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DECISION-MAKING IN PSYCHOTHERAPY

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decisions
psychopathology
psychotherapy

Summary

The aim of this article was to deepen the reflection on the importance of decision-making in psychotherapy. As a starting point, we adopted the views of classic psychotherapists (Eric Berne, Harold Greenwald, Antoni Kępiński) who believed that the patient's decisions make a significant contribution to the formation of mental disorders and their treatment. The development and argumentation of this thesis was supported by knowledge of clinical and developmental psychology as well as clinical illustrations. In the first part of the text, we outlined a classical indeterministic perspective on decision-making and, a way of thinking about decisions based on the notion of the human condition, which is reconcilable with the determinism of psychological mechanisms and useful in psychotherapy. In the next two parts, we focused on identifying the specificities and types of decisions in the patient's life course that can generate and/or sustain psychopathology (adaptive and moral) and those that contribute to treatment (oriented towards truth-seeking and responsibility-taking). In the final section, we attempted to clarify the potential impact of the therapist's decisions on the patient's decisions that are crucial for therapeutic change and made some methodological and practical proposals.

Introduction

Due to the dominance of the naturalistic model of explaining human behaviour, the issue of decision-making is currently rarely addressed by psychotherapy researchers and practitioners. However, the important role of the individual's decisions in the development of mental disorders and their treatment was pointed out by some clinicians in the 1960s and 1970s. For example, Eric Berne [1], Harold Greenwald [2], Antoni Kępiński [3] radically – by current standards of explaining the genesis and mechanisms of disorders – argued that many of our reactions and habits that seem to be out of control have their origin in past automated or repressed decisions. More importantly, these decisions are not necessarily hidden in deep unconsciousness. We can actually trace them back to the moments in our life history when they were born and – under favourable conditions – even correct them.

Nowadays, the issue of decisions in psychotherapy fits into the niche existential approach (in logotherapy, the patient is encouraged to become aware of their own hierarchy of values and to make decisions about them [4]), Prochaska and DiClemente's transtheoretical model (the patient's choices are one of the five main healing processes [5]) as well as some case studies (the patient's decisions are integrated into the analysis of the therapy process, but are not its main focus [6]). In this article, we aim to address the issue of decision-making in a more integral way, without limiting ourselves to the chosen approach. In particular, we will outline a perspective of therapeutic work centred on the patient's decisions and comment on its selected anthropological and psychological aspects.

Decisions and psychological mechanisms

The literature on psychotherapy-related patient decisions is not clear about what they actually are. An act of free will? A function of ego mechanisms or self-control? A mainly rational or emotional act? Taken consciously or developed unconsciously? The ambiguity of the concept of decision is associated with the variety of therapeutic modalities and the different anthropological assumptions behind them. The most fundamental differences in the understanding of human decisions lie in the personal vs. naturalistic understanding of the human being.

The cultural and linguistic reality in which we are immersed implies an understanding of decisions about the shape of one's own life as activities specific to the human being, and therefore based on reason, conscious cognition and free will. The participation of conscious cogitation in such decision-making is well reflected, for example, in the dictionary meaning of the term *decision* (a resolution that results from a choice [7]), while the meaning of free will is a set of antonyms of the term choice (lack of alternative, necessity, and compulsion [8]). Without the assumptions of having the capacity for rational cognition and free will, it is difficult to talk about being responsible for anything, or to take seriously the sense of ethical rules and the socio-legal order.

In psychotherapy, the emphasis on the role of conscious and free choice leading to the desired change is relatively strongest in the logotherapeutic approach. More naturalistically oriented psychotherapists (e.g. those representing the psychoanalytic approach) often focus on explaining human behaviour in terms of intrapsychic and/or interpersonal mechanisms. The changes associated with a patient's psychopathology and recovery are not so much the result of their free, conscious choices as of unconscious or automatic processes of self-regulation, suppression, affective information processing, etc. Supported by experimental results, theories on the unconscious nature of our decision-making [9] and the paradoxical (negative) effects of effortful control processes [10], and also the popular belief that mental disorders, including depression, cannot be cured by willpower, correspond to this approach.

Both perspectives on the human being, the personal and the naturalistic, touch together upon the essence of the human condition. In a very general sense, it is characterised by the gap between what is animal in us and subject to bio-psycho-social mechanisms, and what is specifically human, thanks to rational cognition and free will, which allows us to

transcend this animal naturalness and belongs to the area of spiritual culture, based on higher values [11]. Our condition, stretched between the world of nature and culture, safe adaptation to the environment and the effort of transgression towards the recognition and fulfilment of life's destiny, has for centuries been narrated – imprinted in the products of art and literature – by moving stories of the struggle with oneself and the world (cf. the story of the life and work of Michelangelo Merisi da Caravaggio [12]) and of sometimes dramatic choices (cf. for example, the choice of Antigone, Abraham, or Sophie, forced in Auschwitz to decide which of her children should remain alive [13]).

Similarly, the human condition is imprinted in our intrapsychic world. We feel that we keep making the same mistakes, succumb to uncontrollable reactions and unacceptable habits, but we also, by virtue of conscious decisions, try to resist them and make significant changes in our lives. In the experience of a person who is not coping and seeks the help of a therapist, the power of the habits/mechanisms responsible for life's troubles seems to outweigh the possibility of choices and desired change. Jerome D. Frank and Julia B. Frank refer to this state of mind as a loss of morale (in the sense of a weakened belief in success and willingness to endure hardship and adversity), and they see the aim of therapy, in this situation, as helping the patient to activate the forces that will raise their morale [14], or, employing the language of Irvin D. Yalom, will allow 'the removal of obstacles by using the power of will' [15, p. 346].

We believe that freeing the patient's will or raising their morale is ultimately the result of a series of decisions by the patient and not the result of the therapist's skillful interventions. Depending on their modality, various psychotherapies more or less intentionally lead the patient towards a confrontation with their own decision-making, hidden underneath psychological mechanisms/habits and reactions. Anchored in the natural world, psychological mechanisms and choices as personal acts (conscious and voluntary), although ontically belonging to separate aspects of human reality, can – in the patient's experience – merge into a unified whole. A patient may feel determined by various automatisms of the disorder, family injuries, traumas or biological defects and, at the same time, hold a deep conviction that, in response to all these wrongs or limitations, they cannot or could not do otherwise. What they fail to see or refrain from seeing is that they can, even if only by taking small steps, choose alternative options. For example, they can make a small gesture in a close relationship or forgo it, take treatment or postpone it, endure the hardship of a small change or give in. After all, in the course of even a very severe disorder, there are periods of improvement, which widen the field of rational thinking and thus of deciding on various aspects of life and everyday reality.

In this context, one of the important tasks of psychotherapy, irrespective of its modality, is to recognise and unveil to the patient inconsistencies, gaps, or specific cracks in the psychological insight into the mechanisms of the patient's problematic functioning. Indeed, diligent work on understanding these mechanisms and the persistence of their operation cannot, at the same time, fail to expose gaps for free will, from behind which the patient's decision-making is more visible. For example, in the patient's personal world of meanings, in addition to the desire for health and fulfilment in close relation-

ships, there may also be understandable reasons why they would prefer not to decide to change and give up their role as a sick or disadvantaged person. Of course, the process of uncovering and confronting the patient with their decision-making can be more or less helpful for them depending on how this process is carried out and adapted to the specific mechanisms of the disorder.

Decisions contributing to psychopathology

The patient usually seeks psychotherapy only when they see that repeated attempts to cope on their own with problems that are troublesome for themselves and/or their environment have been unsuccessful. The ineffectiveness of the attempts signals that the problems are serious and that the patient's capacity or willingness to use their own reflection skills and the support of loved ones is insufficient. Eric Berne and Harold Greenwald identified the source of permanent failure to cope with such problems in a number of earlier emotional decisions dating back to childhood.

Eric Berne was mainly concerned with decisions about how to adapt to destructive parental messages, usually expressed indirectly, such as: 'Don't be a child', 'Don't grow up', 'Don't be close', 'Don't be important', 'Don't exist', 'Don't feel', 'Don't think', 'Don't get angry'. The child, for whom the family remains the most important world, cannot remain indifferent to such messages. They can decide to yield to a destructive message completely, partially or symbolically. Alternatively, they may conditionally oppose it, e.g. by deciding that they will nevertheless be valued (accepted) 'as long as they work hard' [16, pp. 173-184]. The child's decisions, based on their attitude to parental messages, are the source of life scripts that are realised in adulthood. Changing scripts requires becoming aware of the decisions that lie behind them and making new alternative choices.

For Harold Greenwald, recognising and making the patient aware of their past, including childhood, decisions and the stories and sets of benefits behind them, was the axis of therapeutic work. In his view, decisions that facilitate the development of problematic habits in adulthood can be made in the context of a variety of challenging moments in life, not just as a reaction to destructive parental messages. Greenwald sought to understand the contexts of the patient's decisions and their hierarchy, and – as if following a thread to the ball – to get to the underlying decisions, no longer functional, but still highly influential on the patient's behaviour. Such was the case of a man who turned to the psychologist for therapy as he was unable to get emotionally close to anyone. He described his condition as if there was a glass pane between him and other people, which allowed him to see them, but at the same time prevented him from making direct contact with them. When Greenwald plainly asked the patient if it was possible that his condition was the result of his choice, the patient thought for a moment and replied: 'Yes. I was very attached to my mother. I loved her and it was a wonderful time. When I was four years old, she left me. Someone said: your mum went for a walk. But my mum never came back. She went to the hospital and died. After that I ran away from everyone in the family who would come near me. I decided that I would never be that close again [...] I would never allow myself

to be approached by anyone again, because I don't want to experience that kind of pain again' [2, p. 14].

Childhood decisions can also have a constructive effect on adult life. An interesting illustration of this is the story of Jerzy, who grew up in a home where his father, under the influence of alcohol, brawled, beat his wife, Jerzy and his younger siblings. Today, Jerzy has a wife, two children and regular (recently less frequent) problems with the law and with keeping his job due to getting into fights. His wife fears for her husband, reproaches him and makes him feel ashamed in front of people, but she still wants to be with him, not least because she appreciates him very much as a father. Indeed, at home, Jerzy functions differently: he shows respect to his wife, is repentant after his excesses, and takes care of the family. He is a warm, caring father and still, even as his children are reaching adolescence, has a great relationship with them. He insists that his life is meaningful and that the only reason he lives is because he has a wife and children whom he loves. When a psychologist asked him how he managed to reconcile his fights with care for his children and family, he replied that when he together with his mother and siblings would run away from their father, he had told himself that he would never hurt a child, and he kept his commitment [17].

It is worth considering whether the examples mentioned above of such consequence-bearing childhood decisions represent merely a certain group of exceptions. Are we during our childhood really capable of making such pivotal decisions that are binding in adulthood? And even if we are, do these decisions represent free, conscious and rational acts, or perhaps other processes to which some clinicians unjustifiably attribute the label 'decisions'?

Leaving the permanence of childhood decisions aside for the moment, there is no reason – within the limits set by the child's stage of development – not to regard them as relatively free, conscious and even rational acts. Indeed, already in the pre-school period a number of important developmental changes take place in symbolic thinking, socialisation, or initiative, which 'helps the child to better understand and put the world around them in order, as well as to think about it in a creative, increasingly independent and complex way'. [18, p. 8]. The child not only can grasp events in the temporal perspective of past-present-future, but can also, depending on the situation, tame it or carry it out in a socially acceptable way [18].

Obviously, the decisions that a pre-school child can make are subject to period-specific misinterpretations of reality. It is difficult for a child to grasp several aspects of a given phenomenon at the same time, to separate someone else's point of view from their own, to make moral principles independent of the authority behind them, not to overestimate, sometimes magically, their own abilities, or to go beyond simplistic conclusions about cause and effect relationships in their thinking, based on their perception of the temporal succession of events. When these developmentally determined distortions are taken into account, the child's interpretation of reality reveals its inner logic. And in this sense, decisions consistent with this logic can be considered sufficiently justified and therefore relatively rational. Thus, for example, the decision of a six-year-old to go to medical school (in order to earn the approval of his doctor father, who has already bought him a flat for

his future practice) or the decision of a girl of the same age to become a 'cardiologist' (in order to save her mother and, for that matter, other heart patients) is rational. So is the child's resolution not to cause trouble for his parents (because they will argue a lot and get divorced) or indeed to cause trouble (to get attention and reunite separated parents).

Childhood resolutions, including those concerning very important matters in life, are usually not permanent. Some of them may last longer, because they still have great significance for a child, if only symbolically. They are intended, for example, to protect against the pain of loss or rejection of a loved one, total helplessness when the health or life of loved ones is threatened, or the break-up of the family, which for the child means the end of the world. They are radical emotional conclusions ('never again...'; 'I will not allow...') derived at a deep level of mental processing, directing the desire for change and melding with it. While such processing itself may be largely unconscious, its finishing touch, in the form of a decision, is a conscious act [19]. This can also be the case when this emotional conclusion, fused with the decision, emerges at the very beginning and becomes increasingly clear in consciousness, or outside of it, but is realised later and only then validated in the form of a decision.

Anchored in fears and the desire to survive, the child's decisions can be described as largely adaptive. The child, in their own way, tries to defend themselves against a life disaster or pain and, as if in a backup mode, to settle for alternative goals. A prototypical example of this is to avoid bonds or insistently force interest by attracting the attention and/or control of a parent or another person who plays the role of an attachment figure when the parent is not sufficiently accessible or emotionally attuned to the child [20]. While early attachment habits are mainly based on the child's biological resources and patterns of interaction with the caregiver, over time, in the process of upbringing and self-education associated with the assimilation of social norms and cultural values, these habits are increasingly co-formed by conscious efforts of the will. Thus, as the child matures and becomes an adult, these decisions also increasingly acquire a moral dimension. This is accompanied by a growing ability to distinguish right from wrong in an objectified way and to take responsibility for one's own behaviour [cf. 21].

According to Harold Greenwald, childhood decisions that are sustained into adulthood, and contribute to the development of psychiatric disorders, have a common denominator. Regardless of the type of childhood needs they involve (e.g. safety, attention, care, control, appreciation, retaliation when these needs are frustrated), they are linked by granting oneself the right to remain an eternal child who does not have to take age-appropriate and social role-appropriate responsibility for oneself and others [2]. Antoni Kępiński understood the dysfunctional choices of adulthood in a similar way. He emphasised that they may refer to habits of emotional reaction reinforced by previous decisions, e.g. using aggression, feelings of guilt or harm, avoidance of hardship, which we too hastily treat as personality traits independent of us and thus, absolve ourselves of responsibility for them [3].

Decisions conducive to therapeutic change

Seeing the patient's early decisions in every automated destructive and/or self-destructive reaction does not necessarily make therapeutic sense. According to the rule 'from the surface to the depth', the analysis of the patient's decisions can start directly with the decisions related to entering psychotherapy and the sessions themselves. Why did the patient decide to have psychotherapy now and not earlier? Why did they choose this therapist and not another? If they had previously participated in therapy, why did they decide then and why did they stop or terminate it? Is the decision for psychotherapy their own decision, or did someone else decide for them? It is, of course, a matter of the patient's decision what they talk about in the session and what they do not talk about; when and if they talk at all; how they report certain content and how they report others; whether they come to the session on time or how much they are late; whether they take steps towards change or only declare them, etc. From a focus on the patient's decisions in the course of the session, it is easier to move on to an analysis of decisions concerning functioning in everyday life and relationships outside the sessions, and then to the contexts, motives, and justifications for these decisions in the present and earlier stages of life.

We think that all decisions of the patient (potentially capable of maintaining a working alliance) that lead to or hinder therapeutic change can be boiled down to two main types: decisions to seek or avoid the truth about oneself and one's own life, and to take or deny responsibility for its various aspects. This thesis, grounded in thinking of the human being as a person using reason and free will, and therefore capable of making conscious, free decisions (also in psychotherapy settings), is consistent with current views in the literature on the importance of truth and responsibility in the therapeutic process. Sigmund Freud [22, p. 185] mentioned that 'the analytic attitude is based on the love of truth'. In more contemporary studies, psychotherapy is seen as a conversation oriented towards the discovery of truth [23] or a search for the truth about one's own life [24], while truth is treated as a healing factor in different currents of psychotherapy [25].

The therapeutic role of responsibility in psychotherapy has been addressed by existential psychotherapists in particular, including Rollo May [26] and Irving D. Yalom [15], but also by the cognitively-behaviourally oriented James C. Overholser, who pointed out that too much emphasis on biological factors or environmental deprivations in explaining disorders can undermine the sense of responsibility for therapeutic change. In his view, psychotherapists should focus patients' attention more on 'personal responsibility for change, development and maturation' [27, p. 369].

Patients' struggle with therapeutic change is, to some extent, a struggle with decisions to avoid the truth about oneself and responsibility for this change, obscured by various defence mechanisms and strategies. A number of psychological mechanisms, calculated to maintain self-esteem and/or avoid disorganising emotions, may be at the service of decisions to avoid the truth about oneself, including the motives for one's own behaviour [cf. 28]. For example, the denial mechanism, the essence of which is the 'deliberate forgetting or ignoring' [28, p. 135] of painful or unwelcome contents for the Self, or the rationalisation mechanism, by which unacceptable behaviour can be justified with good reasons [28].

Decisions to refuse responsibility, on the other hand, seem to be served mainly by strategies of delegating it to someone else (e.g. assuming the role of victim/helpless person) and mechanisms of giving in to impulses (violent reactions, whims) or compulsions (the dictates of internal demands not experienced as one's own) [15].

In claiming that defence mechanisms are at the service of decisions to avoid truth and responsibility, we by no means believe that these mechanisms, by definition used in an unconscious and automated manner, are the direct result of decision-making acts. It can be a matter of decision to agree to maintain existing automated responses, despite being aware of their negative consequences for health and close relationships, or to make attempts to withdraw these responses in favour of more constructive ones. Even deeply unconscious defence mechanisms, such as projective identification, for example, can – with the help of the therapist – be reflected upon during the calming of emotions [cf. 28]. The patient can try to deepen and use their new understanding of themselves and the relationship by making numerous, over time more successful, attempts to change their ways of reacting. However, by the power of their decisions, they can also ignore this possibility, giving up or postponing any attempts made to cure them.

As we suggested earlier, through a therapy that takes into account the personal dimension of the patient's functioning, the patient gradually gains awareness not only of disruptive mechanisms or habits, but also of gaps for free will, i.e. opportunities and situations in which the patient does not have to give in to these habits and can make corrective decisions. Contrary to David M. Wegner's theory of ironic control processes [10], tensing the will to counteract undesirable automated responses does not necessarily lead to their paradoxical intensification (as a result of loading the mind with conscious and more energy-intensive processes, increasing the availability of subconscious processes related to failure). In his earlier work, Wegner himself explained that the multiple repetition of the mind's effortful activities involving conscious control over time leads to their automation (and acquisition of new habits), so they become less energy-intensive and more effective [10].

It should be added that without relying on the patient's ability to make conscious efforts of will, it would not be possible to build a therapeutic alliance, including adherence to the therapeutic contract, despite difficult moments. Moreover, recognising and appealing to this healthier part of the patient (the conscious, reflective, decision-making part) becomes increasingly important in the therapeutic process, especially in the treatment of more severe disorders that seem to overpower free will [29].

What exactly characterises the patient's decisions that are crucial for therapeutic change? In one respect, the decisions leading to recovery are not different from those leading to the development of the disorder. In fact, both are usually taken in a situation of internal crisis, requiring some kind of radical change, or a solution. However, while earlier, originally adaptive decisions are oriented towards a fallback, substitute satisfaction of childish, less mature needs or/and avoidance of the pain of their frustration, later decisions, already related to the attempt at recovery, serve to overcome the crisis resulting from the consolidation of habits derived from earlier decisions. As a result of therapy, the patient heightens the awareness of the use of immature habits and mechanisms, the decisions behind them

and the possibility of changing them, which contributes to compounding the crisis. This is because the patient becomes increasingly aware not only of the hopelessness of their current predicament, but also of their contribution to it. With a better understanding of the motives behind their behaviour and their responsibility for the damage done to themselves and others, they are faced with a crucial choice. They can continue to avoid the truth about their own behaviour and not take responsibility for it (e.g. hide behind the role of a helpless person who cannot be helped), but they can also choose not to ignore it and take the risk of making a change. In other words, they can also become a mature person.

An interesting illustration of this way of thinking about decisions vital to health is the story, described by Neville Symington, of a man with a criminal record, addicted to alcohol and drugs, and married with two children. After he had made previous unsuccessful attempts to break out of his addiction, he was placed in a psychiatric hospital in an alcoholic ward and broke its rules by leaving the hospital grounds and drinking alcohol. He knew he could not be admitted back to the ward. Neither could he go back home because his wife had kicked him out of the house. So he returned outside the hospital, sat on a bench in the pouring rain and said to himself: 'I can do two things: throw a bottle at a hospital window or kill myself'. It was at that moment that the sky lightened and an unexpected thought popped into the man's head: 'Or I can resolve to be cured'. He felt that this experience had initiated his return to mental balance [30, pp. 125-126]. Symington interprets that the unexpected thought 'or I can resolve to get cured', which appeared, as if in reaction to the clearing skies, was in fact the product of a process that had already begun. Its key components were an overwhelming desire to recover and an acute realisation of his condition, i.e. the awareness of having reached the bottom. The conscious outcome of this process, taking place largely below the threshold of consciousness, is what Symington refers to as a genuine choice. Such a choice had not been made during previous attempts to stop drinking, including repeating to himself 'I won't drink, I won't drink'. [30, p. 126].

To complement Symington's interpretation, we could argue that previous attempts at recovery were unsuccessful because – despite his desire or even declared decision to change – the man had not actually made such a decision at the time. Harold Greenwald would say that he had made an alternative decision not to change or to postpone the decision to change, which brought him certain competing benefits to his health, coupled with childhood desires [2]. Perhaps it was only the fact of finding himself in a blind alley where neither a return to hospital nor home and wife was possible that became the catalyst for change. Nor can we exclude the interpretation that the man was intentionally trying to reach the bottom, in some sense setting a trap for himself from which there would be no escape (because there would be nowhere else to go) and no possibility of using props to support his immature claims. Then he no longer would have a way out and, by the power of his decision, could finally bounce back. A sort of attempt to set a trap for oneself that confronts one's immature habits is sometimes the decision to enter therapy, which is not necessarily linked to the decision to change. Such a decision, like its opposite ('but I cannot be helped'), can only crystallise during the psychotherapy process.

At the interface between patient and therapist decisions

Therapeutic change cannot be predicted as it does not only depend on the severity of the disorder, or its mechanisms, but, as we have tried to show, also on the patient's decisions to seek the truth about their life and take responsibility for changing it towards recovery and psychological maturity. Similarly, the success of therapy is influenced not only by the therapist's skills, but also by the decisions behind them related to seeking the truth about the patient's life and taking responsibility for helping the patient work towards changing it.

When the therapist treats the patient honestly and responsibly, and tries to find out what is happening to them, what their problem is, and spends as much time thinking and searching for solutions as is actually needed – in fact, the therapist does everything that is also expected of the patient in therapy. In this way, not only does the therapist model the expected mode of cooperation, but, as it were, between the lines of performing their professional role, the therapist lets the patient know that they care about that patient and their well-being. The patient usually has a history of opposite experiences, and therefore sometimes finds it difficult to believe this, and much easier to devalue it [31], thinking that the therapist is somehow pretending according to the requirements of the professional role (although the convention of the therapist-patient roles, like parent-child, husband-wife, employer-employee, enables security and trust in the relationship precisely because the boundaries of these roles are not crossed).

The patient's realisation that it is possible to be treated decently and respectfully; that the therapist, just by virtue of their professional role, wants to help the patient to get back on their feet, and does so to the best of their ability, can have a corrective and developmental effect not least for two important reasons. Firstly, because it questions the patient's overly one-sided conviction about what people, or at least the people the patient has encountered in life, are like, i.e. that they are rather indifferent, that they cannot be trusted, that they think badly of him/her, or that they do not care about him/her. Secondly, because it casts doubt on the sense of habitually making other people responsible for one's bad luck and personal failures (these are not necessarily living people). Experiencing this kind of relationship with a therapist creates an opportunity to make key decisions for recovery, without which the relationship itself would become neither corrective nor developmental. These decisions (as well as the therapist's life decisions behind the decisions made in therapy) in their essence have an anthropological-moral dimension. The patient can (not necessarily!) accept the more complex truth about the human being, that there is not only evil but also good in people; the patient can also (not necessarily!) face their own responsibility for doing one and the other in interpersonal relationships.

We will illustrate the corrective-developmental significance of experiencing a therapeutic relationship based on the decisions of both the therapist and the patient using the example of a therapy of an adolescent conducted by Janusz Galli [6]. Originally, the case was described in psychoanalytic terms, but we will focus on the intertwining of the patient's and the therapist's decisions, which was crucial for the progress of the therapy. First, we will outline the clinical background of their joint work.

A boy aged 14 was referred to therapy by his father because of tremendous communication difficulties at home and school. Despite numerous tests and attempts at therapy, it had not even been possible to identify the source of the problem. The boy's difficulties were so severe and persistent that he was in danger of repeating a class and dropping out of therapy. During the first year of therapy, the patient, as in everyday life, remained mostly silent. When the therapist addressed him – he would lower his head, and if the latter did not speak – the boy would fall asleep. The therapist tried to interpret his silence in many ways, until finally he himself began to struggle with permanent sleepiness, indifference and disheartening. To his surprise, the boy did not stop his 'unproductive' therapy and kept to his appointments, always arriving at the counselling centre ten minutes before the session started.

When the therapist realised that by means of his interpretations he was trying to defend himself against a total malaise, a state of inner freezing of emotions, and thoughts he shared with his patient, he decided to stop fighting. 'The question arose: who was to share with him the fate of drifting on this mental ice floe from which he could not escape on his own [...]. When I understood this, I subjected myself to this condition. I did not resist it, allowing Z. [the patient – authors' note] to "speak" to me in this "freezing way". Paradoxically, the sensation of freezing, without any meaningful thought, diminished and became more bearable' [6, p. 9]. One may think that this personal decision of the therapist not to separate himself from the patient's mental pain and to carry the boy's misery along with him in order to help him was crucial. It opened the way to the next steps, which in turn allowed the patient to make his own key decision.

It was when the therapist made another decision: he would share his doubts about the therapy with a colleague at the counselling centre, who suggested that he undertake some kind of joint activity with the patient, such as a board game. Janusz Galli was hesitant but followed her advice, hoping that perhaps through a form of play the patient would accept the suggestion to change his way of communicating to a more language-accessible form. This also happened: 'Although reluctantly, Z. decided to play checkers with me. It took us another couple of years to "build up" this new form of communication, until the moment came when the patient's frozen inner self came to life'. The patient became very involved in playing together; he fiercely wanted to win, he would throw out commands, short sentences to rush the therapist, and when Janusz was losing, the boy would comment triumphantly on the therapist's mistakes. When Z. noticed that the therapist was able to endure game after game, his own losses and Z's wins, the former showed the latter sympathy, but also used extended statements more often, talking about his family, politics, or school. Over time, his difficulties with school and peer communication diminished significantly, and to the surprise of those around him, he improved all his marks during the school term and passed to the next grade of the technical school [6].

Let us try to extract the common core of the therapist's and patient's decisions leading to the latter's recovery. They both agreed to make a serious commitment to their relationship, and each, in their own way, really began to care about this relationship. The boy's commitment manifested itself in his determination to come to a seemingly ineffective

therapy, during which he could burden the therapist with the weight of an unsolvable problem. The therapist's commitment (tired of the therapy, but also endeared by the patient's preoccupation with its external framework), was to bear this burden and give up trying to avoid it in favour of accepting and sharing it with the boy. Interestingly, it was only when the therapist stopped walling himself off from the burden imposed by the boy (thus, making the associated psychological pain even more bearable), that he himself decided to share the burden of his helplessness with his counselling colleague, which, as a result, was important for the success of the therapy.

We believe that this deep inner agreement to share with the patient the misery, hardship, burden and psychological pain that the patient brings to therapy, must be extremely opening for the therapist in their relationship with the patient and generally in other relationships as well. Perhaps, this very human attitude is the vehicle for the effectiveness of therapeutic strategies and techniques, which might be worth exploring in supervision work. Does the therapist recognise the psychological burden that the patient wants to place on them? Does the therapist care enough about the patient to accept this burden and carry it through subsequent sessions? Finally, does the supervisor have such consent towards the supervisee and their burdensome experiences marked by anxiety or shame?

Conclusions

Decisions as conscious and free acts of an individual, as well as the impact of other people's decisions on them, both remain a mystery that eludes prediction, which researchers applying the methodology of the natural sciences would wish to achieve. We think that subject phenomena and processes in psychotherapy, including those concerning the decisions of the patient and the therapist, can be more adequately explained using the methodology of the humanities. Especially in the case of psychotherapy research, tailored uniquely for each patient, it is not so much a matter of discovering the regularities of human activity as of interpreting its origins, useful when case studies accumulate. Aren't clinical case studies sometimes reminiscent of historical studies (why certain events occurred) or literary studies (why a character in a book acted in a certain way)?

Viewing the therapy process as a story of the intertwined key decisions of the patient and the therapist is not a completely different option to the explanations offered by various therapeutic modalities. Rather, it is their anthropological complement to the perspective of the human condition and, in particular, to its aspect of the tension between free will and various habits, automatisms, or psychological habits and mechanisms. Including choices as acts of free will in reflecting on the therapeutic process, reduces the risk of reductionist explanations and, in our view, organises and objectifies this reflection.

Unlike the functioning of psychological mechanisms, acts of choice are non-degradable. We can discuss only two main options regarding a particular choice: making it or not making it. Choices that are postponed, not yet crystallised (e.g. due to a preexisting decision not to make it or some other alternative decision), are decisions still not made.

We believe that, regardless of the modality in which the therapist works, sensitivity to the patient's past and present decisions (whether actually made or not made), the role of these decisions in sustaining disruptive psychological mechanisms/habits, can advance therapy. A focus on decisions can be helpful especially for patients who show an ambivalent attitude towards therapeutic change, who are focused on their own suffering, who derive secondary benefits from their illness, as well as those who are stuck in a vicious circle of successive therapies.

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