

# Implicit and Explicit Therapeutic Contracts: Situations that Require Clarification of the Therapeutic Alliance

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## Why is This an Issue for Advanced Students?

In training seminars, the question is sometimes raised, "Why don't we learn about creating explicit contracts in our earlier period of training?" This idea seems rational. As presented in the previous article, "Implicit and Explicit Therapeutic Contracts: Guidelines for Explanation and Clarification," this approach helps the patient and therapist, or client and Counselor, find their common "wave-length" for bringing about positive change. In the simplest terms, the therapist and patient review the **problem**, clarify the **goal** for problem solution, and then discuss the **means**: "**How can our encounters help you overcome the problem and reach your goal?**"

But this issue is not usually raised during the first therapeutic session. The first therapeutic session begins with the therapist welcoming the patient, establishing the first phase of empathic contact, and orienting the patient toward sharing the difficulty that brings him into the therapeutic session. Something like, "I'm glad to meet you. Can we start off with your sharing what the problem is?"

Only after this first orientation is accomplished can the question of the therapeutic contract be raised. If the issue of the therapeutic contract is raised too early, that is, before the patient has fully verbalized the problem, the request for an explicit contract – "**How are our meetings going to help you overcome this problem?**" – can be experienced by the patient as an interruption and a sign of the therapist's impatience.

In addition, many patients will **not** need an explicit contract. The patient's way of sharing and the therapist's style of listening may be sufficient for exploring and deepening a problem as well as for reaching a certain degree of emotional relief and for passing to the stage of problem solution or "construction."

For this reason, it is advantageous to not raise the question of creating **explicit** therapeutic processes too early in the therapist's training. The early part of training is to encourage the student-therapist to find his or her own natural style of listening. At the same time the student is asked to integrate this natural listening style with two basic Biosystemic techniques: body empathy for the body orientation and the use of "key words – directional phrases" for the verbal orientation. And this is usually sufficient for the initial phase of the therapeutic process in which the goal is to help the patient feel comfortable with the therapist as he talks about his principle problem.

## **It Is Not Evident to the Patient that He Must "Deepen His Emotions"**

There comes a point, nevertheless, in which the student begins to notice that the therapeutic situation seems blocked. The patient continues to share, but the therapist has the intuitive feeling that "nothing is happening," or "we're not getting anywhere." Sometimes the patient as well will express this dilemma of "stagnation" or of "turning round and round without advancing."

Another way to express this therapeutic dilemma: Many Schools of Psychotherapy (and Counselling) share a common idea of therapeutic progress: The patient must explore his inner feelings, and this means to actually **deepen his emotional state** so that feelings that have been buried or suppressed can emerge, in tolerable doses, into consciousness. This therapeutic model began with Freudian Psychoanalysis and is now applied by Gestalt Therapy, the diverse Body Oriented Therapies, and even some forms of Cognitive-Behavioral Therapy. But the patient may not know, at the onset of psychotherapy, that this is a part of the goal.

What happens? Practical experience will eventually bring the student-therapist into concrete situations in which his natural style and acquired tools of competent listening are nevertheless insufficient. This goal of this article is to present various therapeutic problems that frequently show, after the initial period of "sharing the emotions," the difficulty in creating therapeutic progress.

The second step – how to unblock the situation by means of creating an **explicit** therapeutic contract -- has already been presented, in schematic form, in an earlier article, "Implicit and Explicit Therapeutic Contracts: Guidelines for Explanation and Clarification," and will be developed still further in future articles that will be based on concrete supervision experiences.

## **Talking from the Head without Contact with the Emotions**

The most frequent problem that blocks therapeutic progress is that the patient describes his problem using words that seem distant, in tone and content, from the underlying feelings. The therapist feels, "The patient is talking about 'fear,' (or anger, or hurt, or sadness), but there is no contact with the emotion. If we continue session after session in this way, there will be no improvement."

Here are several manifestations of "talking from the head without contact with the emotions":

The breath is blocked

The voice tone is flat.

There is little non-verbal expression (face, trunk and limbs immobile)

The words are hurried without pause between sentences. (It feels as if the patient is afraid to be interrupted, and sometimes this is the case.)

In these examples there is an "organic block." This means that body mechanisms are holding the emotions in excessive control or pushing the emotions out of awareness.

### **Continuous Vagueness**

The patient describes situations and feelings in terms of generalities. Even the therapist's request for examples, "Do you remember a moment in which you felt this 'insecurity and fear' (patient's Key Words)?", is responded to with a flow of vague sentences.

### **Fleeing from the Problem**

The therapist knows (perhaps from other sources) that the patient has an important problem. But the patient seems to deviate to situations that are relatively unimportant. Eye contact may also show this flight, with the patient constantly looking away. When the therapist tries to gently indicate this impression of flight, "I wonder if you're telling me what the most difficult moment, the situation that creates the most suffering?," the patient might admit a conscious block: **Shame, an Interpersonal Block:** "I feel very ashamed to talk about all these problems, all these weakness and defects that I have." Another possibility: **Fleeing from Pain:** "It's too painful. I don't want to talk about it." These two possibilities will require different means to overcome the block and establish an explicit contract for future therapeutic work.

### **The Problem is "Out There"**

Many patients will begin their session talking about "those people." In classical psychoanalysis, this is called "projection." However, if the therapist creates questions regarding the patient's own inner feelings – "What do you feel when you're recalling how angry and unfair he was with you" – the response is telegraphic. "Terrible!... He's always acting like that, as if noone else exists in the world!" In other words, the exploration of oneself is brief, condensed, almost non-existent, while the analysis and interpretation of "the other" becomes full-blown, repetitious and tenacious. The therapist thinks, "The Other is out there, we are here, we can change Ourselves, but not the Other." But there is no clear contract nor indication that this is the patient's therapeutic goal.

## “He’s Suffering So Much” or “He’s Ruining His Own Life”

These are other forms in which the problem is “out there.” Very often a wife will complain about the husband’s drinking or physical sickness. “He’s not doing anything for himself!” However, there is little reference to one’s own state of unhappiness. “Maybe you’re feeling helpless,” might suggest the empathic therapist. The response remains unsatisfactory. “Of course. How can anybody be so self-destructive! And he refuses any help! I know he can do something....etc.” The reference point remains “the Other.” There is no contract for self-exploration. The same things happens with a parent who is very preoccupied regarding an adolescent who doesn’t study, who drops out of school, who takes drugs or associates with “the wrong type of people.” The problem remains “out there,” and the therapist’s questions regarding the parent’s inner state are brushed away as if irrelevant. Our point is that the **implicit** contract permits this “flight into the Other and flight from Oneself.” Of course, the work of creating an **explicit** contract might not succeed. But the therapist’s dilemma is at least revealed. Discussion and negotiation of an explicit contract can at least help the person who brings in the problem understand the therapist’s point of view regarding what therapy can accomplish and what it cannot accomplish.

### “Tell Me What to Do”

The patient enters the therapeutic relationship with an idea, “I’ll tell you what’s wrong and you’ll tell me what to do.” In fact, the description of “what’s wrong” may be very brief, vague, telegraphic, and then the ball is thrown into the therapist’s court, “So tell me what to do.” Sometimes the patient adds, “You’re the doctor!”, or “You’re the counsellor, so counsel me!”, and waits for the helper to give the right advice. The therapist might try to throw the ball back into the patient’s court, “It’s for you do decide what to do!”, or, “The answer is inside of you!” But this is still like ping-pong. There has been no development of an explicit contract. For example, the therapist might be thinking, “First, we need a very detailed description of ‘what happened,’ connected to how the patient feels during the problematic episode. After that, we can consider various possibilities of action, reflecting on the ‘advantages and disadvantages’ of each option, until the patient discovers for himself the best option.” But the patient does not know that the therapist has this strategy in mind, because the explicit contract has not been developed.

### “I Feel So Much Anger, But It’s Not Right to Say It”

The patient shows signs of anger, either verbally or non-verbally. The therapist suggests that the patient express this anger. The patient balks. “This isn’t correct.” “I don’t want to hurt him!” “It’s not rational!” If the therapist insists, the situation can become a tug of war. After an exchange of opposing attitudes about expressing anger, the therapist might add, “Now you’re angry with me!” This intervention might be justified in terms of, “bringing out the transfer!” But the patient refuses to acknowledge this anger. This is called “resistance.”

In my opinion, the patient, in this situation, has been put in a double bind. Some people do not accept feeling or acknowledging anger because this contradicts their self-esteem. In addition, the patient does not want to hurt the Other. Nevertheless the therapist insists that the anger is present. And the patient “resists” the intervention.

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How can this knot be untied? In Chapter 4, “From Problem to Solution,” (in **Deep Listening**), it is clarified that to discharge anger in the therapeutic session in no way means that the therapist is favoring the discharge of anger in reality. In fact, the therapeutic goal is often the opposite, namely, to recognize the anger during the therapeutic session and avoid (or contain) the discharge of anger in reality, since the results can be counter-productive, creating escalation of anger and distrust. Therefore, the goal of discharging the anger in the therapeutic session is to attenuate the aggression and bring it under control. All this might be in the therapist’s mind. But if the strategy is not clarified and negotiated with the patient, the

tug of war, misunderstanding and lack of a therapeutic alliance can impede therapeutic progress and even create a sense of alienation, from the patient's point of view.

It might be noted that among many men, the idea of talking about "fear" or "hurt" may be equally resisted because this does not correspond to the image of a "strong man." Therefore, to acknowledge and express parasympathetic-dominant feelings – "weakness," "vulnerability," etc. – may also require the development of an explicit therapeutic contract.

### **Body Interventions: "Can You Express that Feeling with Your Body?" Patient: "That Feels Artificial!"**

The previous article, "Implicit and Explicit Contracts: Guidelines for Explanation and Clarification," deals with the very delicate question, in the second part, of introducing body interventions in the therapeutic process.

Body interventions are useful for countless therapeutic situations, especially in dealing with depression, when the patient's voice carries no emotional force, when breathing is blocked and when there is a general lack of vitality. Other examples: anxiety means a knot between sympathetic and parasympathetic force. A sense of coldness, inhibition, blocked anger or continuous rationality means that body impulses are being suppressed. Therefore, the calling forth of body impulses can play an essential role in many therapeutic situations.

But when the therapist suggests one of many options for involving the body – "Can you intensify that gesture?", "Can you repeat that sigh of exasperation?", "Can you say the same thing standing up with a strong voice?" – the patient is frequently unprepared and surprised by this intervention. Therefore, he refuses. "This is strange!" "It makes me feel stupid!" "I don't see the point!" The therapist may not understand this obstacle, since his own therapeutic work in the Biosystemic Training Group included a great deal of body expression. But the patient has not had the experience of the body-oriented training group! And therefore is not prepared for this therapeutic approach. The implicit contract has not been made explicit.

### **Why is This an Unexplored Dimension of Psychotherapy?**

The absence of an explicit therapeutic contract is not limited to body-oriented psychotherapy. Many psychotherapeutic approaches – "free association" in psychoanalysis, "stay in the here-and-now with that difficult feeling" in Gestalt Therapy, "what image comes to mind" in image-based psychotherapy, "what would you really like to say to that person" in Psychodrama, etc. – are often applied without full explanation or negotiation of the therapeutic contract. The psychotherapeutic literature makes reference to the "therapeutic alliance," but there is little description of how it is clarified, negotiated and developed in a step-by-step manner.

Perhaps one reason for this absence is the complexity, subtlety and individual variation necessary for the development of an effective explicit contract. The previous article, "Implicit and Explicit Contracts" offers some guide-lines and suggestions for creating the Explicit Contract. But there are many obstacles in outlining the method in an article, for example, the multiple dimensions of the issue, the variations in the development of a Therapeutic Contract that are influenced by the patient's personal point of view, and the unexpected consequences that might arise when the therapist broaches this issue. **Conclusion:** the development of this skill requires group supervision sessions. A written article can only give an outline of several basic ideas.