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Chapter 25

Bad Therapy— A Way of Learning

By Moshe Lang

This paper describes a new training technique. The therapist, with a role-playing family, is instructed to do "bad therapy"—to make the family worse. Usually the "patients" and observers regard the "bad therapy" as beneficial—in fact, better than before. Several examples are given and a short discussion follows.

"When I am good I am very very good,
But when I am bad I am better."

Mae West

A well-known Israeli poet sat in a popular cafe on a Tel-Aviv boulevard talking of this and that. The conversation turned to writing poetry and the ability of the public to discriminate the good from the bad. As a result, a bet was made that the poet could write a nonsensical and valueless poem that would become very popular. To everyone's surprise he was a winner. Not only was the poem extremely popular and its

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nonsensical quality unchallenged, but it was regarded as high quality poetry.

Something very similar happened in Australia in the 1940s when two young poets, in setting out to prove the local critics incompetent, wrote poems attributed to an unknown (and nonexistent) poet named "Ern Malley." The poems, to the writers' delight, were enthusiastically praised by the critics. The poets then proceeded to disclose that they had written these poems as a poetical hoax. In their own words "the writings of Ern Malley are utterly devoid of literary merit as poetry." However, the critics and most of the interested public still insisted the poetry was of high quality and so it was acclaimed. In one critic's view "they wrote poetry in spite of themselves." The poems provoked a great Australian debate on the value of poetry in general, these poems in particular, and the role of the critic (Harris, 1961; Jeffares, 1964). Apart from these being good stories to tell, they are worth quoting as they demonstrate the major theme of this paper.

The license to be bad, provocative or devious may release some unsuspected creative processes. Further, such permission has great potential for stimulating new ideas and challenging some of the customary assumptions and habitual ways of thinking and working.

While supervising a therapist whose treatment with a family seemed to be stuck, I suggested that she set up a role-play with her colleagues in the supervision group. Soon after the role-play started it became apparent that the therapist was stuck in just the same way that she had described herself with the real family. She seemed repetitive and overcautious. I stopped the role-play and consulted with her and the rest of the group as to how to improve her therapy. A series of suggestions was made and she returned to the role-play family. Some improvement was noticed, but clearly not enough to bring about a positive outcome. I was still struck by how careful she was and how hard she was trying to be a good therapist.

Spontaneously, I decided to perform a crazy experiment. I stopped the role-play, invited her back to the observing group and proposed that she was trying too hard to do good therapy. I proceeded to ask her, "What would you do if you wanted to do bad therapy, that is, try to make the family worse rather than better?" Her first response was "I'd go back and tell mother she's a terrible pain, a bitch and a nag." So I asked, "Why haven't you done so?" She replied, "She couldn't take it." I asked, "Will she get worse?" "Yes," she said. I said, "This is the kind of intervention we are looking for." With the help of the group we

continued to build a list of "bad" interventions that could be guaranteed to produce "harmful" results.

I then asked the therapist to go back and do "bad therapy" on her unknowing and unsuspecting family. A lively and gripping human drama then proceeded to unfold.

The mother, to the therapist's great astonishment, was delighted to give back as good as she got, revealing a punch hitherto unsuspected. Father, who had been told by the therapist that she felt utter contempt for his passivity and withdrawal, responded by revealing his own distress and feeling of exclusion from his family, and pointed out that he experienced his passivity not as a choice, but as a role forced on him, one which he found very distressing.

During the deroling[1] (Churven, 1977) and subsequent discussion, the group members all agreed that when the therapist was "bad" she was very, very good—in fact, she was better. The discussion in the group was most energetic and lively and some fundamental questions about the basic assumptions governing therapy were raised. The issue of what constituted good or bad therapy, both for this particular family and in general, was brought into focus with heightened urgency and vividness and from a new perspective.

I am reminded of a story of a famous general who received a communique from headquarters which said "you are outnumbered, outgunned and outflanked and no help will be forthcoming. What will you do?" He replied "Attack of course." The major thesis is not that "attack" is always better than "defense" or that "bad" is better than "good" therapy, or that "opposite" behavior for a stuck therapist is better than his "current" behavior, but rather that a good general should always be aware of his position and of the various possibilities of attack as well as defense. In order to properly appreciate the strategic issues involved in defense, he would be well advised to consider ways of attack. To appreciate where one is, it may be valuable to shift position and look back at where you were as the therapist. In order to evaluate your behavior, you may well be advised to behave differently and to closely monitor the responses your new behavior elicits and the nature of the feedback you get.

The story of the famous general reminds me of the infamous one. He was taken prisoner along with his brigade without putting up any resistance. When asked why he surrendered without firing a shot, he replied, "I did not want to give away my position!"

Watching a number of therapists at work I am often struck by their

fear of giving away their position; they appear to be seriously inhibited by the importance they attach to gaining acceptance by the family, apparently at all costs. Others appear too deeply preoccupied with the scientific reliability and validity of their observations and inferences, while some seem more concerned with the maintenance of their superior professional role (cf. Haley, 1979; Whitaker, 1976).

Experimenting with "bad therapy" as a teaching technique for a few years has proven very useful in demonstrating to trainees that such superficial considerations must give way to much more important and fundamental issues. If you find that what you believe to be good and what you have been doing for years is found by both "role-playing patients" and colleagues to be inferior in its effectiveness to that which you believe to be "bad," then you are inevitably forced into some fundamental questioning of the nature of therapy and your own therapeutic endeavors. Furthermore, if in fact your serious attempts to be harmful and to make people worse fail, then you can no longer assume that you really know the score.

On a number of occasions I have used the "bad therapy" technique in ongoing training and/or supervision groups. This technique seems to have had long-term effects on how a particular therapist conducts therapy. This is illustrated in the following case.

CASE 1

Flo, a very experienced social worker, sent the following report of her work with a family before and then after the experience of "bad therapy."

> The family consisted of the mother, a nurse and perfectionist, who came from a disturbed family background. She was seen as "mad" or borderline by herself and the many helping professionals who had been in continuous contact with the family over a number of years. I was afraid of "pushing her over the edge" if I went too far. Father was a barman who worked long hours and in the evenings. The oldest child, Bill, was aged 15, followed by Fred, aged 13—the identified patient. Fred had suffered head injuries following a motor car accident and was epileptic. He lived in a hostel during the week and came home on weekends. A younger boy, John, aged 11, had been before the court for shoplifting and was ordered to see a psychiatrist. Two younger girls completed the family. My contact had been restricted to long telephone calls with

the mother in which she ventilated her negative feelings about the hostel. I responded by patient listening. When the mother decided to discontinue treatment with the psychiatrist who had been seeing her and her two younger sons for six months, I was at a loss to know what to do. I had been counting on this psychiatrist to sort out the family problems.

I decided to present the problem of what to do next to the supervision group. A role-play of the family was set up and, as instructed, I tried hard to make the role-playing mother worse, but was a dismal failure. I was totally unable to produce the negative response I had confidently expected of this "fragile" mother. This left me confused and unable to understand what had happened, and I rationalized the situation by saying to myself that "the role-playing mother didn't respond as the real one would have." After this "bad therapy" experience came the recognition that I was terrified of triggering a response in mother that I couldn't handle, followed by the realization that I wasn't handling the situation anyway.

Finally, I determined to adopt a different role. When the mother next contacted me I refused to talk on the telphone, said I doubted the seriousness of her desire to bring about some change in her situation, and refused further contact unless both she and her husband were involved. This resulted in the father telephoning to ask that I visit them to discuss their difficulties in coping with Fred. Subsequently there were three joint interviews. My perception is that I said and did little. Mother and father talked to each other as if they had never discussed their difficulties before. They maintained that Fred was a handicap to the whole family and that permanent full-time placement was the only solution. I gave the parents the responsibility for finding such a place. They went together to see an institution which they found "quite excellent but not for Fred." They talked about the implications for the whole family if Fred was placed, and then involved the other children in the discussion of what was best for Fred. The decision was made for him to return to live at home. The family then discussed what would have to happen for his return to be a success. It was decided, for example, that his father would need to spend more time at home and with his sons, and become more explicit in his support of his wife. The mother would need to be more explicit in making her needs known, as well as recognizing that Fred's return home could substantially reduce the settlement he would receive in a

pending court case. The parents were given the responsibility for planning his return home and arranging the school transfer. They were able to follow through and Fred returned home without difficulty.

I agree with Flo that the change in her therapeutic style from a passive and accepting listener to an active and effective change agent, who successfully handed back responsibility to the family, can be seen as being triggered by the "bad therapy" experience.

One recent variation of the "bad therapy" exercise has been based on splitting the group into two. While the therapist and some observers are plotting (planning) "bad therapy" in one room, the role-playing family and other observers are (in another room) discussing what have been the shortcomings of the therapy to date and how it can be improved.

The fascinating outcome which occurs almost universally is that when the therapist comes back and does the "bad" therapy, both the role-play family and the observers see him/her as carrying out the plan they had proposed for "good" therapy.

CASE 2

A therapist had been seeing a 15-year-old girl for depression for a couple of months in individual therapy. In the course of treatment she discovered that her patient was using (abusing) sedatives and tranquilizers which had been prescribed for her parents without their knowledge. The danger was that she also talked at times of feeling trapped and of the hopelessness of her current life, and how sometimes she felt suicidal. The therapist struggled with whether or not to tell the parents this, knowing that if she did she would probably lose the girl from therapy. When instructed to plan "bad therapy" in supervision, in conjunction with some of the observers, she decided to prescribe the drugs to the "patient" with the firm expectation that with a free supply of medication she would surely take an overdose. In the meantime the role-playing "patient" and her observers in the other room decided that in order to improve therapy and arrive at a positive outcome, the therapist should do exactly the same, that is, to prescribe medication for the girl, because this would put the therapist in charge of the situation and make the "patient" responsible for her own life, legitimating her independence from her parents.

CASE 3

A very experienced and competent therapist reported to the supervision group about her work with a family which consisted of a woman, her peripheral alcoholic husband and her two uncontrollable children.

The group thought the mother was overprotective and that mother and son were caught up in a vicious circle in which her inappropriate and ineffectual attempts at controlling him led to more unmanageable behavior on his part.

The therapist was sucked into this system and her attitude and behavior towards the mother paralleled mother's attitude towards her own children, that is, the therapist was overprotective and overcontrolling, specifically protecting mother from her own feeling of possibly being a bad mother.

The group was divided into two and the therapist and some observers were asked to decide on ways of making the family worse and how this could be achieved. They decided that as the mother was very concerned about the possibility that she was a "bad mother," this could be worked on to a point where she could be totally devastated by her badness. To achieve this it was decided that the therapist was to confront mother with a barrage of her shortcomings, failings, and inadequacies regarding her husband, her children, and her homemaking until she could take it no longer.

Simultaneously, in the other room the role-play family and their observers agreed that in order for therapy to improve the therapist needed to become firmer, clearer, and more confronting.

After the therapy exercise, the role-play patients were asked who they thought was the better therapist—the one before or the one after the break. They all agreed that the latter was a much better therapist, and in fact they saw her carrying out their plan for improving therapy. They were amazed and could not believe that in fact she was instructed to make the mother worse.

The person who role played the mother reported later:

> The first experience left me fairly unmoved. I began to feel there was no solution to my problem, and that I was somehow alone and responsible for a child I could not control.
>
> The "bad" therapy was at least challenging. She (the therapist) seemed "quite crazy"—she didn't seem to think it mattered that the child was out of control—and then suggested that "perhaps I

was too keen on controlling him anyway, instead of helping him to establish his own limits." She called me a "bad mother"—that surprised me but it was a challenge. I began to see that I could look at being a bad mother; it was suddenly "out there" and not inside me. "Bad mother" was also beginning to be all the things that I had thought of as being a "good mother"—like controlling the children and keeping them clean. I would not go as far as she seemed to think I should, but she was giving me permission to let go a bit. She shocked me into thinking I could leave my anxiety and self-pity behind and be myself, and allow my children to be themselves.

The therapist made it clear she hated my cringing self-pity and said so. She was straightforward and honest, and that both shocked and impressed me. She issued a challenge—I had a choice of rising to meet it or to run away from it. This made me express the anger I had felt for a long time. I saw that my obsession for control was unnecessary and producing bad results. In this I was a "bad" mother. She gave me permission to hand some of my responsibility over to her (cf. Weakland, 1977).

The therapist reported that she was unable to fully carry out the agreed plan. She experienced strong inhibition against attacking the mother as viciously as was decided. This is a very common theme reported by most therapists, that is, a failure to be as confronting and destructive as intended. However, from her perspective she attacked the mother more than ever before and she was totally amazed that the mother did not collapse, and in fact had found this experience helpful.

CASES 4 AND 5

My own first experience of "bad therapy" occurred many years ago. I was working with Tom, a 15-year-old who was referred to the clinic because of delinquent behavior. At that stage in my professional life I was a committed but misinformed Rogerian (e.g. Rogers, 1951; 1961). One day Tom confessed to me that the night before he broke into a school and stole some tape recorders. Without thinking, and to my total horror, I heard myself say, "You stupid idiot—what did you do that for?" Then I was taken aback, feeling I had forever destroyed my chances of doing any good. I had violated the most important principle in ther-

apy—I had broken the spell of acceptance, and in my mind's eye I saw Rogers looking down at me with strong disapproval. However, while I was feeling totally devastated by my mistake, I was surprised to hear Tom say, "You know what—you are damn right." I was amazed to hear him approving of my "bad intervention." This led to a total change in our relationship and considerable change in my ideas of therapy.

Years later, when I was already a family therapist, I had another experience which I believe is worth reporting. A professional colleague phoned and asked if I would agree to see her and her family in therapy. I worked with them for a while and helped them to resolve a number of issues, primarily those to do with her sister. I then terminated with the family. Months later she called me one morning very distressed and told me that her mother had just attempted suicide. Having established that mother was physically OK, I arranged for them to come and see me the following day.

When I arrived at the waiting room I saw Mrs. Blackman. She looked better than I had ever seen her before and I was about to say to her "suicide becomes you." Taken aback by the absolute inappropriateness and the lack of tact of this comment, I naturally refrained.

Months later when many of the family issues were resolved I told the family and Mrs. Blackman what I had been tempted to say. She said, "I wish you had. It has been many years now that I have wanted people to be much more open with me, and maybe that would have been just the sort of thing I needed."

For me one of the important benefits of the "bad therapy" technique has been the increased interest with which I listen to my own urges to make "bad interventions," and also the greater care with which I observe my patients' responses to my "mistakes." I believe this is a common experience among therapists who have participated in "bad therapy" role-play.

There seems to be a general consensus among patients and observers that the therapist doing "bad therapy":

1. Is in control of the therapy, but at the same time hands back responsibility to the patients for their own lives.
2. Communicates more directly and clearly.
3. Relates to the patient as if the latter is strong and capable rather than weak and ineffectual.

In return the patients report that they:

1. Experience an increase in their own strength and assertiveness.
2. Feel freer to express their feelings.
3. Feel more hopeful.

"Bad therapy" doesn't occur only in role-play. I believe it happens daily, as a very important event in the work of most therapists. Unfortunately, this importance often is not recognized.

One of the most interesting experiences that I have in meeting and discussing work with therapists is that of encouraging them to tell me about the "bad interventions" they make from time to time that work for them, interventions which they are usually too embarrassed or ashamed to admit publicly. Once they begin, a wealth of stories gush out.

DISCUSSION

The purpose of this paper has been to describe an interesting and challenging experience, and to recommend the use of this technique to other therapists so that they may hopefully have similar experiences.

Further, it is written with the hope of encouraging the freer use of different supervisory and teaching methods. Role-playing is particularly useful here. To take full advantage of it we can be, and perhaps should be, much more daring and risk-taking than can possibly be allowed in a real life situation, as the risks are being taken with each other rather than with our patients. By now, the imaginative reader will be able to grasp the possibilities and extensions inherent in "bad therapy." Role-playing is a human situation which allows a unique opportunity for experimentation. Therefore, after trying "straight" therapy in role-play, therapists can be instructed to try a number of different approaches, including:

1. The exact opposite of what they have been doing to date.
2. Restricting themselves to "I" statements.
3. Positive relabeling.

My experience is that the practice of therapy with such constraints is highly instructive.

One of the reasons that I am attracted to family therapy/systems theory is that I see it as the most humane, kind and positive way of conceptualizing human suffering and individual symptomatology. Thus, it

would be distressing to me if this paper were to be misconstrued as a recommendation for increased toughness or aggression towards patients. Rather, it provides an opportunity to examine the therapist's work without advocating any specific direction and helps the therapist to become aware of alternative approaches.

This paper does not intend to enter into a detailed theoretical explanation about why "bad therapy" seems to work, apart from raising a few possibilities. It may be that the benefit to therapists of this experience is in its "permission giving" quality. In "bad therapy" therapists are given instructions and opportunities to say and do things that they wish to, but never dare. The "bad therapy" role-play experience is often deeply reassuring to therapists who find that most of their worst fears are not realized. In fact, they find that both their patients and their relationships with them are much more resilient than they thought, and this gives them more courage in similar situations.

Perhaps it is useful on those occasions where the stuck therapist's previous behaviors have become part of the problem rather than its solution. In such a case the instruction for total reversal, that is, to do "bad therapy," clearly brings out how the therapist has contributed to the maintenance of the very problem he was trying to change. This theme is often highlighted and discussed at length after "bad therapy." It leads to much freer and more open discussion of the needs in the therapist that are met by the "maintenance of the problem," such as his need for approval and love by the patients and his need to keep the patients coming.

It may be that the specific message given to the therapist—to do "bad," to harm his patients, to make them worse—stands in direct contrast to the social context in which the therapist and his patient find themselves. Thus, the therapist is placed in a double-bind situation and the only way out of this predicament is through a second order solution—a creative leap forward to a new level of conceptual organization (Goding, 1979; Hoffman, 1979; Watzlawick, Beavin, & Jackson, 1967; Watzlawick, Weakland, & Fisch, 1974). Perhaps it is this new way of thinking and organizing the material that may account for the lasting beneficial effect reported by some therapists.

The discovery that "bad" therapy may be better than "good" forces therapists to look much more closely at outcome and effectiveness rather than method, and thus they may become more like experienced than beginning therapists (Haley, 1972).

It is important to note that, since Watzlawick et al. (1967) developed a coherent theory to explain the use of paradoxes, there have been an

ever increasing number of publications describing a kind of therapy which appears irrational, noncommonsensical, or uncommon (e.g. Haley, 1973; Whitaker, 1975; Watzlawick et al., 1974). This has culminated in a new paradigm of family therapy (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978). However, in spite of the centrality of this approach, to date it has been taught only by didactic, linear, direct, rational, and commonsensical methods (Haley, 1976; Weeks & L'Abate, 1979).

In a recent paper, my colleagues and I (Stagoll, Lang, & Goding, 1979) argued for the importance of the parallel process between training and therapy. The "bad therapy" technique can be seen as extending the principles and the flavor of this other type of therapy to training. Thus, the learning itself becomes indirect, crazy, unusual, as well as, and perhaps more importantly, experiential.

Paradoxical techniques in therapy should be used on resistive families and only when commonsensical and direct methods have failed (Haley, 1976, Rabkin, 1977, Selvini Palazzoli et al., 1978, Weeks & L'Abate, 1978, 1979). This again parallels my own position regarding "bad therapy"; it is potentially a very powerful teaching technique and as such should be used sparingly and only when a free and comfortable relationship exists between group leader and trainees. Further, my experience to date suggests it is clearly more beneficial for experienced therapists who are familiar with the direct approach than for beginning therapists.

Haley writes "to use the paradoxical approach, a therapist must develop skill and must practice. He also needs to be able to think about problems in a game-like or playful way even though he realizes that he is dealing with grim problems and real distress" (Haley, 1976, p. 71).

Others, like Whitaker (1975, 1976), emphasize the use of humor. Again "bad therapy" parallels this. It is a game, it is play, it is fun, at times unbelievably funny, but it is also very, very serious.

SUMMARY

My old uncle told me about this character who complained, "I've been boiling this egg for hours and it's still hard!" This is often a central issue in therapy. Therapists continue with an approach that fails to produce results. This paper describes a specific role-playing technique to help the therapist bring about changes in his way of thinking and working with the specific family in question, as well as in his general philosophy and practice of psychotherapy.

So, when next in a stuck siutation, try this "crazy" technique and you never know, you may, in the words of Mae West:

"Find yourself climbing the ladder of success
wrong by wrong"
or
"You may lose your reputation and never miss it."

REFERENCE NOTE

[1]Deroling is a procedure I always use at the end of a role-play to reduce the mental health risk to the role players, and also to enhance the didactic value to all the participants. The procedure I usually follow is:

a. Each role player is asked to stay in role and tell all other role players including the therapist everything that he has not been able to say before.
b. Each role player is asked to come out of role and as him/herself to tell all others anything they have not been able to say until this point.
c. The role players are then asked to join the larger group, making sure they sit away from each other. They are then asked how each felt playing his/her particular role and how the role-play character compared to him/herself.

The deroling procedure is conducted by someone other than the therapist.

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