The Relationship To Help: Interacting Beliefs about the Treatment Process

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ABSTRACT

Clients and professionals bring to their relationship with each other beliefs about the helping process which can significantly influence the outcome of referral and treatment. This article describes the development of the authors' ideas about this relationship to help and some of the beliefs that contribute to it. In clinical practice, issues around the relationship to help may need to be addressed at the referral, engagement or therapy phases.

KEYWORDS

engagement, interviewing, referral, systemic, therapy

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IF ALL TREATMENTS progressed logically, a typical contact between client[1] and professional would entail: initial referral; a period of assessment; agreement about the problems that will be addressed; engagement on the therapeutic work; a mutual decision that the therapy is completed; termination with a shared sense of satisfaction. However, not all cases evolve so simply. Consider the following.

Example 1

A child's parents referred him for psychotherapy in order that he could 'improve his self-esteem'. Throughout their relationship, the parents had always been in some form of psychotherapy, either individual or marital. They interpreted their son's developing independence as a sign of disturbance and believed that he, too, needed help to understand himself. He was in a dilemma about whether to attend the treatment offered.

Example 2

A father, who had a long psychiatric history, and a mother, who was recurrently incapacitated with severe unexplained illnesses, were being seen with their young son because of his difficulties at school. The parents had moved from one mental-health worker to another about their own problems, and, at the end of the third family session, they announced that they had sought an expert second opinion about their son's 'hyperactivity' and wanted the therapist to support the referral.

Example 3

An adolescent was in contact with four different counsellors, but did not feel that any one of them was helping her. Meanwhile, each professional felt that she or he knew her the best and was most able to help her leave home and start a more independent life.

In this article, we discuss the relationship between clients and professionals, suggesting that both parties come to it with a complex collection of beliefs about the helping process. These include ideas about the meaning of turning to someone else for help and assumptions about offering it. Hence, interactions between clients and professionals are influenced by the stories they have constructed about help-seeking and help-giving. Using case material as illustrations, we discuss some of the beliefs that influence the helping relationship, how they may affect the engagement or treatment process and how the therapist can work with them.

The relationship to help as a repetition of earlier family relationships

We evolved this concept over a number of years of clinical observation, and it is built upon psychoanalytic, systemic and social constructionist theories. We were originally influenced by Freud's description (1895) of 'transference' as a re-creation in the relationship with the analyst of formative relationships with parental figures. Initially, Freud considered that transference manifestations were an impediment to treatment, but later became convinced that understanding their historical origins needed to be the centre of his therapy. Since then, psychoanalytic writers have described how elements of transference enter into people's habitual relationships with others (Sandler, Kennedy, & Tyson, 1979), and Main (1957) eloquently describes the re-enactment of an individual's customary pattern of relationships in interactions with a hospital therapeutic team, to which they unwittingly responded.

In our own work, we observed that some clients engaged us in the same sort of relationships that they had had with all previous helpers. Examples include passive attachment; expectation of an idealized solution; hostile rejection of our ideas; or mounting sense that we were failing them. When we explored the process and its possible origins, we discovered that the pattern of interactions developed with helpers repeated a core feature of the client's earlier family history.

We were particularly struck by a number of mothers who indicated that they had been sexually abused as children and were still suffering the emotional sequelae but, despite our concerned offers of help, never engaged with us. Many of them made an initial loud cry of distress, but did not attend the appointments offered or only came sporadically. Similar problems of engaging adults who had been sexually abused as children are reported by Campling (1992). We had the sense that this pattern recapitulated the women's childhood experiences: for instance, desperately wanting to turn to someone but feeling frightened by the abuser's threats; fearing that they did not deserve to be rescued; or doubting that the non-abusing parent could be trusted to support and protect them. Indeed, sometimes they had actually disclosed the abuse to the other parent, only to find that the support they wanted was not offered. These formative experiences then laid down their expectations of any type of help from anyone in the future, so that their relationships with professionals recreated the same belief that help was both desperately wanted but could not be relied upon.

Egeland (1988), among others, lends support to this interpretation, suggesting that maltreated children's perceptions of attachment figures as unavailable, unresponsive and unlovable affect their own caregiving relationships as parents. They carry expectations that care and nurturance are not available and that they are not lovable persons.

We also worked with the hypothesis that actual experiences during infancy of being forgotten about or ignored by formative 'helpers' (i.e. parents) were re-enacted in the contact with us as potential new helpers. Some clients, believing that no one ever held them in mind, expected to be forgotten as though they did not exist. This anxiety was reflected in their behaviour in various ways, such as their forgetting about appointments and leaving the therapist wondering where they were. One client actually asked us how we managed to remember about her without writing very detailed notes of everything she said. Others telephoned to make a self-referral, but failed to attend for the appointment or just came once and then repeated the cycle a number of times.

Example 4

Ms Graham, a young single mother of a four-year-old child, Rachael, worked as a residential social worker with abused children. Her first communication with the centre typified all later contacts; she telephoned from work saying she could speak only briefly, but she needed help to handle Rachael's defiance because she sometimes felt like rejecting her. Because she sounded anxious and asked for an urgent appointment, she was given one, but she then telephoned to cancel it. She attended the second appointment offered, cancelled the third, attended the fourth, cancelled the fifth and failed to attend the sixth.

In the first two appointments Ms Graham kept, she related that she had never met her mother, who had given her up at birth and that she had been cared for by her paternal grandmother. At the age of four, she and her grandmother came from the West Indies to England to join her father and his new wife. However, the new stepmother resented their presence and within a few months they had moved out to live on their own. Ms Graham had run away from home at 16, complaining that she was given no freedom. The grandmother had died a few months before she

telephoned the centre, and she was still upset by the loss. She had very mixed feelings about her grandmother, being indebted to her for taking her in but resenting her strictness. She both hated and felt sorry for her father and appeared to idealize her mother, keeping a photograph of her by her bedside and believing that she would have been more secure if brought up by her instead.

When Rachael was a year old, Ms Graham had abandoned her outside a police station but had then felt remorse and reported her missing. When Rachael was reunited with her, she thought of putting her up for adoption but had changed her mind, and over the years she was prone to provoke Rachael to cry and would then hug her. In the past, she had briefly seen a social worker, been to a residential family centre and the Family Welfare Association and consulted her GP, but she felt that they all made false promises or fobbed her off.

The therapy team felt that Ms Graham idealized unavailable parental figures and experienced those actually available to her as critical and unhelpful. Perhaps, as a child, she had been preoccupied with whether her natural mother ever thought about her. In order to avoid the fear of rejection by those she might become dependent on, she rejected them first. She was already repeating many aspects of her own history with her daughter, including rejection and mixed feelings. Ms Graham appeared interested when the therapist fed back to her some of these ideas, but she did not return to follow them up.

Over the following three years, Ms Graham renewed contact with the centre four times, always telephoning in an anxious hurry, expressing concern for Rachael's welfare and asking for an urgent appointment. At different times she was given an immediate appointment or a more distant meeting or a contract for a fixed number of sessions, but Ms Graham only attended four out of 19 appointments offered. However, having not come, she usually telephoned to ask for another appointment. Those that she did attend were marked by her irritated rejection of the therapist's comments but also by a reduction of her anxiety and greater warmth towards Rachael. Since Ms Graham easily experienced criticism as rejecting, the therapist was careful to avoid critical sounding interventions. We also suggested that Ms Graham might have a dilemma about whether to remain in contact with us or reject us first and recommended that she come and talk about it if she became aware of those feelings. Clearly, these interventions were only partially successful.

In Ms Graham's final session, she was feeling better about herself as a person and as a mother, and she attributed this to a pay rise. She had decided to search for her mother, although she was aware that she might be disappointed in what she found. She said that she organized her general life so that other people became preoccupied by her: for example, she often kept people waiting. She admitted that, in the past, she had telephoned the centre on impulse and the stimulus to call appeared to be a blow to her self-esteem. In many ways, the call itself was sufficient for her needs.

Ms Graham's repeated approaches to the centre seemed to reflect her relationship to help. Early on in our contact with her, we realized that it would be necessary to map the process by which she engaged us and then made it virtually impossible for the team to help her. The link would need to be made between her current behaviour with professionals and her early experiences of rejection, dependency and fears that she had not existed in her mother's mind. Although making these links did not appear to alter significantly the process of Ms Graham's contact with us, in the end she confirmed many of

the interpretations made and they appeared to have had an impact on her beliefs about herself and her relationship with Rachael.

Other contexts influencing the relationship to help

Systemic approaches are grounded in the principle that context gives meaning to behaviour. People live within multiple levels of context, such as culture, family, relationships with others and ideas about personal identity, which influence their actions and give meaning to them (Cronen & Pearce, 1985; Pearce & Cronen, 1980). People's interactions need to be understood from these various levels and, in our clinical work, we recognized that clients' beliefs about help might be drawn from a number of different living contexts.

Cultural stories about help could include expectations of unlimited provision by the welfare state, fear that you only see a psychiatrist or psychologist if you are 'mad', or that contact with social workers should be avoided because they 'take your children away'. Such beliefs can have their origins in collective cultural prejudices or in actual experiences in the family's or individual's history. Some cultures teach that it is better to 'look to your own' (i.e. confide in other family members rather than outsiders), turn to someone from the same ethnic background or to a faith healer or village elder rather than a mental-health professional. In western society, most men still believe that they should not reveal themselves as vulnerable or needy and feel threatened if they experience emotional problems or are invited to attend family sessions.

Family beliefs are often passed down from one generation to the next and some influence behaviour in relation to helping professionals. For example, families may hold that help is only forthcoming in a crisis or that only practical solutions make a difference or that no member could succeed in life without social-work support.

On a personal level, expectations of future helpers can depend on whether previous contacts with professionals are remembered as rewarding, frightening, impersonal or untherapeutic. In addition, for some clients, a psychiatric or medical diagnosis may become woven into their personal identity, such as 'I am . . . an alcoholic' or '. . . a schizophrenic'. Any challenges to the diagnosis are experienced as a threat to their sense of self and are strenuously resisted.

Our early thinking about the relationship to help focused primarily on the *clients'* stories about being helped. Influenced by second-order cybernetics (e.g. Boscolo, Cecchin, Hoffman, & Penn, 1987), we began to move our attention to *professionals'* ideas about being a helper and their own experiences of receiving and giving help. For example, we recognized our belief that we should offer more appointments to Ms Graham whenever she asked.

As well as drawing from their personal and family beliefs about help, practitioners must also be consistent with their professional and agency contexts, which impose statutory and ethical obligations. These include assumptions about roles, duties, rights and responsibilities.

Example 5

A team of health visitors consulted us about an impasse with a family. The child had previously failed to gain weight and the allocated health visitors planned to monitor his progress. However, the parents aggressively rejected all of their attempts to visit and, even though the health visitors called on the home in pairs, they felt increasingly afraid for their personal safety. Their dilemma of wanting to

continue to visit, but feeling frightened to do so, was invading the whole of their team.

Our discussion with them ranged from whether there were grounds for concern about the child's safety (there were not) to the health visitors' premises about their role in this and similar cases. It emerged that they felt constrained by a number of conflicting professional and personal assumptions. They had originally trained as nurses and recognized their core-professional identity as carers who should support, reduce pain, comfort and always be available to anyone who might need them. However, as health visitors, they had also accepted a monitoring brief which conflicted with their caring role by coercing them towards an authoritarian attitude. As human beings, they were concerned for their own personal well-being.

They were relieved when the contradictions between these contexts were pointed out and they began to question their belief about being ubiquitous helpers. They recognized that they had seen themselves as nurses in the community, who therefore should support all families with young children within their patch, without considering that there might be some families who did not want their input.

As a result of the consultation, they gave themselves permission to make their highest order context concerns for personal safety and their managers agreed for them to stop trying to visit the family.

Professional identities are often built during the training period, and theories and techniques taught then are sometimes applied dogmatically rather than used as guiding principles. For instance, trainers might imply that the treatment they are teaching is 'the best' and graduates go on to respond to all problems in the same way, trying to fit clients to their treatment, rather than find a treatment suited to the needs of the client. Cecchin, Lane, and Ray (1992), therefore, advocate an 'irreverence' to those theories which might constrain practitioners and distract them from listening to their clients.

Cecchin and colleagues (1994) also invite professionals to reflect on any personal 'prejudices' which might colour their practice and identify two versions, the 'wounded therapist' and the 'missionary therapist'. The 'wounded therapist' believes implicitly that people need warmth, understanding and love and should be helped to overcome earlier mistreatment (as the therapist was once helped). The 'missionary therapist' intends to pass on to others the ideal healing that they consider they received in their own family.

The meeting of clients' and professionals' beliefs

The meeting of clients and professionals for the purpose of therapy is also an interaction between their respective beliefs about the helping process. Change will not occur when there is too comfortable a fit between the beliefs. For instance, treatment will be interminable if the family in example 1, convinced that everyone needed prolonged psychotherapy, were to consult a 'wounded therapist', who believed that clients should decide when to terminate their treatment. If the fit is too discrepant and there is dissonance between expectations of the relationship, a treatment alliance is unlikely to develop.

The development of the relationship to help begins well before a treatment contract can be agreed. Even at the referral stage, a large number of other interested parties may already be involved, including family members and various professionals, with an investment in the outcome. The Milan associates (Selvini Palazzoli, 1985; Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980a) discuss how referrers are more than neutral intermediaries in the help-seeking process. Clients may attend for therapy to please or

appease the referrer, while referrers may send clients to another therapist in order to escape an intense relationship that has evolved between them. As a result, they set up in the client's mind expectations about how the new therapist should respond.

Some families become known to a number of practitioners, either concurrently or successively, so that, over time, a large network of helping professionals builds up. These networks can develop a complex dynamic of their own as each worker strives to tackle the problem as they see it. However, they may have been presented with only a partial picture or be replicating interventions already offered. Sometimes, interactions among members of the professional network mirror dynamics among family members, as each professional takes up advocacy of an individual's point of view.

A number of authors, including Britton (1983), Imber-Black (1988), Hardwick (1991), Reder (1983, 1985) and Reder, Duncan, and Gray (1993), have described patterns of interaction that families can develop with networks of professionals. In addition, our notion of the relationship to help acknowledges that client–professional relationships are cocreated. Not only are clients' beliefs about being helped liable to enter into their contacts with all workers, but each professional's response will be influenced by his or her personal and professional contexts. Of course, in many cases, the evolving relationships do not interfere with the progress of therapy. However, there will be some instances in which client-professional interactions in one part of the network impact on the relationships elsewhere, and the reverberations produce conflict in the network or paralysis of the helping process.

In example 2, the father's most recent psychiatrist customarily worked very hard on behalf of his patients, such as telephoning other involved colleagues to advise them what they should be doing. In this case, he wrote numerous letters to the child mental-health team to say what investigations should be done and then wrote around to other child psychiatrists asking them to provide the second opinion that the parents had requested. A teaching-hospital department saw the family and prescribed that we should carry out a course of family therapy, a treatment that we had already attempted without success. In the months that followed, it became clear that work in all the adult and child departments was stuck.

Clinical implications

The relationship to help may need to be addressed at different phases of contact with clients. It might be evident at referral that the referrer should be asked about the history of the client's contact with professionals, including with the referrer. Sometimes it is more appropriate to address similar sorts of questions to the client in the first interview. In other cases, it becomes apparent that the relationship to help is impeding progress in therapy, while occasionally it interferes with termination of treatment. We shall discuss how we respond at the different phases.

An agency's procedures for receiving referrals should be sensitive to relationship-to-help issues. We encourage referrers first to speak to us on the telephone in order that we can clarify details of the problem, what is wanted from us and significant members of the professional network. We do not go through a list of questions as though running through a questionnaire, but are guided by the feedback and select those that allow us to develop hypotheses about the case.

Some questions we might ask in order to map the network of professional relationships linked to the referral are:

- Whose idea was it to contact us?
- Who else is involved and in what way?

- Who knows about this referral and what views do they have about it?
- Is it possible to describe the client's interaction with members of the network?

Exploration of the relationship between the client and referrer can include:

- How long have you been involved?
- How did it start?
- What is your role in the case?
- What interventions have you attempted and with what effect?
- What led you to contact us now?
- If we offer treatment to the client, will your role change?

The history of the client's relationship to helpers can be addressed through:

- Who has the client seen previously about any problem?
- What help was offered?
- How did the client respond?
- What has been effective?
- What has proved unsuccessful?

We might go on to gather information about the referrer's and client's attitudes to the referral through:

- What other help have you considered?
- Have you concurrently referred the client to anyone else?
- What was the client's reaction when you suggested referral to us?
- What expectations do you have of our involvement?
- What expectations do you think the client has?

Sometimes it is worth asking about the referrer's previous contact with us, such as:

- Have you referred here before?
- Did anything happen then that might influence our liaison around this present case?

We try to avoid interrogating the referrer over the telephone with questions which they might consider to be irrelevant to the case. If the answers begin to suggest complexities in the client–professional interaction which could impede engagement, we invite the referrer to an initial meeting with us (Reder, 1985). Alternatively, we may ask referrers who appear to be a useful resource in the early stages of therapy to our first interview with the client. In most cases, we are able to develop hypotheses about the relationship to help and are ready to address it with the client when appropriate.

Many of the questions asked of referrers are equally relevant to the first meeting with the client, especially if we have not had the opportunity to speak directly with the referrer. We usually start circular questioning (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980b) with:

- Whose idea was it for you to come to see us?
- What was your reaction to that suggestion?
- What did you think [that person] hoped for when suggesting you come here?
- What were you hoping would happen here?
- Who else knows you have been referred here?

At some stage in that first meeting we map the client's contacts with other 'helpers', through questions such as:

- Who else have you seen about this problem?

- What were you hoping they would do?
- What did they suggest?
- What effect did their treatment have?
- Who has been helpful to you and who has not?
- How do you explain that [that person] was helpful and that [that person] was not?
- What do you think they could have done to help you?

We have found in other cases that mapping the current relationship to help and exploring its basis in earlier family relationships or beliefs can make a significant difference to the contact.

Work with the adolescent who was seeing a network of competing therapists (example 3) improved markedly when the team drew up on a white board the names of all current 'helpers', including themselves, and added her parents and the inpatient unit that she said she wanted to attend. We then asked her about each in turn, what she had expected of them and what she felt she had derived from them. A link was then made between her profound disappointment that her mother had never been emotionally available to her and the repetitive pattern of disappointments with every professional she had seen. We went on to ask her about her hopes for the inpatient unit and what would need to happen for it to disappoint her. She eventually attended this unit and derived considerable benefit from it (Reder & Duncan, 1990).

Such explorations are particularly important when we hear that clients are currently seeing a number of helping professionals or that we are the latest in a long line of unsuccessful interventions.

It is likely to become apparent at the first session if there is a mismatch between the client's expectations of help and the therapist's beliefs about what is helpful. A common example is the client who seeks practical advice about what to do from a therapist who adheres to a non-directive, understanding approach. When meeting such clients, we try to join with their belief system so that a shared view about therapy can be coconstructed (Cronen & Lang, 1994), by initially offering the requested advice and then monitoring its effect. If, after a number of sessions, there has been little change, we might say:

- Sometimes this advice works, but, since it hasn't made a difference, we need to understand why not.

A similar mapping process to that at the referral stage may be helpful in the course of therapy or towards termination if the relationship to help is beginning to dominate the treatment process. For example, when clients: repeatedly miss sessions; ask for more frequent ones; question whether any treatment is of value; or concurrently attend other therapists. On the other hand, therapists may: feel frustrated with the meetings; reflect that nothing new is emerging in the encounter; be reluctant to end the treatment, despite evidence of positive change; or question their role with the client.

Endings may prove challenging to clients and to therapists (Fredman & Dalal, in press), and this might be the point at which the relationship to help needs to become the focus.

Example 6

A seven-year-old boy had been treated by paediatricians since the age of 6 months for a chronic illness, which often required extended periods of in-patient admission. He had recently been attending a therapist to address his eating, behavioural and relationship difficulties and, by the eighth session, these problems had resolved. His mother then reported that paediatric treatment was no longer

needed and hospital follow up appointments were to be reduced from monthly to six-monthly intervals. She added: 'it takes a long time to adapt to leaving hospital' and the therapist began to worry that she was left as the only support available to the family. She therefore mapped the relationship to help at the next meeting, for example asking:

- What have you been getting from the hospital staff which has been useful to you?
- How is it the same as or different from what I offer you?
- What will you miss most when you don't see the hospital staff so much?
- How could you get these things in other ways?
- What will you be pleased to have finished with at the hospital?

To the therapist's surprise, the mother revealed that she felt able to finish therapy with a sense of satisfaction. However, she realised that she had lost all contact with her general practitioner during the years that she had attended the hospital so frequently and the remaining work was to reconnect her with community services.

Example 7

A team found itself bored during sessions with a family that they felt they had helped earlier on in their contact but no longer had anything new to contribute. The mother had had terrible childhood experiences of abuse and rejection and was referred with fears of harming her daughter. After lengthy discussions during breaks in the sessions, and based on material from the therapy, the team finally offered the following intervention.

You [mother] always wished for a perfect mother–daughter relationship, initially with your own mother and now with your daughter. You have also felt that you needed to keep coming to see us [the team] so that we could help you achieve that ideal. In our experience, we have never seen a perfect relationship, and you will need to find a way to settle for a good-enough relationship together. We have feared that, if we took the decision to end the therapy, you might experience it as a rejection or huge disappointment. However, we suggest that we do end.

The family successfully terminated after this intervention, which pointed out the link between the mother–grandmother, mother–daughter and mother–therapist relationships.

The value of teams or supervisors to help therapists reflect on their contribution to the therapeutic relationship is well-known (Hedges & Lang, 1993), and they are particularly necessary when clients' and therapists' beliefs are too similar or too discrepant. It also can be useful to review beliefs about help when consulting with other colleagues, as in example 5.

Finally, from a service organization perspective, purchasers and managers need to acknowledge the potential impact of people's beliefs about help on service provision. Recent emphasis on 'accessibility' and 'throughput of cases' ignores that client–professional contacts are relationships that may progress illogically and require time to be understood.

Notes

1. We use the term *client* as a shorthand to refer to individuals, couples or families seen by professionals of any discipline.

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