NON-PATIENT PATIENTS

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Most therapists are convinced that among the prime requisites for successful outcome in psychotherapy, are a realization of a need for change, and a desire to change, on the part of the patient. Obviously, there are patients whose treatment can be considered "successful", who do not have the (initial) desire, nor indeed, even the realization that change is needed. Consider, for example, children, who are brought to a Guidance Center by their parents, either because the parents realize the Child's emotional development is not along normally acceptable lines, or because they, the parents, were themselves made aware of the child's problems through, for example, academic failures or court hearings. There is substantial clinical evidence that psychotherapy "works". That is, outside judges, as for instance, the school, the parents etc., agree the child has "improved". Even test findings can indicate "improvement". Yet, it often happens that the child is not aware of the reasons he was brought to the Center and, upon termination of treatment, is unable to verbalize any real changes in him.

There are other types of patients who come to a therapist without a realization of a need for change. Reference is here made to those who are referred by the courts, either directly or through the probation Department. In many instances, therapy is made a "condition" of probation.

In the years I have been associated with this Community Mental Health Center, serving an urban-rural population. I have identified several major types of patients who must be considered reluctant, and who have been found to be most resistive to treatment. I would like to discuss two such types, primarily because they do not fit the usually accepted role of "patient", and yet are offered therapeutic hours.

The first type consists of parents of children referred to the Center. We have, as have many similarly operated Centers, made parental participation in therapy either with the same or different therapist, a requirement for accepting the child into treatment. Actually, the reasoning behind this is equivocal. On the one hand, we are following an established pattern. As far back as 1951, Dorfman stated that even if the parent does not enter treatment, the child who does, changes his perception of his environment, and ultimately will react and interact under this new set of conditions. ("… the fact remains that many children have benefited from play therapy without concurrent parent therapy") (Dorfman, 1951 : 239). On the other hand, empirical evidence shows that when parents gain insight into their role, vis a vis their child, therapy (of the child) is that much easier facilitated.

Because of the economics of time, staff, waiting lists, and other prosaic administrative problems, children, or at least adolescents, are often seen in the group situation. Their parents are also seen in group. And it is here that resistance comes to the fore.

Parents usually see themselves as "refer-ees." The parent groups customarily proceed along similar lines. The initial phase is one of a kind of shock that they, the parents, have to be "seen." ("It is Johnnie who is presenting problems. Nothing is wrong with me.") After this period comes testimonial giving Good or bad. ("Johnnie did thus and such; Johnnie's

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teacher said thus and such; Johnnie is not as————as before". Always the tone is child, rather than parent oriented. Because the children concerned provide much to talk about, and because, after all, it was the child who was referred, the therapist often falls into the trap of maintaining the group at this level. Consequently the "group" remains a collection of individuals who happen to be sharing the same therapeutic hour. There is little group interaction, the group process becomes stalled, and aside from some catharsis allowed the parent, very little that is basic is accomplished.

If the therapist realizes, however, that there is a fundamental attribute common to all members of the group, he can focus on this to achieve some kind of group awareness. This attribute is, of course, the parent-child relationship. Regardless of whether this relationship is positive or negative, it exists. By constantly bringing the discussion to this more broad, more encompassing factor, the therapist can escape the series of one-to-one relationships that are in danger of becoming established.

Parents, at least unsophisticated ones, are usually surprised to find that like Moliere's character who was amazed to learn he had been speaking prose all his life, they *always* have a relationship with their child. And, further, that this is a two-way relationship. The question "How do you suppose your child feels about that?" In reference to something the parent has said or done, often brings a silence. When parents in a group setting are forced to think about a more abstract concept (e.g., relationship) they begin to recognize communality with fellow patients in the group. Also, this tends to reduce the feeling that the therapist sees something "wrong" in them, which in turn lowers resistance.

Our role as therapists after all, does not consist in placing blame as much as it consists of clarifying the situation. Patient's especially "refer-ers" need to recognize this fact, but unfortunately too often see themselves as placed "under the hammer" of the therapeutic situation. Of course, the therapist must consider unconscious motives on the part of the parent refer-ers who, almost always perceive themselves as being somehow responsible for the situation, and suffer guilt, or something akin to this. Their reliance on professionals for help is, it would seem, a tacit admission on their part, unconscious though it may be, that they have failed in their role of parents. Being placed in the role of refer-ee emphasizes this feeling.

Now, it is one thing to teach a child the mechanics of solving addition problems, and it is another to teach him better study habits, to attain a healthier school attitude, and so forth. Similarly it is one thing to teach a child to say "yes sir," and "no ma'am," and it is another, much more important thing to establish a more meaningful two-way relationship between parent and child. When presented with this concept, parents seem more ready to enter into a group, as such, and the group process flows more efficiently. Prognosis for each individual parent-child relationship becomes that much more enhanced.

A similar situation exists with respect to the second type of non-patient patient I would like to discuss. This group consists of spouses who refer their marital partners for treatment. When the refer-er is told he (or she) should enter into treatment, either co-jointly or conjointly, the refer-er/refer-ee conflict arises. This problem was initially brought to my attention when a large influx of requests for marital counselling came to a mental hygiene clinic with which I had been associated. It was

felt that the wives could be treated in a group, but at the time there was no other staff member who felt capable of working with the group of husbands. Accordingly, the husbands were scheduled for individual therapy.

The immediate reaction in the wives' group was "Why me?" The women felt that they made the referral, they perceived the husband as the partner responsible for the marital disturbance and yet they, the "refer-ers" were being seen in therapy. Again, group sessions became testimonial hours, and the group process (and consequently therapeutic progress) was hindered.

Quite often in supervising therapists, I have run into this complaint about this type of group. My reaction, based upon my own experience, is to focus away from specifics to the more abstract; in this instance, as with the previous type of group already discussed, the problem of relationship (in this case, husband-wife) should be stressed.

When faced with the problem of treating the non-patient, the therapist must be aware of the refer-er/refer-ee conflict. This conflict exists within the patient, and all too often exists within the therapist. It is unfortunately too easy to slough off a mother or wife by listening to her complaints, rationalizing by saying she is not the primary person we are dealing with.

It is most important to realize, and to share the realisation with the patient, that he is part of the situation. To facilitate the treatment process, the unconscious motivation, as alluded to above, should be brought to the patient's level of awareness.

The above discussion has centered around therapy groups, probably because fledging therapists face more frustration in this situation than in the one-to-one situation afforded by individual therapy. In the latter type treatment, the patient is likely to terminate the therapy programme himself, taking his child or spouse with him. The hour is then open for the next patient. With groups, a patient leaves, a new one enters, and the group goes on. The therapist is thus constantly confronted with his failures. However, by accepting the non-patient patient as one with a relationship problem, by delineating this problem, and by looking for unconscious motivation in the referral, the therapist can make the therapy hour meaningful, and thus enhance the prospects of successful treatment of the primary patient.

REFERENCES

Dorfman, Elaine 1951 "Play Therapy", in Rogers, C. *Client Centered Therapy*, New York, Houghton Miffin Company, p. 239.