "we".
2) Discussion of the client's participation in the failure.
3) Discussion of the therapist' participation.

SORT #3

REASON: (none given).

1) Critical analysis of the client's share.
2) Critical analysis of the therapist's share.
3) Questions about the failure.
4) Reflection, outlook.
5) Description of current emotional status of the therapist.
6) Current emotional reactions of the therapist about own professional competence.
7) Description of emotional states of therapist in connection with the client.
8) Current emotional reactions giving partial responsibility to the client.
9) Conclusions and actions to take and recommendations.

APPENDIX H
INFORMED CONSENT FORMS

Counseling Psychology
School of Education
University of Massachusetts
Amherst, MA 01003

INFORMED CONSENT FORM

You are invited to participate a ground-breaking study that intends to inquire into the ways in which therapists think about their experiences with failure in their psychotherapeutic practices. It is an exploratory venture into an area about which we know very little at this time, and thus calls for not only an open format but the on-going reflections and critical comments of its participants. Participants' reactions to and questions about the research content and procedures will be considered to be valuable and informative resources by the investigator. Because of the nature of this project, participants will have the roles of co-experts in the investigation of therapists' understandings of failure in psychotherapy.

During the first phase of the study participants will be asked to recall a recent failure with a client and the thoughts they had at the time. These thoughts will make up the sample of a range of possible thoughts after failure. Besides this range of possible ways of thinking after a therapy failure, the project hopes to learn something about the ways these thoughts can be organized. Therefore, the second phase of the study will involve participants in tasks designed to elicit the possible dimensions of thoughts following therapy failures. At the end of phase two you will be asked whether or not you would like to volunteer for the third and final phase. This will involve a meeting with me and with other participants to interpret the dimensions of sampled thoughts after failure that make up the results of the data analysis. These tasks are estimated to require approximately 2-4 hours of your time spread out over two to three separate sessions, depending on whether you volunteer for the final phase. The minimum involvement should not require of you more than two one-hour sessions to take place at your worksite.

The participants in this study will not be placed at any personal, physical or professional risk and all participants' identities will be held at their request in strictest confidentiality. The only participant demographic information to be reported with this study will pertain to general, non-identifying characteristics such as; years of practice, preferred treatment modality, gender. Specific client identifying characteristics will not be used in the study and all client information divulged in the first phase of the study will be considered strictly confidential.

Some potential benefits that may be incurred from participating in this study would be that individual participants will have an opportunity both to learn something more about their own processes of understanding failure and to gain some insight into how their interpretations of failure relate to those of others in the therapeutic community. Participants will also have the opportunity to participate in a research project in which the research process is a learning process for both the participants and the investigator. Unlike many studies in which "subject naivete" is desirable, this project considers participants to be co-experts and co-learners along with the investigator.

Your signature below indicates that: 1) you have decided to participate in the first two phases of this study; 2) at the end of the second phase, you will notify the investigator that you will or will not continue your participation on into the third phase; and 3) you have read and understood the information in this consent form. If you decide to participate, you are free to withdraw consent and discontinue participation at any time without prejudice. If you desire a copy of this consent form, one will be provided for you.

Thank you very much. I look forward to working with you.

_____ _____

Participant's signature Date

_____ _____

Principle investigator Date

Counseling Psychology
School of Education
University of Massachusetts
Amherst, MA 01003

INFORMED CONSENT FORM
PHASE TWO

You have been invited to participate in the final, interpretive phase of this investigation into therapists' understanding of therapy failures. Your role in this phase is essentially that of a co-consultant to the investigator in the interpretation of the results of the data analyses. In your role, you will be collaborating with the investigator and several other therapist/ participants like yourself. Therefore, the confidential nature of your participation in the study will be affected. In light of this change, all participants in this phase will be asked to agree to maintain strict confidentiality concerning the identities of all co-participants. It is expected that this procedure will require about 1 1/2 to 2 hours of your time and that the single meeting required to accomplish this task will take place on the University of Massachusetts campus.

The specific tasks of this phase are to interpret the results of a CLUSTER ANALYSIS and a MULTIDIMENSIONAL SCALING ANALYSIS of the thought-sortings gathered in the first tow phases of this study. Each participant will be provided with computer printouts of the above data analyses, a list of the data (thoughts) used in the analyses, and a compilation of all the concepts and categories generated by you and other participants during the sorting task. Through a process of comparative analysis, in which you will be guided by the investigator, the clusters and dimensions will be given names. The ideas for these names will be cooperatively generated by you and your co-participants. The specific names or concepts to be used in the final interpretation of the results of this study will be decided through a process of dialogue amongst the participants and investigator. The person held responsible for guiding and resolving the process will be the investigator.

The participants in this study will not be placed at any personal, physical or professional risk and all participants identities will be held in strictest confidentiality outside the circle of this phases's co-participants. A potential benefit from participating in this phase is the learning that will result from the proposed cooperative process of interpretation. It will

also be an opportunity to follow this relatively new form of research investigation from its beginning to its resolution. While the final decision as to the content of the analysis is the responsibility of the primary investigator, your insights and understanding of the material and your experiences in the process form the basis for that decision. Finally, I believe that, if your curiosity has been aroused by this study so far, participation in its final phase is a unique opportunity to come away from this process having gained new insights into your own and other therapists' ways of understanding therapeutic outcomes.

Your signature below indicates that: 1) you agree to participate in the final phase of this study; 2) you have read and understood the information in this consent from; and 3) you will maintain the strictest confidentiality of the identities of your co-participants during the study and after its conclusion. If you decide to participate, you are free to withdraw consent and discontinue participation at any time without prejudice. If you desire a copy of this consent form, one will be provided for you.

Thank you very much. I look forward to working with you.

_____ _____

Participant's signature Date

_____ _____

Principle investigator Date

_____ _____

Signature of witness Date

APPENDIX I

PARTICIPANTS' INTERPRETIVE PACKET

SUSAN E. HAWES, Ed.D. candidate
Graves Road
Conway, MA 01341
(413) 369-4992

May 5, 1989

Dear

I have finally been able to have the thought-sortings, that you and the other participants in this study performed, analyzed by computer! Because you responded positively to my invitation to participate in the interpretive process, I'm writing to follow-up and let you know how I have decided to pursue this. Essentially, time is running short for me to finish this project in time to graduate this summer, and so I am forced to ask you to perform this final task by mail rather than in person. I am sorry not to have the opportunity of meeting with you once again for this, as I have so appreciated your comments and insights. I hope that this "mail-response" format will be less of a drain on your busy schedule. Let me add, however, that if you find that you want to discuss something with me directly, please call me collect some evening. I would be delighted to talk anything over with you!

I have included here several pages of information for you to view and respond to. They are:

1) An assortment of categories and sorting principles created by you and your fellow participants. (page one).

2) The Cluster Analysis Plot.

3) The Multidimensional Scaling Plots and Statements.

4) My ideas as to possible interpretations of the dimensions and clusters (3).

5) A form for you to use to suggest your alternatives to the one's I've put forward.

6) Etc. (Informed Consent and a Final Question).

What I would like to ask you to do, if you are still interested, is the following: The purpose of this exercise is to come up with <u>names/terms to describe the cluster and multidimensional scaling results, as the goal is to come up with some understanding of the overriding kinds of thoughts after therapy failure we have</u>. There-

fore, I would first like to ask you to look over the pages in order of appearance (1-4), noting your impressions as you go on the form provided (5). (Due to space limitations, I have not listed all of the specific thoughts as they appeared on the analyses, but have included those that appear to be most representative. I would like you to use as ideas for naming the dimensions and clusters your own intuitions in combination with the sorting responses (1) and my suggestions (4) in an effort to come to some consensus. You may find yourself moving back and forth between all the information I've provided in an effort to come to a solution, or you may find that the ideas come to you quickly. Once you have arrived at your interpretation, please write in on the form provided (5). I would also welcome any comments you have, and I have provided space for them on the form. I have included one <u>final question</u> on the form for you to respond to, as well as another "Informed Consent Form".

Please do not spend more than 1/2 to 1 hour on this! If you are taking longer, you are working much too hard. <u>I am essentially asking you to confirm and/or critique/ supplant my interpretation of the data, not more.</u> Lastly, feel free to withdraw at this point. I recognize that you have very full and demanding schedules, and that you have already contributed enormously to this research.

I cannot thank you enough for all the time you have so generously given to this project. I sincerely hope that I can pull together a dissertation worthy of its participants!

<u>I need to ask that you mail your response back to me no later than May 15, 1989. Otherwise I will be unable to include it in the final draft of the dissertation.</u>

Best of luck. I will be back in touch when the project is over to share with you the results.

Sincerely yours,

Susan Hawes

TABLE OF CONTENTS

The following are contained in this packet. You can read or complete them in the order presented below.

** Please send this back to me in the enclosed, stamped envelope, whether or not you participate in this part of the study.

* Please send only these and the above forms back to me in the enclosed, stamped envelope.

SAMPLES OF PARTICIPANT SORTINGS

The following are a selection of the reasons used by the twenty participants in this study to sort the "thoughts after therapy failure".

1) Locus of Responsibility (Blame) for the failure/Focus of the therapist's concern:
Some Typical Groupings: Self, Self as Therapist, Client, Outside others, Interaction or match between Therapist and Client, Reflections that harbor no blame (philosophical), and Expressions of eeling.

2) From types of Feelings to Explanations/Gut-level responses to distant "professional" comments.

3) Evaluative Sorts, for example:
* Useful (constructive) or not useful (blameful) thoughts to have;
* Do or don't reflect receptivity to learning from the experience;
* Mature or immature statements;
* Voices of experience and inexperience;
* Responses to Feeling like a Failure (from beating oneself up to learning from the experience;
* Neutral (objective) or overinvolved (too subjective)
* From blameful to non-blameful, with one group acknowledging mutual responsibility.

4) The statements do or do not fit my (sorter's) specific experience/ "Things I would or wouldn't say".

5) Hopeful and Pessimistic Thoughts.

6) From statements that are informative about the therapy process to those that could be made in any other context.

7) Questions and Statements.

8) Language reflects differences in systemic and linear thinking.

9) Statements acknowledge failures in thinking and feeling processes.

10) Statements you would find written for publication and statements that might be spoken with a supervisor.

11) Statements that reflect a belief that the world is controllable and those that do not believe we can control people.

12) The voices of shame and of guilt.

CLUSTER INTERPRETATION

Introduction:

The cluster analysis has made a hierarchical interpretation of the ways in which all of you sorted the 110 thoughts last time we met. The thoughts are grouped according to their similarity to one another in descending order of generalizability, that is, from the most general of groups (1 & 2) to groups of greater specificity (10-17). I have reviewed and interpreted these results, but would also like to gather your impressions.

The enclosed plotting of the cluster analysis is somewhat abridged, both in number of thoughts included and the number of clusters, in order to make your job more straight forward. You may want to begin by examining the two most general groups by reading the thoughts organized under those categories. Once you have named them, you can begin to understand the more specific groupings, in descending order or however you prefer.

You may want to consider some of the sorting categories used by you and the other participants to suggest possible interpretations of the groups, or you may simply with to respond intuitively. It's up to you.

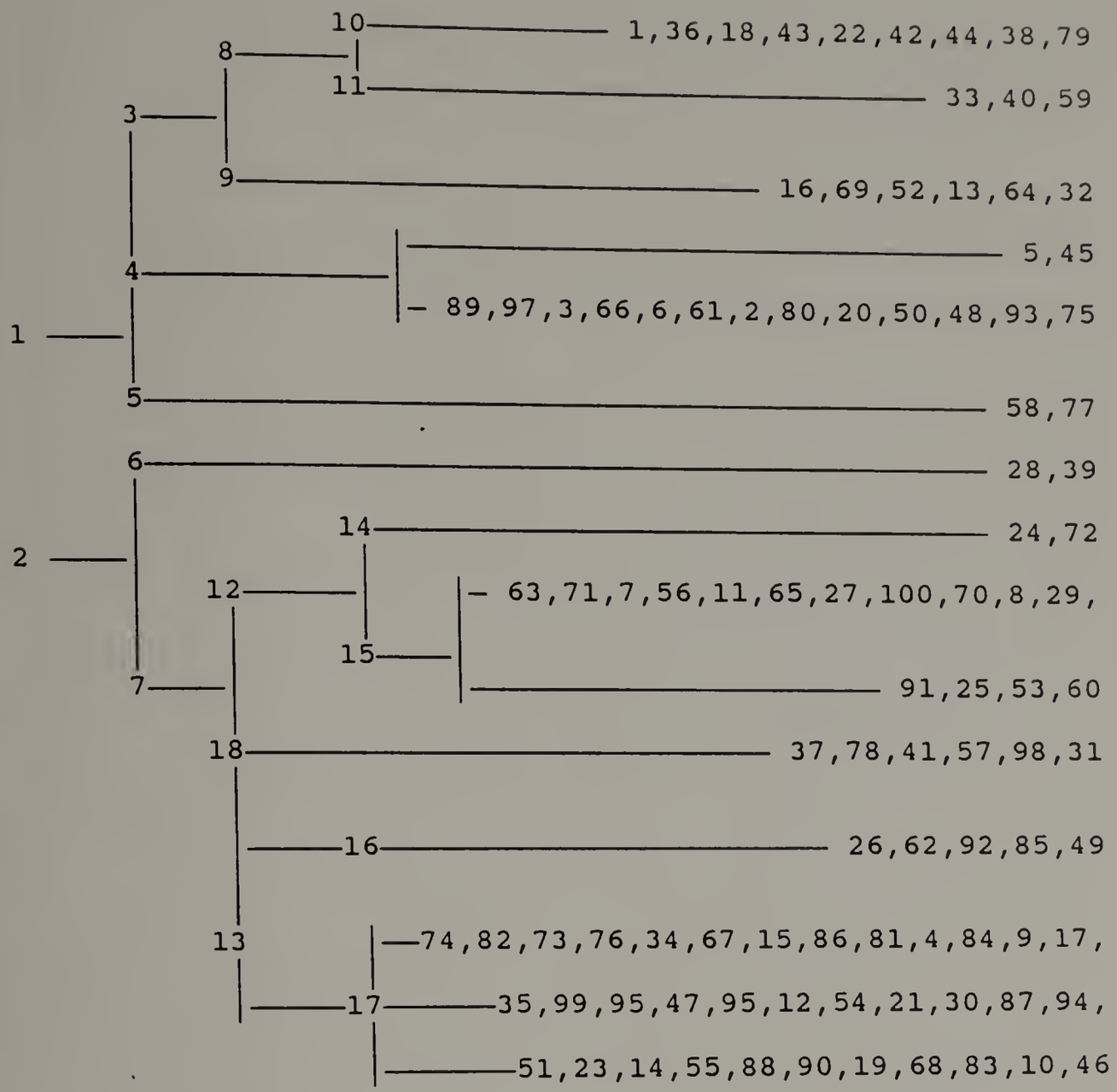
Please make some note of your responses, and then read my interpretation. Now you are ready (!) to record your final decisions on the Response/Interpretation Form.

BEFORE GOING ON TO THE MULTIDIMENSIONAL SCALING:

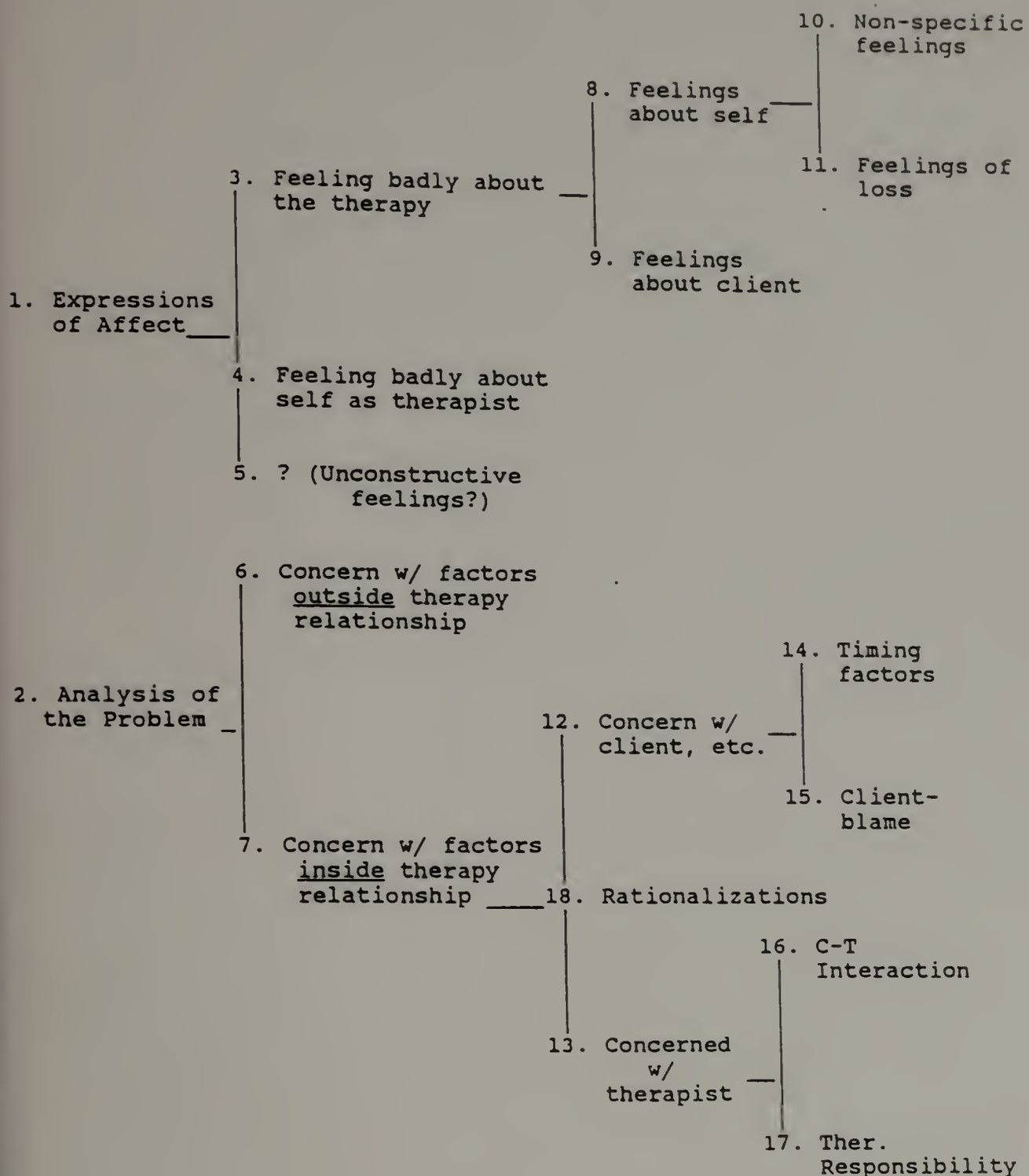
Multidimensional scaling is similar to clustering, in that it visually portrays or represents similarity data. One of the ways it differs from clustering is that is plot the relationships on more than one dimension, and is in that way a more complex representation of the data. It interprets similarity of items as proximity or distance in space, and plots these proximity/distance relationships along several axes called dimensions. Each thoughts is a point with coordinates along each dimension, and those most similar to each other will be chunked together in relation to each dimension.

It's an appealing method because it can, theoretically, produce a smaller number of meaningful and valid representations of how the thoughts have been organized by you. Also, in one of its forms, MDS can indicate the ways the each of you as individuals did or didn't use the dimensions and whether or not you were similar to each other in the ways you used the dimensions.

CLUSTER ANALYSIS PLOT



CLUSTER ANALYSIS INTERPRETATION



MDS SAMPLE STATEMENTS

1+

1. I feel sad, hurt, frustrated.
3. I feel bad about myself as a therapist.
5. I want to be analyzed before I practice again.
18. I'm disappointed.
20. I feel like a failure when someone leaves prematurely.
22. I feel angry.
36. I feel sad.
42. I feel relieved.
43. I feel guilty.
44. I feel angry with client and with myself.
50. I feel guilty for taking her money.
66. I shouldn't be doing therapy.
80. I feel anxious.
64. I'm being used.
77. I feel cooler and distant towards them. They're not my clients anymore.
13. The client makes me feel like a failure.
38. I was very surprised by his departure.

1-

11. I think new meaning may have occurred, but it seems like a little, in light of her many issues.
26. We didn't have an alliance.
53. Was he terrified of the feeling surfacing in the therapy?
62. We just didn't connect.
70. She was too young to benefit from individual psychotherapy.
72. She may be able to do more in therapy another time.
74. Did he have to leave because I was unable to acknowledge the intensity of his experience?
78. Did our interaction result in new meaning for client?
82. Did the failure confirm client's belief that his condition can't be helped?
92. Boundary issues were confused from the beginning.
27. She was so terrified to let in the opinions of others because that meant some loss to her.
25. There's more that needs to be done before she can be helped with her problems as she presents them.

2+

99. If I'd been less understanding, less caught-up in empathy, I might have been more helpful.
94. I should have been more clear in my assessment of the client's strengths and needs.
9. I don't know what to do. Somebody else would know how to do this.
87. I failed to articulate and formulate concrete goals to myself and the client.
86. I didn't pay attention to the dynamics because of my own stuff; I wasn't attending to my own issues.
83. How might our interaction have harmed the client?
81. I didn't hear the client.
76. I have been anxious and confused about what would be helpful; therefore I have been inconsistent.
67. I feel a nagging that there was something there in the client or system that I wasn't picking up.
54. I may have indicated to him that I was not someone with whom he could safely discuss his fantasies.
45. I've needed to consult more.
35. Maybe I inadvertently invited them to leave by even mentioning that as an alternative to the stress of a potentially successful treatment.
30. Maybe I should have prioritized the client's issues.
23. I wasn't able to come up with the right words, the right metaphors, the right way of seeing things....
21. I may have been inflexible; sticking to my own ideas about what would work and not listening to the client's.
17. I needed her to be healthier than she really was, because I was seeing many very disturbed clients at the time.
15. I was trying too hard. Trying to hard doesn't really work.
10. I didn't know what I was doing. I thought I had all the time in the world.
6. I knew I wasn't good enough to be a therapist.
4. My sympathy for the client's situations and experiences blinded my judgement.

-2

91. She wanted me to be her mother, and that couldn't happen.
72. She may be able to do more another time.
70. She was too young to benefit from individual therapy without the support of her family.
58. Client may have given up on therapy forever.
53. Was he terrified by the feelings that were surfacing in the therapy?
52. I've felt frustrated with the client's lack of movement.

-2 continued

29. He was so unwilling to look at his internal stuff, and could only talk about surface issues.
27. She was so terrified to let in the opinions of others, because that meant some loss to her.
24. Maybe it was time for her to stop.
8. She's very devaluing...a classic borderline.

3+

31. I don't believe in coincidences. So, she came here for something I have to offer her, whether I am able to see what exactly that is or not.
37. What can be learned from this?
79. I feel something quite unfinished.
78. Did our interaction result in him having new meaning in any aspect of his life?
59. I with I could continue to work with this client.
57. Maybe it wasn't a complete failure...how could they go back to being the same after that?
98. I've reflected on all that I did, and I'm not sure what, if anything, I would have done differently.
41. Is it a complete failure? I really believe that it was in the client's best interest that I admit I was not able to help and terminate therapy.
40. I feel suddenly cut-off from a person I've developed a relationship with.

3-

8. She's very devaluing...a classic borderline.
28. I really want to help this client, but am being prevented by external factors from proceeding with the process.
39. My supervisor wasn't much help.
56. She conned me into seeing her as more functional than she really was, and I let her down by letting her do that to me.
58. The client may have given up on therapy forever.
91. She wanted me to be her mother and that couldn't happen.
77. I feel cooler and distant towards them. They're not my clients anymore.
71. Whenever I've made an intervention/interpretation, I've felt I'm not getting through; she won't let me in.

MULTIDIMENSIONAL SCALING RESULTS
INTERPRETATION

Introduction

Let me say right off that I have not found the interpretation of these results to have been easy and without complications or contradictions. I have decided to limit the number of dimensions to three because I felt that adding a fourth or fifth dimension only made the groupings less interpretable. In order to determine the nature of the clustering of the thoughts (in this case "points") along the three dimensions, I ultimately chose to examine the most extreme points along each dimension. The further into the center one looks, the less clear the groupings become. I found there to be only one instance in which a group that was not found on the outermost points made sense in a way that informs us.

Before you read beyond this paragraph, I'd like to suggest that you examine the MDS (multidimensional scaling) data yourself. Begin with Figure 2A, which portrays dimensions 1 and 2 along two axes. Dimension 1 is along the horizontal axis and dimension 2 is along the vertical axis. You can find the statements that correspond to the numbers on the table in the MDS Statements pamphlet. "+ and -" signs refer to the statements' positions along the axis. For example "I feel sad" is to the far right and "Boundary issues were confused from the beginning" are at the far left along the horizontal axis of dimension 1. The goal here is to examine these outermost statements and see if they suggest a shared concern or theme, and to do this for all three dimensions. Having done that (over and over!) I was able to come up with the following ways of understanding the dimensions of these thoughts.

Dimension 1: Objective, causal inquiries to affect-driven expressions.
Dimension 2: Locus of responsibility: from Therapist, to Interaction, to Client and others.
Dimension 3: Thoughts that are non-blaming, philosophical and recognizing loss, and Thoughts that may reflect loss of objectivity and an overly blaming attitude.

I found the third dimension particularly difficult to assess, and relied heavily on the ways that you each indicated that you had sorted the thoughts to interpret it. I sensed that dimension 3 reflected some of the evaluative sorts in which some of you organized the thoughts in ways reflecting your assessment of their quality and constructiveness. I will very much appreciate your feedback.

YOUR RESPONSES/INTERPRETATIONS (5)

CLUSTER ANALYSIS: Do you have any suggestions for what to call the 17 clusters?

1..... 2.....

3..... 4.....

5..... 6.....

7..... 8.....

9..... 10.....

11..... 12.....

13..... 14.....

15..... 16.....

17.....

MULTIDIMENSIONAL SCALING: How might you interpret the three MDS dimensions?

Dimension 1.....

.....

Dimension 2.....

.....

Dimension 3.....

.....

COMMENTS and CRITICISMS (optional, of course): Please comment on any aspect of your process or the data that you feel might contribute to our understanding of the results. What were some of the names for the dimensions that you considered before making a final decision?

I would really appreciate it if you would respond to this question and return your response to me in the envelope provided, whether or not you choose to participate in the Interpretive Phase of this study. Thank you very much for your very generous support.

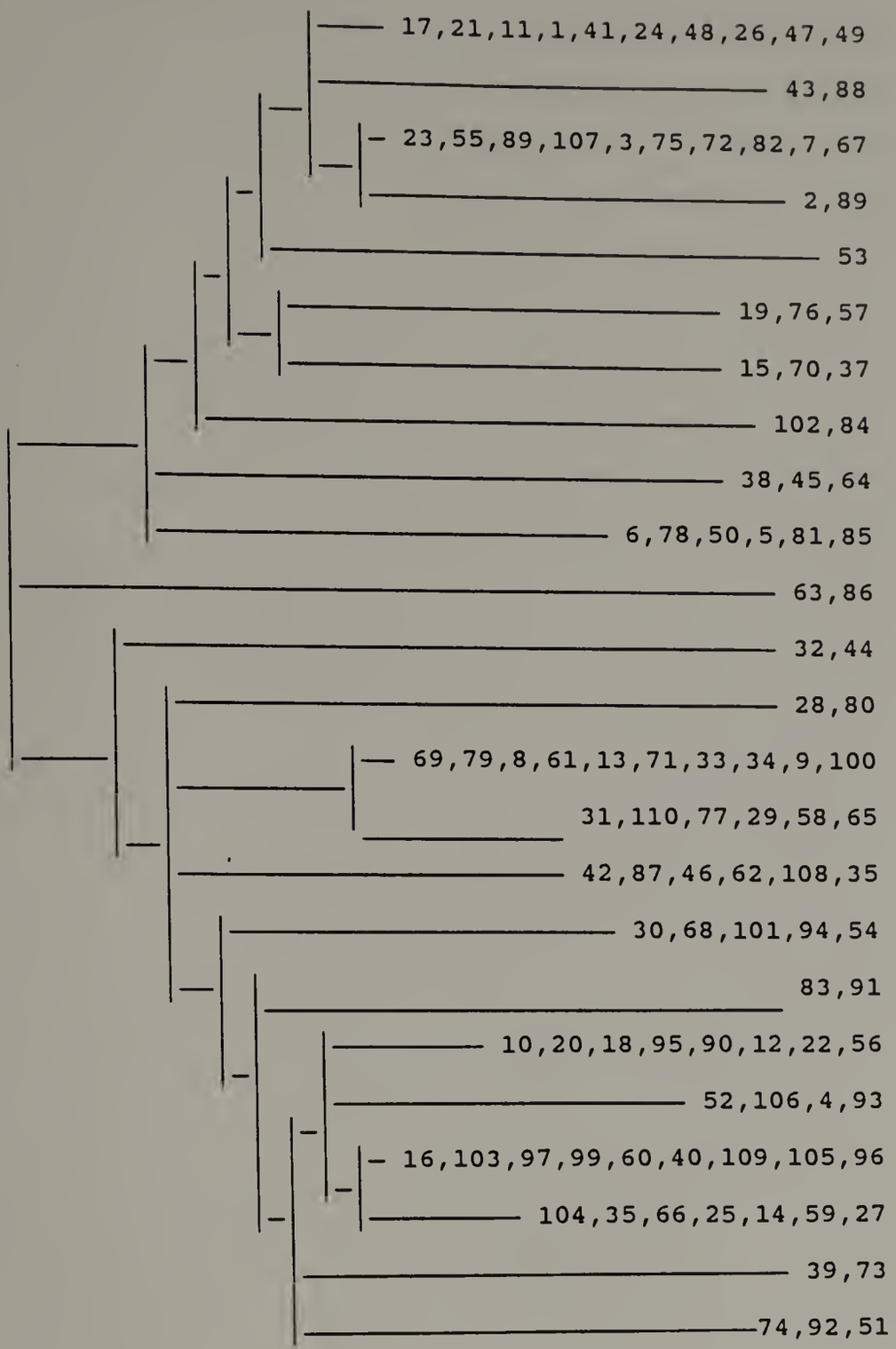
QUESTION: Did you find that your thinking about failures in therapy was in any way affected by your participation in this study? If so, in what ways, and did you find that one "phase" was more of a learning for you than an other? (Phase 1 was the interview and thought-listing part of the study; Phase 2 was the sorting task.)

Would you be interested in learning more about the final results of this research? If so, check the appropriate space below.

_____ Yes, I would be interested in hearing more about the results.

_____ No, I am not interested in hearing more at this time.

APPENDIX J



110 ITEM CLUSTER PLOT

APPENDIX K

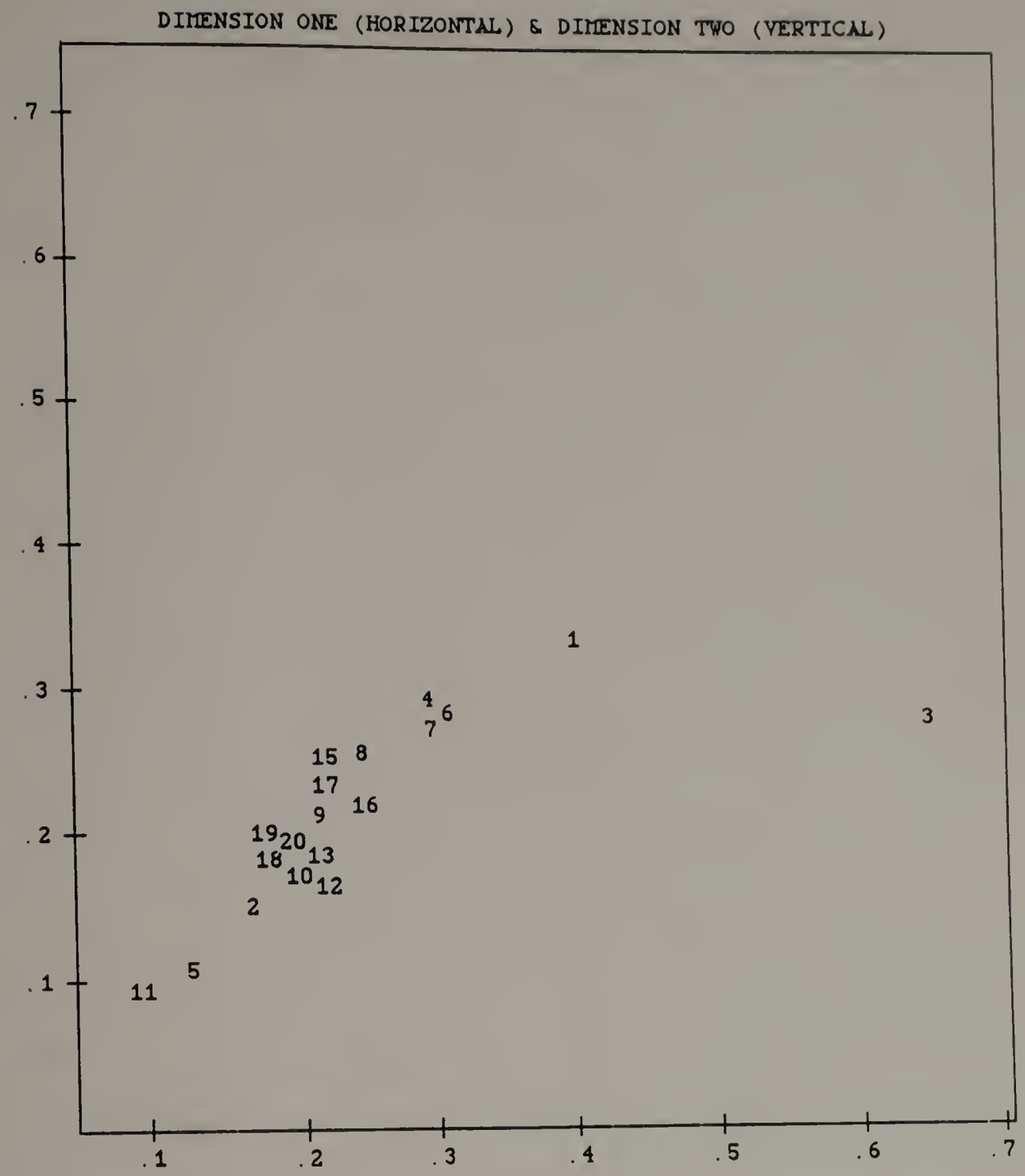
MULTIDIMENSIONAL SCALING COORDINATES

Thought number	Dimension 1	2	3
1	2.2697	-.4421	-.0379
2	1.5212	.7540	-.1187
3	1.9838	.4599	-.2156
4	-.5722	1.0256	-.1338
5	1.7007	.2997	1.6011
6	1.5865	1.0509	-.7807
7	-1.2610	-.2907	-.9419
8	-.8185	-1.4915	-1.4436
9	.1258	1.0371	.0959
10	.2795	1.0880	-.4515
11	-1.7881	-.9537	.5500
12	-1.2675	.9066	.3007
13	1.4502	-1.1643	-.9403
14	-1.0230	.7091	.5045
15	.2460	1.1691	.1818
16	1.5258	.3151	.1335
17	-.2638	1.2041	.7644
18	1.9957	-.3192	.3790
19	-.8806	.2519	-.7828
20	1.7464	.1075	-.2992
21	-.8601	1.4402	.2504
22	2.0058	-.8580	.2176
23	-.7398	1.1231	-.2931
24	-1.333	-1.7940	.9545
25	-1.1513	-1.4515	-.9262
26	-1.4393	-.0786	.1125
27	-1.3856	-1.6044	-.3990
28	-.3658	-.7206	-1.5938
29	-1.1524	-1.6092	-.8722
30	-.9434	1.4065	-.0637
31	-1.1651	-.4419	1.4590
32	1.5110	.1905	-.6362
33	1.3277	-.7453	.8448
34	-.2129	.7687	-.5078
35	-.9402	1.0583	-.1140
36	2.2949	-.7199	.4955
37	-.0993	-.8693	2.4230
38	1.4829	-1.0693	.5851
39	.0116	-.1105	-1.8911
40	1.0986	-.6528	1.2007
41	-1.3472	-.4176	1.3453
42	1.9177	-.9493	.9173
43	2.1326	-.1911	-.3892
44	1.8612	-.5955	.1778
45	.3286	1.0841	1.0224
46	-.8803	.9237	1.0608
47	-.9667	.6769	.3923
48	1.2025	.5061	-.6315
49	-1.3998	-1.1170	.4523

50	1.7223	-.0581	.0829
51	-.1804	.8556	-.7426
52	.7337	-1.5886	-.5979
53	-1.5420	-1.6394	.3876
54	-.9209	1.1037	.0817
55	-1.1720	.7399	.0569
56	-.9043	-.1602	-1.2697
57	-.6073	-.6983	1.6242
58	.1195	-1.7555	-1.0599
59	1.0821	-.4845	1.5948
60	-.6040	-1.4234	.3274
61	1.5554	.7135	-.8691
62	-1.4210	.1407	.6112
63	-.1650	-.8945	-.5035
64	1.7783	-.6364	-.8012
65	-.4214	-1.1566	-.3449
66	2.0446	.3948	-.0051
67	-.1902	1.0741	.7240
68	.0837	.6005	-.6460
69	1.2623	-.3357	-.7122
70	-1.5383	-1.5160	-.6957
71	-.2950	-1.3258	-1.0069
72	-1.6619	-1.7242	.8897
73	.4124	.9702	.8870
74	-1.4190	.4239	.0698
75	1.0834	.3216	.5307
76	.1015	1.2914	.2212
77	.9185	-1.0500	-1.2037
78	-1.7549	-.8525	1.5024
79	1.1253	-.7293	1.4075
80	1.8347	.2131	.0012
81	-.0151	1.1965	.2948
82	-1.6228	-.6471	-.1371
83	-.1569	1.3938	.2992
84	-.5658	.9008	1.0346
85	-1.1113	.4438	.7678
86	-.1142	1.0448	-.0963
87	-.7782	1.1763	-.4421
88	-.8171	.8278	-.5225
89	1.2285	1.2154	-.2436
90	-1.0003	.4044	-.4289
91	-1.1438	-1.4380	-1.2283
92	-1.4252	-.0946	-.2079
93	1.2252	.7793	.8872
94	-.5111	1.1353	-.3531
95	-.8666	.9113	-.0339
96	-.9719	.5715	.3665
97	.9263	.7877	-.5322
98	-.9662	-.1616	1.4916
99	-.5165	1.2125	-.1611
100	-1.2065	-1.3726	-.6346

APPENDIX L

SUBJECT WEIGHTS
3-DIMENSIONAL MDS


DIMENSION ONE (HORIZONTAL) & DIMENSION TWO (VERTICAL)
.7
.6
.5
.4
.3
.2
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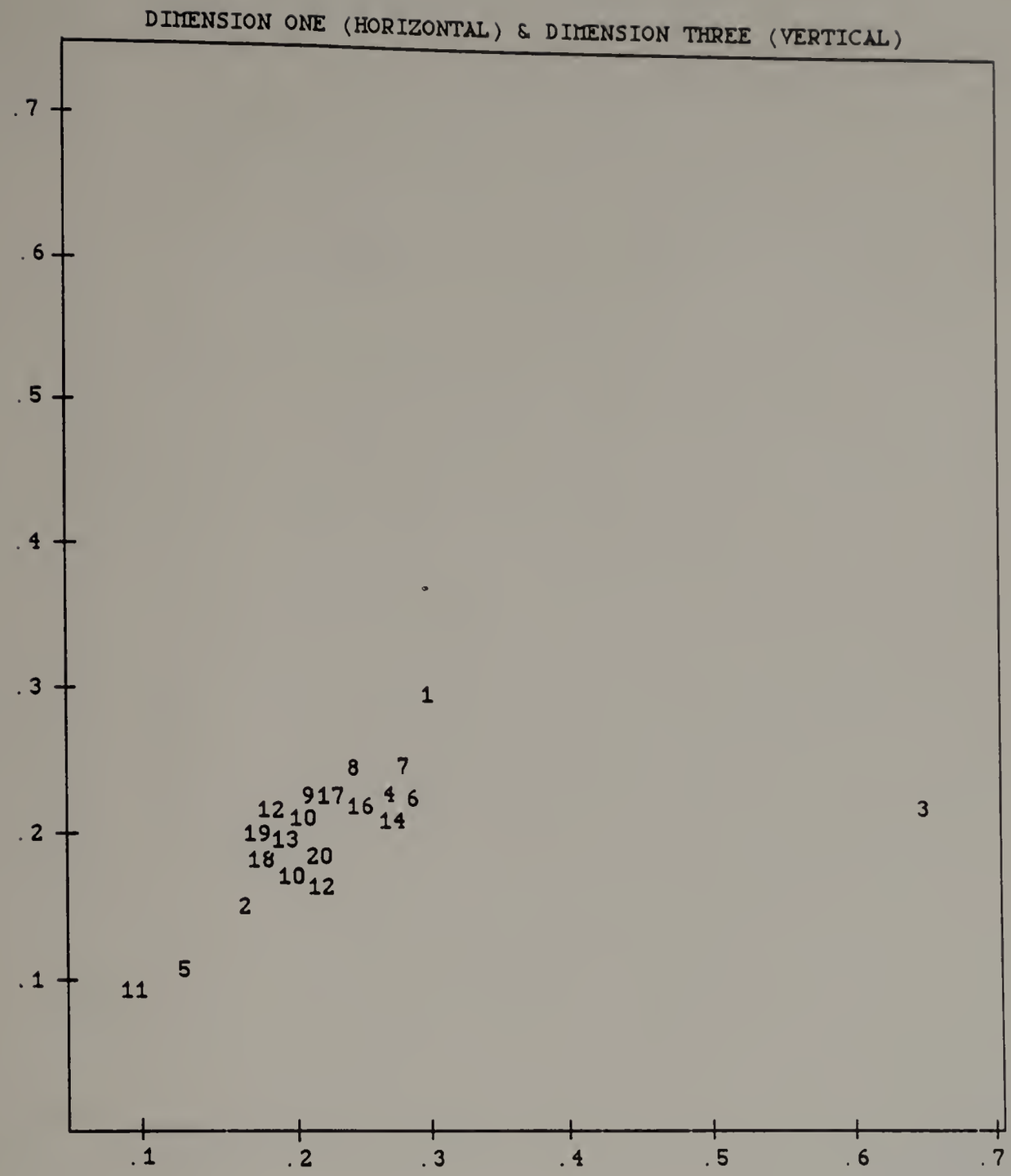
DIMENSION ONE (HORIZONTAL) & DIMENSION THREE (VERTICAL)
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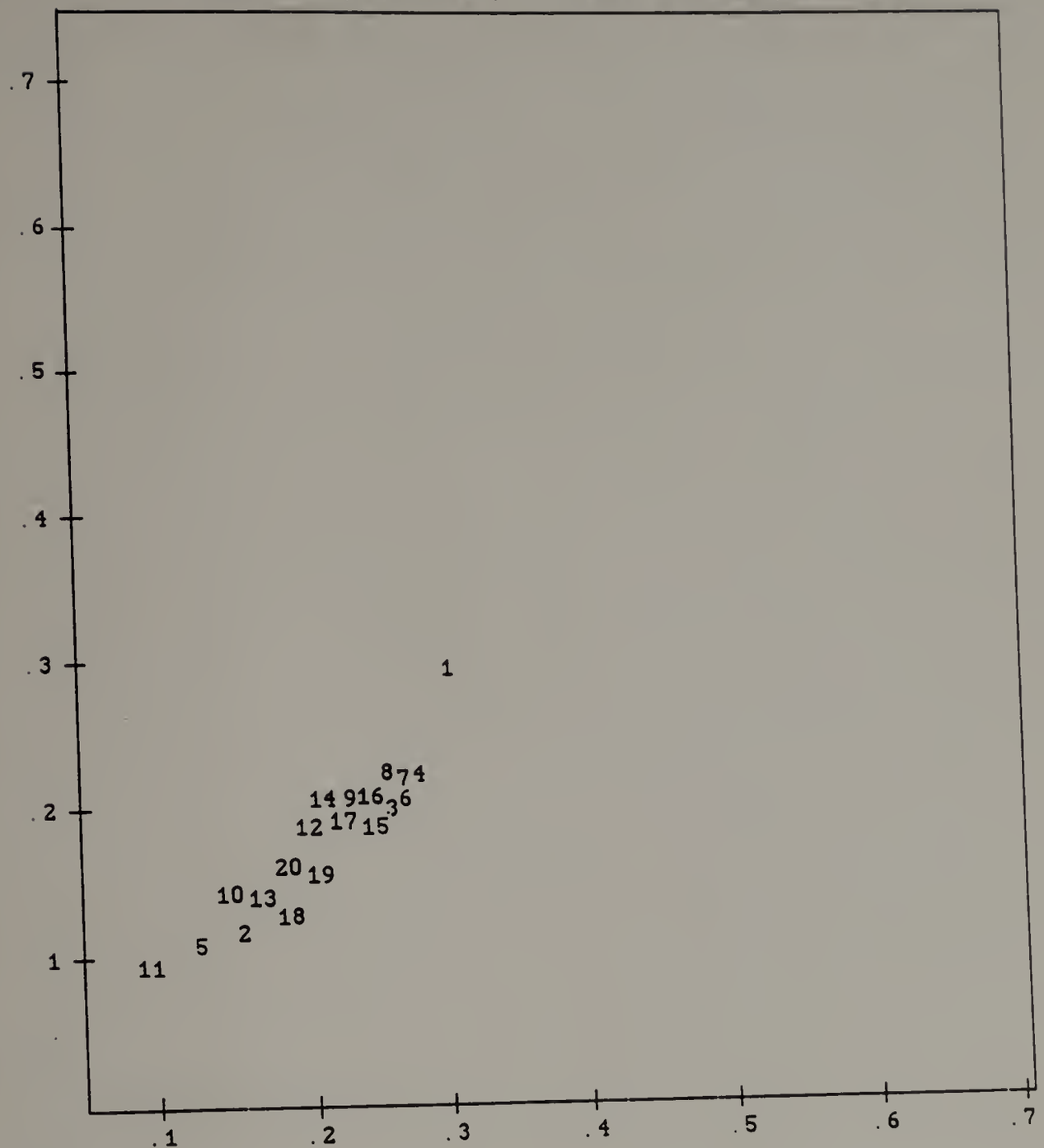
DIMENSION TWO (HORIZONTAL) & DIMENSION THREE (VERTICAL)



APPENDIX M

PILOT THOUGHTS AND INTERPRETATIONS

PILOT THOUGHTS

1. IDIOT (TO MYSELF)! HOW COULD YOU MISS SOMETHING SO OBVIOUS?
2. HE SOLD ME! I BOUGHT RIGHT INTO IT!
3. I REALLY BLEW IT! WHY?
4. WHY WASN'T I A SHARP AS I SHOULD HAVE BEEN?
5. I'M GLAD THE SESSION (THERAPY) IS OVER.
6. I'M NOT EAGER TO DISCUSS THIS WITH MY SUPERVISOR.
7. IT'S NOT FAIR TO MY CLIENTS WHEN I'M NOT AT MY BEST.
8. IT'S NOT GREAT, BUT IT'S NOT SO BAD...NO IRREPARABLE HARM WAS DONE.
9. HOW MUCH OF THIS WAS MY CLIENT AND HOW MUCH OF IT IS ME?
10. I FELT DEVALUED BY THIS CLIENT.
11. I DIDN'T LIKE THIS CLIENT--NO RAPPORT.
12. I'M A TERRIBLE THERAPIST.
13. I'M TOO INEXPERIENCED.
14. MAYBE A DIFFERENT SUPERVISOR WOULD HAVE HELPED.
15. I SHOULD HAVE DONE MORE READING ABOUT THE PROBLEM.
16. I NEVER FOUND THE KEY TO THE LOCK.
17. THE CLIENT WILL PROBABLY GET WORSE OVER TIME.
18. I FELT WORRIED ABOUT THE CLIENT'S CHILDREN.
19. THE CLIENT PROBABLY WILL NEVER GO FOR HELP AGAIN; THIS LEFT A BAD TASTE IN HER MOUTH.
20. CLIENT DIDN'T WANT TO CHANGE ANYWAY.
21. I SHOULD HAVE CONSULTED WITH ANOTHER THERAPIST OF A DIFFERENT MODALITY.
22. OH SHIT, WHY DID I BLOW THAT ONE?
23. I DID SOMETHING WRONG, AND IT'S A THING I DO WRONG A LOT. OH, SEE, I REALLY CAN'T DO IT.
24. I SHOULD NEVER BE A THERAPIST.
25. WHY DIDN'T I HELP THE CLIENT ACCOMPLISH WHAT HE WANTED.
26. CLIENT DID NOT GIVE ME CLEAR SIGNALS.
27. I WAS CONFUSED ABOUT WHAT CLIENT WANTED FROM THERAPY.
28. I WAS CONSTRAINED BY THIS SETTING.
29. WE WEREN'T A GOOD MATCH.
30. I'M GLAD I GOT OUT OF THAT ONE!
31. IT WAS INTERACTIVE: CLIENT WAS NOT CLEAR AND I DID NOT SET GOALS CLEARLY.
32. I REALLY FUCKED UP WITH THIS ONE.
33. I AM DISAPPOINTED WITH MYSELF, I KNEW BETTER.
34. I WAS COMPLETELY OFF BASE IN TERMS OF EMPATHIZING WITH CLIENT.
35. WHY DID I MAKE THAT MISTAKE AGAIN? WHAT WAS GOING ON?
36. MY TIMING WAS WRONG. I WAS PUSHING TOO FAR TOO FAST.
37. MY TONE WAS TOO STRIDENT. I SHOULD HAVE ROUNDED THE EDGES.
38. THE CLIENT NEEDED HELP AND I DROVE HIM AWAY.
39. WHY DID I PUSH THIS CLIENT AND MAYBE IN ANOTHER SITUATION I WOULDN'T HAVE PUSHED WITH SOMEONE ELSE?
40. IT WAS A HECTIC PERIOD. I FELT UNDER DEMAND. I JUST DIDN'T HAVE THE PATIENCE I SHOULD HAVE HAD.

PILOT SORTING CATEGORIES

Participant #1

1) Where the person places responsibility for the failure.

external issues
self
client
specific interaction between these two people
relief

2) Statements reflecting attributions about the problem with all the question thoughts removed: looking for explanations, and questions don't give them.

client-therapist interaction
client
internal self attributions, characterological
attributions to something other than the client and the therapist

3) A flow chart of interpretations and consequences: this is the process which one goes through to understand an event. A sequence of thoughts.

first, ask a question
next, either go down a dead-end path, thinking things that are not going to help you...
or come up with an idea, no matter how valid or plausible...brainstorming of hypotheses
personal feelings about it
guesses about the future

4) Where does, what's the locus of concern? Me and how terrible I am, or my client, what's been done by the client.

feelings of self-depreciation, concern for self
concern with what others think
acceptance, or something
concern for the client
relief

Participant #2

1) Things seemed conceptually different. It's a dyadic relationship and therefore failure can be attributed to one, either or both.

relief
self-blame
shared responsibility
general reluctance to engage
externalizing blame

Participant #2, continued

2) Constructive versus not-so-constructive excuses; stuff that was helpful and not so helpful.
helpful self-analysis or self-criticism
unhelpful defensiveness

3) Therapy relevant versus therapy irrelevant concerns.
exclamation of emotion about what happened
addressing a therapeutic issue

4) Cognitive, intellectual versus affective or emotional responses.
affective, emotional
intellectual, cognitive

5) Attributions that were dead-end versus those that implied something could be done to make it better the next time around; accepting responsibility for future situations in therapy.
attributions that implied that something could be done in the future to make it better
dead-end attributions
somewhere in-between: attributions recognize that something went wrong, but nothing specific is identified. Self analysis is implied

Participant #3

1) Some where the therapist blamed self, some outside, some blame the client, some not blame at all, where therapist not taking it hard...So, I tried to break it up in terms of where the blame, if there was blame (or rather, fault), was going.
therapist failure/mistake
somebody else made a mistake
client and therapist together make a mistake
comme si, comme ca!

2) The certainty with which the therapist is thinking about this failure.
therapist uncertain about what went wrong
therapist has a clear answer or certainty about failure, is finished

Participant #3 continued

3) Sometimes you think there's a technique involved, sometimes you think it's personal failure, other times it sounds as though therapist is seeing it as interpersonal (not personal, not technique), and sometimes it's not thought of as a failure, just glad it's over.

technique
personal
interpersonal
glad it's over, ignoring it

4) Coming from an emotional place and sometimes they seem to be coming from an intellectual or thinking place.

both
thinking
feeling

Participant #4

1) Some general categories were different levels of blaming self, client, relationship and/or external circumstances; whether they were adaptive or maladaptive, global or specific.

open-ended
minimizing damage
blaming client in an unproductive way
fault of the relationship
blame self in a global, unproductive way
fatalistic despair
taking responsibility on self with productive, behavioral suggestions or interventions
relief
external blame
blaming self in a global manner in connection with a specific client
blaming self in a less global manner with a specific client

2) Whether or not the thoughts are helpful or unhelpful, constructive or not.

helpful
unhelpful
possibly helpful, depending on the context

3) How relevant is the client in the thought?

It's me!
It's him/her!
It's us!
It's something else!

Participant #4 continued

4) Thoughts that my training or supervisor would encourage or discourage.

discourage
encourage

5) If I heard another therapist say that, how would I think of it?

rationalization: sour grapes
rationalization: containment of damage to self esteem
too extreme

PILOT INTERPRETATIONS

CLUSTER RESULTS

1) thoughts concerned with explanations for the failure

2) thoughts of self-blame

3) thoughts about external factors

4) thoughts concerning interaction and feelings toward the client

5) thoughts expressing relief

6) thoughts about the future effects of failure

MDS RESULTS

Dimension 1: Stable therapist dispositional thoughts to Interactive and situational thoughts

Dimension 2: Therapist reflects to Therapist projects

APPENDIX N

PARTICIPANTS' INTERPRETATIONS

Participant #4 suggested the following:

Cluster Analysis:

1. I feelings	2.
3. Client Blame	4. Therapist Guilt
5.	6. Relationship Breakdown
7. Both at Fault	8. Frustration
9. Unexpected	10. Painful Feelings
11. Loss	12. Client Fault
13. Failure	14. Philosophical
15.	16. Professional Statements
17. Therapist as authority figure	

MDS:

Dimension 1: Intellectual compensation--personally defensive

Dimension 2: Guilt--Projection

Dimension 3: Looking at larger picture: Systemic--Defensive and projective response

Participant 19 suggested the following:

Cluster Analysis:

1. Affective Expression	2. Problem Analysis
3. AE re the therapy	4. AE re the therapist
5. AE re the client	6. AE re intention of 3,4,5
7. PA re externals	8. PA re internal factors
9. PA re intention of 7&8	10. Description of Feelings, specific
11. Description of feelings, non-specific	12. PA re the client
13. PA re the therapist	14. PA re the therapy
15. PA re interaction	

(this participant altered the numberings on his responses, therefore, many of his labels are difficult to interpret.)

MDS:

Dimension 1: Problematic analysis--Affective expression. (not objective, causal--affect "driven")

Dimension 2: Object of focus(locus): therapist, client, therapy itself, combination/interaction (not responsibility)

Dimension 3: Reflective, observation (objective, neutral)--Participatory, reactive (subjective)

Participant #20 suggested the following:

Cluster Analysis:

1. Feelings	2. Thoughts
3. ?	4. Feeling (blame therapist)
5. ?	6. The power is outside
7.	8.
9. (Feeling) blame client	10. Simple feeling Statements
11. Holding on	12. Looking at client
13. ?	14. It's okay, time
15. How client defeated process	16. ?
17. Thinking about what the therapist might have done wrong	18. Unhooking, bigger picture

Participant #5 suggested the following:

Cluster Analysis:
"Omit #5, and collapse the items into the other six categories: 3,4,8,9,10,11.

APPENDIX O

FREQUENCIES OF DIMENSIONS

	AT	AC	AI	FT	FC	B	R	TM	E
1	7			1				S	L
2	6		3	2	1		3	D	H
3	2		2	2	2	1		S	H
4	3	4		2	2			S/H	H
5	1		1		4			H	H
6	2	4	1	2	1	1	3	H/&	H
7	6	2					1	S	L
8	1		1	2	2		1	S	H
9	4	5		1			1	S/D	H
10	6	2		4		2		D/&	L
11	5	2	2	3	1	1		S/D	H
12	6	2	3	4	1		1	D	H
13	1	1	5	1	2			D	H
14	3	1	2	1				D/&	L
15	4				3			S	H
16	3	5		3	2	3	2	D	H
17	7	1	1	4		1		D	L
18	3	2	2	2			2	D	H
19	2		2	2			1	D	H
20	3			1	1	1	2	S/D	L

AT= analysis of therapist AC= analysis of client
AI= analysis of interaction of therapist and client
F= expression of feelings B= overly blameful
R= rationalization
TM= preferred therapeutic modality:
S= family systems
D= psychodynamic
S/D= mixture of family systems and psychodynamic
H= client-centered
H/&= client-centered and others
D/&= dynamic and others
E= amount of experience at the time of the failure:
H= high
L= low

APPENDIX P

RESEARCH EFFECTS

PARTICIPANT #15

I became most interested in the sorting task as it gave me a chance to learn how other therapists think about failure. Because I ahve pretty strong "constructivist" views, my ideas were not so much changed as enhanced, i.e., the idea that we to a large extent construct the idea of "failure" and "success" or construct them with our clients/client systems. I felt a little disheartened by the feeling of people wanting to help others in very particular ways and sensing failure in their attempts.

PARTICIPANT #20

No.

PARTICIPANT #19

Yes, both in therapy and in my teaching/supervision of therapy.

I felt . . . that I came to gain meaning by being both participant (Phase 1) and observer (Phase 2 and 3). At this juncture I feel both are important.

I also became clearer about my conscious attempt not to blame (as for the unconscious?!!).

PARTICIPANT #4

This was a helpful experience in feeling more awareness around the endings of therapy. The Phase 1 was more evocative and interesting than the sorting activity. The second phase felt more like an intellectual game.

PARTICIPANT #12

I think it gave me an opportunity to just sit down and experience and think about it in the presence of another. That process helped me to clarify the ways I move back and forth between taking all the blame to wanting to blame the client. I more clearly feel able to evaluate my process for a more informed understanding of how I think about failures.

PARTICIPANT # 3

Phase 1 was much more of a learning for me. I enjoyed and appreciated the dialogue.

PARTICIPANT #5

Yes! The sorting task was helpful in putting things in a perspective for me.

PARTICIPANT #10

I don't think my thinking was affected by the study. I had already decided that mistakes were part of the learning process prior to the study.

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