PSYCHOTERAPIA 3 (178) 2016
strony: 23-29
Jacek Bomba[1], Kazimierz Bierzyński[2]

ESTHETIC PSYCHOTHERAPY. NEW DIRECTION OF PSYCHOTHERAPY DEVELOPMENT? *

[1] Psychotherapy Centre, Krakow
[2] Chair of Psychotherapy, Jagiellonian University Medical College

ethics
contract
diagnosis for psychotherapy

Summary: The debate concerning the relations between the treatment of health disorders and psychotherapy has been going on within the Polish Psychiatric Association (PPA) for more than two decades. Aleksandrowicz formulated a radical opinion on the psychotherapy, to wit, that it is a treatment of health disorders with a psycho-social genesis. One of the authors (JB) postulated that the psychotherapy be extended to cover situations of risk of disorder (prevention), and that it deals with unsatisfactory outcome of disorder (rehabilitation). The efforts of the PPA psychotherapists (Pawlik, Tronczyński) resulted in the area of psychotherapy (as well as that of the counseling by psychologists) being financially taken into account by the national health insurance agency. In the second stage of the debate, de Barbaro criticized the medicalisation of psychotherapy, thus claiming its being a legitimate way of dealing with problems other than health disturbance. This approach is understandable especially in the psychotherapy of families and in the therapies promoting the individual development. In view of the fact that a significant portion of psychotherapy is delivered outside of the health care system based on the health insurance resources, in individual services, information concerning the clients is scarce. Nevertheless, the information gathered from supervision and training of supervisors lead to the supposition that the psychotherapists undertake psychotherapy of persons who had not been diagnosed as suffering from health disorders. Moreover, psychotherapists (non-doctors) abstain from making a diagnosis for psychotherapy, formulating their contracts as proposals aiming at exploration. All over the world we can see a growing interest in the esthetic medicine which is using the methods developed for the treatment of people with health disorders, to achieve the desired change of appearance in the clients. We suppose that in the field of psychotherapy a new direction is being born — the esthetic psychotherapy. It employs therapeutic methods to achieve a mental change desired by the client.

*This paper is based on a lecture presented AT the 45. Polish Psychiatric Association Scientific Meeting of Polish Psychiatrists, Katowice**,** June 16th –18th, 2016

Psychotherapy has been continuously developing in Poland since the second half of the last century. In 1959, after a break caused by the World War II and a period of Stalinism, the 26. Scientific Meeting of Polish Psychiatrists held in Szczecin was devoted, besides mental disorders in involution, to problems of psychotherapy. Antoni Kępiński and Stefan Leder presented their, and their teams', experience with group psychotherapy in treatment of psychiatric in-patients [1, 2, 3]. Community of psychotherapists, members of the Polish Psychiatric Association, the largest organization of psychotherapists in Poland, considered psychotherapy as an important method of treatment for people with mental disorders. The most radical representation of this position was definition presented by Jerzy W. Aleksandrowicz [4], declaring psychotherapy as using methods of psychology to treat health disorders of psychosocial pathogenesis. The strict delineation of psychotherapy was criticized as postponing it in prevention and rehabilitation [5]. Nevertheless, medical radicalism of Aleksandrowicz could be understood. Significant changes in the field were appearing in consequence of introduction of humanistic psychology and humanistic psychiatry, in Poland most emphatically expressed by Kazimierz Jankowski [6], Jerzy Mellibruda and Wojciech Eichelberger [7]. Later on, as it happened in American psychiatry and may be even influenced by it, rapid development of neurosciences and neuropsychiatry significantly reduced the role and importance of psychotherapy [8].

In the second stage of the debate de Barbaro turned against medicine for usurpation of psychotherapy. While the first stage debate was carried on within the limits of treatment, the second one has been influenced by the context of medicalization and an idea of inappropriately extending concept of mental disorder [9, 10]. Recognition of psychotherapy as significant method of treatment, prevention and rehabilitation resulted in implementation of basic training in psychotherapy into curriculum of undergraduate medical schools program. Critical position on its medicalization increased doubts concerning legal status of psychotherapist as a profession.

Independently from the contexts of this debate, differences in positions adopted by its protagonists have been rooted in various conceptualizations in their philosophy of medicine and health disorders.

The position presented by Aleksandrowicz is a development of acceptation of a role of psychosocial factors in health disorders pathogenesis. Aleksandrowicz follows then traditional model of disorder as having cause, symptoms, course and outcome. This model also requires an ideal of causal treatment.

The second position underlines understanding of mental health disorders as a consequence of disturbance in individual development resulting in dysfunction and distress. Prevention, treatment and rehabilitation are perceived as stimulation of positive change in development. Moreover, nonspecific factors of psychotherapy, especially support, should be delivered in a way adjusted to individual characteristics of the patient to be effective.

The third one is post-psychiatric and congruent with constructionistic attitude to mental health. To some degree it is connected with earlier rejection of individual disorder in favor of system dysfunction.

In the last reform of healthcare system in Poland, psychotherapy has been enlisted as a treatment being paid by health insurance. Jerzy Pawlik and Krzysztof Tronczyński played a meaningful role in this process. First, they started to arrange reimbursement of psychotherapy

in the Masovian Healthcare Fund, then in other healthcare funds, and, after the healthcare system reform, the new NFZ (National Health Fund) has not rejected this solution. In consequence, psychotherapy has been used in integrated complex treatment of people suffering from mental disorders in in-patient units, day centers and out-patient services.

Nevertheless, rapidly growing number of free practicing psychotherapists form a landscape of Polish psychotherapeutic services. Explanation seems to be complex and muliti-causal. One should, following economy rules, conclude that supply provided by health insurance financed system is lower than demand. Majority of psychotherapists — certified by the Polish Psychiatric Association (and other organizations) are not primarily trained as physicians. Competence of psychotherapists is checked only during training and the process of granting certificates. Professional organizations, including the Polish Psychiatric Association, enforce compliance with the rules of professional ethics codes to a very small extend, if any. It would seem that you do not need to remind the importance of the internal regulations of professional ethics. Associations of psychotherapists have declared their ethical standards [11–15]. All have also ethics commissions or peer tribunals. But, for example, peer tribunals of the PPA have not dealt with any case of unethical psychotherapist's behavior for the last decade. At the same time a new type of NGOs has been founded for support of victims of psychotherapists' failure [e.g., 16]. This may mean that, despite the concern for the development of standards of conduct, their enforcement causes considerable difficulties. This is especially important in face of persistent lack of legal regulation of the status of professional psychologists and psychotherapists. Their work, in addition to healthcare facilities, is treated by law like any other "own business".

At the same time, the healthcare services financing system, provided by the insurer, makes the allocation of funds for psychotherapy low and healthcare facilities receive contracts using external services.

It is not difficult to start a psychotherapy practice. People searching for help find psychotherapy there. Although they have to pay for it, they skip the burden of bureaucracy requiring referrals and exposure to queuing and waiting. Not without significance is also the opinion of certainty of discretion.

Who benefits from psychotherapy in private practices? There is scarce information on users of psychotherapy provided in individual practice service. Medical associations care for statistics on patients using physicians' practice only. No information on clients of other psychotherapeutic services is collected. It is also difficult to differentiate treatment from other forms of services provided by psychotherapy practices.

For several decades psychotherapists have been active in care for children, adolescents and families outside of healthcare system, in outpatient clinics organized within and supported by educational system. KOT (Krakow Therapy Center) is a well known example.

Later on psychotherapeutic services have been financed by social services: crisis intervention, family support or system of supporting psychotherapy from the municipal budget. Psychotherapeutic services are also available in centers organized by religious communities or NGOs.

There is no way to identify beneficiaries of therapy provided there. Nor to find what services are provided: prevention, treatment, rehabilitation. Probably there is even no need for such segregation.

Clients of these services are usually people who are not well off, even poor, who experienced many stressful, even traumatic situations. In such context boundaries between crisis intervention, prevention and treatment is illusory.

Information on psychotherapy provided outside of healthcare system comes from supervision or supervision of supervision practice. We have developed supposition that psychotherapists quite often engage in therapy with people who were not diagnosed as suffering health disorder although the Polish law provides that only physician is allowed to make a statement on health status.

This is not only question of competencies. Even psychotherapists who are also physicians neglect making clinical diagnosis. As if diagnosis served only as a key to health insurance money. Maybe it is not an effect of boredom of bureaucracy proliferation but an effect of following anosological approach and care for individualization?

One cannot fail to notice the impact of the classification of mental health problems on the medical care. It became standard in research. It also became standard in education and, as mentioned above, it is demanded by health insurance service. The practice significantly changed clinicians' language. Diagnoses are limited to tittles of diagnostic categories, or even to numbers starting with "F". These are diagnoses satisfactory for indication to psychotherapy and checking insurance agency. But, are they satisfactory for competent diagnostic hypothesis and control of therapeutic process?

Yet, another supposition turns towards an impact of thinking on uselessness of nosological diagnosis. All attention is concentrated on individual diagnostic assessment of patient's problems, resources and deficits; and on defining them in terms of the theory being the background of psychotherapy.

Well, this optimistic variant, similarly to the first, bureaucratic one — seems, alas, to be unlikely.

Training of psychotherapists is concentrated on contract forming and setting. Therapist's preliminary understanding of the patient's problem is rarely discussed, if at all. Nor precise debate on therapy goals.

It is necessary to underline that our reflections have been based on specific source of information, and they should not be overgeneralized. The reasons of neglecting diagnosis for psychotherapy and specification of therapeutic goals in individual cases should be rather looked for somewhere else.

Psychotherapy has been more and more popular in Poland. Its development is accompanied with blurring boundaries between variety of psychological ways of influence. For a long time the term "psychotherapy", in common language, has got a meaning of anything pleasant and relaxing rather than psychological treatment of disorders. Contemporary culture promotes influence of common language on that used by professionals. Stronger than it happens in the opposite direction.

However, psychotherapy, especially employed in prevention, takes on promotion of individual development as a specific goal. Tradition of this approach is rich and long. The most significant seem to be training analysis in program of education in psychoanalysis. And, later, in 1970s encounter movement originated in California. A Polish example was Center for Personality Therapy and Development founded and run in Warsaw by dr Lidia Mieścicka and

prof. Jerzy Mellibruda. This psychotherapeutic service background were presumptions of humanistic psychology.

Self-awareness, intellectual and emotional insight, improvement of coping mechanisms, widening of support use, improvement in functioning in social group — all they can be recognized as reasonable psychotherapy goals. They are reasonable in psychotherapy used as treatment of people with disorders, and those diagnosed as being at risk of disorder, and those who recovered but still need rehabilitation.

Research in psychotherapy aiming to measure effects of this kind of treatment used a concept of change as the achievement [17]. However, defining features of the change as the goal of treatment (also in psychotherapy) appeared to be not so easy. Beneficial change seemed to be agreeable. However, change "beneficial for health" again met problems associated with disputable definition of health. Actually, there is a debate on what is and what is not beneficial for wellbeing. Such a debate opens space for activities loosely connected with prevention, treatment and rehabilitation.

Wellbeing is, above all, subjective; it is also focused on fulfilling social roles. So, patients' expectations concerning change due to psychotherapy should be approached with respect. The procedure can be regarded as psychotherapy, if the lack of wellbeing is the result of disturbances. In case of psychotherapy, diagnosis for psychotherapy should go first, then negotiation of goals and ways to achieve them, then contract.

Observations in psychotherapy supervision may not be representative for general psychotherapy practice, but point out to a widespread practice that therapists do not pay enough attention to the first two steps. In consequence they cannot be factual in the third one — negotiations. To be specific in negotiations, psychotherapist have to define his/her potential patient's problems in terms of theory, the proposed psychotherapy is based on. Classifications of mental disorders being in use at present are useless for this purpose.

Psychotherapists are also keen to employ their knowledge and skills, specific for psychotherapy, to work with people who have not been diagnosed as suffering from mental disorder, but ask for help in change: improvement of their effectiveness, social appeal, etc.

Applied psychology has developed methods effective in human mental possibilities enhancement, or, vice versa, effective in repression of them. The most spectacular are those employed in training for great results in sports, or special military actions. Probably most of such methods serves to achieve goals external to the subject they are used on. It happens that subjects are not even asked for agreement to participate in such programs.

Such methods are practiced under specific names: training, consulting, coaching, and the list is growing. It is quite possible that psychotherapeutic skills can be useful in practicing these methods of psychological activity. However, therapeutic skills do not turn them into psychotherapy.

In a debate on harmful effects of psychotherapy, adversary[1] of its use as dangerous method, sometimes even close to indoctrination, presented cases of people going for psychotherapy to — generally speaking — improve their quality of life (improvement in professional career development, increasing income, etc.). It was crucial that such clients had been effective in winding certified psychotherapists of various theoretical orientations and

[1] dr n. hum. Tomasz Witkowski

continued therapy even for several years. Our discussant pointed out that these clients were not satisfied, and felt abused.

Similarity of this information with the material subjected to supervision seemed not to be accidental: absence of diagnosis for psychotherapy with the content of vignettes illustrating damaging effects of psychotherapy. Should we, therefore, use the term therapy, i.e., treatment, while speaking about something which is not treatment and aims at goal of personal development?

Make-up, even permanent, had been invented to improve appearance. For similar goals — push-up bra and jockstrap. However, enlarging of breasts, lips, etc. is not called cosmetics, but esthetic medicine.

Is the use of the term psychotherapy to achieve goals defined and expected by client (and not patient, by any of the existing definition of the term "patient"), legitimate? Or, should we admit that calling to life esthetic medicine justifies calling to life esthetic psychotherapy?

We decided to bring up this topic convinced that the problem is not in variety of theoretical presumptions, nor post-modernistic liberation of the term "psychotherapy" from imposed semantic content, but rather in abuse of the term to activities other then prevention, treatment and rehabilitation.

References

1. Kępiński A, Winid B, Mitarski J. Ogólne uwagi o psychoterapii grupowej. NN iPP; 1959, 9 (6): 433–449
2. Kępiński A, Orwid M, Gątarski J. Dalsze uwagi praktyczne o psychoterapii grupowej. NN iPP; 1960, 10 (5): 697–701
3. Leder S, Wolska H. Psychoterapia grupowa w oddziałach psychiatrycznych. NN iPP; 1963, 10: 405–414.
4. Aleksandrowicz JW . Psychoterapia medyczna. Warsaw: PZWL; 1994.
5. Bomba J. O niektórych zagrożeniach psychoterapii. Między deontologią, ideologią a scientyzmem. Znak; 1997, 69 (509): 12–27.
6. Jankowski K. Od psychiatrii biologicznej do humanistycznej. Warsaw: State Publishing Institute; 1975.
7. Mellibruda J, Bomba J, Eichelberger W. Kierunki współczesnej psychoterapii. Materiały I Krajowego Sympozjum Psychoterapii, Warsaw 1974: 3–16.
8. Michels R. Rola psychoanalizy, psychoterapii i innych terapii werbalnych w psychiatrii amerykańskiej. In: Bomba J, de Barbaro B, ed. Psychiatria amerykańska lat dziewięćdziesiątych. Krakow: CM UJ; 1995: 34–41.
9. de Barbaro B. Między rozpoznaniem psychiatrycznym a „rozpoznaniem rodzinnym". Psychiatr. Pol; 2004, 38(5): 771–782.
10. de Barbaro B. Medykalizacja i psychiatryzacja życia codziennego. In: de Barbaro B, (ed.), Konteksty psychiatrii. Krakow: Jagiellonian University Press; 2014: 235–251.
11. Kodeks Etyczny Psychoterapeutów Polskiego Towarzystwa Psychiatrycznego http://static2.medforum.pl/upload/file/kodeks%20etyczny%20psychoterapeut%c3%93w%20polskiego%20towarzystwa%20psychiatrycznego%20uchwalony%202015_10_17(1).pdf.
12. Kodeks Etyczno–Zawodowy Psychologa http://www.ptp.org.pl/modules.php?name=News &file=article&sid=29.

13. Kodeks etyki zawodowej psychoterapeuty Polskiej Federacji Psychoterapii www.psychoterapiapolska.org/kodeks-etyczny-pfp.
14. Kodeks Etyki Psychoterapeuty Polskiego Towarzystwa Psychoterapii Psychodynamicznej http://psychoterapia.olesnica.pl/files/kodeks.pdf.
15. Kodeks Etyczny Terapeuty Poznawczo-Behawioralnego http://www.pttpb.pl/pttpb-info/kodeksetyczny-pttpb.
16. http://www.stopmanipulacji.info.pl/.
17. Czabała JC. Czynniki leczące w psychoterapii. Warsaw: Polish Scientific Publishers PWN; 2000.

address: jacek.bomba@uj.edu.pl