

# PSYCHOTHERAPY BEYOND THE CONTRACT

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I would like to tell you about therapeutic steps, where the role of the client, at least to begin with, is adopted by the therapist. The therapist is committed to assisting individuals, which at this time we can only on the surface call a client. I would not dare to bother you with such things, if it was not for the strong suspicion, that that which I wish to talk about here has its place in every therapeutic relationship, including the classic where the patient comes to the therapist for individual consultation when it is really important for him, he craves it, has a long wait in a queue and has to pay. I want to increase your awareness to the limits of acceptable arbitrariness and responsibility for the patient. I would ask you to examine them and consider if it is not the case that they repeat themselves, to varying degrees of course, in all types of therapeutic relationships regardless of school (method), theory or approach.

I will talk here, based on my own experience, about certain therapeutic steps, where the therapist seeks not only changes, but contact in general with the patient, as the patient completely lacks motivation or does not see any valid reason to make contact. I would also like to use this occasion to ask a question as to what in this group gathered here today are we willing to acknowledge as psychotherapy? This term can be heard, even here, in a variety of meanings and understanding. Another question I would like to raise is as regards the boundary of permissible intervention. I have in mind obviously psychological intervention aimed at assisting the patient and not calling him to order solely to protect his environment.

I shall begin by presenting what we do in our team and how we work. I have the feeling that we are quite alone in what we do and how we do it. We do of course have support from within our team and other teams working in a similar way. But I am interested in reflections from outside of the team from a different perspective. I want to begin with, why and under what circumstances we act, what they are and what risks this brings. While analyzing the reasons for making contact uninvited, we must first of all ask ourselves the question, whether we are willing to work only for those who want our help, or also for those who need it, realizing that the latter is our arbitrary evaluation of the potential client. I imagine that someone needs help and I am ready to not worry unnecessarily about his opinion on this subject, at least initially. At this point an element of risk appears, and the first question, whether such intervention can be undertaken and whether it is a widely understood form of psychological help, or a form of psychotherapy? If, in our discernment there is sufficient reason to start working towards client acquisition, how to proceed in order to minimize the many negative consequences of this situation?

Under what conditions or in what situations do we allow ourselves to make decisions on behalf of others and take steps in the hope that they will be of help to that person, even if he at most agrees. This mainly concerns two groups of patients. The first of which are psychotic patients, often psychogeriatric, with a long history of illness, after many stays in hospitals, with a significant psychological and social degradation. The second group are children and young people from pathological and counter-cultural groups. Both groups include people who often violate the limits of social tolerance, provoking the intervention of family, neighbours, people around them, police, etc. These interventions often result in forced psychiatric hospitalization or court sentences. Every community in a lesser or further state of harmony, more or less precisely defines the limits of what within it is safe and tolerated. Exceeding this limit triggers a spontaneous or a formal environmental intervention that aims to eliminate behaviour of a deviant nature, isolation of deviants, restoring security, in other words the functioning standards in force within a given community. The people I'm talking about, are constantly at risk of such interventions and reprisals from their natural social environment. To apply to these people many coercive measures over a long period of time violates their autonomy and increases mental and social degradation. The consequence is to consolidate the status of deviant, to enhance their life and mental health problems and to reduce the chance of changing their situation and way of functioning. This is for us the specific, serious reason why we have the courage to make contact with them, often against their will and without any clear therapeutic contract. In describing the problems of the people we are dealing with, you must consider that they also have numerous other problems. They live in a hostile or indifferent environment, their basic, natural needs, not only psychological but also physiological, are notoriously unmet. The scope of their social skills and life is poor and their self-reliance extremely limited. They avoid the consequences by destruction, aggression and madness that have become the dominant ways of coping in life for them. The problem however is that these adaptive responses are effective only temporarily, and utterly destructive in the long run, not only for a given person's environment, but also for himself. It is clear also that these people live in constant stress with a constant sense of threat.

Frequently all of their attention and energy are focused on defense and coping with external or internal, real or imaginary hazards. An enormous problem for most therapists or counsellors, is the fact that these people rarely ask for help, and if they do so, then it concerns completely different issues than trying to understand their own behaviour, its consequences and possible revision of such procedures. Most requests for help are of a financial nature, or the desire to avoid social repression that they provoked. This lack of motivation to change and reluctance to seek help in this matter appear to be the unfulfilled conditions that disqualify them for psychotherapy. Almost all therapeutic schools (methods) put the total voluntary and self motivation of the patient and the therapeutic possibility of concluding a contract, as the basic conditions for access to psychotherapy. Therefore, its deliberations I have given the title of "psychotherapy beyond the contract", and you judge, how it relates to psychotherapy.

The aim of the steps we take is certainly not to make someone happy purely based on our own ideas, but rather gradually to create a situation that allows psychotherapy to begin to be understood as a conscious process which takes place between therapist and patient remaining in the emotional relationship, after the conclusion of a contract containing a commonly agreed purpose and principles of conduct. From my point of view, it does not matter whether what I am talking about is called preliminary investigation motivation, and it is then called psychotherapy at some point, when it meets its classical conditions. If, in our work, we will bring it to this condition, motivation, and awareness of the patient that he may have with us the therapeutic contract, as a rule we have already taken the vast majority of therapeutic steps and we don't really have to deal with this person because he already can handle himself. For us, this moment is rather the end of the therapeutic process, or if you like psychological intervention than its beginning. The trick and the difficulty is concerned with his motivation to the conscious process of change.

If you ask what is the reason for the lack of motivation, so common in the environments in which we work, I would say that it does not stem from an informed choice, but rather from the life stories of these people, their living conditions, the way in which they react and understand the world they live in causes them to not believe in the possibility of any change dependent on them. They believe that their situation depends entirely on fate and their impact on their life is entirely dependent on the skilful interim use of their skills. These people do not believe that they can have an impact on their life, their destiny, even on such matters as incomprehensible to them as their own personality, character or behaviour. We firmly believe that a person can have an impact on their behaviour, can guide them and can change themselves very deeply. These are not just our ideals, but this is our reality.

The majority of people we work with are people on their own. Often they are literally alone, but they are also frequently members of a family who either take no interest in them whatsoever or treat them like objects. They are therefore people left completely to their own devices with their basic problems, or at least this is how they feel and comprehend it. For them hostility or indifference is the norm. Our dealings with these people begin with the step, which not by chance in our group we call seduction. **Firstly** - we try to clearly and explicitly show our commitment to their affairs. We repeatedly tell them that we want to help them with various issues, we will come to them regularly unless they make it impossible. We declare our willingness to seek contact with them and to help them, although we generally do not get asked. As a rule, they do not believe, or report various types of reservations and concerns. **Secondly** - we try to as soon as possible, concretely and effectively help them with various problems, which they have too many to count. We try to be in this useful and effective as far as is possible at a reasonable cost (I do not mean money). **Thirdly** - we do not place any or almost any preconditions. We are aware that this is manipulation, and that actually almost anyone, especially those in need of assistance, can be binded in this way. If you will be involved with someone, focused on him, ready to help in the effective aid and you are not going to do want anything in exchange, in my opinion it is just a question of time, when they stop fighting against having contact with us. And this is what happens in our work. Why do we work in this way, why do we begin with seduction? In the first place, the vast majority of these people are in such a situation that no other course of treatment could take place. They are "unconscious" because both their mental state and the real life situation, social, and so on, are so difficult and hazardous, that there is no way he would be interested in dealing with whims such as self-development or expansion of consciousness. They must first meet their basic needs, and a minimum of psychological safety so as to be able to "wake up" to look away from the real or imaginary threats and take advantage of the energy reserves they have saved in this way, for use on the meta level. This is the basic reason why we allow ourselves such manipulations. We realize that if someone can not satisfy their own needs themselves and suddenly there appears an effective, good source which almost unconditionally meets these needs, it inevitably leads to dependence. Such a person begins to become involved with this source, with the person, and the consequence is to begin the whole process of transference, projecting unrealistic expectations and development of the therapeutic emotional relationship.

Of course, speaking of this I deliberately simplify and exaggerate to be clearly understood, but please remember that this process takes many months and sometimes years, along the way occur many crises, disappointments, trials, tests and failures. In my opinion it is only a matter of agreement, whether you call it psychotherapy, or the initial stage of motivation to change. Our psychotherapy is called the bond between the therapist and the patient, where as a result of an emotional relationship that develops, there occurs the process of

unlocking further emotional potential release of new opportunities and the verification of expectations and existing ways of coping by the patient with their mental health problems and life. It is obvious that the person who can handle himself, functions just as ably in real life situations.

I will now discuss the potential dangers of this kind of conduct that we put into practice as regards to our patients, at least those risks of which we are aware. The therapist who enters into a relationship with a person, with his family, and sometimes even with a social group, gaining immense power, the possibility of enormous influence, and thus the possibility of exploitation and ABUSE OF POWER. I will not talk here about a situation when someone is doing it consciously. I want to tell you about the consequences of abuse of power when this happens without an awareness of the consequences.

The first threat is DOMINATION, that is nonconsciously imposing your own decisions and shaping the situation contrary to the readiness and willingness of the patient to a greater extent than is necessary. I do not know where to mark the boundary to determine when it is clear that we are making abuse of this power, when we use it more than is necessary for the protection of this person or his environment. Illusion is the sense that the boundary is due to my contract with the patient. The situation is like dating someone in prison. My client has a very limited choice and would agree to a lot of things so long as for example he did not go to jail, or have worse conditions than those already existing. It is irrelevant whether we arrange it or not, because his choice to me is just a game.

The second such danger is INDOCTRINATION. We have to deal with it always in this type of relationship, the question is whether we are aware of this or not, do we control it and is the use of indoctrination something that is seriously justified. When working with children or young people of a certain age, it is impossible to protect yourself from the modeling of patients, and perhaps it would be unwise to avoid the transmission of certain patterns of behaviour. For example you can teach them what is right and wrong, or teach them to form and resolve questions themselves, etc. It is no coincidence what you learn. If I speak here of indoctrination as a threat, then I do so in the sense of changing someone more than is meritedly justified.

Another threat is DEMORALIZATION (I am not talking here about morality but of morale), the unnecessary risk of dependence by needlessly doing things for them. This results in a substantial reduction in the level of responsibility of these persons for their lives, for their choices and the consequences of those choices. To me any kind of help poses the threat of this kind of demoralization and consequently reducing someone's feeling of responsibility. It is a matter of reason, conscience, and the heart, which help someone considers as necessary, what help is that "feeding" life-saving, and which is now an unnecessary dependence.

Also a threat is to induce and then LETTING DOWN EXPECTATIONS. This issue is particularly emphasized by our team, because we believe that very many embedded problems are taken by people from their let down expectations. I understand that anyone may happen to arouse an expectation, that then turns out to be impossible to realize. I am also aware that many patients expect from us things that they have never been promised. But a professional therapist should be aware of this, include it in their steps and neutralize the effects, and also strive to ensure that someone's expectations of us are realistic and appropriate. One has to be clear that the way we conduct ourselves and everything from which we begin our contact with the patient, is a kind of deceit. We pretend for this person to be someone else than we are ready to be in the long run. So we inevitably awaken different expectations, and then inevitably disappoint them. However, a reasonable boundary must be maintained. We do this because we do not know any other way, which in relation to those people would be similarly effective.

Another very serious threat are the effects of DROP OUT. From our point of view, it does not matter whether it us or someone else who drops out from the therapy. However we must bear in mind, that this person really depends on us, on whose life we have a great impact, in whom we have already provoked an emotional process by which they have lost much of their routine self-defense mechanisms. They have lost part of them or they are severely weakened, as they find themselves in a specific correction situation, one that deviates from normal life. In my opinion, this happens in any therapeutic process, although the consequences are not always so clear. An example might be a child from a group of counterculture that it functioned well in. In his life story it was the first system which was not only social, but also emotional, which was supporting enough for him, that kept him alive. Such groups are a problem in social terms, but for those children it is a very common psychological and life saver.

In intervening as regards to such a child, we lead to his exit from the group in such a way that he really can not go back to it. Also, what happened to him in the meantime, what he saw and understood, also prevents him from returning. If at that moment we fail in something (e.g., no money gained for the continuation of the program or made a mistake), or he withdraws, the outlook for this person is pretty bleak. For the fate of these people it does not matter on who we can shed responsibility. There are also such problems, which we

mentioned on the occasion of family therapy that working with people who provoke many dangerous situations, not only for themselves but for others also, we are in a position to choose between protecting the patient, and protecting his environment. There is in most cases no way out, it is only a choice of the lesser evil.

When it comes to ways to dealing with all these ethical issues, unfortunately, we do not have any revelations. First, we try to, especially in relation to young people who are learning a profession, strive for them to distinguish friendship from friendliness that is to distinguish being involved with another person from getting involved in their problems. It seems that every person, even intuitively senses whether someone is looking for contact with them as a person, or if someone is looking for contact with them to be of assistance, or to solve a problem. This is a very important distinction in my opinion. But some people, especially novice therapists tend to seek in their contact with the patient approval, sympathy or affection. They do so for various reasons: ignorance, misunderstanding, but also from the need to enhance themselves. In this way they create inappropriate expectations as to being involved and not just focusing on the problems of the person, but also on themselves. Once again, the problem lies in where is this limit for it to make sense, because to focus only on someone's problems while ignoring the person is a mistake. I do not know explicit solutions to this and other problems. I only indicate what should be covered on reflection. As I already said, we also try to provide the assistance necessary to make this process begin, the process of waking consciousness in others, responsibility, formulating their own goals, make their own mature decisions. We offer various forms of group work (group therapy, support groups, work with families), so that the patient is not "hung" on only one therapist, so that the source of support, or the source for new experiences, was not only the therapeutic relationship, but also other relations with others that may be corrective.

All these steps are accompanied by the initial and ongoing education of members of the therapeutic team and our own training. We try to make sure that everyone on our team is part of a supervisory group or has an individual supervisor. Most often, if possible, we work in teams of at least two to be able to rapidly exchange thoughts and reflections. We also spend a considerable amount of time discussing with the team what we do, what we face, what we do not understand. This allows us to support and work with our own moral and emotional problems from which we are not free in the course of our work.

In conclusion, I would like to return to the comparisons of the ways in which we work discussed here and the resulting clinical and ethical issues, to the situation of establishing contact and concluding the contract in the classical psychotherapy office. In my own psychotherapy practice with motivated patients and in the experiences of many of my colleagues with whom I was able to openly talk about all these problems and doubts that arise every day. They occur only to a much smaller degree and have much less dramatic effects. It happens very rarely that my patient really is at the outset interested in deepening and broadening their awareness and support for this awareness resulting from changes in their functioning. As a rule, they only expect relief of their symptoms, help to avoid the consequences of their actions, confirmation of their own rationalization or shifting responsibility for their own problems and choices to their loved ones. I almost always have to participate in a certain game pretending to go along with that (e.g., not speaking clearly as to how I understand their expectations and for what I really am ready), otherwise they will not be willing to take up contact with me. Of course, in my office I meet their mental needs and not their everyday life ones, but I think the difference is more quantitative than qualitative.