Patient's failures and psychotherapist's successes, or failure in psychotherapy in the eyes of a psychotherapist

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Summary

Aim: To determine what significance psychotherapists attach to failure.

Methods: The study group included 100 psychotherapists. A qualitative method (open questions) and a quantitative method (Self Confrontation Method by Hubert Hermans) were used. An analysis of psychotherapists' comprehension and experience of failure, and an analysis of emotions felt when succeeding or failing in psychotherapy were performed.

Results: 94% of psychotherapists declared that they experienced failures in the course of their professional work. The failures were accompanied by particularly negative emotions and were quantitatively and qualitatively different from the emotions felt when a patient's therapy was completed successfully. A failure was most frequently (76 out of 100 psychotherapists) perceived as premature termination of treatment by the patient where therapy cessation was attributed in 70% of cases to factors within the patient's control. Psychotherapists evaluated their competences highly – they claimed to possess qualities predisposing them to an average success rate of 73%. They rated their job satisfaction at the level of 80%. Sixty-one percent of psychotherapists discussed their failures at counselling supervision meetings.

Discussion: A tendency to preserve one's self-esteem and to strengthen one's self displayed by psychotherapists is evident in the process of analysing previously committed mistakes.

Conclusions: Psychotherapists experience failures and they are most frequently inclined to attribute them to factors within patients' control.

failure, psychotherapy, psychotherapist

INTRODUCTION

The starting point for deliberations about failure in psychotherapy is a reflection on the antithesis of failure – psychotherapeutic success. What constitutes success in psychotherapy?

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Different schools of psychotherapy define psychotherapeutic success differently. In his early works, Freud wrote that effective psychoanalysis improved the patient's ability to love and work (lieben und arbeiten). Contemporary psychodynamic psychotherapists frequently evaluate the efficacy of their work using the terms 'insight' and 'personality change'. Changes in these areas are perceived by them as more significant and desirable than the alleviation of symptoms

or an improvement in the patient's overall functioning [1]. The humanistic approach to counselling describes therapeutic success as establishing the therapeutic alliance which makes the client feel respected, cared for, accepted and safe, and as a consequence, enables the client to explore the hidden self, the part of which he/she was ashamed or afraid of [2]. The ensuing change should lead to symptom alleviation and development of new behavior patterns [2]. The cognitive-behavioral approach focuses on altering behavior and changing non-adaptive beliefs into adaptive ones. However, this approach emphasises that the achievement of therapeutic success depends on the patient's understanding and acceptance of therapy principles and his/her active cooperation and involvement in the fulfillment of therapy tasks [3]. The interpersonal approach focuses on the patient's interpersonal experiences and the relationship between them and the patient's symptoms. In their work with patients, therapists pay particular attention to interpersonal life stressors, the individual's social support network and his/her biological and psychological sensitivity [4].

Although the techniques employed to induce change vary and the time needed to achieve the goal differs, the goal – psychotherapeutic success – is not always achieved. Meta-analyses by Hansen et al. demonstrated that psychotherapy lasting an average of four sessions contributed to curing 14% of patients, produced an improvement in 21% of patients, did not induce any changes in symptoms in 57% and caused an exacerbation of symptoms in 8% of patients. [5]. In meta-analyses of other authors (depending on the assessment criteria adopted), a percentage of psychotherapy patients experiencing an exacerbation of symptoms fluctuated between 5% and 10% [6]. Even among patients suffering from disorders with a high percentage of positive therapeutic outcomes, e.g. panic attacks, only 50-70% of patients reached a state of normal functioning following the completion of therapy [7].

What does success/failure in psychotherapy depend on? – this question still applies and is explored in research on psychotherapy. Lambert, while conducting a meta-analysis of research results, proposed a division of factors which impact therapy success in the form of a chart called 'Lambert's Pie'. According to Lambert, client fac-

tors and psychotherapeutic events account for 40% of variance in therapeutic outcomes, the therapeutic relationship accounts for 30%, techniques and psychotherapy models account for 15%, and expectancy and placebo effects account for 15 % of variance in therapeutic outcomes [8]. In his monograph, Mick Cooper proposed the following division: psychotherapeutic orientation, client factors, therapist factors, therapeutic relationship factors, and factors associated with therapy techniques and the therapist's professional experience [9]. A great number of variables which are of significance in the psychotherapy process confirm the complexity of the eventual outcome of psychotherapy (success/failure). It is reflected in therapists' understanding and experience of success/failure although few studies using this perspective have been conducted on the subject.

METHODS

A questionnaire containing general information about psychotherapists and questions regarding the understanding of success/failure in psychotherapy constituted the research tool. Numerical data were analysed quantitatively: frequency, percentage, mean, and standard deviation. The quantitative analysis of emotions felt by therapists in reference to success/failure was conducted using the Self-Confrontation Method by Hubert Hermans adapted to Polish by Piotr Oles [10]. Study participants evaluated the intensity of their emotions regarding the following situations on a 5-point scale: 1) the patient's failure to attend a scheduled appointment, 2) premature termination of treatment by the patient, and 3) successful therapy completion. The quantitative assessment of the experienced emotions, following test key application, produced results in the S, O, P, N coefficients. Within each coefficient, participants could obtain a score from 0 to 20 reflecting emotion intensity. The higher the score, the greater emotion intensity experienced. Coefficient S is the aggregate of points for four emotions which express strengthening one's sense of self (self-esteem, sense of control, sense of power, self-confidence, pride). Coefficient O is the aggregate of points for four emotions which express closeness and unity with another person (care, love,

affection, intimacy). The difference S-O can be established for each evaluation. The experience of strengthening one's sense of self is stronger than the experience of closeness when S > O, and weaker when O > S. Both types of experience co-exist when S = O. Coefficient P is the aggregate of points for four general, positive emotions (joy, happiness, pleasure, inner peace). Coefficient N is the aggregate of four general, negative emotions (worry, unhappiness, despondency, disillusionment). The difference P-N can be established for each evaluation. It reflects a person's mood evoked by a given situation. The mood is positive when P > N, negative when N > P and ambivalent when P = N. [10]. The results of the Self-Confrontation Method are presented as mean values and standard deviation. The differences were analysed with the T-student test. The correlations between the variables describing the level of the psychotherapists' competences (psychotherapy training, certificate in psychotherapy, evaluating the psychotherapy process, analyzing the videotape material) and the percentage of the patients showing improvement and job satisfaction were established with U Mann-Whitney Test. The correlations between the quantitative variables were established with the r-Pearson test. The level of statistical significance was adopted at p<0.05. Responses to open questions in the survey were analysed qualitatively.

PARTICIPANTS

The study group comprised 100 psychotherapists: 80 male and 20 female with a mean age of 41 years (SD=9). All study participants received university education, 62 of whom held a degree in Psychology, 19 – in Pedagogy, 14 – in Medical Science and 5 held a degree in another, unspecified field. The average length of employment in their acquired profession was 14 years (SD=10), and the average length of working as a psychotherapist was 10 years (SD=9) and ranged from 1 to 56 years. Seventy percent of the participants completed the full counselling and psychotherapy training, 27 held a Certificate in Psychotherapeutic Counselling, and 13 also held a Certificate in Psychotherapeutic Counselling Supervision.

Among the surveyed professionals, those using the psychodynamic (N=50%) and systemic approaches (N=50%) dominated. Therapists using the cognitive-behavioral approach (N=20%) and Erikson's approach (N=20%) constituted a sizeable group. Almost 60% of the therapists used more than one term to describe their psychotherapeutic orientation. The dominant form of therapy offered by the study participants was individual therapy (N=79), and to a lesser degree, group therapy (N=24), couple therapy (N=20) and family therapy (N=14). The therapists devoted an average of 18 hours per week to psychotherapy work. However, discrepancies in this regard were substantial and ranged from 1 to 56 hours per week. Almost 60% of the therapists evaluated the effects of their work. The majority of them (92%) presented psychotherapeutic procedures applied in their work with clients at clinical supervision meetings (individual and/or group supervision sessions), sometimes presenting recordings of psychotherapy sessions (32%). Eight of the surveyed practitioners did not participate in any form of clinical supervision.

RESULTS

Ninety-four percent of psychotherapists admitted to having experienced failure in their professional work They perceived failure as: N=76 premature termination of treatment by the patient (e.g. a female patient discontinued therapy without prior notice), N=4 the patient's lack of motivation, N=5 the patient's resistance, N=25 the psychotherapist's mistakes (e.g. inability to maintain professional boundaries; rigid adherence to a particular technique; setting too fast a pace of therapy), N=24 no change (e.g. no improvement; lack of positive outcomes), N=10 non-establishment/disturbance of the therapeutic alliance (e.g. inability to establish rapport with the patient; non-establishment of a therapeutic relationship), N=5 termination of treatment by the therapist.

In line with predictions based on literature reports and own clinical observations, failure was most frequently defined as premature termination of treatment by the patient. Identifying psychotherapeutic failure with premature termination of treatment by the patient was reflected in the similarity of emotions felt in both types of

situation. The feelings experienced by the psychotherapist when he/she fails were similar to those felt when the patient terminates therapy prematurely. (S r=0.734; O r=0.544; P r=0.516; N r=0.404 p<0.001). A subsequent question in the survey regarded psychotherapists' understanding of premature treatment termination and patients' reasons for it. According to psychotherapists, the primary reason for treatment termination is the patient's lack of motivation or insufficient motivation for therapy N=53. The therapists also indicated limitations arising from the patient's mental state N=26 (e.g. personality disorders; psychotic decompensation), difficult emotions experienced by the patient: anguish N=10, anger N=2, fear N=34 (e.g. being afraid of what one can see; fear of opening up; fear of change; experiencing pain which they do not want to experience). Financial factors N=13 (e.g. lack of money) or life changing events N=8 (e.g. moving house, having a child) were listed as external factors within the patient's control. A discrepancy between the patient's expectations and the therapeutic reality N=31 (e.g. the patient envisages the therapy differently; the patient wishes to receive a fast-acting remedy for his/her problems) was cited as a reason for therapy termination. Reasons which were within the therapist's control concerned errors in his/her work N=48 (e.g. a badly drawn contract; therapeutic approach not suited to the patient's disorder and capabilities) and difficulties in establishing the therapeutic alliance N=44 (e.g. a negative relationship; discord). According to the therapists, patients terminated therapy not only as a result of a lack of changes N=22 (e.g. no changes in areas crucial for the patient), but also as a result of achieving changes which they expected when therapy commenced N=9 (e.g. satisfaction with outcomes; symptom improvement).

The psychotherapists were asked about their methods of coping with failure, actions taken when they experienced failure. Sixty one of those surveyed use supervision, 23 discuss the issue with their co-workers (e.g. I discuss it with my colleagues; talk with other team members; analyse the problem with other therapists). Fifty two of the study participants analyse the situation by themselves (I observe; contemplate; analyse; try to understand; draw conclusions). Twenty seven therapists admitted to reacting emotionally to failure (e.g. I am profoundly affected by it; I am concerned about it; I want to change my job; I feel guilty; I am saddened by it; I am despondent; I feel angry and annoyed; I judge myself harshly; I blame myself). Other ways of responding to failure included: physical activity as a means of releasing negative emotions N=5, expanding one's knowledge N=3, discussing failures during one's own therapy sessions N=2.

The psychotherapists were also asked about what they considered the desired outcome of therapy. Most frequently, the psychotherapists perceived their therapeutic success as an improvement in the patient's quality of life N=42 (e.g. fulfilling life; improved functioning; improved quality of life; greater satisfaction). Twenty six psychotherapists described effective therapy in terms of insight (e.g. self-exploration; self-understanding; self-reflection; self-awareness). Twenty four therapists identified the desired therapy outcome with change (e.g. a positive change; a change in one's life; a beneficial change). The desired outcome of therapy was frequently associated with symptom improvement N=19 (e.g. alleviation or disappearance of symptoms; lack of symptoms; suppression of symptoms). Eighteen psychotherapists indicated an improvement in the patient's interpersonal relations (e.g. openness in relationships; closeness in relationships; fulfilling relationships). Fifteen psychotherapists evaluated therapy efficacy with respect to the degree to which the goals of the psychotherapy treatment contract were attained (e.g. goal achievement; therapeutic goal attainment). The desired psychotherapy outcome was also defined as an enhancement of the patient's own competencies N=7 (e.g. inner autonomy; influence on one's life; control over one's life) and also as an increased liking for oneself N=5 (e.g. increased liking for oneself; self-acceptance; self-support). The desired psychotherapy outcome was sporadically defined as discontinuation of destructive behaviour patterns N=2, putting one's past in order N=2, decreasing the intensity of negative emotions N=2 (e.g. dilemmas become less acute; feelings of guilt are assuaged; fear is eliminated), accepting limitations N=2, a change in personality structure N=2, own development N=2, maturity N=3, coping with emotions N=2.

One of the surveyed individuals used Freud's description of the goal of psychotherapy – ability to love and work. Subsequently, the study participants were asked to provide a qualitative and quantitative assessment of their feelings in the following situations: 1) the patient does not attend a scheduled appointment, 2) the patient terminates treatment prematurely, and 3) the patient successfully completes therapy. The intensity of emotions experienced by the therapist in these situations is presented in figures 1, 2 and 3.
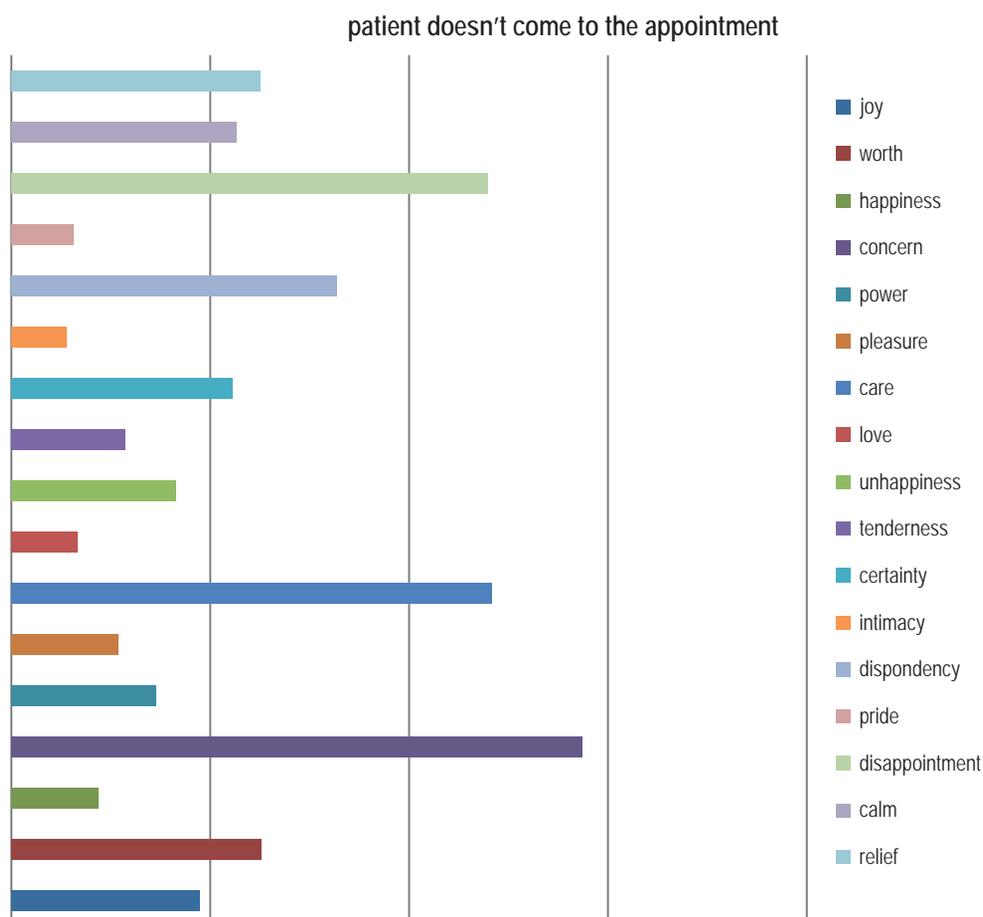
patient doesn't come to the appointment

Figure 1. The affective response of the psychotherapists in the situation, when the patient doesn't come to the session.

An analysis of emotion intensity was performed according to the Self-Confrontation Method key and differences in the emotions experienced when succeeding and failing were established. The differences are presented in figure 4.
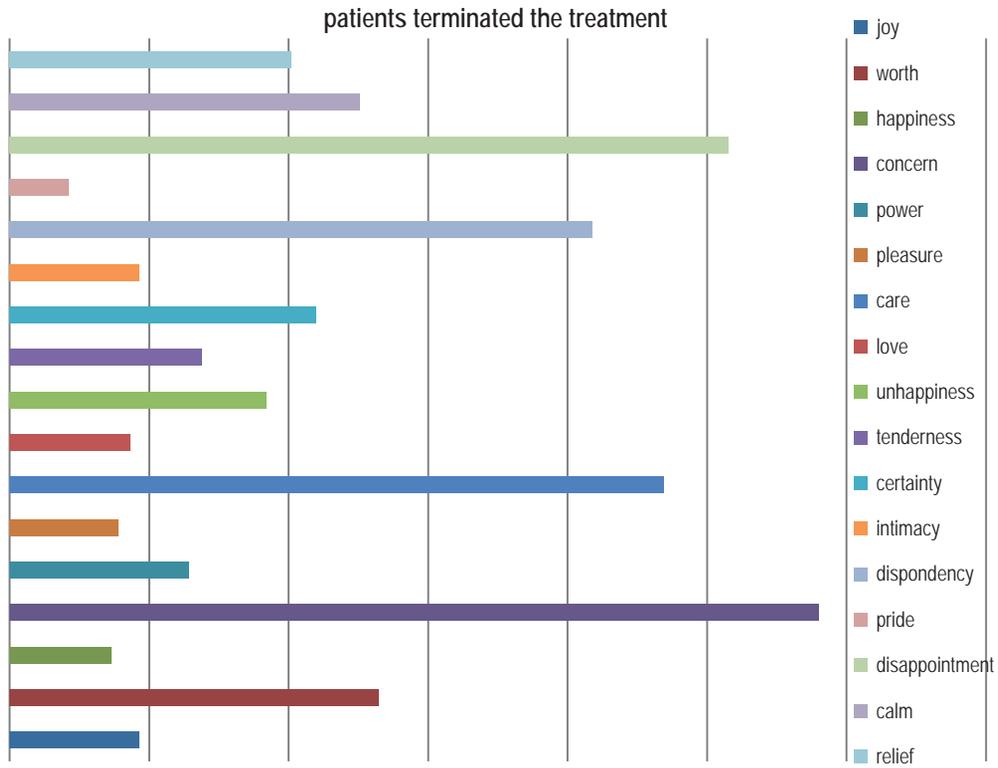
patients terminated the treatment

Figure 2. The affective response of the psychotherapists in the situation, when the patient terminates the treatment prematurely.
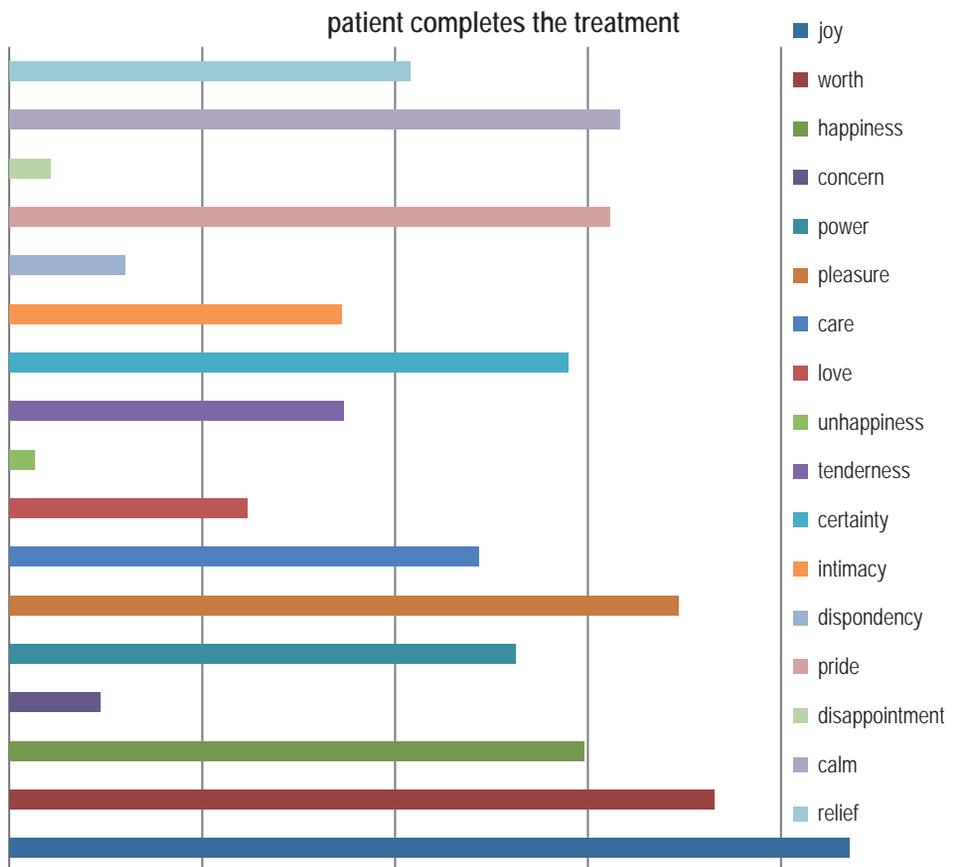
patient completes the treatment

Figure 3. The affective response of the psychotherapists in the situation, when the patient completes the treatment.
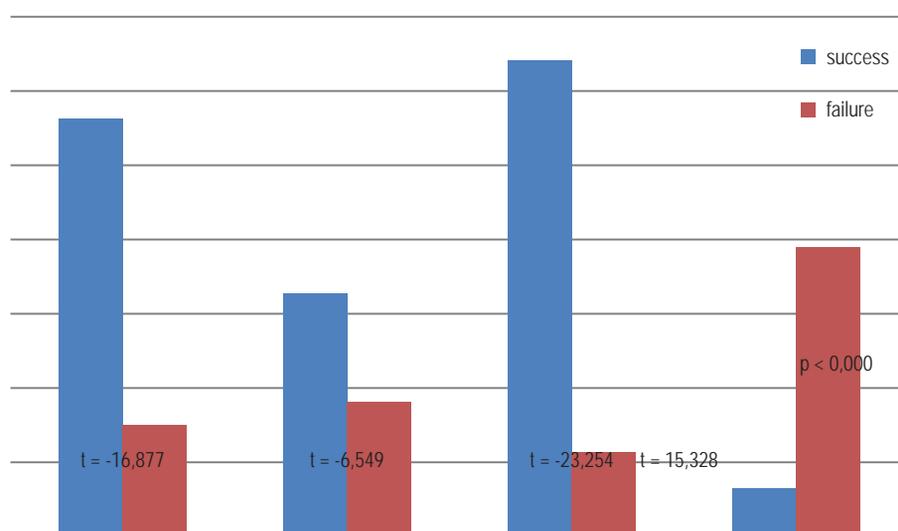
Figure 4. The differences (measured by t-Student's test) in affective response of the psychotherapists in the situation of failure and success in the therapy.

The study participants were asked to list qualities predisposing psychotherapists to attain success. The following features dominated among those listed by psychotherapists: empathy N=45, intra-psychic qualities N=33 (e.g. insight; good contact with oneself; self-awareness; being in touch with one's emotions; self-understanding; inner order; unwavering self-respect; inner stability; strong sense of self); cognitive predispositions N=24 (e.g. knowledge; good memory; intelligence; continuing professional development), mindfulness N=18, self-development N=17, communicative competence N=17, flexibility N=15, patience N=14, genuineness N=13, openness, N=13, sensitivity N=11, experience N=11. The therapists were asked to evaluate, on a scale of 0% to 100%, the degree to which they possessed the qualities listed by them. The average score was 73%.

The study participants were also asked to evaluate, on a scale of 0% to 100%, how satisfied they were with being psychotherapists. The average score in the study group was 80%.

The psychotherapists were asked what methods of increasing professional competence they considered most effective. The following responses were provided: supervision N=67, workshops N=34, training sessions N=28, conferences N=25, literature N=25, own psychotherapy N=23, conversations with colleagues N=19, training courses N=18, working with patients N=8, internships N=5, pursuing a hobby unrelated to work N=3, practising co-therapy N=1.

The last question in the questionnaire related to the study participants as patients. The psychotherapists were asked what annoyed them about therapists who were treating them. The question was aimed at changing the participants' perspective from being psychotherapists to being patients. Seven of those surveyed provided a 'nothing' response. Three participants stated that it was difficult for them to name the cause of anger towards their therapists since they rather understood their emotions in the context of their own problems and transference. Sixteen participants commented on the behavior of their therapists during treatment sessions (e.g. drowsiness, yawning, consuming food or drink or answering the telephone during the session, being late for the session, recording the session without the client's consent, sexual advances towards the client, when I was leaning forward, he was leaning back). Twenty participants expressed reservations concerning their psychotherapists' limited involvement in therapy sessions (e.g. inertia, passivity, insufficient interventions, silence, lack of interpretation, little activity, lack of feedback). The patients – psychotherapists also complained about emotional distance N=11 (e.g. distance, withdrawal, coldness, restraint), lack of mindfulness N=5 (e.g. routine, lack of attention), imposition of the therapist's perspective N=9 (e.g. cooking up his/her own stories, forcing the patient to accept the therapeutic 'guru', negating the patient's thoughts). The surveyed individuals also

emphasised a lack of understanding in the therapeutic relationship: the therapist did not understand me N=5, the therapist's interventions were not clear to me N=5. A few comments regarded the therapist's transference N=6, underestimating the role of the family N=2, the therapist's rigidity N=2, a lack of consistency on the therapist's part N=2, insufficient exploration of the patient's problems N=2, reaching the decision to terminate therapy by himself/herself, without consulting the patient N=1, a lack of competence N=2, focus on support instead of insight therapy N=2.

An analysis of correlations between quantitative factors was conducted. The results are presented in tables 1 and 2.

Table 1. The correlations (measured by Pearman's test) between the age of the therapists, length of employment, length of employment as a psychotherapist, having the certificate in psychotherapy and working time per week and job satisfaction, evaluating the possession of qualities predisposing to success and evaluating the percentage of patients showing improvement.

	job satisfaction	possession of qualities predisposing to success	percentage of patients showing improvement
age	r=-0.023 p=0.832	r=0.047 p=0.666	
length of employment	r=-0.099 p=0.355	r=-0.108 p=0.319	r=0.043 p=0.723
length of employment as a psychotherapist	r=-0.135 p=0.206	r=-0.228* p=0.033	r=-0.090 p=0.460
psychotherapist's certificate	r=-1.525 p=0.127	r=-0.480 p=0.631	r=-0.095 p=0.924
working time	r=0.049 p=0.646	r=-0.167 p=0.120	r=0.085 p=0.485

Table 2. The correlations (measured by Pearman's test) between affective response of the psychotherapists in the situation of failure and success in the therapy and the age of the therapists and their length of employment as psychotherapists.

	success				failure			
	S	O	P	N	S	O	P	N
age	r=-0.350*** p=0.001	r=-0.188 p=0.078	r=-0.326** p=0.002	r=-0.150 p=0.160	r=-0.109 p=0.306	r=-0.177 p=0.095	r=0.050 p=0.638	r=-0.247* p=0.019
length of employment as a psychotherapist	r=-0.405*** p<0.001	r=-0.123 p=0.247	r=-0.395*** p<0.001	r=-0.086 p=0.418	r=-0.147 p=0.164	r=-0.281** p=0.007	r=0.194 p=0.065	r=-0.292** p=0.005

Advanced analysis between the variables describing the level of the psychotherapists' competences showed that psychotherapy training, certificate in psychotherapy, evaluating the psychotherapy process, analyzing the videotape material did not correlate significantly with the percentage of the patients showing improvement and job satisfaction. The percentage of the patients showing improvement did not correlate with the age of the therapist, length of employment, length of employment as a psychotherapist, working time, job satisfaction and the possession of qualities predisposing to success in psychotherapy, as well. There was a significant correlation between job satisfaction and the possession of qualities predisposing to success in psychotherapy: rho=0,24 p=0,026. The psychotherapists, who assessed possessing more of the qualities predisposing to success, declared higher job satisfaction.

DISCUSSION

Almost all psychotherapists acknowledge that they experience failure in their professional work. Psychotherapists are inclined to attribute them to factors within the patient's control and, to a lesser degree, to their own personal flaws or professional incompetence. Similar observations were made by Eaton et al. [11]. According to Anderson, this type of perspective serves to maintain one's positive self-esteem and job satisfaction [12]. Job satisfaction among psychotherapists is high – the current study demonstrated the average job satisfaction to be 80%. Job satisfaction in our study was not

related to the therapist's age, length of employment in their acquired profession and in the occupation of a psychotherapist, working time, and possessing a formal proof of competence in the form of a psychotherapist's certificate. A study by Topolinski and Hertel additionally demonstrated that the level of job satisfaction was higher if the psychotherapist's personality traits were congruent with the theoretical therapy model adopted in his/her workplace and was particularly high in self-employed, open and psychoanalytically oriented psychotherapists [13]. Psychotherapists also highly valued qualities predisposing them to achieving success in psychotherapy, 73% on average. Ninety percent of psychotherapists evaluate their work above the 75th percentile, whereas in reality the curve representing quality of work has a normal distribution. Furthermore, 90% of therapists are inclined to believe that their work performance is superior to that of their colleagues [14]. The overwhelming majority of cases described and presented publicly in the form of publications, conference presentations and training materials concerns psychotherapeutic successes. 'Collecting' successes play an important role in building the therapist's positive self-esteem. As we have demonstrated in the current study, experiencing success (successful completion of therapy by the patient) and failure (premature termination of therapy by the patient) evokes a range of emotions in the therapist. Success is accompanied by positive feelings which are significant in the process of strengthening self: one's self-esteem, a sense of power, self-assurance. Moreover, these emotions surpass the pleasant emotions associated with contact with other people: care, love, tenderness. In accordance with an analysis by Hermans (S-O), this suggests that success is more important for therapists in the context of their self-evaluation than in the context of their relationship with the patient. The experience of strengthening one's sense of self and the experience of pursuing contact, balance in situations of failure. Negative feelings clearly dominate in such situations. Therefore, psychotherapist may be inclined to protect their self-esteem by not acknowledging or minimising the significance of failure. A great number of studies have documented psychotherapists' limited competency

to identify periods of exacerbation in patients being treated by them [14,15]. Psychotherapists do not want to acknowledge their failures but, if they eventually confront them – when the patient does not attend a scheduled appointment and/or terminates treatment – they are prone to analyse the situation in the context of factors within the patient's control. In our study, failure was most frequently, i.e. by 76 out of 100 therapists, defined as premature termination of treatment by the patient, which in 70% of cases was attributed to factors within the patient's control. Previous research exploring therapists' perspective on therapy discontinuation by patients revealed a similar tendency. Treatment cessation was perceived by therapists as: lack of motivation for therapy [16], resistance [17], too great a difficulty in talking about problems [18], fear of being dependent [19]. In reference to the discussion on the psychotherapist's role in the treatment process Todd et al., who took into consideration the mechanisms of transference and counter-transference, noted that all the categories of reasons believed to be within the patient's control, can and should also apply to therapists [20]. The therapist's negative or problematic feelings towards his/her patient may have a significant impact on the course of treatment including its premature termination [21]. The few available comparative studies juxtaposing the perspectives of the therapist and the patient, apart from demonstrating their relative closeness, indicate differences between them: in therapists' perception, the significance of resistance and apparent improvement is overemphasised while accidental factors and patients' dissatisfaction with therapy are underestimated [17,20,22]. An observation made in the current study concerning the reversal of the study participants' perspective from being a therapist to being a patient is interesting. The surveyed psychotherapists who perceived themselves as effective and who attributed failure to factors within the patient's control were highly critical of their therapists' annoying habits. The current study demonstrated that the therapist's age and work experience correlated with lower intensity of emotions regarding the need to strengthen self, and lower intensity of positive emotions while failure evoked less intense negative feelings. Simplify-

ing, with age and experience, psychotherapists experience fewer positive emotions associated with success and fewer negative emotions connected with failure. Additionally, with time, premature termination of treatment by the patient evokes fewer emotions associated with the need for closeness: care, tenderness, love, intimacy. The obtained results can be interpreted in two ways. It is possible that with age therapists gain experience and become less emotionally involved and more humble about the results of their work. It is notable that changes regarding the intensity of emotions felt when succeeding/ failing during the therapist's professional career do not go hand in hand with a greater level of job satisfaction, a hypothesis that a less intense emotional reaction to success/failure may be associated with a degree of indifference or professional burnout. However, research indicates that professional burnout is not associated with the psychotherapist's age, gender, educational level or theoretical orientation but with his/her ability to implement strategies of coping with emotions and possession of personality traits of an effective psychotherapist [23,24].

Although psychotherapists are inclined to attribute failure to their patients, they do not reject these experiences completely. Out of the surveyed psychotherapists, 81% actively tried to work through their failures using, primarily, supervision, discussions with colleagues and self-reflection. Acknowledging one's mistake, reflecting on it and attempting to establish one's role in a problematic situation is associated with recognizing one's impact and constitutes a crucial point in the process of change. This is the contemplation stage, which leads to the commencement of behavior change [25]. The commitment of mistakes accompanied by conscious reflection on them may produce a modification of one's pattern of behavior and may contribute to one's development [26,27]. Admitting a mistake to oneself is difficult but acknowledging it to one's mentor and/or colleagues during supervision is far more challenging. A study by Ladany revealed that supervisees withheld some information from their supervisors [28]. This is caused by the unpleasant emotions of fear, shame and guilt experienced in such situations [29]. Shame hinders one from facing oneself and others in truth and thereby prevents one from analysing

the committed mistake and drawing a lesson from it. A sense of guilt, if mature, facilitates remedial action. Otherwise, it leads to self-accusation and self-blame [30]. Analysing mistakes may be beneficial to both the therapist and the patient. Patients seeking treatment reveal weaknesses and an inability to cope, which are frequently accompanied by feelings of shame [29]. In the course of treatment, they unearth shameful aspects of their self which have been carefully hidden. The mature attitude of the therapist who examines his/her mistakes with humility and accepts failure as an inherent part of his/her professional activity may provide the patient with a corrective experience and may constitute a source of support [26]. Students and supervisees also feel relief when their teachers share their failures with them [26]. Contact with a psychotherapist or supervisor who displays a mature attitude to his/her mistakes and failures, is capable of identifying his/her flaws and using them constructively, may provide a student or supervisee with a model of the appropriate treatment of oneself and one's successes and failures.

LIMITATIONS AND FUTURE DIRECTIONS

Undoubtedly, the study's limitation lies in the exclusive use of a self-report questionnaire as the research tool, which made the evaluation subjective. The number of questionnaires distributed was twice as high as the number of questionnaires returned, which suggests considerable reluctance to study participation. The group of 100 psychotherapists was not particularly numerous but it was decided not to expand the study group through online surveying and to limit it to direct surveying to ensure that the individuals participating in the study are psychotherapists. The study was limited to Polish psychotherapists only. A cross-cultural study would undoubtedly prove interesting.

Conclusions: Psychotherapists experience failures and they are most frequently inclined to attribute them to factors within patients' control. A tendency to preserve one's self-esteem and to strengthen one's self displayed by psychotherapists is evident in the process of analysing previously committed mistakes.

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