

## CHAPTER 8 - THE DIALOGAL APPROACH TO PSYCHOPATHOLOGY AND THE IMPLICATIONS FOR PSYCHOTHERAPY

The primary statement of this thesis is that the healing is found through the meeting in the psychotherapeutic relationship. This is based on Martin Buber's philosophy and the dialogal approach which evolved from his beliefs. The term dialogical therapy was first used formally to refer to a distinct psychotherapeutic approach in late 1983 or early 1984. It was then incorporated into the name of the Institute for Existential-Dialogical Psychotherapy in 1984 in San Diego. Thereafter, it was changed to The Institute for Dialogical Psychotherapy (Hycner, 1991). The term dialogal is used throughout this study as it is the more commonly used term and does not signify that any specific branch of the movement is being followed. This chapter explores the fundamental principles of the approach and the benefits derived from it in terms of psychotherapy and the healing of the patient.

The dialogal approach to psychotherapy and psychopathology is grounded in the works of Martin Buber, a Jewish philosopher of the early part of the twentieth century. Dialogal means relational. Buber became aware, especially during the first world war, of the breakdown of relationships and connections between people which resulted in the dehumanisation, objectification, isolation and alienation of man. He believes that this was further exacerbated by modern technology which ignores relationships between people and focuses on material gains and achievement. Buber states that this led to a split between man and his world, man and others as well as within the psyche itself. Buber (1958) declares that "all real living is meeting" (p. 11) and advocates that the healing of these splits can be achieved in the meeting between two people in an I-Thou relationship.

Dialogal psychotherapy is thus an approach where psychotherapy is centred on the meeting between the therapist and patient/family as key to the healing mode. Dialogal psychotherapy is not identified with any specific school of psychotherapy, theoretical orientation or technique. The basis of this view is that the approach, the process, and the goals of psychotherapy must be grounded in a dialogal perspective (Hycner, 1991).

Like phenomenology, dialogal psychotherapy recognises the human being as a whole, unique individual functioning within the context of his world. Herbert Spiegelberg (1972), a prominent phenomenological scholar, views Buber as fitting within the broader understanding of the phenomenological approach. The perspective of the whole is always returned to as the individual lives in relationship with people on a daily basis.

In order to meet and connect fully with another person, dialogue is necessary. This does not only mean languaging but a connecting with the person's feelings and psyche which can occur even in silence as genuine dialogue means experiencing the other person's world. Buber asserts that one must "bring oneself" into the process of dialogue and "make the contribution of one's spirit without abbreviation and distortion" (Friedman, 1985, p. 87). Dialogue is viewed as "central to the process of understanding and the search for truth" (Halling & Leifer, 1991, p. 3). It is only in a genuine dialogue

that the real dimensions and depth of any human being can be truly explored and understood. Friedman (1985) declares that, for Trüb, the "dialogical meeting is both the starting point and the goal of therapy" (p. 34).

Buber's focus on the relational aspects of existence introduces the concept of the 'between'. This is the unique connection, the space, the interpersonal quality of the relationship created by the two people involved which recognises that subject and object are not separate. Friedman (1985) quotes Buber, 1969, as claiming that "the sicknesses of the soul are sicknesses of relationship" (p. 97) and that the "soul is never sick alone, but there is always a between-ness also" (p. 36). This emphasises that no-one lives and experiences in complete isolation but is always in relationship to someone or something. The creation of dialogue in the between is what Buber calls the dialogal.

In dialogal psychotherapy, therefore, the therapist and patient work in relationship which is a mutual striving to achieve the patient's growth and return to relationship. The therapist and patient experience together in the between and create a new reality of intrapsychic, interpersonal and transpersonal dynamics. The focus is more on the here-and-now and the self in relation to others which creates a different level of receptivity and responsiveness in the unique space created by the therapist and patient together. Hycner (1991) states that it is out of the here-and-now and the between that the answers will emerge.

By working in the between and accepting Buber's statement that all real living is meeting as the essential element of human existence, the focus becomes the manner in which people relate to others in their uniqueness and otherness and not just with the content of their own experience. This shifts the focus to the psychotherapeutic relationship. The therapist becomes a partner in the dialogal process as well as providing him with a "touchstone of reality" (p. 205), that is, a central event in a person's life which gives his life meaning. Thus, the person is met with respect and valued for who he is as a whole human being living and relating in the world. The therapist provides an experience that is unique, meaningful and confirming for the patient (Friedman, 1985).

Heard (1993) describes how every human being is capable of I-Thou relationships. Every time an individual relates in an I-Thou moment, it creates a new reality as it is in the between that we experience in an immediate and direct manner. Experiencing a touchstone affects one totally at a level that is neither subjective nor objective as both these forms of reality require reflection. A touchstone of reality is felt at a pre-reflective level. Heard describes this as apprehending but not comprehending the experience as one cannot experience one's wholeness and reflect on it at the same time. The person must be open in the encounter to allow the touchstones to evolve so that an idea of direction can be gained. Touchstones are not static but are constantly being shaped and changed by dialogal encounters with others. A touchstone is a unique sense of reality which is true for each individual. Heard states that it is in the meeting of the between that one's uniqueness is either disconfirmed or confirmed. The patient who is fragmented or dysfunctional is interacting in a world where his touchstones have been unacceptable to others which has resulted in a disconfirmation of himself. If the reality of one's touchstones is denied, the individual becomes more isolated and

separated from any sense of being real as a person. In turn this affects his ability to relate in a meaningful way in the world. It is only in the between that the healing can occur as this is where the therapist lives the experience with the patient. If he does not meet the patient in the between, the therapist will be distanced so it is often better to simply share feelings than interpret. This meets the patient more fully as it is in the dialogue that our humanness evolves. Thus, Heard maintains that if people are to be healed, dialogue must be made available to them.

The therapist is required to bring his own touchstones into the psychotherapeutic encounter in order to help heal the patient. This does not mean sharing one's own experiences with the patient but being present in an authentic manner which deepens the psychotherapeutic relationship and assists the patient to connect in a meaningful way. Although both can be altered in the process, the focus is on changing the patient's touchstones to allow growth and direction.

### BUBER'S CONCEPT OF THE I-THOU AND I-IT:

Buber (1958) bases this dialogue in the between on the meeting of two people in an I-Thou relationship. Meeting someone as a Thou means fully connecting in a meaningful relationship in which the whole human being is met - body, mind and soul. This conveys a genuine interest in and respect for the person as a unique and separate individual. Buber says the I-Thou is spoken with the whole being and is thus the primary word of relating as it allows another person to fully experience the individual's world.

The I-It encounter involves meeting the other as an object and a means to an end. Meeting the person as a separate object devalues, dehumanises and alienates him. Thus, I-It is the primary word of separation as it creates barriers between people. Within the I-Thou attitude, separateness is present in a positive way in the sense that there is a recognition that both are unique individuals meeting the world together in a new relationship.

Buber's philosophy does not imply any dualistic rejection of the ordered world of I-It but only an interpretation of that world by the I-Thou attitude. Both forms of relating are present in any relationship and the I-It form underlies the I-Thou form of relating. Buber states that both operate to create a relationship which alters in closeness and distance according to whichever attitude is dominant. So, it is not that the I-It attitude is necessarily incorrect as it is impossible to constantly connect at the depth required for I-Thou interacting. Problems arise when the I-It attitude is dominant. This creates an empty, meaningless and superficial connection in which the other is not met as a worthy and unique individual. This negates the other as a human being of value. The Cartesian and medical model approaches encouraged the I-It attitude in its most extreme form. These approaches, in turn, created the need for people to be met as human beings and not objects. Another danger is that when one meets others as objects (I-It), the tendency is to view oneself in a similar manner, hence negating one's own value. If one values oneself, one will value others and be able to relate in a deep and meaningful manner with integrity (Hycner, 1991). If we are ever to have caring and compassionate societies, the I-Thou manner must become the principle underlying people's approach to life.

The therapist and patient together form a relationship that creates a connected "we" rather than a separate subject and object. This relationship is greater than each individual as well as greater than the sum total of the two together. Buber uses the Taoist expression "wu-wei" (non-doing) to describe the core of the I-Thou relationship where the focus is on the therapist and patient being together in the between rather than doing something like following a technique (Friedman, 1985). Buber (1965) writes that each person is made present by the other and the relationship takes place in the here-and-now in a mutual and direct meeting. In the psychotherapeutic relationship, the therapist and patient should ideally meet in an I-Thou encounter where the patient is valued and confirmed. The I-It encounter is a dangerous space as objectifying the person means there is no acknowledgement of the between and, therefore, no authentic meeting. If there is no real meeting, there can be no potential for healing as Buber avers that a person can only become a whole human being when he is present in a mutually confirming interaction. A genuine approach to others invites a reciprocal response and the between implies involvement and genuine concern. The aim is a rhythmic balance of relatedness and separateness whilst exploring the patient's world. This balance can be a difficult task for the therapist to achieve (Hycner, 1991).

#### BUBER'S CONCEPTS OF MUTUALITY AND INCLUSION:

The I-Thou relationship includes openness, mutuality, presence and directness. In order to understand the experiences of the patient, the therapist must form a close, connected relationship with the patient where both are present in the encounter. This is described as inclusion or "imagining the real" (Hycner, 1991, p. xiii). Buber maintains that inclusion is broader than empathy or identification. Identification implies understanding through one's own feelings and experience. The element of inclusion takes empathy further than a one-sided quality provided by the therapist to include the therapist's emotional involvement within the patient's world. Inclusion or imagining the real means a mutual contact, mutual trust and mutual concern about the patient's problems but it is not a fully mutual process. Buber (1965) describes this as "a bold swinging... into the life of the other" (p. 81) where the therapist is able, with a concerted effort, to go to the patient's side and yet still experience himself. Stern (1989) describes Schachtel's view that the therapist moves from an "autocentric" attitude, where the other is seen simply as an "object-of-use", to the "allocentric" attitude which is described as "curiosity, an openness or receptivity that requires the tolerance of ambiguity, and uncertainty and sometimes pain" (p. 24). This requires the therapist to become human at a basic, primary level. The therapist must never lose his own sense of reality or experience. This calls for the therapist to be personally involved and yet appropriately objective in understanding this unique person. Buber (1965) describes this as a "detached presence" (p. 71). He alleges that we do not experience the other through empathy but by understanding what the patient's experience and world are like for him. Only true inclusion can confirm the other's experience and world in a way which will allow him to move into the world in a different manner. Hycner (1991) submits that this confirmation of the patient affirms his existence even when his behaviour is unacceptable. By having the above qualities and being authentic, Jourard, 1971, maintains that the therapist provides the patient with a role model with which he can identify (Friedman, 1985).

With two people meeting in a genuine, deep, caring relationship, the question of

whether both are as deeply involved in the process and in the same manner is of importance. Mutuality means real, active involvement as a therapist in response to the patient's experiencing whilst limiting the openness of himself to what is appropriate for the moment. Buber (1965) submits that "you are not equals and cannot be" (p. 172) as it is the patient's experience and life that is the focus of importance. Mutuality means being able to see, feel and experience the patient's world from both sides and this meeting and sharing, especially in a bodily-felt sense, allows the therapist to be touched by the patient's experience. Jacobs states that the task of psychotherapy sets two people in different positions to each other because the task is to heal the patient and not the therapist (Friedman, 1985). The psychotherapeutic relationship is a common meeting ground but each enters with a different position, personal stance, role and function. Healing depends as much on the recognition of differences as the mutual trust and meeting.

Based on Buber's I-Thou relationship, the central element of the dialogal approach is that there is "healing through meeting" (Hycner, 1991, p. xii). Healing means to make whole. What has been injured and is not whole is the person's trusting relationship to others. Dialogal psychotherapy is an invitation to form a human encounter and explore and experience the self in a genuine relationship. This requires a willingness and openness to the other to be who he is in complete authenticity. Thus, it is in the meeting in this special relationship that the patient can travel the journey to healing and fuller integration by re-establishing the relational links he has severed.

#### THE VALUE OF CONFIRMATION:

Buber (1965) declares that one experiences oneself as human when one is confirmed by another with complete acceptance as a person in the process of life. Friedman (1985) asserts that "mutual confirmation is essential to becoming a self" (p. 119). Buber stresses that confirmation is not static and includes confirming the patient's whole being and all his potentiality. Life is thus not simply lived as an individual or a member of society, in isolation or togetherness, but as a whole constantly flowing from one to the other. Hycner (1991) quotes Buber, 1957, as stating that "man is not to be seen through, but to be perceived ever more completely in his openness and his hiddenness and the relation of the two to each other" (p. 51). Laing (1969) describes how the individual's sense of identity requires reflection and feedback from others to confirm it. Inclusion provides confirmation by the therapist which begins to replace the disconfirmation that the patient has experienced in his family and world. Thus, if one understands the patient's inner, personal experiences and goes further to his being-in-the-world to try and re-establish links, the patient feels more confirmed and real and is able to move into relationship with more congruence. Thus, inclusion lies at the centre of confirmation.

#### THE GOALS OF PSYCHOTHERAPY:

The common goal is the healing of the patient but the therapist and patient have very different relationships to that goal. Buber (1958) claims that the aim of healing is "the regeneration of an atrophied personal centre" (p. 133) so that the patient can find his own sense of unity and wholeness. He maintains that the integration of the personality is not an end to itself but that one becomes whole in order to be able to respond and relate to what addresses one in the world. Buber stresses the unity of the body and

mind in health which he views as indicating the more unified soul of the person. He states that the more dissociated and damaged the soul is, the more it is at the mercy of physical influences. It is thus important to gain back that wholeness as, the stronger and healthier the soul, the more able it is to guard the unity of the body and mind. This understanding and search for the wholeness of the person will lead to his healing and his return into relationship in his world. Farber (1966) states that in this process the therapist and patient must face the despair that is central to the healing through meeting. In the search and dealing with despair, Buber (1947) states that one cannot be certain and absolute about knowledge and thus one exists on a "narrow rocky ridge between the gulfs where there is no sureness of expressible knowledge but the certainty of meeting what remains undisclosed" (p. 184). Thus, the therapist and patient together explore the unknown within the safety of the psychotherapeutic relationship.

Friedman (1985) submits that when the above relationship and process have been achieved by experiencing inclusion and imagining the real, the patient can move beyond the trauma. The patient will then have a choice of remaining true to his own experience of reality at the cost of being cut off from the community, or of cutting himself off in order to fit the expected social norms. This would apply when the person's community, for example, the family, is very disturbed. However, generally, the aim is to find a balance between remaining an individual, unique person functioning within the larger framework of society.

#### THE DIALOGAL VIEW OF PSYCHOPATHOLOGY:

Both the phenomenological and dialogal approaches view psychopathology as a disturbance of the person's entire existence. Dialogal psychotherapy views man's existence as grounded in relationship and meeting and psychopathology is thus a disturbance in the relational aspects of living and meeting. In neurosis there is a flight from meeting as the self turns inward and cuts itself off from the nourishment of others. In so doing, the patient withdraws from his world of relationship and becomes isolated. May (1983) speaks of neurosis as a way of preserving the self from threat and blocking off aspects of the environment in order to cope more adequately with the remainder. Society exacerbates the isolation by rejecting and not confirming the person who does not conform to its norms and expectations. Likewise, simply medicating or hospitalising patients without the healing I-Thou relating, further isolates and disconfirms them.

Based on Buber's I-Thou relationship, one can view part of the disturbance of inter-relating as due to differences in the I-Thou manner of relating. Friedman (1960) supports Ebner's views that the "irrationality of the insane man lies in the fact that he talks past men and is unable to speak to a concrete Thou" (p. 185) which means his world has become a projection of the I without the Thou. Friedman (1985) declares that Ebner even goes so far as to say that insanity is "the end product of 'I-solitude' and the absence of the Thou" (p. 3). In this barren world where the individual has withdrawn into isolation, there is little to confirm the individual's sense of self in relation to others. The focus becomes I without any mirror to reflect back an image of the self in meeting which can result in a narcissistic focusing on the self - either in a self-glorifying or self-deprecating manner. Thus, the isolation exaggerates self-perception precisely because there is no feedback from others and the world is narrowed down to experiencing only

the self. Straus (1962) states that the most important aspect of the I-Thou relationship is that it allows us to see things, not only in relation to ourselves, but in their individual entirety and meaning. When the I-Thou relationship is disrupted, it becomes difficult to see the meaningful whole and "every attempt to create order increases disorder" (p. 275). This increasing disorder is clearly described by Laing (1969) when he speaks of the terror of the fragmented person when he is treated as an It as he requires constant confirmation from others of his own existence as a person. Without this confirmation the fragmented person's whole existence is experienced as threatened.

Farber (1966) believes that the psychotic has an "equal failure of knowledge, judgement, and experience in the world of It" (p. 148). This implies that there is not only a failure to meet others in the Thou manner but an increasing inability to function even in the alien and isolated world of the It to which the psychotic has withdrawn. Psychosis is not simply an altered reality but a disconnection from the world so the patient needs to be reconnected in relationship in a meaningful way. In his overwhelming despair, the psychotic is desperately needing the connection and confirmation of himself by others. The patient's dilemma lies in having to choose between living his own reality in isolation or re-entering the world of communication and connection (Friedman, 1985).

Buber (1958) views psychopathology as the absence of confirmation. Laing (1969) supports Buber's view that disconfirmation is the base of psychopathology which Laing believes starts with the mother's lack of responsiveness to the child threatening him with a loss of his sense of self. A sense of emptiness and futility pervades when there is no confirmation of the self or a feeling of being of any use to anyone. The empty and isolated person would rather be falsely confirmed than not at all. The intense focus on the self in psychopathology and Winnicott's description of the False Self indicate the attempts of the individual to gain that confirmation. Thus, the isolation, self-focus and the creation of a False Self persona fulfil the dual role of protecting as well as seeking to meet the needs of the self. However, Laing believes any meeting that falsely confirms is inauthentic as a real relationship only becomes a possibility when the other is confirmed.

Disconfirming experiences result in disillusionment. The individual may respond by becoming more realistic or embittered and chronically cynical. The person may remain disappointed and cynical in order to avoid further disillusionment which changes his perceptions of the past, present and future and erodes the sense of a congruent, balanced reality. When a patient is disillusioned and does not attempt to come to terms with such a deep experience of disappointment, the past is shattered and the future foreclosed as experience is altered and narrowed. This results in changes in relationships to people and to the world in general as feelings of dismay, horror and other negative emotions result. There is a sense of the loss of innocence and discontinuity which raise questions about the self and one's own judgement. Initially this feels intolerable and impossible to survive and drives the patient deeper into isolation with little or no connection in relationship (Socarides, 1977).

In this isolated world of the It, the individual is disconnected from meaningful confirmation and relationship. May (1969) claims that dialogue with the world is scarce and often faulty. He states that the degree of psychopathology can be measured by the

lack of dialogue and views psychotherapy as assisting the patient to develop the capacity for dialogue. Confirmation can only occur in relationship with another and this meeting requires dialogue. The dialogal view is that psychopathology is an "aborted dialogue" (p. 140) and it is only in genuine dialogue and meeting that healing can take place (Hycner, 1991). Buber (1965) views genuine conversation and the fulfilment of the relationship between two people as "an acceptance of otherness" (p. 69) where both individuals are acknowledged in their wholeness. Trüb maintains that true confirmation of the other means that one values him "as a human being, and not just as a sick person" (Friedman, 1985, p. 139). This confirms the patient as a whole, unique person of worth and reinforces the view that one can never reduce man to compartmentalised pieces of a whole.

Buber (1965) states that an individual is only able to have a true relationship with genuine dialogue when he is psychologically independent. This is critical to understand as fragmented and psychotic people have little or no sense of boundary between the self and the other and are thus at extremes of distance and relatedness. This implies that they are not separate and not in real relationship. The first priority is then to create a relationship where dialogue can be resumed.

#### THE IMPLICATIONS OF THE DIALOGAL APPROACH:

Dialogal psychotherapy rests firmly in the psychotherapeutic relationship, that is, in the between created between the patient and therapist. Through dialogue in the unfolding of the narrative, the psychic conflicts and the wounded manner of inter-relating emerge to be worked with and the true essence or being of the patient is revealed. The goal of psychotherapy is to improve the patient's ability to relate in the world as a whole person. Both the therapist and patient must work together towards this goal and the dialogue may be limited as Buber (1965) believes the therapist may only enter into the patient's world as far as he allows him to. The therapist must know and view his own woundedness before entering the psychotherapeutic relationship. This author's belief is that the therapist is accountable and responsible as he has knowledge, has been trained and must beware of doing harm. The therapist accepts the uniqueness and limitations of each relationship and the reality of the between which means the psychotherapy is not totally his success or failure. However, responsibility for growth depends on both the therapist and the patient in the psychotherapeutic relationship. Buber stresses the need for man to take personal responsibility when entering into a real relationship. May (1958) alleges that many of Kierkegaard's concepts had an effect on the significance of the therapist in relationship with the patient. Kierkegaard emphasises the necessity for commitment in discovering a particular truth and May believes there is a necessity for the patient to be committed to his psychotherapy in a passionate and involved way. Talk and intellectualisation are simply a means of avoiding commitment and dealing with the real issues. Friedman (1985) stresses that what takes place in the relationship between the therapist and patient is more important than the skill of the therapist.

If psychopathology is a disturbance of man's whole existence, one should ask what the problem is saying about the person's existence. The answers lie in the problem which manifests itself. The pathological behaviour calls the world to respond and it is in this behaviour that the seeds for healing lie. It is the messages in the pathological



behaviour which need to be heard and integrated for the person's existence to become whole.

Dialogal psychotherapy accepts the value of the problem. Problems are not to be eliminated but explored and integrated as they force one to face issues and aspects of the self and the world which are being avoided. Problems force us to listen to what the mind and body are trying to convey and make the individual deal with the real issues in order to integrate them within. However, people tend to ignore these messages as the answers may not meet their expectations or may shatter the illusion of control that is so critical to one and all. Thus, it can take an extreme breakdown of the whole system, as in psychosis, to force the individual to face the problems (Hycner, 1991).

However, to view psychopathology only as a problem is an I-It approach which negates the real issue of relationship as well as the person himself. In exploring the aborted dialogue the therapist makes the patient feel confirmed and this involves recognising his uniqueness, affirming his experience, despite still viewing certain behaviour as unacceptable. The aim is to help the patient experience himself concurrently as a centred individual as well as in relation to others. The task of the therapist is to embody and substitute himself for outside relations which will help restart the dialogue with the world out there.

Genuine dialogue has both structure and freedom. The structure is the backbone of the conversation where the focus of attention is on the phenomena which are heard and interpreted with integrity and respect. There is also the freedom to be playful and imaginative which allows for exploration and discovery and ensures that the process is not hindered by theory and diagnosis. In this combination of structure and freedom, called the dialogal process, a "foundation of trust and cohesiveness emerges that allows the dialogue to deepen and expand" (Halling & Leifer, 1991, p. 8). Halling et al. (1994) view the phenomenon as being at the centre of the dialogue and allowing it to come alive is critical for growth. Prouty (1994) states that Sartre stresses the importance of allowing the phenomenon to be "what it is, absolutely, for it reveals itself as it is" (p. 32) in a non-symbolic manner and in languaging. Direct contact is the basis on which the understanding unfolds (Halling & Leifer, 1991). However, the phenomena are always viewed within the context of the whole and the therapist starts with and constantly returns to the person's everyday world of relating and functioning.

Although the focus is on the phenomenon, it is not primarily a matter of what the patient talks about but the way he experiences it, expresses it and relates to the meaning it has for him that is important. Psychotherapy is always a process as is life and it is only through the "deeply felt, concrete, emotional, experiential process" that change occurs (Rogers et al., 1976). Thus, psychotherapy is always in process and every forward movement in psychotherapy redefines the whole (Boelen, 1963). It is important to be aware of the relational aspects of life and being-in-the-world throughout the psychotherapy in order to assist the patient to become more aware of other people and not simply focus on himself. Thus, the initial focus on the self to develop some kind of centredness within is then shifted outwardly to relationships in the world.

The therapist and patient form a psychotherapeutic relationship in which the dialogue

allows for an exploration of the patient's experiences in order to address the issues and heal the self. The psychotherapeutic relationship is a meeting where therapist and patient connect at the very essence of their being (Buber, 1965). The therapist allows the patient to "see through him, as through a glass, the essence of all things" (p. 190). This allows the patient to uncover his own essence and make it his own central core. Kruger (1988) describes a true encounter as a space in which two people allow a freedom of expression of who they are in a manner without fear which allows them to unfold their true presence. Rogers believes the patient cannot be separate or fixed but is viewed as someone in the process of growing and becoming a more integrated person (Hycner, 1991).

Mutuality and inclusion are critical concepts for growth as they allow for deeper exploration and understanding of the patient's experience which facilitate psychological and emotional growth. The therapist can imagine the real, especially with his body, as he lives the experience with the patient. It is not simply a feeling but an I-Thou moment where the therapist is completely involved in the essence of the experience. Mutuality implies a giving of the self of the therapist for the purpose of healing the patient. Mutuality means being able to see, feel and experience the psychotherapeutic situation from both sides and this experiencing of the patient's perspective in a bodily sense allows the therapist to be touched by the patient and what he can do for him. As the patient is unable to cope with his problems, and this is why he has come for help, the therapist has to be present on both sides - the patient can only be where he is. Because the therapist and patient have different attitudes towards the situation, the therapist is able to do something the patient is not (Hycner, 1991).

Being real, active and involved as a therapist demands that the therapist is present in the psychotherapeutic space in an authentic manner which confirms the patient. Stone makes the valid statement that failure to show a reasonable human response at appropriate times can invalidate the patient work done in a good psychotherapy (Friedman, 1985). Hycner (1991) claims that a balance must be maintained between being a person and a professional. It is not the therapist's model of training that heals but the wholeness and availability of the self. So, the therapist must first be a person available to others as a human being and, secondly, as a trained professional. Trüb suggests that this will allow him to calm the patient's "psychic tension" (p. 34) and free him to interact within the larger framework of his world (Friedman, 1985).

It is important for the patient to experience the therapist as capable and emotionally balanced as he is entrusting his whole being to the therapist. That the therapist is human and fallible can be a help in enriching the psychotherapeutic experience by making the patient feel that he is normal as all humans are fallible. This recognition of fallibility also prevents both the therapist and patient from falling into the trap of viewing the therapist as the all-knowing expert. The all-knowing expectation can become a danger in psychotherapy as the patient may feel a pressure to abandon his own subjective perceptions for the therapist's so-called expert, objective ones. The therapist should be perceived by the patient as a human being but needs to be experienced as a more integrated and balanced one than the patient in order for the patient to trust that the therapist can survive the ordeal of journeying through his chaotic world.

Hycner (1991) submits that the therapist's role is to listen to the messages that the patient's problems are highlighting. The therapist listens to what the problem is communicating and makes it comprehensible for the patient. He does this by allowing the message to surface and deepen in the between. This process may be thwarted by resistance which may interfere, for example, due to the fear of a lack of control felt by the patient when the message tells him to make a major lifestyle change because the status quo is no longer healthy. It is critical for the therapist and patient to dialogue with the problems and even with the resistance which is an integral part of the self and has value in protecting the self. The therapist may also be resistant due to his own fears or anxieties in exploring specific issues or of being lost in the unknown. Resistance may also occur when the therapist imposes a method or theory on a patient which he resists because it fails to meet his needs and impedes the flow of relating in the between. It is critical for the therapist to meet the patient authentically even if this means sometimes being in opposition. The therapist meets the patient at his point of resistance because it is at this point that he has been most wounded and abandoned by others. Hycner states that it is the greatest challenge for the therapist to genuinely be with someone who is experienced as oppositional. Friedman (1985) claims that this is not a negation of the other as "even this meeting in opposition confirms for the other that he is the one he is" (p. 136) as it confirms that he is real and alive. The aim is to help the patient realise that hiding aspects of himself is an existential reality we all experience and not a pathological state. Ultimately, it is the trust in the therapist and the psychotherapeutic relationship that allows the patient to progress forward in the path to healing. With trust and confirmation, the therapist and patient can search for the balance between hiddenness and openness (Hycner, 1991).

In meeting the patient in the between with respect, he will be confirmed in his entirety. The core of the healing is in this confirmation. By confirming the patient the therapist shows him that he is a person of worth and this frees him to explore and grow. Friedman (1985) highlights Buber's view that when the patient is met as a whole human being at the core of his being, he will learn to trust existentially. He also refers to Jourard's statement that the therapist's belief and faith in the patient's potential to surmount the obstacles that have prevented him from reaching a balanced, connected way of being are of critical importance. This healing, Buber says, is not gained through insight and analysis but through genuine dialogue and authentic meeting. The healing through meeting does not mean a passive confirmation, but includes a challenge and encouragement as part of the process to growth and integration. Friedman succinctly describes this process when he says "the therapist may have to wrestle with the patient, for the patient, and against the patient" (p. 137).

As the struggle for insight, understanding and healing continues, the patient slowly incorporates the new learning. Stern (1983) maintains that the process of change that occurs in psychotherapy is that new experiences are not simply added but integrated with previous experiences in order to gain a cognitive equilibrium. At each stage, the form of the information changes and becomes more articulated which moves the process further. An important point is that attention alone is insufficient to create change and cannot be forced - the therapist and patient must be open and allow the unformulated experience to brew and organise itself. Only then can attention be focused on it usefully. New formulations can be created as a result of the acceptance

of previously rejected views and beliefs.

Whatever the problems, views or beliefs, what is important is that which has relevance for the patient. There is always more than one meaningful interpretation, so the patient can choose to keep the status quo or explore further for alternative possible meanings. This allows the patient to finally accept the new meaning and not remain entrenched in a dysfunctional pattern to avoid facing the deeper, more relevant issues. Stern (1983) asserts that the restriction of thought is a "stupidity" (p. 92) as it prevents any questioning of the familiar and allows no curiosity for further exploration. If the painful issues remain unformed and thus unheard, then there is uncertainty and anxiety of the unknown and a desire to remain in the familiar without realising it is this very process that creates the anxiety. It is only in remaining open and being curious that the patient is able to move into uncertainty in a healthy manner of exploration and discover new insights. Stern views the process as a progressive awakening of curiosity where the patient moves from "familiar chaos into creative disorder" (p. 93). This process allows experiencing to impress itself on conscious awareness and is a result of the therapist and patient together creating in the between. He supports Fingarette's statement that an insight is a reorganisation of meanings of present experience and a reorientation towards the future and the past. This can only occur if the process is given respect and the space in which to unfold. Stern cites Bruner's assertion that each new formulation of experiencing has the quality of an "effective surprise" (p. 95) as the unformulated experience is now symbolised and has meaning as it provokes a feeling of recognition of something seen and felt vaguely before. An adjustment is made to include the meaning and suddenly and unexpectedly the insight is clear and the patient is freed to journey further.

To achieve this the therapist must shift the focus from doing to being with the patient so that he is able to listen and live in the space with the patient with less mental clutter. Gendlin (1964) cautions the therapist not to distract this process from unfolding by too many interpretations and his rule for focusing is to "keep quiet and listen!" (p. 125). How a patient thinks and feels when alone is different from how this process occurs within an interpersonal relationship as the manner of experiencing it is different. The therapist can open or close that process by responding to the underlying, implicitly functioning process which the patient tends to ignore. The therapist's responses in the ongoing interaction assist in carrying forward the patient's experiencing. Initially this carrying forward of experiencing occurs only within the psychotherapeutic relationship but, once the process has become integrated, the patient is able to take this into the world of relationships.

As there are many possible interpretations for an experience, the patient can choose from many different emphases on his versions of reality. However, reality is not simply an objective fact independent of the individual but exists between those in the relationship as the self develops in relation to others (Brice, 1984). Friedman (1985) states that the therapist does not have a "monopoly on reality" (p. 216) in this mutual relationship. It is simply that he has more experience in inclusion and experiencing both sides of the relationship. How the patient perceives and experiences his reality is vitally important in understanding how and why he has lost the ability to inter-relate in the world. The patient's perceptions of the influence of his subjective experiences, the

past and his beliefs are of major consideration. It is in the dialogue with the person and problem that meaning is found.

Friedman (1985) submits that Searles provides pertinent points which assist the therapist in his goal of finding meaning and healing the patient. First, is the realisation by the therapist that the patient has relied on his best judgement over the years in which his perceptions and reality have developed. Secondly, the therapist must accept the patient's feelings about his world from the beginning of psychotherapy rather than challenging them. This means that the therapist never intimates that the patient's world is crazy but candidly acknowledges and confirms the patient's reality. This meeting the patient with respect for his reality confirms him as worthy and frees him to connect with his experiences and remember his past. The identification with the image the therapist is developing, assists the patient in becoming whole and integrated, replacing the "repressed, fragmentary, and contradictory self-images" (p. 213) learned in life with a more cohesive sense of self. So, the therapist is required to look alternatively at the patient's world, sharing it with him, but also giving glimpses of his own view of the world. This helps the patient consider alternative views, broadening his limited and constricted view of the world. Finally, it gives him back a sense of shared reality and confirms him as a human being. In this whole process, the therapist has moved from the position of having primarily empathised with the patient to assisting the patient to understand what is required from him to live in relationship in his world.

In order to achieve this growth, the therapist suspends his judgement as to what the patient should discuss or even in what direction the psychotherapy should move, thus fully respecting the patient's experience (Hycner, 1991). Each individual's experiences are unique so it is a challenge for the therapist to understand and appreciate the meaning, breadth and depth of the patient's subjective experience. People in the patient's world have not understood his experiences and reality which have left him unconfirmed, with little feeling of value or worth. Thus, it is important for the therapist to be fully present to the patient ensuring that he gives of himself in the encounter and is available at every moment, fully attending to the essence/beingness of the patient. To achieve this the therapist must bracket, suspend, temporarily set aside all presuppositions, opinions and biases to enter into the patient's world of significant meanings. If this does not occur Buber (1965) maintains that mis-meetings may result. Apart from bracketing, the therapist must be open, with wonder, to what can unfold rather than only to what should happen. This means allowing himself to be amazed at what unfolds and Buber encourages the therapist to go "beyond the obvious, the visible, and to focus on the 'soul' of the person" (p. 80) which means connecting at a level below the psychopathology at the core of the patient's being. The focus is on the here-and-now and sensed-meaning of the moment in the ongoing experience. This shows the patient that the therapist is genuinely interested in his experience which begins to establish trust. Despite the focus being on the here-and-now, the therapist must always return to grounding the experience in the patient's real world context (Hycner, 1991).

The strength of dialogal psychotherapy is that the value of treating the human being is recognised rather than simply viewing the patient as a sick person. Sick does not mean being out of touch with reality but only that there is help needed to bring the patient into a dialogue of touchstones where he can connect with meaningful experiences

(Friedman, 1985). The basis of this approach is respect for the person in his entirety. By meeting each individual as a unique and worthy person, the possibility for healing is intensified. The stress on dialogue in the psychotherapeutic relationship highlights that the therapist and patient are working together to achieve the goal of healing. This connectedness further confirms the patient's worth but also reduces the patient's sense of isolation. If someone enters the patient's chaotic and isolated world with respect, care and a genuine desire to heal, the patient's loneliness is reduced. Being met as a worthwhile person allows him to move beyond the constricted space in which he lives. By surviving the chaos together, the patient can gain courage to fight his monsters, overcome them and be free to return to a world of healthy relationships.

With the focus on the fact that the problem and cure are in the interpersonal realm, the disconfirmation and perceived attack on the self and identity can be healed within relationship. Confirming the patient allows the past to be restored and the future opened up. This allows the patient to be who he is, that is, different and fallible but worthy. Some ambivalence and disappointment may remain but in allowing others their limitations we allow them to be real. If the focus is on the disappointment, important questions may not be asked which can be the patient's way of avoiding taking responsibility for his life. The process of self-examination should occur as a move to self-maturity but often tends to be viewed as a failure of the self. However, failure can allow the patient chances to mature as he gains new insights and it is sometimes necessary to disillusion the patient if he has unrealistic expectations. Coming to terms with disillusionment also means valuing the illusion and reality that existed when the patient was less integrated and the value this had in assisting him to survive in society. As the individual heals, he can return to what was and is real and good in his existence (Halling, 1996).

The overall aim of dialogal psychotherapy is for the patient to return to a world of healthy relationship. However, the therapist will be unable to aid this growth if the family, community or culture destroy or thwart any attempts at wholeness. The focus on the whole, unique person must never be lost. In the psychotherapeutic relationship, each moment is always understood within the greater context of the patient's world. Hence the previous statement that psychopathology is a disturbance of this person's entire existence. Health is then viewed not as an adjustment to society and its norms but grasping one's own touchstones of reality in dialogue with the touchstones of others (Friedman, 1985).

Trüb believes that Buber's congruence as a man and a philosopher resulted in his truly living the philosophy he spoke of. Karl Wilker (as cited in Friedman, 1960) states that Buber "belongs to the most powerful renewal not only of a people but of mankind" (p. 5). The tragedy is that his profound wisdom is insufficiently understood and practised in the Western world where a basic respect for man is still lacking in so many areas. It thus becomes an important goal for the field of psychotherapy to aim at meeting patients as whole, unified human beings with respect.