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THERAPIST'S HUMANIZATION OF THE PATIENT: PROMOTING AND INTERFERING FACTORS

The dynamic development of research focusing on effective elements in psychotherapy has revealed not only which therapeutic techniques are particularly effective in treating specific disorders, but also which elements of the therapeutic relationship make psychotherapy work. The latter include therapeutic alliance and therapist's empathy. Both of these concepts are complex, multidimensional constructs; they seem to share one crucial element – the humanization (mentalization) of the client: the fact that the therapist ascribes psychological depth and agency to his/her patient. In this context, we formulate a question concerning the factors that might facilitate or interfere with this kind of therapist's attitude. We look for an answer to this question not only in the literature on psychotherapy but also in the area of social psychology. Taking into consideration the conclusions derived from both research domains, we formulate recommendations for clinical practice intended to humanize the relationship between the therapist and his/her client. We also formulate research questions aimed at empirical verification of the recommendations.

Keywords: humanization of the client in the therapeutic relationship, therapist's mentalization, therapeutic relationship.

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THE HUMANIZATION OF THE CLIENT IN THE THERAPEUTIC RELATIONSHIP AND THE EFFECTIVENESS OF INTERVENTIONS: INTRODUCTION

In the recent decades, the interest of researchers studying psychotherapy has focused on the question of factors whose importance to the outcomes of psychotherapy has been scientifically confirmed. The evidence-based practice approach in psychotherapy initially led to the identification of therapeutic techniques with proven effectiveness in the therapy of specific disorders (cf. Nathan & Gorman, 1998). Subsequently, attention was drawn to the key importance of the therapeutic relationship itself for the success of the psychpotherapeutic process (Norcross, 2002; Norcross & Lambert, 2011; cf. Rakowska, 2011). The results of meta-analyses indicate that the quality of the therapeutic relationship significantly affects the outcome of therapy and is more important to it than the therapist's approach or specific therapeutic techniques (Lambert & Barley, 2002; Norcross & Lambert, 2011; cf. Czabała, 2011).

The aspects of the therapeutic relationship named as the key ones – namely, those variables regarding which sufficient evidence has been collected to consider them significantly related to the outcome of therapy – included therapeutic alliance and therapist's empathy (Norcross, 2002; Lambert & Barley, 2002; Norcross & Wampold, 2011; cf. Czabała, 2011). Therapeutic alliance refers to the quality of the cooperative relationship between the client and the therapist; it comprises a positive bond (mutual trust, positive attitude, respect, and care), agreement on the aims of work, commitment to their achievement, and a sense of partnership (Horvath & Bedi, 2002). Empathy is defined as understanding the clients' feelings and communications, openness to what the clients are experiencing, and encouraging them to explore their own experience, as well as understanding the causes underlying the way in which they experience reality (Bohart et al., 2002). In the present paper we argue that both of these complex, multidimensional concepts have a common denominator: therapist's humanization of the client. Supportive of this thesis, the results obtained using tools for measuring them are significantly correlated; it has even been suggested that these tools describe one basic factor underlying the measured constructs – the good/bad relationship dimension (cf. Salvio et al., 1992).

As suggested by the literature on the attribution of mind (mentalization), the therapist's humanization of the client could be defined as seeing the other persons as psychological subjects, that is, attributing to them the ability to experience feelings, to formulate beliefs, and to consciously direct their own actions

(Waytz et al., 2010). It seems legitimate to assume that the therapist's humanization of the client is a necessary (though insufficient) condition of building a high-quality therapeutic alliance with the client and of empathy with the client felt and expressed by the therapist.

Waytz and colleagues (2010) distinguish two basic elements of mentalization: the attribution of the capacity to experience (feel) and the attribution of agency (the capacity to plan and act purposefully). By contrast, the signs of dehumanization (dementalization) that people encounter on a daily basis consist in partly denying the other person a psychological depth (perceiving a person as to some extent devoid of human characteristics, such as interpersonal warmth or cognitive openness) and/or agency (perceiving a person as partly devoid of intrinsically human characteristics such as intentionality, intelligence, rationality, morality, or maturity) (Haslam, 2006; Bastian & Haslam, 2011). It is worth noting that perceiving a person through the prism of the category of "people suffering from mental disorders" marks the person out as particularly prone to dehumanization, since it is commonly believed that suffering from a mental disorder adversely affects the way the person experiences reality as well as his/her agency – two basic attributes of humanity (Haslam, 2006; Haque & Waytz, 2012).

In this context, the question arises of whether phenomena such as dehumanization (dementalization) of individuals perceived as suffering from mental disorders can take place in institutions established for the purpose of treating disorders. Is it possible that mental health care specialists, following the principles of professional ethics in their work, especially the principle of care for the patient's welfare, engage in behavior that can be classified as manifesting a dehumanization of their clients? Further in this article we shall present arguments in favor of a positive answer to this question. Next, we will move on to the field of research on psychotherapy.

The view that the humanization of the patient is of tremendous importance to the effectiveness of the therapist's interventions appears to be commonly held in the literature belonging to the canon of knowledge on helping (cf. e.g., Kępiński, 1989). The requirement that the specialist–client relationship should be a subject–subject one is now a kind of standard, common to various services in the area of mental health care and prevention (cf. e.g., Stemplewska-Żakowicz, 2009; Józefik, 2011; Popielski, 2008). Perhaps this is the reason why the relations between the therapist's humanization of the client and the effectiveness of therapy have not provoked research interest so far – at least the authors of the present article are not aware of any studies directly addressing the question of relations between humanization/mentalization (of the patient by the therapist)

and the outcomes of therapeutic interventions. We therefore refer to research results that can be regarded as indirect evidence for the existence of a link between the humanization of the patient and intervention effectiveness.

Because the question of the processes underlying the therapist's humanization of the client has not been an object of systematic research in the context of psychotherapy so far, further in the article we will move on to the field of social cognition studies. In particular, we will be looking for factors – crucial for the problem addressed in this paper – promoting the dehumanization of the interaction partner: are there any situational determinants that may impair the willingness to humanize the other person? Next, we will relate the conclusions derived from this research to the realities of clinical practice. In particular, we will discuss the possible influence of the processes interfering with the willingness to humanize the interaction partner on the therapist's work, as well as the issue of whether these processes should be regarded as unambiguously harmful, or perhaps (sometimes) useful in clinical practice. Finally, new directions of research, aimed at verifying the usefulness of the recommendations for clinical practice made in this article, will be suggested.

THE QUESTION OF HUMANIZATION AND DEHUMANIZATION IN THE SPHERE OF HELPING

Let us begin with the question of whether it is possible for a well-educated therapist, pursuing the patient's welfare in his/her work, to behave towards clients in ways that could be considered as dehumanizing. In this context, it is worth recalling David Rosenhan's (1973) already classic studies. In one of them, mentally healthy individuals reported at mental hospitals complaining that they heard voices. The aim of the experiment was to check whether (and if so, in what way) these individuals would be recognized as healthy. Immediately after being admitted to the ward, each of the so-called pseudopatients stopped complaining about anything and started to behave in a manner as ordinary as possible. Apart from name and surname as well as – in some cases – occupation data, pseudopatients answered honestly the questions that they were asked. This is an important aspect of the study: the pseudopatients were healthy, well-functioning people who openly described their experiences – neither in their life histories, nor in their behavior was there anything that would suggest deep pathology. Despite normal behavior and extraordinary willingness to cooperate, none of the pseudo-

patients was recognized by the staff as a healthy person. Nearly all the people admitted to the ward were diagnosed with schizophrenia.

The label of a person with schizophrenia turned out to be surprisingly persistent – in fact, no behavior on the part of the pseudopatients was enough to cancel it. That label was a kind of distorting filter that all information about a particular person was passed through. An angry reaction to the bahavior of a staff member was interpreted as a symptom of the pseudopatient's psychopathology rather than as a response to a violation of norms by the hospital employee. The fact that the pseudopatients made notes did not provoke questions from the medical personnel but was interpreted instead as a disorder symptom. Thus, it was not the label that was rejected in the light of normal behavior and facts from the person's life denying any pathology; on the contrary: it was the person's behavior and life history that were interpreted in such a way as to fit in with the previously attached label of "mentally ill."

In a few hospitals, the pseudopatients observed the reactions of the staff to politely formulated and situationally appropriate questions. The answers received were usually perfunctory, given quickly "on the run," without eye contact, and would frequently bear no relation whatsoever to the content of the questions asked. These observations were compared with those obtained at a university faculty where staff members had a reputation for being so busy that they did not have time for their students. A young woman approached the faculty's staff members rushing for a meeting or for classes. She asked them for directions and, among other things, about enrollment criteria. Each of the staff members thus approached stopped to talk to her, and some even engaged in showing her the way to the office. A huge contrast was observed between the reactions of medical personnel and the reactions of faculty staff to the questions of a future student. An interesting light is shed on this difference by Rosenhan's (1973) experiment in which a young woman's request for directions was addressed to doctors at a university medical center. Their level of willingness to cooperate (establishing eye contact, engaging in a short exchange or a longer conversation) was significantly lower when she added "I am looking for a psychiatrist" as an explanation than when she said she was looking for an internist. This effect clearly shows that mental disease involves serious stigmatization – the very fact of looking for a psychiatrist lowered the level of willingness to cooperate in people otherwise usually eager to engage in helping.

Rosenhan (1973) stressed that the results of his study involving pseudopatients do not attest to a lack of professionalism or good will in hospital staff. On the contrary: he observed that a substantial majority of the staff members were

very well-prepared individuals willing to help suffering patients. It was the situational context – the context of a mental hospital, with its clearly marked borders between "the healthy" and "the ill," between "the privileged ones" and those "deprived of their rights," with a strict hierarchy and with the patients being commonly perceived through the prism of their social role – that led to distortions in perception and erroneous conclusions.

It thus turns out that the very classification of a person into the category of "patients" can lead to a situation in which professionals willing to help dehumanize that person and perceive him/her through the prism of this stigmatizing category. Waytz and colleagues (2010) emphasize that two types of circumstances promote mentalization: the first one is – willingness to understand, predict, and/or control the other person's behavior, and the second one is willingness to build a relationship with the other person. Let us look at circumstances of the first type – willingness to understand other people's behavior. The state of uncertainty about the causes of the observed behavior and a sense of having no influence over that behavior are known to breed discomfort motivating people to recover a sense of the situation's comprehensibility and meaningfulness. Unpredictable behavior of the observed person fosters the attribution of mind (specific intentions, beliefs, or feelings) to that person, which reduces the observer's uncertainty: the so far incomprehensible behavior now acquires a justification (Waytz et al., 2010). It is also known that individuals who are not liked and who are perceived as dissimilar from the self, undesirable as partners in a relationship, become objects of dementalization and dehumanization (Bastian & Haslam, 2010; Waytz et al., 2010). Perhaps, then, in a situation when motivation to build a relationship with a person is absent, perceiving the person through the lens of a specific label (e.g., "a schizophrenic") is an alternative to mentalization – a way of reducing uncertainty regarding who that person is and what are the causes of his/her sometimes "weird" or untypical behaviors. Such labeling undoubtedly reduces uncertainty in the therapist by making all the behaviors of the person explainable ("everything he/she does is simply a symptom of disorder").

In this context, it is not unjustified to ask what circumstances make it possible for a well-educated therapist following the principles of professional ethics to lose motivation to build a relationship with the client and perceive him/her as a "case" rather than as a person. In order to find the answer, let us first have a look at what the literature on psychotherapy reveals about the significance of such manifestations of the therapist's humanization of the client as entering into

a cooperative relationship with him/her as a partner or empathizing with his/her experience[1].

THE SIGNIFICANCE OF THE HUMANIZATION AND DEHUMANIZATION OF THE INTERACTION PARTNER: THE PERSPECTIVE OF RESEARCH ON PSYCHOTHERAPY

Research proves that therapists differ in effectiveness; there are those who achieve better results (their clients make greater progress in shorter times) and those whose work brings significantly worse results (Okiishi et al., 2003; Lutz et al., 2007). Even when researchers made efforts to minimize the impact of the therapist on the outcome of interventions, it turned out that it was not therapeutic techniques but, precisely, differences between therapists that predominantly determined the effectiveness of psychotherapy (Shapiro, Firth-Cozens, & Stiles, 1989).

Wolfgang Lutz and collaborators (2007) analyzed data concerning the therapies of 1,198 clients who worked with 60 therapists. It turned out that 8% of variance in the outcomes of therapy was explained by which therapist a particular client saw. In the study by John Okiishi and colleagues (2003), which covered data collected from 1,841 clients and 91 therapists, it was shown that therapists differed dramatically from one another in the level of effectiveness. The clients of the most helpful therapists (labeled *supershrinks*) achieved considerable improvement in the shortest time. The clients of the least effective therapists (labeled *pseudoshrinks*) experienced no positive change or even experienced a decline in their well-being despite remaining in therapy for a long time. These differences cannot be explained by the diverse seriousness levels of the difficulties that the clients experienced, since both supershrinks and pseudoshrinks worked with similar groups. Moreover, it turned out that the therapists' effectiveness level was not related to any of the variables describing intertherapist

[1] Following the assumption adopted in the present paper that the therapist's humanization of the patient is a necessary (though not sufficient) condition for building a high-quality therapeutic alliance and for empathizing with the patient's experience, we cite the results of research concerning the significance of the above elements of the therapeutic relationship to the effectiveness of therapy, treating them as indirect evidence for the existence of a link between the therapist's humanization of the patient and the effectiveness of therapy. We also wish to stress that the assumption we adopted is an effect of theoretical reflection. Further inference, making use of knowledge from the field of social cognition, will lead to considerable modifications of that original assumption. The conclusions following from the reflections presented in this paper require empirical verification, which we will return to further in the article.

differenes (these were: the type of training, the length of training, theoretical orientation, and gender). In this context, the key question seems to be what characteristics of therapists determine whether participation in therapy conducted by them leads to desirable changes or just the opposite: to a derterioration of the client's condition.

The study by Zuroff and colleagues (2010) sheds interesting light on this problem. They discovered that what was responsible for the differences in effectiveness between therapists working with clients suffering from depression was the degree to which these therapists were perceived by their clients as empathic, genuine, and having a positive attitude. This kind of attitude on the therapist's part is strongly associated with the humanization of clients – seeing them as human beings in the full sense of the term, showing interest in their beliefs and experiences as well as respect and care. Lambert and Barley stress that it is impossible to distinguish between the influence of the therapist's characteristics and that of the therapeutic relationship on the outcome of therapy, since these two elements are strictly interrelated (2002, p. 21). Their review of research shows that therapists who are effective in their work are perceived by their clients as understanding, accepting, empathic, kind, and supportive. Moreover, compared with their less effective colleagues, these therapists less often exhibit such negative behaviors as blaming, ignoring, or rejecting. This is another argument supporting the thesis that the therapist's orientation towards building a relationship with the client combined with the willingness to understand him/her are conducive not only to the humanization of the client (cf. Waytz et al., 2010) but also to the effectiveness of therapeutic interventions.

The quality of the therapeutic relationship – and of therapeutic alliance in particular – is an important aspect of psychotherapy, attracting an increasing amount of attention among scientists studying the factors that determine the effectiveness of therapeutic activities (cf. e.g., Horvath et al., 2011). Research confirms the existence of a link between the therapist's empathy and the quality of therapeutic alliance, empathy turning out to be more strongly related to the therapist–client bond as an element of that alliance than to elements concerning agreement on the aims and methods of therapeutic work (Elliott et al., 2011, p. 136). The researcher and at the same time an excellent practitioner who was the first to point out the importance of the quality of the therapeutic relationship to the success of the therapist's interventions was Carl Rogers. He identified the conditions that were necessary as well as sufficient for the client to achieve greater internal consistency in the course of therapy (i.e., to experience internal conflicts less intensely) and for the client's conduct to evolve towards more ma-

ture behaviors than those exhibited before the commencement of therapy (Rogers, 1992, p. 827). These conditions comprise, among other things, the therapist's genuinness, unconditionally positive attitude towards the client as a person, and empathy with the client. Rogers gave his conditions the status of hypotheses, inviting researchers to verify them in the course of scientific inquiries.

The invitation was accepted and resulted in numerous studies concerning, for example, the link between the therapist's empathy and the effectiveness of interventions, conducted in the 1970s and 1980s (cf. Elliott et al., 2011). In the 21st century, scientists directed their attention to the biological basis of empathy, which found expression in studies in the field of neuroscience (cf. e.g., Batson, 2009). Currently, researchers are again interested in the relationship between the therapist's empathy and the effectiveness of psychotherapy, and meta-analyses comprising numerous studies from this area show that – as Rogers predicted – therapist's empathy is a significant element of a helpful therapeutic relationship (Elliott et al., 2011). It is worth mentioning in this context that therapist's empathy as evaluated by the client is a better predictor of therapy effectiveness than therapist's empathy as evaluated by an external observer or by the therapist himself/herself (Elliott et al., 2011, pp. 135, 141). Research clearly shows that clients do not differentiate between empathy and other elements of the relationship associated with therapy effectiveness – their evaluations of the therapist's empathy correlate highly with evaluations of the extent to which the therapist is genuine and has a positive attitude towards the client (Elliott et al., 2011, p. 136).

Researchers currently exploring the relationship between therapist's empathy and the effectiveness of therapy not only refer to research on psychotherapy but also use the achievements of social neuroscience. Combining the knowledge generated in both areas, they distinguish three main processes that contribute to empathic reaction to the interaction parter (Elliott et al., 2011, p. 133). The first one is the process of emotional simulation, in which elements of the partner's physical experience are reflected in the person who is in contact with him/her; this involves the activation of that person's brain primarily in the structures of the limbic system. The second of the main processes that condition empathic reaction to a person is perspective-taking, which consists in adopting the interaction partner's perspective – in understanding how this person may feel in a particular situation. What is characteristic of this process is brain activity in temporal cortex and medial prefrontal cortex – in those neural regions that play an important role in the perception of people and in social cognition, including the formation of impressions of people, the understanding of other people's beliefs (mentalization), or the attribution of traits (Harris & Fiske, 2009). The third of

the processes connected with empathic reaction to the interaction partner is emotion regulation, thanks to which the person in contact with someone suffering copes with the distress caused by exposure to the suffering of another, which enables the person to summon up their own resources and engage in helping. This process involves the activation of brain structures such as orbitofrontal cortex or the inferior parietal cortex of the right hemisphere.

It can be asked at this point whether empathizing with the client's experience requires effort, knowledge, skills, and conscious adoption of particular attitudes on the therapist's part – or perhaps, in some therapists at least, it is natural and spontaneous. It is known that the emotional simulation process does not occur in every kind of contact and does not always trigger feelings similar to those experienced by the interaction partner (Batson, 2009, p. 5). It can therefore be assumed that the other two processes – taking the client's perspective and the regulation of one's own emotions enabling active engagement in helping – are of key importance to the quality of the therapeutic relationship. The literature on the factors that foster building high-quality therapeutic relationship highlights therapist's attitudes and behaviors that are manifestations of both these processes. Below, we briefly discuss these attitudes and specific behaviors of the therapist.

Being attentive, nonjudgmental, and open to discussing the subjects introduced by the client – these are elements of the therapist's attitude that make him/her likely to be perceived as empathic (Elliott et al., 2011, p. 143). A specific behavior manifesting the above attitude is, for example, encouraging the client to explore their own experience by means of references to their feelings. By contrast, clinician's behaviors such as giving advice, interrupting, or avoiding eye contact are associated with the therapist being perceived by the client as nonempathic (Elliott et al., 2011, p. 143). An empathic therapist is able not only to take and understand the client's perspective but also to adjust the degree to which he/she reveals the empathic understanding to the client's preferences: to individuals who are suspicious, unmotivated, and hostile towards authorities, offering distance in a relationship is more empathic than supportive and accepting communications (Elliott et al., 2011, p. 146) The above recommendation is a particularly good illustration of the link between the therapist's empathy and the humanization of the client – expressing understanding for the client is not a value in itself but merely one of the ways in which the therapist takes into account the individual perspective of the person he/she is working with.

Therapists open to contradictory feelings, sometimes stemming from countertransference, are perceived by their clients as more empathic (Peabody & Gelso, 1982). In the moments when therapeutic alliance deteriorates, which inevita-

bly happen in the course of therapeutic work, what stimulates the improvement of the quality of the therapist–client relationship is the therapist's open and non-defensive attitude to the client's expression of negative feelings (Safran, Muran, & Eubanks-Carter, 2011). Especially at the beginning of therapy, the client may approach the therapist and the very idea of psychotherapy with reserve or even with reluctance – also in that case the therapist's open and accepting attitude to the client's objections is of tremendous significance to the quality of the therapeutic alliance being formed (Horvath et al., 2011, p. 44).

In the literature on the work of clinicians, emphasis is placed on the costs borne by the person remaining in close contact with clients who have many difficult and even traumatic experiences behind them (Bride, Radey, & Figley, 2007). Attention is drawn to the need to develop a strategy of coping with these costs, which in turn is connected with the third of the basic processes described above, associated with empathic reaction to the interaction partner: the emotion regulation process. The aim of this kind of strategy is to ensure that empathizing with clients and commitment to helping lead above all to satisfaction, not to the therapist's occupational burnout (Radey & Figley, 2007).

The literature on psychotherapy provides plenty of valuable information about what attitudes a therapist should develop and what skills, manifested in specific behaviors in contact with the client, he/she should possess in order for the therapeutic relationship being developed to be a subject–subject relationship, conducive to the client's achievement of positive changes. One may have the impression that it is impossible for a well-educated and constantly developing therapist, who has his/her work supervised and receives positive feedback information from the supervisor, to dehumanize the client. The literature on the subject reveals that humanization, manifesting itself in empathizing with the client's experience and in the ability to build a high-quality therapeutic alliance, is largely an effect of the therapist's professional development. In the course of training, a clinician develops perspective-taking skills and learns strategies of coping with his/her own emotions caused by contact with other people's suffering. An inevitable element of this process, highly valued by therapists, is supervised practice (Dyck & O'Donovan, 2003).

Naturally, the extent to which a trainee therapist is able to master the skills necessary for building a cooperative therapeutic relationship with the client depends not only on the quality of the training and the level of the therapist's commitment to his/her professional development but also on the individual characteristics he/she possesses when beginning to prepare for the profession.

Regardless of whether the humanization of the client is assumed to be predominantly an effect of the therapist's individual characteristics possessed already before taking up professional training, or primarily a result of the knowledge, skills, and attitudes acquired in the course of training, it seems that the ability to build a subject–subject relationship with the client as depicted in the literature on psychotherapy is the therapist's attribute. In this sense, for a well-educated therapist – aware of the principles of professional ethics, with helping the clients as his/her main goal – it seems virtually impossible to dehumanize the patient. But is it really impossible? Rosenhan's study (1973) as well as media-publicized cases of harmful behavior that therapists who had previously enjoyed recognition in the community perpetrated towards their patients contradict this conclusion. While the common reaction of the public to cases of this kind is outrage, the professional community frequently reacts with surprise. Sometimes there appear comments such as: "Therapists are only human and can make mistakes." However outrageous such statements may seem in the context of the debate on client abuse, they do highlight a certain obvious fact: therapists are subject to the same information processing phenomena as other people. They are not free from cognitive biases, affecting the way they interpret information and the kind of behavior they engage in in particular situations. The above observation directs our search for possible causes of dehumanization of the interaction partner towards research concerning not psychotherapy as such or the helping relationship but human functioning in general.

In what circumstances can a person perceive (and treat) the interaction partner as an object? Processes promoting the tendency to treat others as subjects, to empathize with them, to enter into relationships with them, or the opposite – to deny their status as human beings and their positive characteristics, have been studied in social psychology for a long time (cf. Leyens et al., 2000; Opotow, 1990; Bar-Tal, 1989; Tajfel et al., 1971; see also: Kofta, Baran, & Tarnowska, 2014; Tarnowska, Sławuta, & Kofta, 2012; Tarnowska, 2011; Kofta, 2009). It is, therefore, in this area that we will look for an answer to the above question. We believe that relating knowledge derived from research in basic psychology to therapeutic practice may help better understand the determinants of the therapist's humanizing (and dehumanizing) treatment of the client.

DETERMINANTS OF THE HUMANIZATION AND DEHUMANIZATION OF THE INTERACTION PARTNER – THE SOCIAL COGNITION PERSPECTIVE

What kind of processes can be triggered off when there is an encounter between two people who have not known each other before? Let us imagine a situation well known to clinicians: a client with an appointment enters the office for the first consultation. The conception proposed by Marilynn Brewer (cf. Brewer & Harasty Feinstein, 1999) concerning the formation of an impression of a person posits that an impression can result from two kinds of processes: either from focusing on specific characteristics of the person perceived as a separate, individual being (so-called *person-based impression formation*) – or from perceiving the person through the prism of the social category they have been classified into (*category-based impression formation*). The mode of information processing is chosen in a relatively early phase of contact. Susan Fiske and colleagues (Fiske, Lin, & Neuberg, 1999) emphasize that people spontaneously and automatically (and thus outside conscious control) perform a categorization of the person they are dealing with; what is more, this categorization is accompanied by a specific affect towards the person – so-called *schema-triggered affect*. Consequently, we can expect that, at the very sight of the client entering the office, the clinician in the example will classify him to a particular social category (e.g., teenage boys) and experience positive or negative affect being an expression of his personal attitude towards that category (e.g., a liking for the client rooted in his previous experience in work with teenagers).

Many traits and characteristics may trigger social categorization processes, which are then used for organizing and interpreting the subsequently obtained information about the person. Which characteristics serve as the basis of categorization depends on the cognitive and social context, although some traits (such as age, gender, or skin color) are privileged in this respect (Fiske, Lin, & Neuberg, 1999). At the first contact, an evaluation of the person's importance is also performed (i.e., of the degree to which they are interesting and/or significant to the observer), which determines whether the observer will stick to the category-based impression or shift his/her attention to the person and analyze their characteristics more carefully. Perceiving people as significant is linked with the prediction of contact or willingness to establish contact with them (enter into a relationship with them) – individuals who are or will be in some relationship with the observer are perceived in a more individualized way (Fiske, 1993). Again, therefore, orientation towards entering into a relationship with the person

emerges as a condition of interest in their individual characteristics, including their mental states (cf. Waytz et al., 2010). Let us imagine that the clinician in our example noticed, when inviting the teenage client into the office, that a man with a parcel in his hands was approaching the receptionist. Having classified that man into the category of "delivery man," the clinician immediately decided that the category was not important to him at the moment and, stopping at that, focused all his attention on the teenager entering the office.

Shifting attention to the person does not guarantee individuation but merely makes it possible. Individuation takes place when the initial categorization (in our example: "a teenage boy") is treated only as one of the person's attributes, to which information about other characteristics is added, making up a fully individualized picture of the person. We are then dealing with the way of forming an impression of a person that Marilynn Brewer and Amy S. Harasty Feinstein (1999) refer to as *person-based* or *bottom-up* (from data to a cognitive representation): a representation of the person is gradually constructed based on the acquired data about that person, on the conclusions that follow from these data, and on generalizations. Alternatively, an impression of a person can be constructed on the basis of knowledge about the category that the person has been classified into. This is a process that Brewer and Harasty Feinstein refer to as *top-down* (from stereotypical knowledge to data, category-based), in which knowledge about a category determines what one pays attention to, how one interprets information, and in what way one acquires new data about the person. New information is adjusted to the knowledge about the category; the observer seeks consistency between the information acquired and stereotypical knowledge (Brewer & Harasty Feinstein, 1999).

Both modes of processing may be thorough – it is not the case that one of them involves a predominance of automatic processes and the other one consists in conscious and careful collection of data. Both strategies of constructing an impression of a person may involve meticulous collection of information. In the case of forming an impression based on initial categorization, this consists in relating the data concerning the person to the knowledge about a prototypical representative of the category, identifying inconsistencies between the information acquired and the knowledge about the category, and – as a result – developing an individualized impression of the person as a member of a particular social group. Still, it is stereotypical knowledge that will influence the manner of collecting data about the person (and, consequently, the obtained data themselves). One then devotes more attention to information connected (consistent or inconsistent) with stereotypical knowledge and remembers it better, and it is mainly

such information that the general impression of a person is based on. Information unrelated to knowledge about the category is overlooked, less well remembered, and less often included in the general representation of the person. The ready representation is linked in the observer's memory with knowledge about a particular category (the person is remembered as a subtype or a specimen of the category). If the clinician in our example constructed his impression of the teenage client in this way, he could, for example say this after the meeting: "For a teenager, Janek is very reflective – he will not make a decision hastily but rather consider the possible consequences of each solution for quite a long time." A prototypical representative of the "teenage boys" category is, according to the clinician's knowledge, rather impulsive. Consequently, the therapist paid attention to the information that was inconsistent with the stereotypical knowledge and remembered it well. At the same time, in the process of forming an impression of his client, he might have omitted those data that were not connected with his knowledge about the "teenage boys" category (and which might have been diagnostically significant). Such reliance in the process of impression formation on the knowledge about the category that the person has been classified into sets the limits within which data is acquired – the person is of interest not as a unique individual but merely as a representative (specimen) of a particular category, which, naturally, may lead to partial dehumanization.

For the above reasons, person-based impression formation is a much more recommended strategy in the clinical context. It is worth stressing, too, that this process does not guarantee proper acquisition of information about the client, as it may be very superficial. A case in point is the so-called halo effect, in which the first pieces of information of particularly positive or negative significance influence the formation of expectations concerning the person, thus determining the further seeking of data and, consequently, the general impression of the person. However, careful collection of person-related data leads to the formation of a complex and at the same time integrated representation, which may comprise contradictory elements (Brewer & Harasty Feinstein, 1999). This way of forming an impression of a person is the most likely to occur when the relationship between the observer and the observed is marked by strong interpersonal orientation – that is, when the relationship itself is important to the observer (who is personally involved in it), not when the main aim of the encounter is to collect information about the person. The higher the level of closeness, the more willing people are to build an impression based on person-related information, not on the knowledge about the category that the person belongs to. Perceived community of goals, perceived similarity, and perceived closeness, as well as willingness to

invest in the relationship – these factors are conducive to humanization (Kofta & Sławuta, 2011; Brewer & Harasty Feinstein, 1999; Opotow, 1990; Bar-Tal, 1989).

And what is it that fosters category-based impression formation? This type of impression formation process is promoted by a situation in which belonging to a particular category is evident and perceived first, before there is an opportunity to see the person as an individual rather than just as a member of the category (e.g., presence or absence of a doctor's lab coat inside the ward in a psychiatric hospital). What also strengthens the perception of a person in terms of a category they have been classified into is a situation in which division into categories involves the observer's self and leads to specifying the category that the observed person belongs to as distinct from the category that the observer identifies with (Us vs. Them categorization). The already classic research in social psychology proves that people automatically (nonintentionally) evaluate as well as treat those individuals better whom they consider as belonging to their own group better than those classified as members of a different group, even when the division into groups is based on an artificial criterion introduced exclusively for the purposes of the experiment (cf. e.g., Tajfel et al., 1971). Another circumstance conducive to category-based perception of a person is a situation in which the person is classified into a category that strongly stands out against others (e.g., into a minority group).

In everyday interactions, the categorization tendency prevails over the individuation tendency, since using a category gives the observer immediate access to useful data (concerning the appropriate affective, cognitive, and behavioral reactions to the person encountered) with a minimum of cognitive effort (Fiske, Lin, & Neuberg, 1999). It is therefore worth stressing that perceiving others in terms of social categories is a natural process, indispensable to social functioning. At the same time, it is known that categorization distorts information processing and imposes a certain orientation on it – it promotes limited search for data (the information collected is that which refers to stereotypical knowledge), confirming initial assumptions, and omitting information unrelated to knowledge about a given category (cf. e.g., Rudman & Borgida, 1995).

Individuation requires resources of attention, time, and motivation to study the person's characteristics carefully. With limited attention resources, even strong motivation to form an accurate impression is not sufficient, and so people fall back on categories. Noise as well as anxiety or "mental noise" limit attention resources and hinder individuation (Fiske, Lin, & Neuberg, 1999). In this context, it becomes understandable that a well-educated clinician, motivated to help,

may perceive his/her client through the lens of a particular category due to a considerable (and situationally determined) limitation of his/her own cognitive resources. As we have pointed out earlier, shifting attention to the person (making a decision about the person's high level of significance to the observer and devoting time to collecting information about them) does not guarantee individuation because it may only result in a confirmation of the initial categorization (so-called confirmatory categorization) or in recategorization. The clinician in our example collected information about the teenage client all the time relating it to the "teenage boys" category and, as a result, recategorized his client as an "atypical" representative of the category of teenagers.

The factors that cause a greater tendency to confirm the initial categorization include threat to self-esteem (to the self or to the group one belongs to) and the need to justify one's privileged position (Fiske, Lin, & Neuberg, 1999). Moreover, individuals in a power position are less prone to individuation with regard to those whom they perceive as lower in rank. Additionally, a high level of the need for domination is linked with a lack of desire to pay attention to others (Fiske, 1993). These conclusions refer particularly to the therapeutic relationship, which is, by definition, an asymmetrical one, with the clinician positioned in the role of an expert – the superior role – and the client as the party "seeking assistance" and thus – at last to some degree – in a position inferior to that of the therapist. This very fact constitutes a risk factor as regards the therapist's willingness to individuate the client. If this is combined with the hostile attitude on the part of the client, who accuses the therapist of ineffectiveness and questions his/her competence, then the outcome is a simultaneous threat to self-esteem. The client could additionally doubt in the value of psychotherapy and psychology as a scientific discipline, which would be a threat to the group that the therapist probably identifies with strongly. This kind of situational context would thus increase the tendency to dehumanize the client and classify him/her as "noncooperative" or "unlikely to recover"; it could lead the therapist to unintentionally adopt an attitude towards the client that would differ considerably from his/her desired humanizing attitude.

The above example is not meant to present the dehumanization of the interaction partner as an inevitable consequence of specific situational determinants. Rather, it is intended to show how some situational factors – not necessarily the clinician's general, stable characteristics – may interfere with the therapist's willingness to build a subject–subject relationship with the client. To conclude, professional preparation and willingness to help are only necessary but not sufficient conditions of perceiving the client in a human way. In the further part of

the article we propose recommendations for clinical practice, aimed at strengthening the subject–subject relationship between the therapist and the client, taking into account both the context of research on psychotherapy and the conclusions that follow from research in the field of social cognition.

RECOMMENDATIONS FOR CLINICAL PRACTICE AND PROPOSALS CONCERNING THEIR EMPIRICAL VERIFICATION

Therapists categorize of their clients not only automatically, as part of the process embedded in every kind of social interaction, but also consciously, in order to formulate a so-called case conceptualization. What kind of difficulties does the client experience? What psychological mechanism underlies them? What factors that give rise to difficulties can be distinguished in the client's cognitive, emotional, and behavioral functioning? Without this kind of categorization, a therapist would not be able to formulate preliminary recommendations for the client or decide on which interventions can be used during the therapeutic contact. In this sense, the client is not only a psychological subject that the therapist enters into contact with but also an object of the clinician's cognition. Conceptualization consists in classifying the client's difficulties into particular categories (e.g., the category of mental disorders that the client suffers from) and in explaining his/her functioning as an effect of particular cognitive-affective schemas, which allows, for instance, to predict the client's reactions to specific types of intervention. Conceptualization identifies the client's limitations in the sphere of experience (when it concerns, e.g., difficulties in experiencing positive emotions in a person suffering from depression) and agency (e.g., when it describes the factors that determine the existence of a person's egodystonic characteristics); it is therefore a way of thinking about the patient that apparently seems to compete with mentalization processes (cf. Waytz et al., 2010). Is it really legitimate to perceive formulating a conceptualization as an activity that interferes with the humanization of the patient?

Shari Geller and Leslie Greenberg (2002) convincingly describe the condition, overriding Rogers's triad, that the therapist should meet in contact with the client: presence. The therapist's presence consists in directing attention to the uniqueness of the client's experience while at the same experiencing himself/herself as a separate whole. It requires the suspension of expectations and knowledge concerning diagnostic categories – so that the therapist can focus as much as possible on the client's unique experience. The level of the therapist's

presence as rated by the client turned out to have good prognostic validity – clients reported a high quality of therapeutic alliance and positive changes following those sessions during which they had a sense of the therapist's presence (Geller, Greenberg, & Watson, 2010).

Is it possible to reconcile the task of creating a conceptualization and monitoring the effectiveness of interventions with full humanization of the client and with building a cooperative relationship in which the client is regarded as a unique individual rather than perceived in terms of diagnostic categories? It seems very useful in this context to turn to philosophy – to Martin Buber's famous *I and Thou* (1992). Buber says that a person's first "word" is not "I" but "I–Thou" – a relationship. Pure relationship is simply remaining in a relationship – coexistence. If one starts to examine the other person, change them, or use them for a purpose (also: take advantage of them), then the word "I–Thou" becomes "I–It." The "I–It" relationship is a dehumanized contact, indispensable not only in the process of semantic cognition but also in the process of planning and proposing specific changes. The "I–It" relationship is therefore fully justified. For instance, taking the client's medical history (and thus performing categorization), giving the client a task to do at home, or proposing a particular technique are examples of moving away from "pure" "I–Thou" relationship. Buber even says that it is impossible to function in an "I–Thou" relationship permanently, but it is, unfortunately, possible to function permanently in an "I–It" relationship.

What can prevent the humanization of the client is the therapist's anxiety – a sense that his/her privileged position in the relationship is not justified because he/she does not feel like an expert but rather like a helpless observer of the client's difficulties, which in turn threatens the clinician's self-esteem. In contrast, the ability to construct conceptualizations, which leads to making conscious decisions concerning one's own competence to work with a particular person, is an important security factor. A therapist who advises the client to turn to another clinician, knowing that work with that person is beyond his/her competence, not only acts in keeping with the principles of professional ethics but also cares for the comfort of his/her own work. A therapist who, in the course of work with a client, is able to assess all changes in the client as they occur and design his/her interventions accordingly (which requires making the client an "object" of cognition) makes it more likely for therapeutic contacts to end in success. At the same time, the success of therapy must not be the therapist's goal in itself. A situation in which the success of therapy becomes the therapist's dominant goal should be a kind of warning signal and induce the therapist to reflect. This kind of personal goal on the therapist's part frequently emerges in response to

helplessness and a threat to self-esteem, which appear in the course of work with a person experiencing serious difficulties, not receding despite prolonged therapeutic work.

What therefore seems crucial is therapists' ability to switch between two modes of processing information about the client – humanizing and dehumanizing, based on the comprehensive, holistic perception of a person and based on reference to specific analytic categories. A clinician should be able to build contact and adopt an empathic attitude of acceptance towards the client as well as analyze and structuralize information about the client when planning interventions and monitoring their effectiveness. Being both an expert and a partner in a relationship is an extremely difficult and straining task, emotionally as well as cognitively. In this context, recommendations concerning therapists' care for their own condition (e.g., by ensuring appropriate workload and sufficient time for rest, by investing in their own development, and by taking advantage of supervision) acquire special importance; negligence in this area may lead to serious mistakes in practice, such as dehumanization of the client, which is prevented neither by professional training alone nor by years of experience.

Emphasis in the training of psychotherapists should be placed on both of the above elements important for the therapeutic relationship. Proficiency in formulating conceptualizations and planning interventions as well as the ability to adopt the client's perspective and empathically adjust to his/her needs both seem to be indispensable to the possibility of building a subject–subject relationship, contributing to the client's achievement of positive changes. Relating the above idea to knowledge about the determinants of mentalization, it can be assumed that the most general precondition of the humanization of the client is willingness to build a relationship with them – so that the ability to explain their behavior thanks to well-constructed conceptualization does not exclude or compete with mentalization processes in the context of the therapist's motivation to understand the client's actions. At the same time, a well-constructed conceptualization facilitates adopting the client's perspective , for example by making it possible to perceive the client's behavior as a consequence of his/her earlier experience. A person who has many times experienced rejection from significant others expects rejection in the relationships that he/she regards as valuable; such a person may therefore express mistrust or hostility towards the therapist – and the more so the more important the therapeutic relationship becomes to them. Understanding this enables the therapist to empathize with the client; it reduces the risk of perceiving such a client as "noncooperative" and a "difficult case,"

thus protecting the therapist's motivation to build a relationship with the client and, consequently, to humanize him/her.

In conclusion, we believe that formulating a conceptualization is not an activity that competes with the humanization of the client. On the contrary: it is a manifestation of professional objectification (understood as interpreting a person's functioning through the prism of knowledge about categories – e.g., diagnostic categories and cause-end relationships, at least partly abstracting from the person's self-agency and capacity to experience). However, this kind of professional objectification might actually enable understanding the client as a fully functioning person, with resulting humanization of the client in the therapeutic relationship (e.g., by creating conditions conducive to the therapist's positive attitude towards and empathy with the client as well as increasing therapist's tolerance for the difficulties that inevitably arise in the therapeutic relationship). Conceptualization thus might foster the therapist's willingness to build a subject––subject relationship with the client, and such willingness seems to be a precondition of successful therapy. As Antoni Kępiński writes: "Other people's mental states can therefore only be learned on the plane of 'animization,' i.e., of a living-to-living relationship, . . . a subject-to-subject relationship" (1989, p. 16). On the other hand, he adds: "A psychiatrist must not forget that he/she is a doctor, a naturalist by education, and should maintain a certain distance from emotional reactions, both their own and the patient's. They must, as it were, create a third party, an ideal observer following both their own and the patient's psychological reactions. This third, fictional observer is precisely a psychiatrist and a naturalist, observing the examiner and the examinee without emotional involvement, treating their experience as an object of study. The ability to maintain balance between the animist and naturalist attitudes determines the outcome of both examination and treatment" (p. 21).

The conclusions formulated above require empirical verification. Research on psychotherapy has a serious ethical limitation, however: it would be unacceptable to refer clients, on the one hand, to therapists who focus exclusively on creating conceptualizations as well as planning and implementing interventions, and on the other – to clinicians using only those interventions that aim at strengthening contact and achieving an empathic understanding of the client, in order to verify the hypothesis that neither of these orientations alone leads to lasting positive change being achieved by clients. A promising direction seems to be the analysis of methods employed by those therapists who stand out as particularly effective – those that Okiishi and colleagues (2003) would classify as "super-shrinks." An interesting research question seems to be how much attention they

devote in their work to humanizing and objectifying the client. A method of analysis that could prove useful in this context appears to be the grounded theory method (Charmaz, 2009), allowing to formulate broader categories found in analyzed communications without their preliminary conceptualization.

Another research direction to follow in verifying our recommendations for practice could be based on using the simulated client method, common in medical contexts but not in the context of training future psychotherapists (cf. Zalewski, Filipiak, & Tarnowska, 2012). In this case, the research question would concern whether or not a clinician working under heavy strain (both cognitive and emotional, generated, for example, by a threat to self-esteem) would differ significantly from a clinician working in neutral conditions in terms of the humanization of the person playing the role of a client. The person playing the role of a client could in turn evaluate the clinician in terms of the extent to which he/she was present and empathic during the meeting and to what extent a cooperative relationship was built. The research questions we propose and the ways of operationalizing them are open-ended suggestions and an invitation to debate. Our aim has been, above all, to provoke reflection on the factors that influence the therapist's humanization and objectification of the client as well as on the role of these factors in the process of psychotherapy.

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