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# „SOMETHING EMPTY HAS BEEN FILLED" – INDIVIDUAL PSYCHOTHERAPY OF A PATIENT ADDICTED TO PSYCHOACTIVE SUBSTANCES, CONDUCTED IN THE PRISON AND BASED ON THE EXISTENTIAL ANALYSIS PARADIGM

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**Summary**

The article presents the process and the effects of individual psychotherapy of a patient addicted to alcohol and drugs, conducted in the prison. The psychotherapy was based on the ideas of existential analysis (Frankl, Längle). This is the first case of applying this method in prison isolation conditions in Poland. The therapy was focused on the symptoms of addiction and fundamental existential motivations. Building a good therapeutic relationship in the difficult prison background was an essential part of the healing process. As a result, the ex-patient has kept abstinence from psychoactive substances and has not committed any crime to the present day (since seven years from the end of therapy). He has lived according to his newfound authentic values and has experienced fulfilment. The presented case illustrates that existential analysis creates a possibility of comprehensive work on the whole addicted person's psychological and spiritual problems and can be applied as an effective tool in the process of resocialisation.

**addiction, prison, existential analysis**

## Introduction

The professional literature emphasises that previous solutions found in the treatment of addiction in penitentiaries are insufficient because of the specificity of the penitential context of therapy and the addicted prisoners' problems. Specific aspects of the penitential context mainly include: dual roles (prisoner-patient, officer of the prison service-therapist), the institutional coercion to undergo therapy (regardless of a prisoner's attitude), a highly manipulative approach of prisoners to therapy (as instrument to accelerate conditional release from prison) and a high level of the prisoners' distrust of therapeutic personnel [1,2]. The addicted prisoners are characterised by personality disorders, a tendency for chronic anger and aggressive behaviours, spiritual poverty, a value system which justifies crime, addiction to crime and the experience of growing up in a dysfunctional environment [3-5]. The implication of these facts is a need for a broad view of the patient with all his problems in varied areas, and to work on his pro-criminal attitudes and patterns of thinking. It is suggested that the goal of therapy should be to maintain abstinence and to stop committing crime by the patient [1,2,6]. It is being paid attention to the need for a many-sided and long-term treating [4] and the important role of the therapeutic relationship [6]. At the same time, there are noticeable deficits in professional literature and in the training offer directed to professionals bringing help

to addicted prisoners [1,2]. This underlines the need for continuous diversifying and improving the therapeutic offer, looking for "new sources of theoretical inspiration" and wider opening for "modern trends, which have a status of acknowledged therapeutic and clinical attitudes in many countries, while in Poland they are still not well known and considered as 'alternative therapies' or 'news' " [2, p. 321].

In this context, the presented two-year process of psychotherapy of a patient addicted to psychoactive substances, which was based on the assumptions of existential analysis, may serve as a source of inspiration. According to information available to the author of the article, this is the first case in Poland of applying this method in prison isolation conditions.

## The patient's profile and the beginning of treatment

The patient's life was centred on abusing psychoactive substances since he was sixteen years old. At the beginning, he drank alcohol. Later, he also started to smoke marijuana and to take amphetamine, cocaine and hallucinogenic substances (LSD, Ecstasy). After having finished technical college, he did not pass the final exams. Later, as he said, he worked sporadically in the country and abroad. During his stay in the country, he lived with his parents. At that time he committed some crimes, often being under the influence of alcohol and drugs. Those were mainly batteries, sometimes very brutal ones (at the beginning "someone provoked me", later "I provoked people"; "I could not let go during the fight"). Sometimes he also destroyed property and affronted police officers. When he was twenty-five, he moved from his parents to live with his fiancée in a separate apartment. Shortly after, their daughter was born. They planned to get married, but the patient was arrested and sentenced to seven years in prison. Once jailed, he joined a criminal subculture ("grypsera"), what was a sign of his hostile and dismissive attitude to people not belonging to his group, especially to officers of the prison service and other prisoners. According to an unwritten code, the subculture's members should stand up against the rules of the prison system, obey criminals who have a higher position at their hierarchy, and demonstrate slyness and power, understood as not expressing feelings and being aggressive [7].

It is worth adding that the prison regulation obliges addicted prisoners to undertake treatment at a therapeutic ward designated from above, sometimes in a different part of the country. If the prisoner refuses therapy, his chance for acceleration of conditional release from prison significantly declines. Also, a writ may be issued to enforce compulsory therapy. Therefore, every addicted prisoner must end up in the therapeutic ward and therapeutic personnel must lead the treatment, independently of a prisoner's will [2]. In practice, the prisoners' first contact with therapy takes place in the atmosphere of coercion. Because of fear of negative consequences they do rather not call it directly, but instead decide to lie that they are personally motivated to start therapy. An additional factor which escalates prisoners' distrust and aversion is the fact that usually their therapist is an officer of the prison service and is identified with the oppressive system.

During the stay of the aforementioned patient in prison, the psychologist diagnosed him with alcohol addiction. The patient signed the "consent for treatment" and after two years since being arrested, he was directed to The Therapeutic Ward for Prisoners Addicted to Alcohol, which was located in a semi-open penal facility. He was twenty-seven years old at that time. After he had arrived at the ward, his motivation to therapy was mainly external – he probably wanted to improve his penal situation.

The patient's documentation pointed to alcohol addiction and antisocial personality disorder (examination by experts appointed by the court). During his stay in the therapeutic ward, and as further information about his previous functioning was added, the diagnosis was broadened to include drugs addiction, too. At the same time, the diagnosis of antisocial personality disorders was questioned. Although his functioning in the past was antisocial, changes taking place in the therapy process, especially emotional awakening, feeling guilty and developing the ability to empathize, did not fit to the clinical picture of antisocial personality disorder. It is possible that the "antisocial" functioning of the patient was conditioned rather by addiction to psychoactive substances and adaptation to his environment than his original personality structure. In this context, we would rather speak about a "temporary specificity of personality functioning" in the course of addiction than about an antisocial personality disorder [8, p.64].

## Methods

I based the psychotherapy of the patient on assumptions of existential analysis created by Victor Frankl and developed nowadays by Alfried Längle and his co-workers [9]. The existential analysis assumes a three-dimensional character of human nature including corporeality, psyche and spirituality (personal or noetic dimension) [10]. This is a phenomenological-personal psychotherapy supporting the patient in his pursuance of existential fulfilment in the areas of four fundamental motivations oscillating around themes such as ability of existence, life, being oneself and meaning of life [11]. The structural model of the fundamental motivations is used in diagnostics, in understanding the symptoms of the patient and in conducting therapeutic interventions [9].

From the perspective of existential analysis, addiction develops on the basis of personal deficits in the area of the four fundamental motivations. Their distribution is individual, but common to all addicts is the inability to achieve existential fulfilment. In the depths of their experience, we would find a sense of inner emptiness and a kind of hunger of life, which patients try to fill with compulsive behaviours or psychoactive substances, while progressing away from their own spiritual core and authentic values [12-14]. By using psychoactive substances, an addicted person tries to create an alternative world, in which they experience a sense of security, joy of life, self-esteem and meaning [12].

The existential analysis has created its own specific methods and is open to techniques from other therapeutic schools, but the most important role is played by the personal relationship between psychotherapist and patient and their individual existential experiences [10]. The attitude of the therapist

should be phenomenological, that is open and free from prejudice, striving to capture the phenomena themselves. In the first and basic step, the psychotherapist strives to accept and understand the patient as they are and then refers to his theoretical knowledge and clinical experience [9]. In the treatment process, the therapist actively strives to "meet" the patient and make a contact with their authentic depth, through initiating and maintaining a dialogue [12].

## The frame of psychotherapy

Two periods can be distincted in the presented treatment process of the addicted patient. The first stage (in the prison therapeutic ward), which resulted from the prison's procedure, lasted three months and was lead in parallel with the group therapy [1]. At that time, we built the germ of the therapeutic relationship with the patient. I also noticed first effects of our work. This experience was so inspiring that I decided to check whether it would be possible to continue systematic psychotherapeutic sessions within the rules of the prison system. After obtaining the consent of my superiors, I shared this proposal with the patient. He decided to continue the treatment, even though this was associated with a longer absence from the place of his residence and with less frequent visits of his family. In the second stage, the patient was living in the prison semi-open ward and working, and came to the individual session to the prison therapeutic ward once a week. During the last months of his stay in prison, the therapeutic sessions were held every two weeks and often hovered around the topic of the patient's experiences related to his passes (outside prison). The therapeutic sessions lasted about 50-60 minutes.

## Issues and course of the psychotherapy

The issue of the sessions was focused mainly on understanding and recognizing how the dynamics of addiction affects the patient's daily functioning and his experiencing of life and himself. We also concentrated on solving the patient's personal problems located in the area of the individual fundamental motivations. We worked systematically, among others, on recognizing and dealing with the hunger for psychoactive substances, coping with the risky situations for maintaining abstinence, strengthening the acceptance of loss of control and building motivation to live in sobriety. With the increase of the level of the patient's trust in the therapeutic relationship, as well as his commitment, more deep and personal problems of the patient came up during the subsequent sessions.

### First fundamental motivation (I FM)

On the basis of the first fundamental motivation, these were anxiety, insecurity and lack of basic trust, which had appeared in various areas of his life, especially in the interpersonal sphere. The patient identified anxiety with weakness and he was ashamed of it. He did not try to deal with this issue from the personal (noetic) level, and reacted aggressively in situations, in which he felt threatened. Aggressive

behaviours were an attempt to regain a sense of power and influence and to control the threatening - In his personal experience, reality. They had a long life history. During his childhood, aggressive behaviours were modelled and strengthened by his close relatives. Over time, they had become a permanent element of his lifestyle: "I think that others are plotting and I'm making a plan to dispose of them". The use of psychoactive substances, joining a criminal group and subsequent acts of aggression gave him the illusion of security and strength: "When we were thirty people going to the disco, I felt safe". There is no doubt that the deficits in the area of the first fundamental motivation also contributed to the patient's decision to join a criminal subculture. By belonging to the group of "grypsera", he felt protected in prison.

In the beginning, we worked on applying techniques to deal with aggressive reactions such as breathing and internal dialogue, but this turned out to be insufficient. Only after work on accepting his emotionality (II FM) and building the foundations of his self-esteem (III FM), an open conversation about anxiety and the potential resignation from aggressive behaviour became possible. Previously, the ability to "let go" had been perceived by him as personally humiliating, and the experience of anxiety had been a taboo subject. It turned out that applying elements of biographical work was also indispensable. The patient did not feel accepted, protected and safe in his childhood. He experienced physical violence of his father and struggled with it in solitude: "I was so scared ... I remember only great fear ... I was afraid to oppose him ... I thought he was immortal ... I thought I would grow up and I would get revenge on him ... I was ashamed of being afraid, of being weak." These experiences destroyed or did not even allow the patient to develop a basic sense of security and significantly impaired his ability to trust. At that time he also stopped believing in God as a source of protection and support.

The conversation about childhood, conducted in an atmosphere of respect, acceptance and empathy, turned out to be a breakthrough and the patient began to allow himself to experience and express (during the therapeutic sessions) feelings of fear, insecurity and helplessness. After then, it became possible to start building his internal support. The patient, with my support, tried to deal with himself as with a "frightened child" (as he described himself) and this was giving slow, but good results. He also began to rebuild the basic trust in a higher power: "I have read in a book about God that he protects us like a mother protects her child, her baby, and every evening I imagine that I am an infant in the arms of my mother… I forget all my problems". The patient also started changing his behaviour towards his social environment. His hostile attitude towards the prison staff and co-prisoners weakened considerably. He began to ask himself: "Maybe it's me who threatens others?" After some frames of his internal sense of security had been built, he decided to step out of the prison subculture. After then, he felt "less safe", but at the same time, he was ready to face the consequences of his decision.

The first fundamental motivation confronts a person with the question: "Can I be here?" On the one hand, it is a question about living conditions such as the living space, protection and the experience of being accepted. On the other hand - about human abilities: "Can I manage? Can I do it?" The more we worked

on the inauthentic attitudes of the patient, the clearer revealed his lack of self-confidence and fear that he would not be able to cope with his own life. He experienced fears in various basic life situations, especially in the interpersonal ones. At the time when people naturally acquire life skills, he has resided in an alternative world created by psychoactive substances and in the criminal world, where among important competencies are physical strength, the ability to mask feelings and demonstrate ruthlessness, violence and bullying, cheating or clever using others for one's own purposes, and collecting "big" money with the least effort. These skills have proved useless in the process of adaptation to a new stage in his life. Therefore, the patient had to learn basic skills in everyday situations such as conversation with the prison tutor, participation in AA meetings, working on the prison construction site and later - working in the hospice and exiting to the pass. We confronted his subsequent fears and were looking for new ways to deal with everyday situations. We worked on activating and strengthening the patient's own resources. In this process of developing new competencies, the patient often experienced helplessness and confusion, but as time passed, he learned to accept these feelings and even take them with humour. He also often asked about my opinion: "Is this behaviour normal or not? How would you behave in this situation?".

Second fundamental motivation (II FM)

The second fundamental motivation is related to the human being's abilities to be emotionally moved and to enter into closeness with themselves and the surrounding world. These abilities are the basis to develop empathy, to build close relationships and to experience different values, including the basic value – life. At the beginning of the therapy, the patient's emotionality was quite narrowed down. His attitude was dominated by hostility and indifference. In this area, I started our work from sharing basic information about feelings and their role in human life with the patient. Then he began to practise systematic monitoring and writing down his emotional states and their causes. We analysed the effects of this work at each session and later the subject of feelings became a natural part of the subsequent sessions. On the patient's path to acceptance of his own emotionality, we had to face some blockages. The first of them was related to the patient's beliefs about masculinity, according to which a man should not express emotions, and the second - to the rules of the prison subculture ("We mustn't cry"): "Once at a funeral of my friend I was the only person who didn't cry and I was proud of it". We discussed the validity of these beliefs and I presented professional knowledge about male emotionality, what interested him. I also included elements of bibliotherapy, proposing him to read Antoine de Saint-Exupéry's books. We talked about the author who was a brave pilot during the war but at the same time showed his emotional sensitivity in books such as "The Little Prince" [15].

With the passing of time, the demonstrative attitude of the patient: "I do not care about anything, you can't do anything to me and I can sit here to the bell" (to the end of the sentence) began to break down. One warm day, after a year and two months of the therapy, he looked through the bars at the sunny sky and

began to cry. He let himself express his real feelings about the deprivation of liberty. Later he became ashamed and attempted to deny them, and I tried to accompany him in an accepting and empathetic way.

Another ground-breaking situation took place one month later. The patient reported that he felt sadness related to his stay in prison, but he was unable to express it: "I can't cry, I feel blocked here [around the diaphragm]. I would like to show my feelings, but the pain is blocking me… it's no such thing as leg pain… it is psychic. I'm ashamed of it". A conversation about his difficult childhood experiences, including three suicide attempts, which he had made when he was seven, brought him "relief and cleansing". At childhood, he often experienced suffering related to his experiences of violence and somatic diseases. Later, his main source of pleasure became psychoactive substances. As a result of addiction, he became indifferent to the valuable possibilities, which were present in his life. He experienced himself as "a robot, who would never die". Through unblocking his feelings, the patient slowly began to enter into emotional contact with his environment and gradually discover what moves him in a positive way and gives him pleasure. He felt that "life is valuable" and he was afraid to die: "I stopped being indifferent to myself and to life."

The second fundamental motivation encompasses also the theme of interpersonal relationships. The patient's attitude to other people was dominated by distrust, vigilance and readiness to aggressive reactions. He lacked empathy and elementary respect for others, who were not perceived by him as individual and sentient beings, but rather as a tool to satisfy his own needs or to achieve private goals, e.g. material benefits. Harming other people through beatings or thefts gave him an illusive sense of superiority, pride and strength. The striving to demonstrate his own superiority was present in his functioning all the time - before and after he had been imprisoned. Sometimes, especially at the initial stage of the treatment, he said that others were only "living beings" in contrast to himself and other members of the criminal subculture, who were "people". He also advocated various beliefs about the inferiority of women, which seemed to be not fully internalized opinions of his reference group.

Listening to these dehumanized contents without intervening required some effort and self-restraint from me. However, as a psychotherapist, I could not attempt to influence his beliefs in a direct way even though I understood them as harmful or dangerous. Instead, I started to look for ways to sensitize the patient in interpersonal relations. During subsequent sessions, when the theme of other people appeared, I initiated dialogues about their feelings, e.g. about how the men from his cell felt or what his fiancé felt like as a result of his particular behaviour. At first, the theme of others' feelings seemed strange and difficult to him, but slowly he began to make small progresses. At some point, I arranged a possibility for the patient to support another prisoner, who had finished the basic therapy and had been moved to his prison ward. When I asked the patient about his will to support this co-prisoner, he was very surprised because until that time he had never thought that he could help anyone. After he calmed down, he took my gesture positively - as a sign of my trust in him. During the session, we worked on understanding how that boy (co-prisoner) could feel and how to get in touch with him. The patient decided to skip his prison subculture's affiliation and

not to treat him from a superior position. He also noted that if he wanted to be able to empathize with that boy, he “mustn’t have bad intentions”. In order to develop empathy ability in the patient, I also included elements of bibliotherapy. We analysed, among others, "The Little Prince" [15] in terms of the characters' feelings and motives and we were looking for understanding terms such as “love” and “responsibility”. With time, the patient began borrowing novels and historical books from the prison library on his own and "entering into the characters", although at the beginning it was a great effort because of his difficulties to concentrate.

The patient claimed that he did not know what closeness was. We analysed the history of all relationships he has had during life. We were looking for positive experiences with other people. We found that in early childhood he liked his great-grandparents and grandma. Those memories felt for him like an "unpleasant touch" and later like "warm and positive power". He also started to understand the illusory nature of relations with his "colleagues" from the criminal environment. After his arresting, nobody showed interest in him or looked for contact with him. Only his mother (sometimes with his father) and fiancé visited him. The patient’s attitude to his fiancé was saturated with the need for domination and control, which was, together with his problems with jealousy, the theme of many sessions. With time, ambivalence appeared in his attitude - he hesitated between attempts to control and "to let go". The latter was difficult to him, but he already knew that it was the right direction. He stated: "I have treated her like a thing. I don’t even know how she is like. I'd like to meet her. I am curious about her". At one point he noticed that his contacts with other people had improved and when he listened to them, “they talk and talk and then they like me". He felt more comfortable in interpersonal contacts and he began to speak at the AA meetings. After about a year and seven months since the beginning of the therapy, he was able to recognize the feelings which he could activate in the victims of his crimes: "Inside myself I carry the pain of all the people I have hurt and I would like to cry my heart out. I wonder how I can redress”.

### The third fundamental motivation (III FM)

In the area of the third fundamental motivation, the patient had difficulties in uncovering his own authenticity and individuality. He did not contact with his personal feelings or his conscience and as a result, he did not live authentically. He built his identity on false premises such as the illusory conviction of his own superiority, strength and indestructibility. His self-image was a facade and did not correspondent to reality. Because of shame, he tried to hide behind this created image. In situations in which his self-image was threatened, e.g. by someone’s criticism, he reacted with anger or aggression. The false belief about himself was strengthened by experiencing power in situations such as taking amphetamine, acts of aggression, or cooperation with the criminal subculture. He had lived in an environment focused on alcohol, drugs and crimes and had accepted its norms, without considering whether or not this corresponds with his depth. In the early stage of treatment, he evinced motivation to understand his own previous behaviours

and this opened the possibility of initiating the process of self-discovery. At the beginning, it was difficult to him. From the perspective of time, he stated: "I didn't know myself too much. I knew my name, my address, my age and nothing more". When we began to reflect on the patient's self- image, the conversation was almost blocked by his strong shame. He was opening little by little and told that he was ashamed of himself in many aspects, starting from the smallest details of his appearance, through his character and ending with a lack, as he said, of life achievements. The inner truth was far from the facade he had presented to the world and in which he had tried to believe.

He saw himself, among others, as "ugly", "stupid", "shy", "helpless", "bad" and "a bit hard-working". We analysed where these beliefs came from and whether and how they were related to the patient's real experiences. We also discussed the constancy of character traits and a human's ability to change them. At the beginning, the patient identified himself as a "bad" man, who was not able to do "good" things in life. Later, we found in his biography the childhood dream to become "a soldier, a patriot, to fight evil, to suffer for others". After some time, the patient perceived that he was able to be courageous because he "had dared to speak about himself". From the perspective of building the patient's sense of his value, feedback was important. Every time I saw any of his resources or achievements, I talked about them. The patient became convinced that "I believed in him", what was helpful. When some effects of therapeutic work became visible, he met with the appreciation of his fiancé. Also the prison tutor expressed a positive opinion about him towards his mother. These were building experiences. But the patient also had to face the criticism of some prisoners, who attributed "abnormality" and "being brain-washed" to him. The patient often questioned whether he was "normal" and wanted to know my opinion on this matter. I tried to convey to him that different people and different environments may have different norms, which results in different ways of life, and that he has the right to decide for himself, regardless of the opinions of others. He also wondered whether he was truly himself after the change of some of his patterns of thinking and behaviour. The therapeutic relationship has become a space in which he could discover himself.

An important issue in the process of searching for his own authenticity was to face the theme of his belonging to the prison subculture. I was aware that was a highly sensitive subject on the line between prison service officer and prisoner. That is why I only initiated it by asking about the value of his commitment to the subculture from his point of view (how it was related to his authentic needs and feelings) and I left free space for him. After a few more sessions, he started to speak about this issue on his own initiative. He said that he was trying to look at it "from different points of view, not only like a criminal". I encouraged him to look for his own personal attitude, independently of any external expectations. Eight months later, the prison tutor informed me that the patient had dropped out of the subculture and had asked him to tell me about it. After that event, the patient said that the questions about the subculture "had ticked in him like a bomb" and then he decided "not to sacrifice" for the criminal group. He understood that the role of a prison subculture member did not correspond with him: "Last year I thought that being in prison

for a few years was ok, that it was normal. Now I see that this is a bad place. I feel anger. This doesn't suit me". In the last weeks of therapy, the patient also decided to stop stealing. He said with emotional movement: "Once I robbed an old man and then the woman in the court wrote that I was demoralized. I was offended then, but now I see that she was right. […] Recently I heard an old woman complaining that she had been robbed and so had no money for her ticket. Then I felt that I don't want to do it anymore. I don't want to steal".

Fourth fundamental motivation (IV FM)

The fourth fundamental motivation is closely related to the problem of meaning, which can be recovered by experiencing or creating something valuable or, if such a possibility does not exist, by maintaining a valuable attitude [10]. In this area the therapeutic work hovers around such topics like activating a sense of responsibility for one's own life, searching for valuable opportunities in the current life situation and defining the goals and directions of life.

In the second year of treatment, the patient complained that he "felt empty, as if he had no soul". We started our work from looking for valuable opportunities in his current life and we noticed that even in such a limiting situation as prison isolation, it is possible to find and get involved in something meaningful. The patient discovered values like his life, sobriety and his daughter. Therefore, he participated in the therapy and in AA meetings and undertook efforts to leave prison faster. During telephone conversations with his fiancé and daughter, he stopped focusing on controlling them and began to show interest in their life and join it as much as possible. In searching for valuable inspiration, we also turned to literature – "The Philosophy Fables" [16]. The story about the human heart as a place, where the greatest treasure was located, was the most inspiring to the patient. In the process of redefining the patient's value system, he often experienced confusion. He asked: "As a prisoner, alcoholic and drug addict, do I have the right to a new view of the world? Is it normal that I find fulfilment in therapeutic talks, contacting with my family, working on the construction site or just looking at the sky?" He discovered that life is a value itself, regardless of material status, which had occupied a high position in his previous system of values. He began stating that "others have money and I have feelings" and appreciating "the inner peace". He summarized: "something empty has been filled". The patient experienced a kind of "existential revolution". From the conviction of being a victim of fate and circumstances and the tendency to blame others, he moved to taking active responsibility for his own life. In the place of an indifferent emptiness, the sense of life's worth was born. A life, which he could develop in a constructive way: "I wonder what God has created me for. I am sure - not to make me sin, steal, drink or beat… Life is short and we should do something with it. The soul is eternal. It was put into this skin for some reason. Life should be used somehow. I don't know how, yet".

## The therapeutic relationship

At the beginning of the treatment, we did not talk about the patient's feelings related to the therapeutic relationship. At that time it was impossible because of the low level of his trust and his limited skill of recognizing and expressing his own emotions. I have never met with his open hostility, aggression or any behaviour overstepping my personal boundaries. I noticed, however, his attention to maintaining distance: after entering the therapeutic room he always moved the armchair away, he increased the physical distance while talking in the hall, he did not respond to my smile. For some time, even when we were working on his personal problems, I had the feeling that he was completely focused on himself and he spoke to me as I was not present. Later, I initiated an open dialogue about the therapeutic relationship and the patient was ready to start a conversation. He claimed that he trusted me only partly because I was an officer of the prison service. At the next stage of the treatment, his behaviour was slowly changing - he responded to my contact in a more active way, he started smiling and joked sometimes. He often asked questions and was interested in my point of view on varied issues. Later he also began to understand the value and specificity of the therapist's work in prison and expressed his appreciation and gratitude. After more than a year he said: "I like coming here. I don't come to you as to a prison employee… rather as to a colleague… no, as to a friend. This is the first time in my life."

In the existential analysis the phrase "the lamp is lighted from the outside" is being used [12], what means that without constructive interactions with other people, without the experience of "meeting", a human being is unable to develop themselves. In the case of such extensive deficits as the patient had, the mere use of therapeutic techniques would not be enough. The experience of a safe relationship was necessary. I aimed to saturate it with acceptance, endurance and my authentic presence there. I was attentive to the psychological and spiritual needs of the patient as well as to the situations wherein he gave in to the dynamics of addiction in the form of, e.g.: unrecognized hunger for psychoactive substances or a way of thinking shaped by the mechanism of illusion and denial. In those situations, I shared my observations with the patient openly, what aroused his resistance sometimes ("at the beginning, I felt angry, but later I noticed that you see more"). Through the therapeutic relationship, the patient could experience acceptance, empathy, attention, respect and appreciation and build inner structures from these "bricks". Only then he was able to enter into other interpersonal relations and to shape his life in a responsible way, without the illusory support of psychoactive substances.

## Results

Positive effects of the treatment gradually manifested in the daily functioning of the patient in the conditions of prison isolation, and later in the way of leaving prison. In the past, he had felt strong euphoria when leaving prison, which had led him to an immediate return to psychoactive substances, and consequently - to subsequent crimes and loss of freedom. This time, in the centre of his experience there

was joy and the desire to meet his fiancé and daughter. According to information obtained from the ex-patient (after seven years from the end of therapy), he has maintained abstinence from psychoactive substances since that time. He also got married to his fiancé and has led a family and professional life. He wrote that he felt "happy". He also got involved in the AA community and shared the testimony of his life, also in prison. He was not found to have committed any crime during that time.

## Conclusions

Information obtained in the course and after the end of the psychotherapy process indicates the durability of the effects. The treatment resulted in the patient's freedom from psychoactive substances and criminal acts and in his personal fulfilment, which resulted from the realization of authentic values. The result of therapy is an incontestable value from the perspective of the individual life of the patient and his family. Considered in a broader context, it can become a source of inspiration in developing and improving forms of professional help addressed to persons who are addicted and in conflict with the law. Existential analysis adequately corresponds to the specific needs of addicted prisoners discussed at the beginning because of its holistic vision of the human being, which allows for comprehensive work on patients' psychological and spiritual problems, and the central role of the "meeting-oriented" therapeutic relationship. A therapeutic relationship filled by acceptance, empathy and appreciation, and within healthy borders, can become a gate through which a person serving a prison sentence may come back to the society or appear in it for the first time. It would be worth to verify the above conclusions by the analysis of subsequent cases and empirical studies.

## References

1. Fudała J, Głowik T, Witek S. Więźniowie się leczą. Ter. Uzal. Współuzal. 2000; 5.
2. Majcherczyk A. Specyfika terapii uzależnienia od środków psychoaktywnych w zakładach karnych. Alkohol. Nark. 2007; 20(3): 321–342.
3. Zajęcka B. Terapia osób uzależnionych od alkoholu w jednostkach penitencjarnych. Prace naukowe Akademii im. Jana Długosza w Częstochowie. Seria: Pedagogika. 2008; t. XVII, 125-140.
4. Fudała J, Głowik T, Witek S. Specyfika leczenia odwykowego w zakładzie penitencjarnym. Alkohol a zdrowie, 1997; 18: 22–25.
5. Witkiewicz B. Psychologiczna charakterystyka pacjentów-więźniów oddziału odwykowego. Alkohol a zdrowie. 1997; 18: 28–30.
6. Głowik T. System terapeutyczny w jednostkach penitencjarnych. Świat Prob.. 2002; 5.
7. Szaszkiewicz M. Tajemnice grypserki. Kraków: Wydawnictwo Instytutu Ekspertyz Sądowych, 1997.
8. Jakubik A. Zaburzenia osobowości. Warszawa: Wydawnictwo Lekarskie PZWL, 1999.
9. v. Kirchbach G. Existential analysis. Europ. Psychother. 2003, 4(1): 33-46.
10. Frankl V. Wola sensu. Założenia i zastosowanie logoterapii. Warszawa: Wydawnictwo Czarna Owca, 2010
11. Längle A. Analiza egzystencjalna – poszukiwanie zgody na życie. Psychoter. 2003; 2 (125): 33–46.
12. Längle A. Niepublikowane materiały ze szkolenia w nurcie analizy egzystencjalnej i logoterapii prowadzonego pod patronatem Gesellschaft für Logotherapie und Existenzanalyse - Wien (GLE-International). Warszawa, 2014.

13. Evstigneeva E. Opioid drug addiction and the fundamental existential motivations. Existenzanal. 2015; 32 (2): 107–110.
14. Muir B. Addiction and meaning. Existenzanal. 2015; 32(2): 111–115.
15. Saint-Exupéry A. Mały książę. Białystok: Krajowa Agencja Wydawnicza, 1993.
16. Piquemal M. Bajki filozoficzne. Warszawa: POLITYKA Spółdzielnia Pracy, 2002.

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