We work in a culture of escalating fear, neo-conservatism, economic rationalism, and insurance company intrusion. In our endeavour to keep psychoanalytic therapy viable, many of us are currently grappling with questions about the transparency of our methods and the core capacities of practitioners. Whilst we do not seek a single approach—the complexity of human experience requires more than one way of thinking and intervening—we are paying greater attention to our convergences rather than, as in the past, predominantly focussing on our divergences.

In the spirit of these developments, I will illuminate an area of our work that, despite its acknowledged importance, remains somewhat opaque and mysterious: our mistakes.

Given the paucity of literature specifically dealing with mistakes, I propose that we designate a proper place at the table for them. I hope in some small way, to contribute to expanding the thoughtful and transparent space for creatively exploring our supervision boundary mistakes.

1. Briefly look at the literature on mistakes
2. Discuss supervision and our mistakes
3. Look at our paradoxical boundary functions and challenges as supervisors
4. And finally, take you on an open-bus tour of the Mistake Evidence System I have formulated
1. The Literature

In *Learning from Our Mistakes* (2002) Casement points out that little has been written concerning the analyst and analytic therapist’s mistakes. His book is a valuable exploration of the importance of internal supervision of mistakes—particularly those arising from dogmatic practices. In contrast, I did not find another recent book, *Bad Therapy: Master Therapists Share Their Worst Failures* (2003) at all useful. I can’t resist this quotation, complete with syntax errors, from John Gray of Mars and Venus fame.

… my experience counselling others has been one of tremendous success and only positive experiences. The only problem that used to happen—and I don’t allow it to happen now because I only do brief therapy—is that people come in with a crisis and I would help them to resolve things very quickly. Then, after we were done they just wanted to keep coming in to meet with me because they so enjoyed the experience.

(p.90)

There are several interesting articles. For example, Chused and Raphling, in *The Analyst’s Mistakes*, discuss how mistakes result from inherent uncertainties of the analytic process and from the continuing effect of the analyst’s unresolved conflicts, clinical experience, skill and personal life events. In ‘Common Mistakes in Psychotherapy’, Buckley, Karasu and Charles conducted a study on negative therapy outcomes in which they surveyed 20 supervisors on the mistakes of psychiatric residents. The most common mistakes included wanting to be liked by patients, premature interpretations, overuse of intellectualisation, inability to tolerate patients’ aggression and avoidance of fee setting.

I also want to acknowledge the Self Psychology literature on therapeutic error. Although, I am currently researching it, I do not yet feel proficient enough in this area to comment on it here.

2. Supervision and Mistakes

Despite some useful literature, there remains much for us to think about regarding our mistakes and those of our supervisees. Quintessentially, how does a supervisor practically enable a new therapist to transform the mistake space into a generative space? My supervisees have found that reading case mistakes of ‘the experts’, sometimes written with the not-so-hidden agenda of showing how smart they are, does not equip them, as new therapists, to deal with mistakes in the here-and-now and, indeed, often reinforces their notion that there is ‘one way.’ Neither does simply emulating a supervisor’s idiosyncratic method ensure an independent mistake system for the supervisee.

Please note that I use the term ‘system’, to refer to thinking processes—observation, reflection, appraisal and formulation—and not to prescriptive systems with ‘fail-proof recipes. All therapists require a thoughtful mistake system—a thinking approach to grapple with feelings, thoughts and impulses, and to appraise management options, make appropriate choices and carry out such actions as internal containment, offering an apology, exploring experience, making therapy changes, providing support and enhancing skills.
The aim of supervision is to provide external supervision of the supervisee’s work in order to enable his or her own internal supervision. (This is Casement’s useful term for internal observation of one’s work). Our supervision functions, whether singularly or in combination, comprise teaching, holding, containment, critical appraisal, exploration and enablement. Whilst much of the supervision focus with experienced therapists concerns countertransference, much of that with new therapists concerns anxieties about mistakes.

Our challenge is to enable them to evolve, with awareness, an independent system for working with them.

Mistakes generally fall into one of three categories: formally documented mistakes (e.g. ethical codes), conventionally accepted mistakes (e.g. only listening to content material) and by far the largest, grey zone mistakes (e.g. a transference enactment). Mistakes are subject to patients’ and therapists’ experiences and often involve confusion, ambiguity and uncertainty. The initial identification of a mistake may be made by the patient, the therapist or another person such as a family member, employer or supervisor. However, since mistakes are contingent upon time, place and person and may not be obvious, many are difficult to identify and formalise. For example, a mistake with one patient at one point in time, may not be a mistake with another patient, or indeed, with the same patient at another time. What the therapist perceives as a mistake may not be a mistake for the patient and vice versa. Given these vicissitudes, defining a mistake is challenging. Whether formally documented, conventionally accepted or a grey zone puzzle, I think it is ultimately the patient’s experience and perception of his experience that determines a mistake.

Thus, in my definition a psychotherapy mistake is something the therapist thinks or does (or fails to think or do), which unintentionally adversely affects the patient either directly, or indirectly, through compromising the course or quality of the therapy.

This means that a mistake may involve a verbal or non-verbal action or alternatively, the absence of a verbal or non-verbal action—inaction. A mistake does not always directly affect a patient negatively, but the mistaken thought, action or inaction may affect the course or quality of the therapy and thereby the patient. A mistaken thought (e.g. a wrong formulation or assumption) exists within the therapist’s mind, and it must either be verbalised—a verbal action—or used to influence or instruct an action or inaction, for it to render a negative effect. Feelings and impulses are not mistakes in themselves, but they may lead to mistaken actions or inactions. Since the negative effect of an action or inaction is not intentional or expected, we need to distinguish between malpractices and mistakes.

**Figure 1: THE MISTAKE TRIANGLE**
Mistakes can trigger the therapist’s triangle of feelings, thoughts and impulses, which in turn may inhibit the capacity for empathy, containment and ‘not knowing’. This includes feelings such as shame, embarrassment, confusion, remorse, and anxiety; thoughts such as ‘I want to get rid of this patient’; and impulses such as to hastily apologise, confess, deny, ignore or blame. These states may yield interventions that further compromise the therapy. We might say that mistakes sometimes elicit mechanisms that shift the therapist from a depressive to a paranoid-schizoid position—from concern to fear.

Recently, a supervisee who had mistakenly provided reassurance instead of exploring the meaning of his mistake for the patient, said to me, ‘Ah well, this is the one profession where it’s OK not to know. I really like the fact that we don’t need to know.’ Whilst this might have reassured him, I did not feel at all reassured about his understanding of the ‘not-knowing’ concept! Psychodynamic therapy requires the sophisticated ability to assume concurrently a ‘not-knowing’ and ‘knowing’ stance. This is one of what I call the inherent clinical paradoxes and I will say more about them shortly. Whilst the notion of ‘not knowing’ is currently in fashion, we must carefully distinguish between therapeutic ‘not knowing’ and ‘not knowing’ as an excuse or euphemism for lousy work. We aim to help supervisees to free their minds and to ‘not know’ this patient at this time, yet simultaneously, to ‘know’—to integrate and apply ethics, theory, clinical principles and practice conventions. Similarly, with mistakes, we encourage supervisees to ‘not know’ and ‘know’. In my view, it is much harder to therapeutically ‘not know’ when we do not have a mistake system in which to contain ‘not knowing’ and being confused i.e. we need to ‘know’ in order to empty our minds and ‘not know’.

Attending to one’s own mistakes is palpably different from helping others to attend to theirs and hence there are many questions to consider. For example, does a good-enough therapist always make a good-enough supervisor? How does a supervisor enable a supervisee to develop a therapeutically viable and independent mistake modus operandi? How does a supervisor attend to his or her own supervision mistakes?

As supervisors, we strive to be aware of conscious and unconscious aspects of the supervision. As in therapy, failing to reflect adequately on our supervision and our mistakes compromises the quality of our work. Here are a few examples of my many more supervision mistakes:

› Not dealing with my supervision mistake!

› Relying on the supervisee’s internalisation of my approach without translating and
naming it and thus inhibiting the supervisee’s development of an independent thinking system.

› Being random, ad hoc or sloppy: thus my approach is not clear and debatable.

› Using a confused approach without saying I feel confused!

› Being opaque or overly intellectual, not transparent and graspable—I am the smart one here!

› Being dogmatic and rigid: I have the answers!

› Basing supervision on my astute insights and hunches: rely on me and my fabulous acumen!

› Being passionately empathic and overly holding—at the expense of dispassionate empathy, confrontation and appraisal.

› Being overly confrontational without providing sufficient support. Colluding with supervisees who fail to present direct material e.g. tapes, transcripts.

With experience, therapists develop personal systems for identifying and working with mistakes. Experienced therapists learn that the ability to work usefully with mistakes provides opportunities for therapeutic meaning-making, reparation, the prevention of a further mistake and often, to enhance the working alliance. An inability to identify or work with mistakes may in turn lead to further mistakes, complications, premature termination or even death.

What about new therapists? New therapists frequently attend to mistakes in ad hoc ways, randomly, as ‘hit or miss’ affairs or indeed, not at all. Sometimes they subscribe to the ideal that they should never make mistakes, may be too embarrassed to discuss them, or even to acknowledge them privately. Some fear litigation by patients, poor assessments by seniors, or alienation by colleagues. Others simply do not allocate enough time and mental space to reflecting on their mistakes. Unfortunately, new therapists are also quick to pick up our own bad habits, such as blaming the patient for a mistake—‘My ‘borderline’ is so resistant.’

Supervisees who are new to psychoanalysis have often been trained in cultures that perpetuate a lack of transparency about mistakes. Tacit agreements that they should not disclose mistakes to themselves, each other or their patients, serves to increase their performance anxiety, which interferes with their capacity to contain, think and make sound assessments and interventions. They sometimes find it difficult to understand the mistake paradox: that we work less effectively with our patients when we ignore our mistakes.

Instead of using their energy to strive grandiosely for perfection, we need to assist new therapists to direct their energy towards developing effective personal systems for confronting their mistakes and for making meaning of them. This does not mean that we encourage them to embrace shoddy work or compromise their efforts to provide best practice. Best practice requires that we uphold the highest standards in all that we do, including attending to mistakes along the way.
In supervision, new therapists also need to learn how to address their mistakes comprehensively—i.e. mistakes in all task areas. For example, how to link frame management issues to intrapsychic functioning. Whilst supervising mistakes pertaining to the therapy relationship, empathic failures and countertransference is obviously important, there are other dimensions, perhaps less ‘juicy’, that also require attention. For example: duty of care failures, not referring for medication or hospitalisation when indicated, imposing a spiritual or new-age agenda, subservience to insurance company demands, leaving other patients’ files on the desk, late reports, inadequate history taking, or even an unsuitable consulting room set-up. (In my favourite example, the therapist places the chairs directly facing each other and then makes fanciful interpretations about why the patient isn’t free associating). Ethical violations extend to many more activities than ‘sex with a patient’. Indeed, we might ask whether this constitutes malpractice or a mistake. And what about less tangible ethical problems such as making a patient feel more ‘mad’ or ‘bad’?

Whilst reading or listening to accounts of isolated mistakes in isolated case vignettes is helpful for new therapists, it does not ensure a sound understanding of all the dimensions of mistakes. Our job as clinical supervisors is thus to aid supervisees in recognising ‘The Full Monty’ of mistakes. Given the complex layers of the work, new therapists require a full and flexible way to independently reflect on their mistakes.

Unfortunately, since little has been written specifically about therapy and supervision mistakes, we do not have clearly identifiable systems for knowing and not knowing our mistakes. This is surprising since we have well-documented systems for ‘knowing’ and ‘not knowing’ in other tasks. For example:

- Intrapsychic change systems—such as to enable a patient to take back his projections and increase his capacity for positive introjection
- The intricate system of free association and listening freely—of temporarily emptying our minds and listening in a state of reverie
- The highly determined practical frame system—50 minutes, regular appointments, fee and leave policies etc.
- Assessment systems to establish the patient’s suitability for therapy
- Systems of building up and timing interpretations
- Systems for monitoring countertransference

3. Boundaries and Supervision

We will now home in on a specific dimension of supervision with the new therapist: boundaries. One way of conceptualising boundaries is in terms of our paradoxical role tasks. As therapists and supervisors, we negotiate many paradoxes in our clinical work. I term these The Inherent Clinical Paradoxes’. Perhaps the most well known is the participant-observer paradox. Here I will focus
only on the boundary paradox, which involves concurrently 'connecting' and 'separating'.

In my view, a boundary is a temporal, spatial or functional signifier—it simultaneously defines that which is inside and that which is outside. Whether concrete or abstract, boundaries exist both within and between phenomena e.g. people, places, internal or external worlds. Boundaries demarcate 'shared' and 'apart' times, spaces and functions. In relationships, boundaries enable us both to connect with and to separate from others. In therapy and supervision, our paradoxical boundary task entails concurrently 'connecting' and 'separating' with patients and supervisees. We use relational boundaries to connect: to engage, hold, combine, enclose, accommodate, include, bounce off or kick against. We also use relational boundaries to separate: to segregate, expand, limit, distinguish, protect, release, exclude, disentangle, or indeed, even to flee across the border!

**Types of Supervision Boundaries**

Supervision addresses five types of boundaries: between the supervisee and supervisor, the supervisee and the patient, the supervisor and the supervisee’s patient, the supervisee’s internal world and his or her work, and the supervisee and ‘the profession’. Supervision boundary mistakes reflect our connecting and separating problems: too much, too little, too late, too soon or not at all. We might use a boundary perversely for separation when connection is required or vice versa. Sometimes we manifest mistake patterns and are routinely better at connecting than separating or vice versa. For example, a supervisor might fastidiously begin and end sessions on time, pose interesting process questions, but find it difficult to be emotionally present. Always the observer—seldom the participant!

When we are too separate and not connected enough, we might become: unempathic, withholding, intellectual, depriving, persecutory, inhibiting, rigid, controlling, disengaged or remote. When we are too connected and not separate enough, we might become [also] unempathic, enmeshed, self-disclosing, overwhelmed, collusive, entangled, enacting, undifferentiated, reassuring, or discharging. Here are some examples.

**Table 1: Examples of Supervision Boundary Challenges**

**BOUNDARY 1: THE SUPERVISEE AND ‘THE PROFESSION’**

**Task Aim:** To translate and uphold boundaries of the profession with the supervisee

**Challenge:** The supervisor does not attend to any of the following supervisee issues

**REGISTRATION & QUALIFICATIONS**
e.g. under-trained but worksqualified ‘psychotherapist’ as a fully

**ETHICAL FOUNDATION**
e.g. is not ethically accountable or body to a professional board

PSYCHOANALYTIC PARADIGM
e.g. problematic fusion with new age, religious or political agendas

PRACTICE CONVENTIONS
e.g. eschews a core clinical principle such as free association or 50 minute sessions

ROLE CONCEPTUAL BINARIES
e.g. poor negotiation of symptom alleviation intrapsychic change

TRAINING INSTITUTION MATTERS
e.g. unsuitable for membership, training or completion of training

BOUNDARY 2: THE SUPERVISEE AND THE SUPERVISOR

Task Aim: To manage boundaries in the interests of the supervisee’s professional growth
Challenge: The supervisor does not attend to any of the following deficiencies in his or her own work

MAINTAIN SUPERVISION FRAME
e.g. overly social during session or flirtatious with supervisee

ENABLE INTERNAL SUPERVISION
e.g. no mistake system—overly reliant on internalisation of supervision

FACILITATE INDEPENDENT APPROACH
e.g. no balance generated between conventions and creative initiative

TEACH ETHICS, THEORY & PRACTICE
e.g. insufficient input, dogmatic, lack of rigour, rigid or chaotic

HOLD & CONTAIN
e.g. inadequate emotional holding or mental containment

APPRaise QUALITY OF WORK
e.g. lack of appraisal, avoids confrontation, or is persecutory or disabling
BOUNDARY 3: THE SUPERVISEE AND THE PATIENT

**Aim:** To assist the supervisee with connection and separation boundary functions with patients

**Challenge:** The supervisor does not attend to any of the following supervisee issues

**ATTENDING TO MISTAKES**
e.g. too dependent on supervisor re identifying or managing mistakes

**PSYCHOTHERAPY FRAME**
e.g. separates ‘practical’ issues (e.g. fees) from intrapsychic

**PARADOXICAL FUNCTIONS**
e.g. separates observing/participating or leading/following

**RELATIONAL STANCE**
e.g. collapses the boundary between empathy and reassurance

**APPLYING TECHNIQUES**
e.g. does not crosscheck content and process evidence in formulations

BOUNDARY 4: THE SUPERVISOR AND THE SUPERVISEE’S PATIENT

**Aim:** To monitor one’s own feelings, thoughts, impulses, actions and inactions re the patient

**Challenge:** The supervisor is not aware of how his or her countertransference instructs the supervision. For example, the patient wants to terminate therapy prematurely due to the cost.

**FEELINGS**
e.g. feels no affective connection to patient

**THOUGHTS**
e.g. does not think about what the above might mean

**IMPULSES**
e.g. an urge to hastily ‘advise’ the supervisee

**ACTIONS (VERBAL OR NON-VERBAL)**
e.g. suggests that supervisee interprets the patient’s self-destructiveness
INATIONS
e.g. does not explore lack of affective connection with the patient

BOUNDARY 5: SUPERVISEE’S INTERNAL WORLD AND HIS OR HER WORK

Aim: To assist the supervisee with internal-external connection and separation boundary functions
Challenge: The supervisor does not attend to any of the following supervisee issues

‘SUPERVISION’ OR THERAPY?
e.g. the supervisee regards supervision primarily as personal therapy

MONITORING COUNTERTRANSFERENCE
e.g. cannot distinguish the counter transference source—‘me’ or you

MINDFUL OF PERSONAL LIFE EVENTS
e.g. cannot identify the effect of personal experiences on the work

SELF-AWARENESS
e.g. unaware of his or her impact on others

PERSONALITY PROBLEMS
e.g. unaware of or fails to attend to problematic personality dynamics

4. The Mistake Evidence System

Finally, I will briefly introduce the mistake-reflection system I have gradually built up over the past 20 years in dealing with my own mistakes and assisting my supervisees. The system is described in a book I am completing entitled Making Mistakes and Making Meaning in Psychotherapy. My intention has not been to re-invent the wheel, but simply to name and describe ways in which we might think, be confused, not know and know. My aim here is not to teach the system—that entails a two-day workshop.

The system comprises five dimensions: Conceptual Foundation, Mistake Sequences, Working Phases, Receiving and Providing Supervision and Making Meaning.

Why the title of ‘The Mistake Evidence System’? CBT practitioners aren’t the only ones who are evidence-based. I argue that psychoanalytic psychotherapy is concerned with many kinds of evidence, including content and process evidence. Mistakes may arise when we do not collect enough evidence, adequately reflect on it, crosscheck it, carefully integrate it into formulations, or appropriately communicate our understanding of it to the patient. This system adopts the abiding injunction of creative writing teachers: ‘show, don’t tell!’ Hit and miss interpretations involve telling based on assuming, enacting, discharging, prescribing, guessing or reassuring. Evidence-based interpretations involve showing based on observing, experiencing, exploring, reflecting, and crosschecking.
When working with a mistake, I advocate that we use internal and external evidence during each phase: identification of the mistake, reflection on the triggers, mechanics and sequence, appraisal of management options, implementation of management action and evaluation of management actions. These working phases vary in duration and sequence. Sometimes we manage a mistake within a session and sometimes it involves weeks, months and much pain, supervision and working through.

**Dimensions of the Mistake Evidence System**

**Conceptual Foundation**: this concerns the definition and determinants of a mistake.

**Mistake Categories and Examples**: includes examples of mistakes in each area of our work: the Contextual Framework, Change Functions, Relationship Stance, Affective Engagement, Intervention Stages, Frame Management, Internal and External Therapeutic Techniques and Mistake Management.

**The System in a Nutshell**

At the core of the system is the therapist’s reflection on his or her mistake mechanism. This is comprised of the therapist’s triangle of feelings, thoughts and impulses. The triangle may be triggered by the therapist (e.g. exhausted and unavailable), the patient (e.g. a projective identification), someone else (e.g. spouse phones to attack therapy), a previous mistake (e.g. failure to assess suicidal risk or suitability for therapy) or pragmatic factors beyond control (e.g. the freeway is closed). The resulting permutations on this triangle may yield a mistaken thought, action or inaction. Here’s an example. The trigger is the patient’s silence. The new therapist feels anxious and has an impulse to stop the silence. The therapist then makes a hasty and lengthy reflection about the patient’s anxiety. The therapist feels better but her poorly timed and inaccurate intervention frustrates the patient and halts his associations. In this common example, the therapist has not applied thought to her feelings and impulses before taking action.

**Figure 2. THE MISTAKE MAKING SEQUENCE**

1. TRIGGER

2. MISTAKE MECHANISM
The Mistake Awareness Sequence
Identification > Reflection > Options > Management > Evaluation

3. MISTAKE MANIFESTATION

4. IMPACT

5. RESPONSE

The Mistake Management Sequence
Identification > Reflection > Options > Management > Evaluation

Whatever the permutations between feelings, thoughts and impulses, a clinical mistake ultimately involves verbal or non-verbal actions or the absence of action. This is termed the mistake manifestation. The mistake may affect the patient in various ways (sometimes even initially positively e.g., a rescuing enactment), degrees of severity and vary over time. This is termed the mistake impact. The impact may or may not result in a demonstrated response by the patient, be it verbal, non-verbal, direct or indirect. Of course, the mistake may also affect the therapist and when it involves someone in addition to the patient and therapist, such as a family member or another professional, then the responses of these others is relevant.
The first sequence of awareness shows that if the therapist becomes aware of his or her triangle dynamics, he or she can avert a potentially mistaken intervention. The second sequence of awareness, the Mistake Management Sequence, shows how, after making a mistake, the therapist can use awareness of it and its mechanics to manage it therapeutically.

My supervisees have found The Mistake Checklist to be particularly useful in building up their reflective capacities. This is a list of factors pertaining to each working phase. The aim is not to fill it out religiously, and hence supervisees use it flexibly to prompt their thinking and understanding.

The last dimension concerns how the therapist or supervisor can make meaning from making mistakes. The upside of our mistakes is that they provide fresh and unexpected avenues for making meaning—of our work with a particular patient or supervisee, of our clinical skills, of ‘the profession’ and of ourselves. In my view, meaning is not something we find, but something we make. As therapists, we cannot provide happiness or meaning to our patients, but we can try to facilitate their own capacities for making meaning and happiness. As supervisors, we cannot provide formulae to ensure mistake-free therapy, nor shortcuts for mistake management, but we can enable supervisees to develop an independent system of internal supervision.

Finally, there are innate limitations to our work and any mistake system must allow for them. For example, we are limited in thinking about thinking, in our theories of the human condition, in understanding the meaning of another’s material, in connecting with the affective experience of the other, and of course, ever limited in our understanding of ourselves. In the light of these limitations, we could say that the new therapist embarks on a journey where it is more usual to make mistakes than fully attuned interventions. In Greek mythological terms, supervisees who have unintentionally ‘shed blood’ may need our help with internally transforming their pursuit by the avenging Furies into soothing by the more kindly Graces.

References


With thanks to Carol Bolton for her suggestion to include this dimension. Thanks also to other PPAA Conference discussion participants for suggesting the inclusion of the boundaries between
the supervisor and the supervisee’s therapist, the supervisor and the supervisor’s supervisor and
the supervisor and the supervisor’s therapist. I will include these suggestions in subsequent papers.

An earlier version of this paper was presented at the PPAA Conference, June, 2005

## Appendix I: The Inherent Clinical Paradoxes

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Paradox</th>
<th>Concurrent Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boundaries</td>
<td>Connect</td>
<td>to connect &amp; separate</td>
</tr>
<tr>
<td></td>
<td>&lt; &gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Separate</td>
<td></td>
</tr>
<tr>
<td>Engagement</td>
<td>Observer</td>
<td>to be an observer &amp; a participant</td>
</tr>
<tr>
<td></td>
<td>&lt; &gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Participant</td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td>Know</td>
<td>to seek knowledge &amp; to suspend knowledge</td>
</tr>
<tr>
<td></td>
<td>&lt; &gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not know</td>
<td></td>
</tr>
<tr>
<td>Containment</td>
<td>Take in</td>
<td>to mentally take in &amp; give back</td>
</tr>
<tr>
<td></td>
<td>&lt; &gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Give back</td>
<td></td>
</tr>
<tr>
<td>Holding</td>
<td>Support</td>
<td>to emotionally support &amp; release</td>
</tr>
<tr>
<td></td>
<td>&lt; &gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Release</td>
<td></td>
</tr>
<tr>
<td>Understanding</td>
<td>Inside</td>
<td>to understand what is inside &amp; what is outside</td>
</tr>
<tr>
<td></td>
<td>&lt; &gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outside</td>
<td></td>
</tr>
<tr>
<td>Attending</td>
<td>Content</td>
<td>to attend to both the content &amp; the process</td>
</tr>
<tr>
<td></td>
<td>&lt; &gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Process</td>
<td></td>
</tr>
<tr>
<td>Reflecting</td>
<td>Creatively</td>
<td>to generate creative &amp; ordered reflections</td>
</tr>
<tr>
<td></td>
<td>&lt; &gt;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ordered</td>
<td></td>
</tr>
</tbody>
</table>
Spontaneity
Play to play
< > & to be responsible
Responsible

Rules
Keep to keep the rules
< > & to break the rules
Break

Empathy
Compassion to be compassionate
< > & dispassionate
Dispassion

Direction
Lead to provide direction
< > & to follow the patient
Follow

Values
Uphold to uphold ethics
< > & refrain from prescribing values
Refrain

Awareness
Aware to be aware that we are unaware
< >
Unaware

Presence
Alone to be alone
< > & to be with the other
With

Theory
Eschew to put theory aside
< > & to integrate it
Embrace

Interventions
Construct to construct
< > & deconstruct interventions
Deconstruct

Thoughts
Independent to think independently
< > & within conventions
Conventional

Dr Wendy-Lynne Wolman
G.P.O. Box T1754
Perth WA 6000